**Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements [CMS-1851-P]**
**Summary of Proposed Rule**

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## I. Introduction and Background

On April 6, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 17338) a proposed rule updating the Medicare hospice payment rates, wage index and Hospital Quality Reporting Program (HQRP) for FY 2027. This proposed rule also includes an analysis of Medicare non-hospice spending under a hospice election, including details regarding a hospice service and spending variation index (SSVI) that is intended to help CMS monitor utilization of hospices and signal potential program integrity risks. In addition, this rule also proposes that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election, rather than upon request. This proposed rule also includes requests for information on enhancing community palliative care services under current Medicare benefits; the development of a hospice-specific wage index using Bureau of Labor Statistics (BLS) data; and information regarding the overlap between hospice and assisted suicide or "medical aid in dying." With respect to the Hospice Quality Reporting Program (HQRP), CMS proposes to add an icon on the Medicare.gov Compare Tool to identify hospices that have failed to meet HQRP reporting requirements, and also provides an update on the recently-implemented Hospice Outcomes and Patient Evaluation (HOPE) assessment tool.

CMS estimates that the overall impact of the proposed rule will be an increase of $785 million (2.4 percent) in Medicare payments to hospices during FY 2027. CMS notes that wage index addenda for FY 2027 (October 1, 2026 through September 30, 2027) will be available only through the internet at https://www.cms.gov/files/zip/fy-2027-proposed-hospice-wage-index.zip

**Comments on the proposed rule are due by June 1, 2026.**

## II. Provisions of the Proposed Rule

A summary of key data for the proposed hospice payment rates for FY 2027 is presented below with additional details in the subsequent sections.

| Summary of Key Data for Proposed Hospice Payment Rates for FY 2027 | | | |
|---|---|---|---|
| **Market basket update factor** | | | |
| Market basket increase | | | +3.2% |
| Required total factor productivity (TFP) | | | -0.8% |
| **Net TFP-adjusted update reporting quality data** | | | **+2.4%** |
| **Net TFP-adjusted update not reporting quality data** | | | **-1.6%** |
| **Hospice aggregate cap amount** | | | $36,210.11 |
| **Hospice Payment Rate Care Categories** | **Labor Share** | **FY 2026 Federal Rates Per Diem** | **Proposed FY 2027 Federal Rates Per Diem** |
| Routine Home Care (days 1-60) | 66.0% | $230.83 | $236.56 |
| Routine Home Care (days 61+) | 66.0% | $181.94 | $186.53 |
| Continuous Home Care, Full Rate = 24 hours of care, $72.00 hourly rate | 75.2% | $1,674.29 | $1,728.02 |
| Inpatient Respite Care | 61.0% | $532.48 | $546.46 |
| General Inpatient Care | 63.5% | $1,119.86 | $1,232.71 |
| **Proposed Service Intensity Add-on (SIA) payment, up to 4 hours** | | | $72.00 per hour |
| Notes: The Consolidation Appropriations Act of 2021 changed the payment reduction for failing to meet quality reporting requirements from 2 to 4 percent beginning in FY 2024. | | | |

### A. FY 2027 Hospice Wage Index and Rate Update

1. FY 2027 Hospice Wage Index

The hospice wage index is used to adjust payment rates to reflect local differences in area wage levels, based on the location where services are furnished. CMS requires each labor market to be established using the most current hospital wage data available, including any changes made by OMB to the Metropolitan Statistical Area (MSA) definitions (§418.306(c)). CMS discusses its prior adjustments to the delineations of the labor markets based on OMB MSA definitions. In the FY 2025 Hospice final rule (89 FR 64208 through 64224), CMS finalized the implementation of new labor market areas based on the revisions in OMB Bulletin No. 23-01 beginning in FY 2025.

