

# Health Trends

## Whitepaper: Where Is Hospice Underused?

Companion to 2024 County Hospice Use Atlas examining Hospice Use in the Last Year of Life Among 2024 Medicare Decedents

*August 2026*

## Executive Summary

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This paper presents a county-level analysis of hospice use among the 2.53 million Medicare beneficiaries who died in calendar year 2024, based on linkage of the CMS Hospice Limited Data Set (100% claims, 2023–2024) to the Master Beneficiary Summary File. Nationally, **52.8 percent of 2024 Medicare decedents used hospice in their last twelve months of life**. We summarize the principal findings below.

- **More than two-fold variation between states.** After age-/sex-adjustments, Utah decedents used hospice at 68.5 percent compared to New York decedents at 29.3 percent. Washington, at 46.2 percent, ranks 43rd of the 52 territories analyzed (i.e. 50 states, D.C., and Puerto Rico).
- **Wider variation across counties.** Among 3,023 analyzable counties, the 90th-percentile county (63.7 percent) runs 1.7 times the 10th-percentile county (37.1 percent). Nine of the twelve lowest-use large counties in America (500+ decedents) are in upstate or metropolitan New York; the highest use counties are in Utah, Wisconsin, and Florida.
- **Significant variation across counties within the same state.** Using Washington State as an example, age-sex-standardized county use ranges from 64.4 percent (Whatcom) to 22.4 percent (Ferry).
- **A persistent racial gap.** White decedents used hospice at 55.6 percent versus 40.7 percent for Black, 40.0 percent for Hispanic, and 38.4 percent for Asian/Pacific Islander decedents.

Low-use counties merit particular attention. In these counties, either eligible patients are dying without hospice services, or end-of-life care is being delivered through other, typically more intensive, settings. Both possibilities carry consequences for hospice operators, for Certificate of Need applicants who must document need, and for equity-focused outreach efforts. We publish the complete county-level results separately as the companion volume, the 2024 County Hospice Use Atlas (Health Trends), which is updated as new claims are released.

## 1. Background: Why Use-Rate Geography, and Why Now

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Hospice now serves about half of Medicare beneficiaries at the end of life, and the benefit is undergoing a period of significant change. The HOPE instrument replaced the Hospice Item Set on October 1, 2025, introducing new real-time assessment and submission requirements backed by a 4-percentage-point payment penalty. Medicare hospice spending reached \$28.3 billion across more than 6,700 hospices in 2024, with market entry concentrated in a small number of open-entry states, and program-integrity scrutiny has intensified accordingly. In the subset of states with Certificate of Need, hospice-specific review criteria require applicants to demonstrate localized need as a condition of market entry.

In this environment, the central empirical question is what is the share of individuals who could benefit from hospice who actually receive it in a specific market. National averages cannot answer this question, and public data files stop at the state or provider level and/or lack the decedent denominators a true use rate requires.

## 2. Data and Methods

The analysis links two CMS Limited Data Set (LDS) research files: the **100% Hospice Standard Analytic File** (base claims, calendar years 2023 and 2024) and the **Master Beneficiary Summary File** (2024):

- **Denominator.** All Medicare beneficiaries with a validated date of death in 2024: 2,533,349 decedents, assigned to their county of residence and characterized by age, sex, and race/ethnicity from enrollment records.
- **Numerator and window.** A decedent counts as a hospice user if any hospice claim falls within the last twelve months of life. Because annual claim files are keyed to the claim through-date, the 2023 file is required to observe late-2023 episodes of early-2024 decedents; a fixed twelve-month lookback then gives every decedent an identical observation window regardless of death month. The headline measure is therefore “hospice use in the last 12 months of life,” slightly broader than at-death enrollment measures.
- **County estimates.** County rates are directly age-sex standardized to the national decedent population, then stabilized with empirical-Bayes (beta-binomial) shrinkage toward the national mean, which prevents sparsely populated counties from dominating the extremes. Counties are the finest geography the LDS supports.
- **Suppression.** Counties with fewer than 11 decedents are not reported; 3,023 of 3,224 U.S. counties support publishable estimates, covering 99.0 percent of decedents.
- **Completeness.** Because the hospice benefit remained carved out of Medicare Advantage through 2024, hospice claims capture MA and fee-for-service enrollees alike, and MBSF death records cover the full Medicare population.

