

Overview

The Medicare Fee-for-Service (FFS) hospice benefit provides palliative services for pain and symptom management, as well as emotional and spiritual supportive services, to beneficiaries who are terminally ill with a prognosis of six months or less. Within this report, we provide hospice-level reporting of statistics related to non-hospice Medicare spending that occurs during hospice election as well as other utilization statistics regarding the Medicare hospice benefit. The intent of this report is to identify hospices that may be outliers compared to their peers.

Methodology

Data for analyses come from the CMS Chronic Conditions Warehouse Virtual Research Data Center (CCW VRDC), where 100% of hospice fee-for-service (FFS) claims for FY2024 were extracted on May 9, 2025, and claims for FY2025 were extracted on January 15, 2026. Because of when claims were acquired, results for the last half of FY2025 may be incomplete. In addition to hospice claims, we also collect all Medicare FFS non-hospice Part A & B claims and Part D Prescription Drug Events (PDEs) for the same time period for those beneficiaries with a hospice claim. We make a small set of exclusions to hospice claims (roughly 0.5% of hospice claims per year) if claims are duplicates, have missing dates, or more than one hospice claim overlaps another from the same provider. We do not make any additional exclusions to the non-hospice Part A & B claims and Part D PDEs.

Hospice level of care is identified from a hospice claim using the following revenue codes:

- Routine Home Care (RHC): Revenue Code 0651
- Continuous Home Care (CHC): Revenue Code 0652
- Inpatient Respite Care (IRC): Revenue Code 0655
- General Inpatient Care (GIP): Revenue Code 0656

Minutes of service by discipline are identified from a hospice claim using the following revenue codes:

- Skilled Nursing: 055x
- Medical Social Services: 056x
- Aide Services: 057x
- Physical Therapy Services: 042x
- Occupational Therapy Services: 043x
- Speech Therapy Services: 044x

Days of care in a non-skilled nursing facility or skilled nursing facility are identified through HCPCS code Q5003 (non-skilled) and Q5004 (skilled).

A beneficiary's lifetime length of stay (LOS) is calculated by first limiting the analysis to all beneficiaries whose final claim in the year examined does not indicate they are still a hospice patient (i.e., a patient's last hospice claim does not have a patient discharge status code equal to "30" which indicates they remained in hospice). Then, we count the total number of days a beneficiary has used hospice since the date of their first hospice election (even if their first hospice election began before the start of the fiscal year examined). Note that in a given year, some discharges were beneficiaries leaving hospice alive, and those could have returned to hospice in a later year, adding to their total lifetime length of stay.

Information on hospice characteristics such as year the hospice began to bill Medicare, ownership, facility type, city, state, and whether the hospice's address is located in an urban or rural area comes primarily from the Provider of Services file (<https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-internet-quality-improvement-and-evaluation-system>). Missing information is supplemented by cost reports.

Additional Data Cleaning and Data Construction Notes:

- Statistics looking at average minutes have been cleaned so the minutes of service on a particular day for a particular discipline (which may be composed of multiple staff, e.g., two or more nurses seeing a hospice patient in a given day) will not exceed 48 hours.
- For certain outcomes (e.g., beneficiaries with visits in the last two days, LOS, and live discharge, etc.), results are set to missing if the denominator is 0 (or in the case of LOS, there are no beneficiaries whose last day of hospice in the FY was a discharge).
- For this analysis, we do not include transfers (patient discharge status code = 50 or 51) as a live discharge since beneficiaries remain within a hospice election when they transfer hospices.

Overview of the Excel File:

The following tabs are included in the Excel file.

- **Total SSVI Score:** For each hospice, we report their FY2024 and FY2025 non-hospice spending score, their utilization score, and the sum of those two scores, the total SSVI (service and spending variation index) score. Missing values indicate the

hospice did not receive a score because no hospice claims were available during the time period examined. The methodology for how scores are constructed is found in the section titled **Scoring Methodology**.