For FY 2027, CMS proposes the hospice wage index will be based on the FY 2027 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2022 and before October 1, 2023 (that is, the FY 2023 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but includes a 5-percent cap on wage index decreases. Thus, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving routine home care (RHC) or continuous home care (CHC) and applied based on the geographic location of the facility for beneficiaries receiving general

inpatient care (GIP) or inpatient respite care (IRC). CMS notes that the pre-floor and pre-reclassified hospital wage index used as the raw wage index for the hospice benefit are subject to application of the hospice floor. The pre-floor and pre-reclassified hospital wage index below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.[1] For FY 2027, the 5 percent cap on wage index decreases will continue to be calculated at the county level as well (see the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64220 through 64224)).

CMS also proposes to continue to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all core-based statistical areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. In FY 2026, there is one CBSA without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The proposed FY 2027 wage index value for Hinesville-Fort Stewart, Georgia is 0.8917.

For rural areas without hospital wage data, CMS uses the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. As part of CMS' adoption of the revised OMB delineations in FY 2025, CMS rural North Dakota became a rural area without a hospital from which hospital data can be derived. To calculate the wage index for rural area 99935, North Dakota for FY 2027, CMS proposes to use as a proxy the average pre-floor, pre-reclassified hospital wage data (updated by the hospice floor) from the contiguous CBSA: CBSA 13900-Bismark, ND; CBSA 22020-Fargo, ND-MN; CNSA 24220-Grand Forks, ND-MH; and CBSA 33500, Minot, ND. This results in a proposed FY 2027 hospice wage index of 0.8299 for rural North Dakota.

Previously, the only rural area without a hospital from which hospital wage data could be derived was Puerto Rico. For FY 2027, based on the adoption of the revised OMB delineations, there is a hospital in rural Puerto Rico from which hospital wage data could be derived. CMS proposes that the wage index for rural Puerto Rico would be based on this hospital data. Specifically, the proposed pre-hospice floor unadjusted wage index for rural Puerto Rico would be 0.2577 with an adjusted wage index by the hospice floor of 0.2964. Because 0.2964 is more than a 5-percent decline in the FY 2025 wage index, the 5-percent cap would apply and the proposed FY 2027 wage index is 0.3990.

2. FY 2027 Hospice Payment Update Percentage

CMS estimates the FY 2027 market basket percentage increase and the productivity adjustment based on IHS Global Inc.'s (IGI's) forecast using the fourth quarter 2025 forecast, the most recent available data. For FY 2027, the estimated inpatient hospital market basket update of 3.2 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA, currently estimated to be 0.8 percentage points. This results in a proposed hospice payment update percentage for FY 2027 of 2.4 percent; CMS proposes to revise this amount in the final rule if more recent data

[1] For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, CMS would multiply 0.3994 by 1.15, which equals 0.4593.

become available. Hospices that do not submit the required quality data under the HQRP would receive a payment update percentage for FY 2027 of -1.6 percent.

CMS proposes to update hospice payments by applying the 2023-based IPPS market basket percentage increase for FY 2026 of 3.2 percent, reduced by the statutorily required productivity adjustment of 0.8 percentage points along with the wage index budget neutrality adjustment to update the payment rates. For the FY 2027 hospice wage index, CMS proposes to use the FY 2027 pre-floor, pre-reclassified IPPS hospital wage index.

CMS notes that in the 2022 final rule it rebased and revised the labor shares for the RHC, CHC, GIP, and IRC using cost report data for freestanding hospices. The labor portion of the hospice payment rates is currently as follows: for RHC, 66.0 percent; for CHC, 75.2 percent; GIP, 63.5 percent; and for IRC, 61.0 percent.

3. FY 2027 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[2] To calculate the wage index standardization factor, CMS simulated total payments using FY 2025 hospice utilization claims data with the FY 2026 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor and the 5-percent cap on wage index decreases) and FY 2026 payment rates and compared it to its simulation of total payment using the FY 2025 hospice utilization claims data, the proposed FY 2027 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2026 payment rates. By dividing payments for each level of care using the FY 2026 wage index and FY 2026 payment rates for each level of care by the proposed FY 2027 wage index and FY 2026 payment rates, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Tables 1 and 2 (reproduced below) lists the proposed FY 2027 hospice payment rates by care category and the proposed wage index standardization factors.