### 2.1 Validation against MedPAC

MedPAC’s March 2026 Report to the Congress, produced independently from the same underlying claims universe, provides an external benchmark for this analysis. As presented in the table below, estimates are generally consistent across the variety of measure that MedPAC publishes:

| Measure                          | This analysis (2024)       | MedPAC (2024)              |
|----------------------------------|----------------------------|----------------------------|
| Hospice use among decedents      | 52.8%                      | 52.9%                      |
| Median days of hospice (users)   | 17 (last-12-month window)  | 19 (lifetime)              |
| White decedents                  | 55.6%                      | 55.6%                      |
| Black decedents                  | 40.7%                      | 40.9%                      |
| Hispanic decedents               | 40.0%                      | 40.4%                      |
| Asian/Pacific Islander decedents | 38.4%                      | 39.7% (Asian American)     |
| Native American decedents        | 40.4%                      | 41.0%                      |
| Age 85+ / 75–84 / 65–74 / <65    | 65.4 / 53.5 / 41.5 / 30.5% | 65.2 / 52.9 / 41.1 / 29.8% |

Two published MedPAC figures are not directly comparable by construction: mean days (this analysis truncates days of use at the 12-month window, yielding 67.4 days versus MedPAC’s lifetime measure of 99.6) and the live-discharge rate (MedPAC’s 19.1% is computed among all hospice patients in the year, most of whom survive; among decedents, whose final episodes overwhelmingly end in death, the analogous share is 2.3%).

### 3. National Findings

Hospice use rises steeply with age at death, from 30.5 percent of decedents under 65 to 65.4 percent of those 85 and older, and differs by about 15 percentage points between White decedents and each other racial/ethnic group. We present these results in Exhibit 1 and Exhibit 2. Both estimates are consistent with the national literature; the LDS additionally allows these patterns to be decomposed to specific markets, as presented for Washington State in Section 5.

#### Hospice use in the last 12 months of life by race/ethnicity, 2024 Medicare decedents

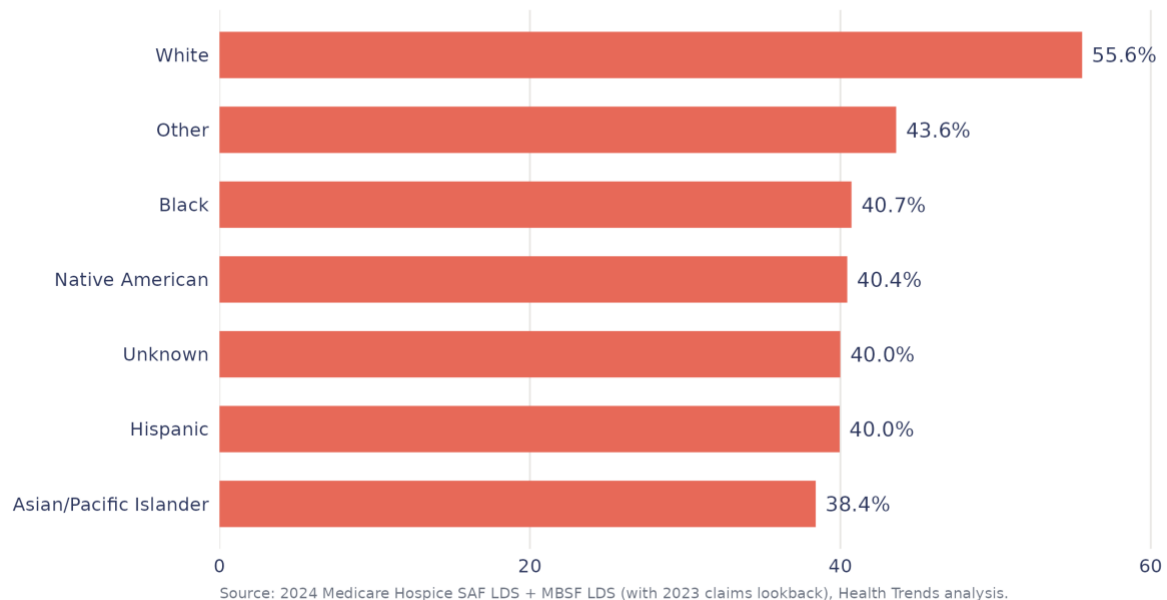


Exhibit 1. Hospice use in the last 12 months of life by race/ethnicity, 2024 Medicare decedents.