- **FY2025 - Data:** This tab shows non-hospice spending and other hospice utilization information for hospices with claims data in FY2025.
- **FY2025 - Scoring Components:** This tab shows the FY2025 scores associated with each hospice and which components contributed to that score.
- **FY2024 - Data:** This tab shows non-hospice spending and other hospice utilization information for hospices with claims data in FY2024.
- **FY2024 - Scoring Components:** This tab shows the FY2024 scores associated with each hospice and which components contributed to that score.

Columns in the FY2025 - Data and FY2024 - Data tabs:

The information in each tab is shown at the level of a hospice. Each hospice with at least one claim in the year described is shown. Below we describe the columns within these tabs.

- **CCN:** The CMS certification number of the hospice.
- **Hospice Name:** The name of the hospice from the Provider of Services (POS) file.
- **Year Hospice First Billed Medicare:** This information is taken from the POS file and represents what is called the “Original Medicare Participation Date.”
- **Ownership:** This is information on ownership from the POS or cost report data. If the hospice does not have ownership information, the ownership type is listed as “Unknown.”
- **Facility Type:** This is information on facility type from the POS or cost report data. If the hospice does not have facility type information, the facility type is listed as “Unknown.”
- **City:** This is the city of the hospice’s mailing address as found in the POS.
- **State:** This is the state of the hospice’s mailing address as found in the POS.
- **Hospice Address Urban/Rural:** This shows whether the POS lists the hospice’s mailing address as urban or rural. For cases where the POS lists nothing, we geocode the street address and label it as urban if it is located within a metropolitan or micropolitan statistical area and rural otherwise.
- **Non-Hospice Spending per Day (All Days):** The sum of non-hospice spending (e.g., apportioned claim payments for non-hospice claims that occur during a beneficiary's hospice election) associated with beneficiaries receiving services from

a particular hospice divided by the number of days the hospice provided during the fiscal year examined.

- **Non-Hospice Spending per Day (All Days Only from Beneficiaries with Non-Hospice Spending):** The sum of non-hospice spending (e.g., apportioned claim payments for non-hospice claims that occur during a beneficiary's hospice election) associated with beneficiaries receiving services from a particular hospice divided by the number of days the hospice provided during the fiscal year examined where there is non-hospice spending.
- **Total Non-Hospice Spending:** The sum of non-hospice spending (e.g., apportioned claim payments for non-hospice claims that occur during a beneficiary's hospice election) associated with beneficiaries receiving services from a particular hospice.
- **Beneficiaries Served:** The number of unique beneficiaries the hospice served in a given year. Beneficiaries may be listed under multiple hospices within a year if they are treated by multiple hospices within a year.
- **Decedents Served:** The number of unique beneficiaries the hospice served in a given year who have a date of death when the data was pulled. Decedents may be listed under multiple hospices within a year if they are treated by multiple hospices within a year.
- **Days of Hospice:** The number of RHC, GIP, IRC, and CHC days recorded on hospice claims.
- **Percent of Days that are RHC/GIP/IRC/CHC:** We divide the number of days of a particular level of care by the total number of days provided by the hospice.
- **Percent of Days that are RHC and the Site of Service is NF/SNF:** We divide the number of days that we identify as both having a level of care of RHC and a site of service as Nursing Facility or Skilled Nursing Facility by the number of hospice days.
- **Percent of Beneficiaries who Died in Hospice and Last Two Days were RHC with at Least One Skilled Visit During Last Two Days:** We first identified all beneficiaries who died in hospice (patient discharge status code of 40, 41, or 42). We then determined if their last two days of hospice occurred consecutively. We then only examined beneficiaries whose last two days were billed at RHC. For each hospice, we divide the number of beneficiaries meeting those criteria who also had a skilled visit (nursing (RN or LPN), medical social services (MSS), or therapy) by the total number of beneficiaries who met the earlier criteria. Hospices who do not have any such beneficiaries that meet the criteria may have their percentage listed as missing.
- **Average and Median Length of Stay (LOS):** We determine the LOS based on beneficiaries whose last day in hospice of the FY had a patient discharge status

code other than “30” (continuing hospice) or “50” (transfer) or “51” (transfer). Hospices that have no beneficiaries meeting that criteria have a missing result. Each beneficiary meeting those criteria is assigned to a single hospice and the LOS of each beneficiary is based on their lifetime length of stay (which may have occurred across multiple hospices). We then compute an average and median LOS for each hospice using beneficiaries for each hospice that satisfy the previously mentioned criteria.