[2] CMS proposes using FY 2025 claims data as of January 15, 2026 to calculate the wage index standardization factor (the most recent available).

| Table 1: Proposed FY 2027 Hospice RHC Payments | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **FY 2026 Payment Rates** | **SIA Budget Neutrality Factor** | **Wage Index Standardization Factor** | **Proposed FY 2027 Hospice Payment Update** | **Proposed FY 2027 Payment Rates** |
| 651 | Routine Home Care (days 1-60) | $230.83 | × 0.9999 | × 1.0009 | × 1.024 | $236.56 |
| 651 | Routine Home Care (days 61+) | $181.94 | × 0.9999 | × 1.0013 | × 1.024 | $186.53 |

| Table 2: Proposed FY 2027 Hospice CHC, IRC, and GIP Payment Rates | | | | | |
|---|---|---|---|---|---|
| **Code** | **Description** | **FY 2026 Payment Rates** | **Wage Index Standardization Factor** | **Proposed FY 2027 Hospice Payment Update** | **Proposed FY 2027 Payment Rates** |
| 652 | Continuous Home Care Full Rate = 24 hours of care | $1,674.29 ($69.76 per hour) | × 1.0079 | × 1.024 | $1,728.02 ($72.00 per hour) |
| 655 | Inpatient Respite Care | $532.48 | × 1.0022 | × 1.024 | $546.46 |
| 656 | General Inpatient Care | $1,199.86 | × 1.0033 | × 1.024 | $1,232.71 |

Tables 3 and 4 found in the proposed rule preamble list the comparable FY 2027 proposed payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $227.32; Routine Home Care (days 61+), $179.24; Continuous Home Care, $1,660.52; Inpatient Respite Care, $525.11; and General Inpatient Care, $1,184.56.

In the FY 2016 Hospice final rule (80 FR 47172), CMS implemented a Service Intensity Add-on (SIA) payment for RHC when direct patient care is provided by a registered nurse (RN) or social worker during the last seven days of the beneficiary's life. The SAI payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. For FY 2027, the proposed SAI payment is $72.00 per hour, up to 4 hours. In addition, for FY 2027, the proposed SIA budget neutrality factor is 0.9999 for RHC days 1-60 and 0.9999 for RHC days 61+.

5. Hospice Cap Amount for FY 2027

By background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[3] The aggregate cap amount was set at $6,500 per beneficiary

[3] If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days, then for inpatient care the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

when first enacted in 1983, and was adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the IMPACT Act of 2014, beginning with the 2016 cap year, the cap amount for the previous year is updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September 30, 2025 and revert to the original methodology, but this sunset provision was extended, by the CAA, 2023 until September 30, 2032. The proposed hospice aggregate cap amount for the FY 2027 cap year would be $36,210.11 per beneficiary or the FY 2026 cap amount updated by the proposed FY 2027 hospice payment update percentage ($35,361.44 * 1.024).

**B. Non-Hospice Spending During a Hospice Election**

1. Medicare Non-Hospice Spending

In the proposed rule, CMS provides a detailed analysis on non-hospice spending for hospice beneficiaries during an election using FYs 2020 through 2024 data. CMS emphasizes that hospice services are intended to be comprehensive and inclusive and that since the creation of this benefit, it has reiterated that "virtually all" care needed by the terminally ill individual should be provided by the hospice and that it would be unusual and exceptional for services to be provided outside of the hospice for these individuals.

In FY 2024, the agency found that Medicare paid over $2.1 billion for Part A and Part B items or services while a beneficiary was receiving hospice care. Notably, non-hospice spending has increased by 160 percent from FY 2020, with the most substantial year-to-year increase occurring from FY 2023 to FY 2024. CMS observed payment increase across payment categories including durable medical equipment, home health, inpatient, outpatient, carrier/physician supply, and skilled nursing facility.

In addition, total drug spending by Medicare, states, beneficiaries, and other payers in FY 2024 under Part D was $1.0 billion for hospice beneficiaries during a hospice election (of which $813 million was paid by Medicare). For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment of an illness or condition completely unrelated to the terminal illness or related conditions.