### Hospice use in the last 12 months of life by age at death, 2024 Medicare decedents

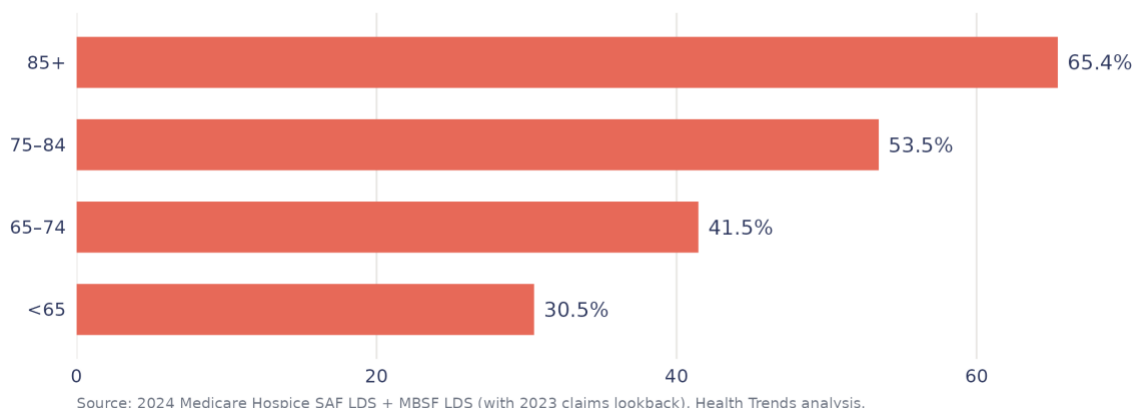


Exhibit 2. Hospice use by age at death, 2024 Medicare decedents.

Depth of use also differs by group. Median days among users is 18 for White decedents versus 13–17 for other groups, and late enrollment (seven days or fewer) accounts for about a third of users in every group. This pattern suggests that differences in access arise at the point of referral, not only at election of the benefit.

## 4. Geographic Variation: States and Counties

State-level use spans 29.3 percent (New York) to 68.5 percent (Utah), a 2.3-fold spread. High-use states cluster in the Mountain West, the upper Midwest, Florida, and Arizona, while the lowest tier comprises New York, Alaska, the District of Columbia, the northern Plains, and Puerto Rico (28.4 percent).

Washington, at 46.2 percent, ranks 43rd among the 50 states and the District of Columbia. We present the complete state ranking in Appendix A.