- **Percent of Beneficiaries Discharged with LOS of 180 Days or More:** We determine LOS as described previously. Hospices that have no beneficiaries meeting that criteria have a missing result. We only examine claims that are a beneficiary’s final claim in the FY examined and have a patient discharge status code other than “30” (continuing hospice) or “50” (transfer) or “51” (transfer). For each hospice, we divide the total number of discharged beneficiaries (as described above) with a LOS of 180 days or more by the total number of discharged beneficiaries (as described above). Hospices who do not have any such beneficiaries that meet the discharge criteria may have their percentage listed as missing.
- **Percent of Discharges (Live or Dead) that Were Live Discharges:** For each hospice, we look at all discharges (not just the final discharge in a year) as defined by those which are not “30” (continuing hospice) or “50” (transfer) or “51” (transfer). Death discharges are those with a value of “40”, “41”, or “42”. Live discharges are all other discharges not including the values already mentioned. For each hospice, we divide the number of live discharges by the total number of discharges.
- **Number of Discharges (Live or Dead):** The number of discharges by a hospice in a FY where the patient discharge status code does not equal “30” (continuing hospice) or “50” (transfer) or “51” (transfer).
- **Average Minutes per RHC Day:** We divide the total number of minutes of a particular discipline of care (skilled nursing, MSS, aides, physical therapy, occupational therapy, speech therapy) by the total number of RHC days. Minutes are capped at 48 hours per day per discipline so as to minimize the impact of erroneous outliers on the results.
- **Average Visits per RHC Day:** We divide the number of visits of a particular discipline of care (skilled nursing, MSS, aides, physical therapy, occupational therapy, speech therapy) by the total number of RHC days.
- **Percent of RHC Days on the Weekend with at Least One Skilled Visit:** For each hospice, we divide the number of RHC days on the weekend with at least one skilled visit (nursing, MSS, therapy) by the number of RHC days on the weekend. Hospices with no RHC days on the weekend have a missing value.

- **Percent of Live Discharges where Beneficiaries Return to the Same Hospice in Seven Days:** For each hospice, we divide their number of live discharges where the beneficiary returned to the same hospice within seven days by their total number of live discharges.

Scoring Methodology

Based on the information included in this report, there are three different scores that are calculated.

- **Non-Hospice Spending Score:** Hospices can receive a score of 0 through 8 depending on their level of non-hospice spending. Hospices with no reported non-hospice spending receive a score of 0. The remaining hospices are divided into 8 groups of roughly equal sizes that correspond to their level of non-hospice spending. Thresholds for these levels, and the number of points assigned, are shown below.

Non-Hospice Spending Score	FY2025 Thresholds		FY2024 Thresholds	
	Non-Hospice Spending is Greater than this Amount	Non-Hospice Spending is Less than or Equal to this Amount	Non-Hospice Spending is Greater than this Amount	Non-Hospice Spending is Less than or Equal to this Amount
0	\$0.00	\$0.00	\$0.00	\$0.00
1	\$0.00	\$6,352.84	\$0.00	\$5,964.19
2	\$6,352.84	\$20,612.10	\$5,964.19	\$19,061.63
3	\$20,612.10	\$42,911.79	\$19,061.63	\$41,318.35
4	\$42,911.79	\$76,801.05	\$41,318.35	\$72,896.46
5	\$76,801.05	\$133,440.80	\$72,896.46	\$124,893.05
6	\$133,440.80	\$246,123.06	\$124,893.05	\$227,185.05
7	\$246,123.06	\$517,204.41	\$227,185.05	\$520,100.16
8	\$517,204.41		\$520,100.16	

- **Utilization Score:** Hospices can receive a score of 0 through 8 depending on their outcomes on the measures below.
 - Every hospice starts with a score of zero.
 - A hospice is assigned a point if they provide both no CHC and no GIP during the year examined.