Thus, in total, non-hospice Medicare expenditures occurring during a hospice election was $2.1 billion for Parts A and B spending, plus $813 million for Part D spending, or about $2.8 billion in FY 2024. Further, hospice beneficiaries had $510 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $71 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election.

CMS also examines Medicare payments for non-hospice items and services for certain diagnostic coding groups including neurological/degenerative, heart/cerebrovascular, respiratory, cancer, and all other diseases.

2. Service and Spending Variation Index (SSVI)

CMS provides details on a newly created service and spending variation index (SSVI) that is intended to help CMS monitor utilization of hospices and signal potential program integrity risks. The SSVI includes a comprehensive scoring system that is calculated using nine claims-based measures, each representing different aspects of hospice utilization as well as non-hospice spending.

To calculate the SSVI score, CMS first determined a threshold for each of the nine metrics. For the non-hospice spending component of the SSVI score, CMS created eight separate thresholds for total non-hospice spending, For most of the individual measures, CMS established the threshold at the top or bottom 25 percent of the distribution. CMS cautions that a hospice that falls into this quartile on a single measure does not necessarily indicate poor performance or improper practices. The objective of the SSVI is not to evaluate hospices based on a single metric, but to identify hospices that are outliers across multiple independent metrics. A hospice triggering that threshold across many distinct metrics could indicate unusual utilization that may require further review.

For these utilization metrics, when a hospice's outcome for that metric surpasses the metric's threshold, then the hospice receives one point in its score for that metric. CMS then adds each of the nine scores, that is, one score per metric, together to calculate the SSVI score. The total SSVI score is derived by adding together a hospice's total non-hospice spending score and their utilization score. The lowest SSVI score a hospice can receive is zero, that is, a score of zero for each of the nine metrics, and the maximum SSVI score is 16, that is, with the highest points assigned for each of the nine metrics. A higher SSVI score represents a potential higher level of concern, as this may signal potential program integrity risks or inappropriate utilization especially when a hospice's SSVI score is substantially higher than its peers.

In Table 9 in the proposed rule (reproduced below), CMS describes each of the nine metrics and the threshold values for those metrics. Given that CMS calculates a hospice's SSVI score using an evaluation of nine metrics, a high SSVI score indicates to CMS that a hospice might have more than one area of concern and may require additional targeted education or oversight, such as medical review, education, and investigations that could result in payment suspension, and revocation, if there is identified fraud, waste, or abuse. In other words, each score used to calculate the SSVI score can be used to identify a specific area of concern for a hospice, and the SSVI score itself provides an aggregate measure to evaluate a hospice as a whole. The SSVI can assist interested parties in comparing hospices on a holistic scale.

**Table 9: Description of SSVI Metrics, Threshold Values, and Points Allocated**

| Metric Description | Threshold Value | Points |
|---|---|---|
| Providing no Continuous Home Care and no General Inpatient Care (Utilization) | 0 | 1 |
| Percentage of Routine Home Care days that are provided in a nursing home or skilled nursing facility (Utilization) | Greater than or equal to 40% | 1 |
| Percent of the last two Routine Home Care days of life with visits (Utilization) | Less than or equal to 25$^{th}$ percentile (in FY | 1 |