### Hospice use among Medicare decedents, highest and lowest states, 2024

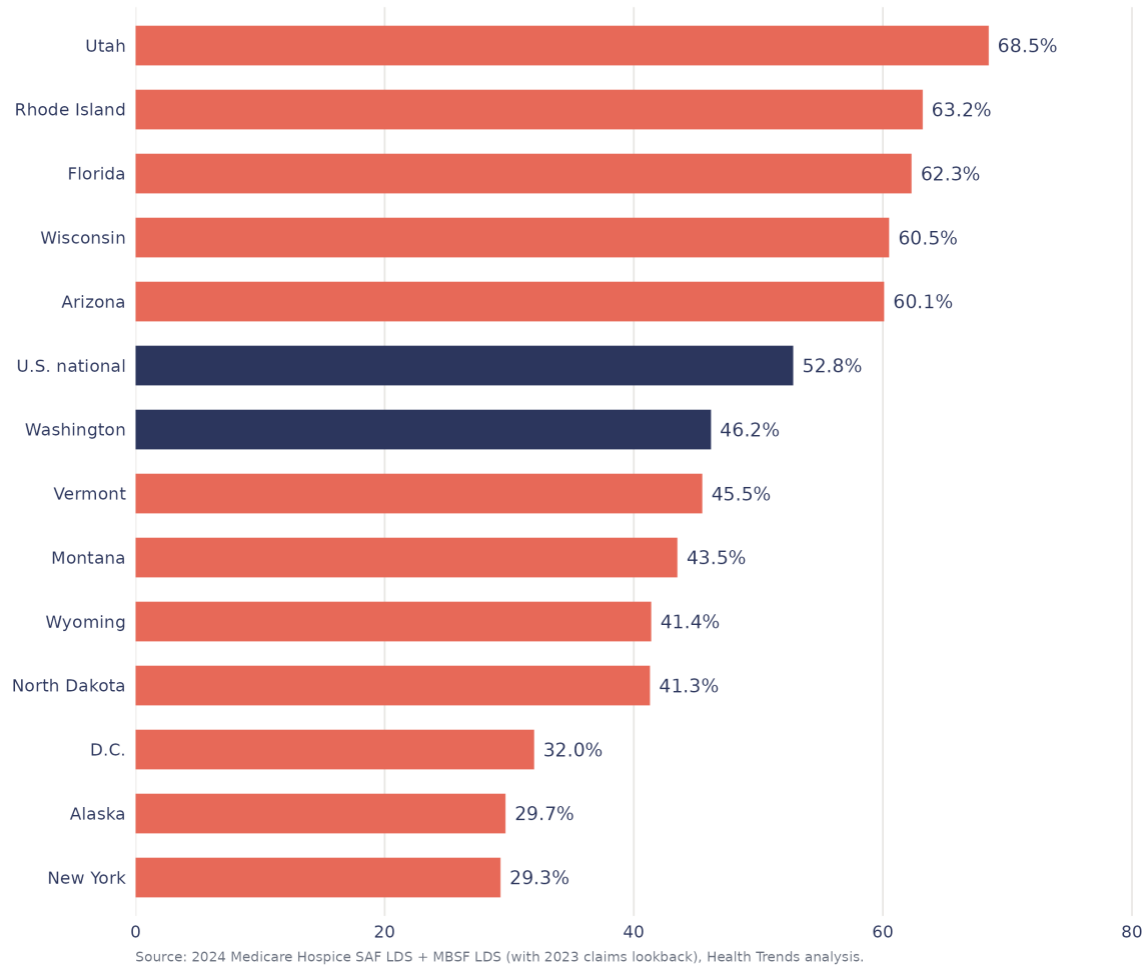
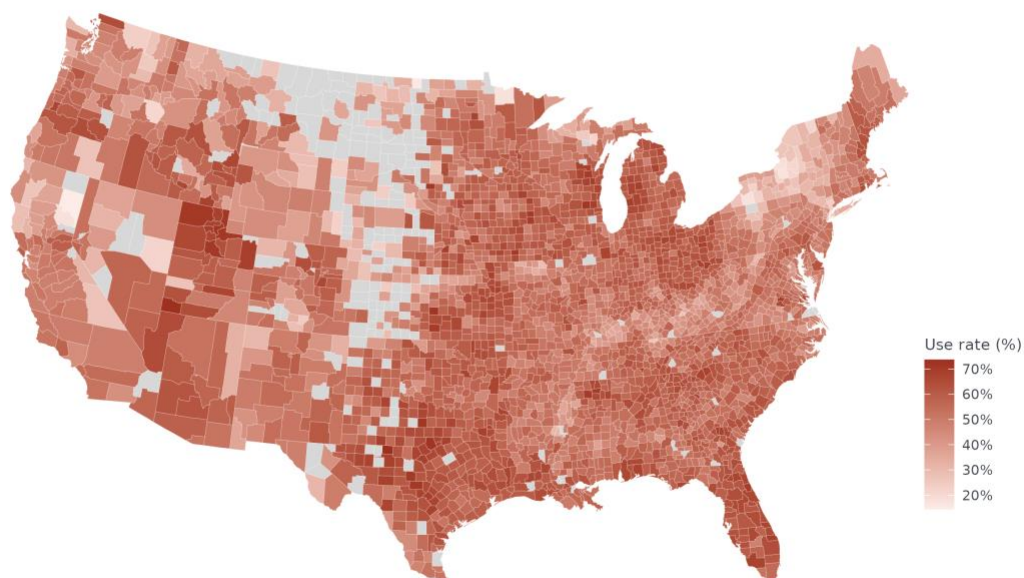


Exhibit 3. Highest- and lowest-use states, 2024 (Washington and the national average highlighted).

County-level variation is wider still. Across the 3,023 analyzable counties, standardized use ranges from under 20 percent to 82 percent, with an interdecile range of 37.1 to 63.7 percent. As presented in Exhibit 4, this variation exhibits clear geographic structure: uniformly high-use regions (Utah, Arizona, Florida, and eastern Wisconsin), uniformly low-use regions (upstate New York and the Dakotas), and, of particular relevance to operators, low-use counties located within otherwise high-use states.