- A hospice is assigned a point if 40% or more of their RHC days are provided in a nursing home or skilled nursing facility in the year examined.
- A hospice is assigned a point if they have a rate of providing skilled visits during the last two RHC days of life that is less than or equal to the 25th percentile during the year examined.
- A hospice is assigned a point if their percentage of discharges that are live is greater than or equal to the 75th percentile during the year examined.
- A hospice is assigned a point if their percentage of discharges with a LOS of over 180 days is greater than or equal to the 75th percentile during the year examined.
- A hospice is assigned a point if their average skilled nursing minutes on RHC days is less than or equal to the 25th percentile during the year examined.
- A hospice is assigned a point if their percentage of weekend RHC days with a skilled visit (nursing, MSS, therapy) is less than or equal to the 25th percentile during the year examined.
- A hospice is assigned a point if their percentage of live discharges where beneficiaries return to the same hospice in seven days is greater than or equal to the 75th percentile during the year examined.

Thresholds for each year are shown below:

	Condition required for each measure to be assigned a point	
	FY2025	FY2024
No CHC and no GIP	No CHC and no GIP	No CHC and no GIP
40% or more RHC days in nursing home or SNF	>= 40%	>= 40%
Rate of providing skilled visits during last two RHC days of life	<= 87.5%	<= 85.7%
Rate of live discharge	>= 33.3%	>= 33.1%
Rate of discharge for beneficiaries with a LOS of over 180 days	>= 46.7%	>= 47.7%

	Condition required for each measure to be assigned a point	
	FY2025	FY2024
Average skilled nursing minutes on RHC days	<= 9.9	<= 9.8
Percentage of weekend RHC days with a skilled visit	<= 4.8%	<= 4.8%
Rate of live discharge where beneficiary returns to the same hospice in seven days	>= 18.2%	>= 15.0%

- Total SSVI Score (Sum of Non-Hospice Spending Score and Utilization Score):** A total score is derived by adding together a hospice’s non-hospice spending score and their utilization score.

A distribution showing the number of hospices by their total score is shown below.

Total Score	FY2025		FY2024	
	Number of Hospices	Percent of Hospices	Number of Hospices	Percent of Hospices
0	4	0.1%	6	0.1%
1	87	1.3%	91	1.4%
2	332	5.0%	334	5.0%
3	527	7.9%	564	8.4%
4	714	10.7%	760	11.3%
5	887	13.4%	838	12.4%
6	890	13.4%	918	13.6%
7	898	13.5%	862	12.8%
8	899	13.5%	920	13.7%
9	571	8.6%	629	9.3%
10	407	6.1%	366	5.4%
11	230	3.5%	255	3.8%
12	122	1.8%	116	1.7%
13	55	0.8%	48	0.7%
14	18	0.3%	28	0.4%
15	1	0.0%	0	0.0%
16	0	0.0%	0	0.0%
Total Hospices	6,642	100.0%	6,735	100.0%

Note: The development of the FY2025 Hospice SSVI included 6,750,840 hospice claims, representing 6,642 hospices and a total of 156,514,386 hospice days. The data used was pulled from the CCW VRDC on January 15, 2026. The development of the FY2024 Hospice SSVI included 6,409,155 hospice claims, representing 6,735 hospices and a total of 148,012,785 hospice days. The data used was pulled from the CCW VRDC on May 9, 2025.

FY2025 - Scoring Components and FY2024 - Scoring Components tabs:

These tabs show which measures a hospice receives points for, and in the case of the non-hospice spending score, how many points are assigned. For each column, a value of zero means the hospice did not receive points for the measure. For each component of the Utilization Score, a hospice can receive either 0 points or 1 point for each of the eight measures. The Non-Hospice Spending Score only examines non-hospice spending, and

hospices can receive from 0 through 8 points depending on their level of non-hospice spending, as described previously.