| Table 9: Description of SSVI Metrics, Threshold Values, and Points Allocated | | |
|---|---|---|
| **Metric Description** | **Threshold Value** | **Points** |
| | 2025, the 25th percentile was 85.7%) | |
| Percentage of total discharges that are live discharges (Utilization) | Greater than or equal to the 75th percentile (in FY 2025, the 75th percentile was 47.5%) | 1 |
| Percentage of discharges with a length of stay of over 180 days (Utilization) | Greater than or equal to the 75th Percentile (in FY 2025, the 75th percentile was 33.2%) | 1 |
| Average skilled nursing minutes on Routine Home Care (Utilization) | Less than or equal to 25th Percentile (in FY 2025, the 25th percentile was 9.8 minutes per day) | 1 |
| Weekend Routine Home Care days with a skilled visit (nursing, medical social worker, or therapy) as a percentage of total RHC days (Utilization) | Less than or equal to 25th percentile (in FY 2025, the 25th percentile was 4.8%) | 1 |
| Percentage of live discharges where beneficiaries return to the same hospice in seven days (Utilization) | Greater than or equal to 75th percentile (in FY 2025, the 75th percentile was 15%) | 1 |
| Total non-hospice spending | Between 0 and the lowest spending eighth of hospices (in FY 2025, values greater than 0 and less than or equal to $6,352.84) | 1 |
| | Between the lowest eighth and two-eighths of hospices (in FY 2025, values greater than $6,352.84 and less than or equal to $20,612.10) | 2 |
| | Between two-eighths and three-eighths of hospices (in FY 2025, values greater than $20,612.10 and less than or equal to $42,911.79) | 3 |
| | Between three-eighths and half of hospices (in FY 2025, values greater than $42,911.79 and less than or equal to $76,801.05) | 4 |
| | Between half and five-eighths of hospices (in FY 2025, values greater than $76,801.05 and less than or equal to $133,440.80) | 5 |
| | Between five-eighths and six-eighths of hospices (in FY 2025, values greater than $133,440.80 and less than or equal to $246,123.10) | 6 |
| | Between six-eighths and seven-eighths of hospices (in FY 2025, values greater than $246,123.10 and less than or equal to $517,204.40) | 7 |
| | Between seven-eighths and highest spending eighth of hospices (in FY 2025, values greater than $517,204.40) | 8 |

CMS plans to determine the SSVI for individual hospices each fiscal year using that applicable year's data. In this proposed rule, CMS publishes the SSVI scores calculated from data for FYs

2024 and 2025 because these are its most recent and complete years of claims data. Table 10 from the proposed rule (reproduced below) shows the distribution of the number of hospices by their total score for hospices in FYs 2024 and 2025 claims.

| Table 10: Distribution of SSVI Score for Hospices in FY 2024 and FY 2025 Hospice Claims | | | | |
|---|---|---|---|---|
| | FY 2024 | | FY 2025 | |
| Total Score | Number of Hospices | Percent of Hospices | Number of Hospices | Percent of Hospices |
| 0 | 6 | 0.1% | 4 | 0.1% |
| 1 | 91 | 1.4% | 87 | 1.3% |
| 2 | 334 | 5.0% | 332 | 5.0% |
| 3 | 564 | 8.4% | 527 | 7.9% |
| 4 | 760 | 11.3% | 714 | 10.7% |
| 5 | 838 | 12.4% | 887 | 13.4% |
| 6 | 918 | 13.6% | 890 | 13.4% |
| 7 | 862 | 12.8% | 898 | 13.5% |
| 8 | 920 | 13.7% | 899 | 13.5% |
| 9 | 629 | 9.3% | 571 | 8.6% |
| 10 | 366 | 5.4% | 407 | 6.1% |
| 11 | 255 | 3.8% | 230 | 3.5% |
| 12 | 116 | 1.7% | 122 | 1.8% |
| 13 | 48 | 0.7% | 55 | 0.8% |
| 14 | 28 | 0.4% | 18 | 0.3% |
| 15 | 0 | 0.0% | 1 | 0.0% |
| 16 | 0 | 0.0% | 0 | 0.0% |
| **Total Hospices** | **6,735** | **100.0%** | **6,642** | **100.0%** |

**Source:** The data used was pulled from the CCW VRDC on January 15, 2026.

**Note**: The development of the FY 2024 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. The development of the FY 2025 Hospice SSVI included 6,750,840 hospice claims, representing 6,642 hospices and a total of 156,514,386 hospice days.