## Hospice use among Medicare decedents by county, 2024 (age-sex-standardized, EB-smoothed)



Source: 2024 Medicare Hospice SAF LDS + MBSF LDS (with 2023 claims lookback), Health Trends analysis. Gray = suppressed (<11 decedents) or no data.

*Exhibit 4. Age-sex-standardized, EB-smoothed hospice use by county, 2024. Gray = suppressed (<11 decedents) or no data. (Alaska and Hawaii counties are included in all tabulations.)*

### 4.1 The lowest-use large markets

Restricting the analysis to counties with at least 500 decedents (964 counties) removes small-population noise and isolates the largest concentrations of potential unmet need. Nine of the twelve lowest-use large counties are located in New York, including the Bronx, Kings (Brooklyn), and Westchester, each with thousands of decedents annually, along with two Puerto Rico municipios. We present these counties in the table below.

| County                  | Decedents (2024) | Standardized use |
|-------------------------|------------------|------------------|
| Cattaraugus, NY         | 815              | 16.6%            |
| Onondaga, NY (Syracuse) | 3,885            | 17.3%            |
| Oswego, NY              | 1,031            | 17.5%            |
| Bronx, NY               | 7,442            | 19.8%            |
| Oneida, NY (Utica)      | 2,201            | 20.3%            |
| Cayuga, NY              | 687              | 20.6%            |
| Clinton, NY             | 767              | 20.7%            |
| Madison, NY             | 597              | 20.8%            |
| Kings, NY (Brooklyn)    | 12,417           | 21.8%            |

| County          | Decedents (2024) | Standardized use |
|-----------------|------------------|------------------|
| San Juan, PR    | 3,155            | 22.6%            |
| Westchester, NY | 6,291            | 23.2%            |
| Caguas, PR      | 1,092            | 23.6%            |

At the other extreme, the highest-use large counties are Washington County, Utah (73.3 percent), Jefferson County, Wisconsin (71.3 percent), and Utah County, Utah (70.9 percent). These counties indicate the use rates that mature hospice markets achieve and provide reasonable upper bounds for need projections in other markets.

## 5. Washington State: A Case Study in Within-State Variation

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Washington's 46.2 percent use rate places it 43rd nationally, below each of its neighboring states, and its Certificate of Need program makes county-level need evidence directly relevant to agency decision-making. Within-state variation is substantial. As presented in Exhibit 5, standardized use ranges nearly three-fold, from Whatcom (64.4 percent), San Juan (61.6 percent), and Cowlitz (61.2 percent) counties down to Grays Harbor (32.5 percent) and Clallam (30.1 percent) counties, with a cluster of eastern and rural counties, including Adams, Lincoln, Okanogan, and Ferry, in the low twenties. We note that King County, the state's largest county by decedent volume (12,133 decedents), stands at 44.9 percent, about eight points below the national average and about twenty points below the rates achieved by comparable large counties elsewhere.

### Age-sex-standardized hospice use by county, Washington, 2024

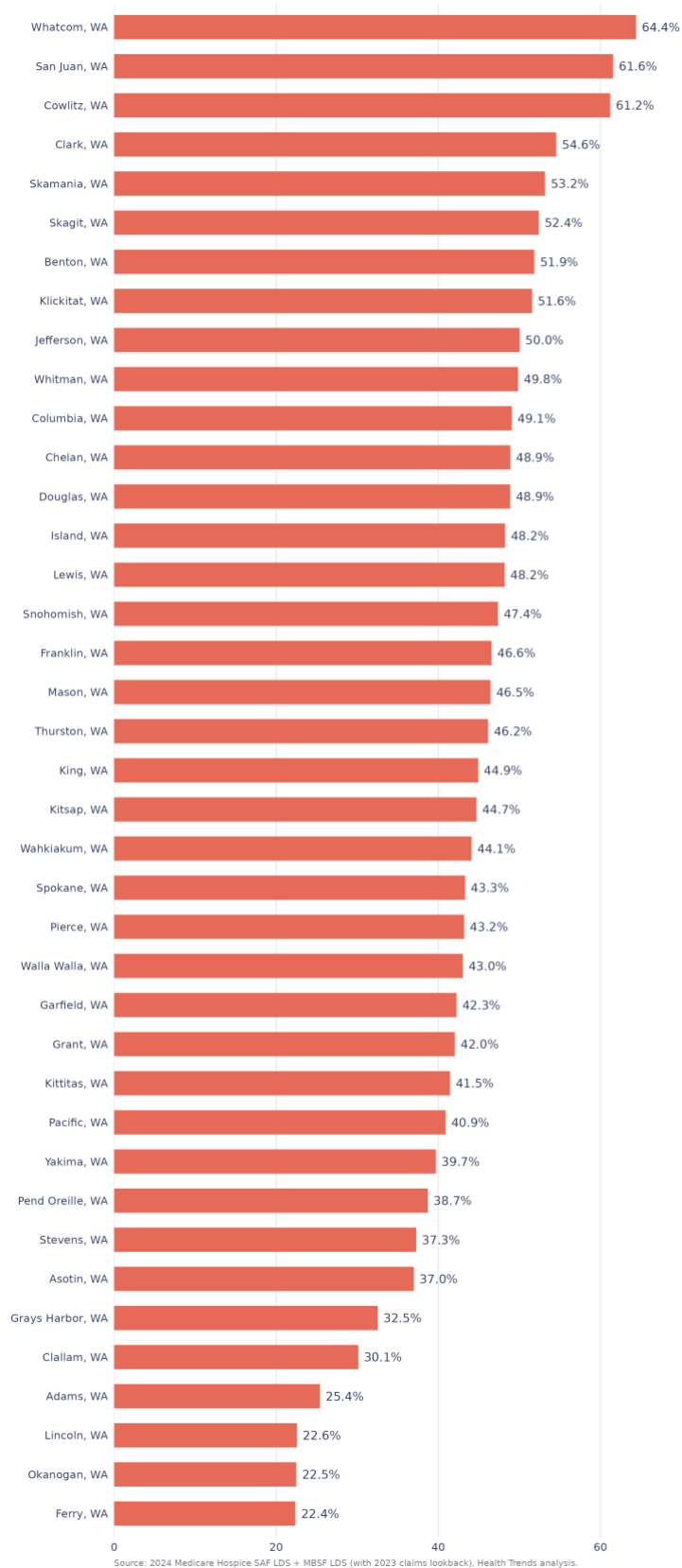


Exhibit 5. Age-sex-standardized hospice use by county, Washington, 2024.

For Certificate of Need purposes, the implication is direct: need methodologies anchored to statewide or national averages will understate the gap in the specific counties where use runs in the twenties and thirties. Furthermore, the demographic decomposition underlying these rates, available at the county-by-race-by-age level, subject to cell-size rules, supports need projections that current public data files cannot.

## 6. Applications

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- **Growth and service-area strategy.** Candidate markets can be ranked by standardized unmet-need headroom rather than raw population, distinguishing genuinely under-penetrated counties from those where enrollment is high but late.
- **Certificate of Need support.** Decedent-based county use rates, standardized and smoothed, provide the strongest available empirical foundation for need projections, and for responding to claims of market saturation, in hospice Certificate of Need states including Washington.
- **Equity outreach with a measurable baseline.** The national 15-point racial gap varies considerably by state. In New York, White decedents use hospice at only 31.8 percent, the lowest White use rate in the nation, while in Arizona the gap between White and Native American decedents is nearly 30 points (62.6 versus 33.3 percent). County-level decomposition allows organizations to convert equity commitments into targeted plans with trackable baselines.

## 7. Limitations

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The measure is hospice use within twelve months of death, not enrollment at death, and will read a few points above at-death measures by construction. Race/ethnicity is drawn from the Medicare enrollment race code, which undercounts Hispanic and Asian beneficiaries relative to the RTI-enhanced code (not available in the LDS extract used); the reported gaps are therefore conservative for those groups. County is the finest geography the LDS supports, and county of residence may differ from the location where care was delivered. Empirical-Bayes smoothing deliberately pulls sparse counties toward the mean, so true extremes in very small counties are muted rather than exaggerated. Finally, claims measure enrollment rather than clinical appropriateness. A low use rate identifies counties where eligible patients may not be reached; determining why, and how best to respond, requires local clinical and community context.