CMS states that it will post the metrics and the SSVI scores for FYs 2024 and 2025, additional data from claims-based measures, and related documentation on the methodology on its Hospice Center webpage at https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center. CMS states that its goal is to identify individual hospice vulnerabilities to help focus program integrity efforts, such as conducting medical reviews, providing additional education, and conducting investigations into individual hospices that could result in administrative actions like payment suspension and/or revocation of hospices demonstrating fraudulent behavior. CMS also believes the public will benefit from the enhanced transparency these data provide, allowing beneficiaries and their families the ability to make more informed choices regarding care at the end of life. **CMS seeks feedback on the metrics used to calculate the SSVI score, the threshold values and point assignments.**

## C. Proposed Election Statement Addendum Changes

1. Background

CMS finalized a policy, for elections beginning on and after October 1, 2020, that requires hospices to provide a hospice election statement addendum to beneficiaries, their representatives, non-hospice providers, or Medicare contractors, upon request. The purpose of the addendum is to notify the hospice beneficiary (or representative) of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the beneficiary's terminal illness and related conditions. The addendum is subject to review and must be updated, as needed, when the plan of care is updated in accordance with §418.56. The hospice must provide these updates, in writing, to the beneficiary (or representative).

Currently, if the beneficiary (or representative) requests an addendum at the time of hospice election (that is, within the first 5 days of the hospice election date), the hospice would have 5 days from the date of the request to furnish this information in writing. If the addendum is requested during the course of hospice care (that is, after the first 5 days of the date of the hospice election), the hospice has 3 days from the date of the request to provide the addendum in writing. However, if the beneficiary dies, revokes, or is discharged within the required timeframes, the hospice would not be required to furnish the addendum in this circumstance. These timeframes, and others, for providing the addendum are outlined in §418.24(d). The required content of the hospice election statement addendum is outlined in §418.24(c) and summarized in the table below.

| **Required Content of the Hospice Election Statement** | |
|---|---|
| Addendum title ("Patient Notification of Hospice Non-Covered Items, Services, and Drugs") | A written clinical explanation written in language that the beneficiary (or representative) can understand |
| Hospice Name | References to any relevant clinical practice, policy, or coverage guidelines |
| Individual's name and medical record identifier | Information on the purpose of the addendum and the right to immediate advocacy through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice's determination |
| Identification of the terminal illness and related conditions | Individual (or representative) name, signature, and date signed, along with a statement that signing the addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not the individual's (or representative's) agreement with the hospice determinations |
| A list of the individual's condition present on hospice admission (or upon POC update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions | The date the hospice furnished the addendum |

2. Proposed Mandatory Hospice Election Statement Addendum for all Elections

CMS proposes to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for hospice election beginning on or after October 1, 2026. Accordingly, CMS' proposal would modify the current requirements at §418.24(b)(6), (c), and (d) to make the hospice addendum mandatory for beneficiaries, their representatives, non-hospice providers, or Medicare contractors, at the time of hospice election as a condition of payment.

CMS reiterates that hospices may provide the election statement addendum in any format that best suits their needs, provided that the content requirements at §418.24(b) and (c) are met (85 FR 47070); however, if desired, a model hospice election statement addendum is available on the Hospice Center webpage at https://www.cms.gov/Center/Provider-Type/Hospice-Center.

CMS emphasizes that this proposed change is necessary given the significant increases in non-hospice spending patterns and that the current framework, where the hospice election statement addendum is provided only upon request, has not achieved the intended accountability objective of ensuring that hospices provide virtually all care needed by terminally ill individuals as required under the Medicare hospice benefit. CMS also notes that many beneficiaries may not understand the importance of requesting the addendum, may not understand their right to receive this information, or may not receive it in time to make fully informed decisions about their care, also not achieving the intended transparency objective. Further, the substantial growth in non-hospice spending, particularly for services that may be related to the terminal illness and related conditions, indicates potential gaps in coverage transparency and coordination between hospice and non-hospice providers.

CMS notes that its burden estimates completed in FY 2020 (84 FR 38484) already assumed that hospices would provide the addendum to all beneficiaries. CMS' revised 2027 burden estimates demonstrate a significant total overall burden reduction for non-hospice providers of $40.6 million, as well as a net hospice provider burden reduction of $20.8 million.