## 8. About Health Trends

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Health Trends is a Seattle-based health economics and analytics consultancy supporting health systems, medical groups, and health law firms since 1996, providing payer negotiation, valuation, business strategy, Certificate of Need, market intelligence, and health-law economic analysis services across the Pacific Northwest and nationally.

Website: <https://healthtrends.consulting/>

## Appendix A. Hospice Use Among Medicare Decedents by State, 2024

| #  | State          | Use rate | #  | State                | Use rate     |
|----|----------------|----------|----|----------------------|--------------|
| 1  | Utah           | 68.5%    | 27 | Nebraska             | 54.0%        |
| 2  | Rhode Island   | 63.2%    | 28 | Illinois             | 53.3%        |
| 3  | Florida        | 62.3%    | 29 | Tennessee            | 53.1%        |
| 4  | Wisconsin      | 60.5%    | 30 | Arkansas             | 52.7%        |
| 5  | Arizona        | 60.1%    | 31 | Massachusetts        | 52.6%        |
| 6  | Ohio           | 59.5%    | 32 | Connecticut          | 52.1%        |
| 7  | Iowa           | 59.1%    | 33 | New Mexico           | 51.6%        |
| 8  | Delaware       | 59.1%    | 34 | Virginia             | 51.5%        |
| 9  | Kansas         | 58.8%    | 35 | Mississippi          | 51.3%        |
| 10 | Texas          | 58.4%    | 36 | Pennsylvania         | 50.7%        |
| 11 | Idaho          | 58.3%    | 37 | Maryland             | 49.8%        |
| 12 | South Carolina | 57.9%    | 38 | California           | 49.8%        |
| 13 | Minnesota      | 57.8%    | 39 | New Jersey           | 49.1%        |
| 14 | Colorado       | 57.3%    | 40 | South Dakota         | 48.0%        |
| 15 | Oklahoma       | 57.1%    | 41 | Kentucky             | 47.9%        |
| 16 | Michigan       | 56.3%    | 42 | West Virginia        | 47.7%        |
| 17 | Alabama        | 55.9%    | 43 | Hawaii               | 47.2%        |
| 18 | Georgia        | 55.6%    | 44 | <b>Washington</b>    | <b>46.2%</b> |
| 19 | New Hampshire  | 55.6%    | 45 | Vermont              | 45.5%        |
| 20 | Indiana        | 55.5%    | 46 | Montana              | 43.5%        |
| 21 | North Carolina | 55.5%    | 47 | Wyoming              | 41.4%        |
| 22 | Missouri       | 55.5%    | 48 | North Dakota         | 41.3%        |
| 23 | Maine          | 55.4%    | 49 | District of Columbia | 32.0%        |
| 24 | Louisiana      | 55.1%    | 50 | Alaska               | 29.7%        |
| 25 | Nevada         | 54.6%    | 51 | New York             | 29.3%        |
| 26 | Oregon         | 54.1%    | 52 | Puerto Rico          | 28.4%        |

Use in the last 12 months of life among 2024 Medicare decedents, by state of residence. Puerto Rico shown for reference; territories with suppressed or minimal counts omitted. Source: 2024 Medicare Hospice SAF LDS + MBSF LDS (2023 lookback), Health Trends analysis.

## Appendix B. Data and Reference Sources

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- CMS Limited Data Set files (Hospice SAF; Master Beneficiary Summary File), accessed under DUA — <https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/limited-data-set-lds>
- MedPAC, March 2026 Report to the Congress, Ch. 10: Hospice (benchmark figures) — [https://www.medpac.gov/wp-content/uploads/2026/03/Mar26\\_Ch10\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch10_MedPAC_Report_To_Congress_SEC.pdf)
- CMS, FY 2026 Hospice Final Rule fact sheet (HOPE implementation) — <https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospice-wage-index-payment-rate-update-hospice-quality-reporting-program-requirements-final>
- CMS HOPE (Hospice Outcomes and Patient Evaluation) — <https://www.cms.gov/medicare/quality/hospice/hope>
- NBER SSA–FIPS state and county crosswalk (2020) — <https://www.nber.org/research/data/ssa-federal-information-processing-series-fips-state-and-county-crosswalk>
- Hospice News, hospice Certificate of Need landscape — <https://hospicenews.com/2022/06/28/the-uncertain-future-of-hospice-certificates-of-need/>