**D. Proposed Clarifying Regulation Text Changes**

1. Discharge from Hospice Care

This rule proposes conforming regulation text changes to allow a physician designee and the physician member of the interdisciplinary group, in addition to the hospice medical director, to discharge a patient from hospice care, which will help improve flexibility for hospices and reduce regulatory burden. CMS notes that § 418.26(b) requires that prior to discharging a patient for any reason listed in §418.26, the hospice must obtain a written physician's discharge order from the hospice medical director. To align with the updated payment regulations at §§418.22 and 418.102(b), and to create greater consistency between key components of hospice regulations, CMS proposes conforming additions to §418.26(b) to state the hospice may also obtain the written physician's discharge order from the physician designee, as defined at §418.3, or physician member of interdisciplinary group.

2. Face-to-Face Encounter

This rule also proposes conforming regulation text changes to the hospice telehealth face-to-face policy in accordance with the Consolidated Appropriations Act (CAA), 2026. In accordance with section 6209(f) of the CAA, 2026, CMS proposes amending §418.22(a)(4)(ii). The regulatory language would require the hospice to collect data reflecting face-to-face encounters furnished using telecommunications technology, which includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner, and the hospice would do so by reporting a G-code identifying that a face-to-face encounter was furnished using telehealth technology.

**CMS seeks comments on these proposed amendments and on the use of the new G-code identifying face-to-face encounters furnished via telehealth.** CMS states that it would issue further subregulatory guidance on implementation of this provision, including the exclusion from this permissible use of telehealth, via a Change Request (CR).

## E. Requests for Information on Medicare Services and Payment Structure

This proposed rule includes requests for information on enhancing community palliative care services under current Medicare benefits; the development of a hospice-specific wage index using BLS data; and information regarding the overlap between hospice and assisted suicide or "medical aid in dying."

1. Request for Information on Ways to Enhance the Provision of Palliative Care Outside of Hospice Care: Current Coverage, Billing Practices, and Opportunities for Improvement

As background, CMS notes that palliative care is often thought of in concert with hospice care; however, it is not mutually exclusive to the end of life. Medicare defines palliative care as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (§418.3). CMS notes that palliative care is a method of care delivery that is provided throughout the continuum of illness, it can be furnished under various Medicare benefits prior to a beneficiary's decision to elect hospice care.

Medicare does not currently offer a dedicated palliative care benefit, though various palliative services are offered across existing Medicare programs. Most community palliative care services fall under Medicare Part B, which reimburses for reasonable and medically necessary outpatient care. These include access to mental and behavioral health services, including counseling provided by clinical social workers, and rehabilitation therapies such as physical, occupational, and speech therapy aimed at reducing symptom burden and maintaining function. CMS notes that telehealth, expanded in recent years, further enhances access to palliative expertise for homebound or mobility-limited patients. Medicare Part B also covers certain medical supplies and equipment needed for palliative care, such as oxygen and wheelchairs. CMS notes that Medicare Part A also provides limited outpatient related support and Medicare Part D further

contributes to outpatient palliative care by covering prescription medications for symptom management, such as analgesics, antiemetics, and anxiolytics.

CMS notes that because Medicare does not recognize palliative care as a distinct billable service, providers must rely on a variety of codes and benefit categories. Physicians and advanced practice providers typically bill evaluation and management (E/M) visits for outpatient or home-based palliative encounters. Clinicians may provide symptom management, chronic disease support, advance care planning (ACP), and behavioral health care through standard E/M visits or specialized billing codes. Clinicians could also use chronic care management (CCM), complex CCM, principal care management (PCM), and transitional care management (TCM) codes to support ongoing coordination of care, which is central to high-quality palliative care for complex conditions. Code Z51.5 Encounter for Palliative Care can be used; however, it does not specify what services this code encompasses. These codes also may not reflect the time-intensive nature of holistic, interdisciplinary palliative care.

**CMS is interested in understanding how community providers bill for palliative services, which CPT or HCPCS codes they rely on, and what barriers they face in using ACP, care management, or telehealth codes.** Specifically:

- Do the E/M codes, care management codes, and ACP codes represent the majority of the billing codes providers use to capture community palliative care services?
- What services are typically provided when Z51.5 is billed?
- Are there challenges in meeting documentation requirements or integrating non-billable team members, such as social workers, chaplains, or nurses who are crucial to palliative care delivery?
- Is there uncertainty about compliance requirements or concern that billing for palliative care will result in claims denials?
- What non-medical services, such as caregiver training or spiritual care, would most benefit patients if reimbursed? And what enhancements to existing benefits (not requiring legislation) could strengthen palliative care? These might include expanding social worker billing privileges or creating standardized codes or definitions for serious-illness care.

In addition to providing feedback on billing practices, interested parties can offer insight into broader systemic challenges, staffing limitations, claim denials, and palliative services they provide but cannot bill for under Medicare's current structure. Specifically:

- What aspects of palliative care are financially unsustainable for providers?
- What documentation requirements do providers typically use, or suggest using, to identify the provision of palliative care?
- Do providers commonly refer patients for home health services when a patient needs palliative care concurrently with curative or life-sustaining care?
- What services do providers typically offer patients who are not eligible or ready to elect hospice care but require palliative services?

2. Request for Information Regarding Construction of a Hospice Specific Wage Index

In response to numerous, ongoing comments from interested parties regarding the hospice wage index, CMS has examined possible alternatives to using the IPPS wage index for geographically adjusting hospice payments. In 2007 and 2022, for example, MedPAC proposed using the BLS for wage data and to construct new wage indexes to more accurately reflect local area differences in labor costs between and within MSAs and statewide rural areas.[4] CMS also notes that it has investigated using alternatives to the IPPS wage index for other non-hospital settings, as hospital cost reports may not be representative of the occupations relative to post-acute care settings.

In September 2025, CMS hosted a Technical Expert Panel (TEP) with 14 participants representing various interested parties including industry associations, academia, and hospices, to seek feedback on a proposed alternative to the current hospice wage index. CMS also provided a technical report for the TEP panelists that gave additional details regarding the potential methodology that could be used to construct a new hospice specific wage index and preliminary results for how specific hospices would be impacted. The TEP summary report, which summarizes the discussion and recommendations of the TEP, as well as the TEP technical report, which provides a detailed examination of the discussed alternative approaches, may be found at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospice/hospice-educational-resources.

In this proposed rule, CMS is looking for feedback on how the BLS Occupational Employment and Wage Statistics (OEWS) data, and other public data can be used to construct a hospice specific wage index. CMS requests input to understand the advantages and limitations of the suggested approach in using BLS data and cost reports to support the construction of a hospice specific wage index. In addition, as discussed elsewhere in the Federal Register, CMS notes that it is also considering the potential use of alternative data sources in other payment systems including the Inpatient Rehabilitation Facilities (IRF) PPS and Skilled Nursing Facilities (SNF) PPS. CMS seeks feedback on the unique considerations applicable to hospices and the potential use of alternative data sources.

CMS seeks comment on the five components of how a new hospice specific wage index would be constructed: (1) Source data for determining area wages, (2) Occupational mix weights, (3) Hospice specific wage index construction, (4) Labor market areas, and (5) Transition policy. These are discussed in more detail below.

(1) Source data for determining area wages

When considering a source for wage data, CMS believes it is important that the data used is public to promote transparency, such that relevant interested parties would have access to the data and can conduct their own analyses. CMS cites that the BLS OEWS data provides MSA-level wage data for health professionals, including clinical and administrative office staff, which is updated annually using a pooled sample of six semi-annual surveys. BLS OEWS data includes information on the wages that employers paid to their employees. It does not include self-employed contract labor wages or benefits paid to employees. The hospice specific wage index

[4] MedPAC, Report to Congress, 2007, p.124-125, and MedPAC, Report to Congress, 2023, p.386.

would also include the use of freestanding hospice cost reports, claims, and Census Bureau population data.

CMS states that it would only use freestanding hospice cost reports to ensure cost accuracy, as facility-based reports may share costs with the larger facility. Claims data is used to retrieve the total minutes of care delivered by the seven different disciplines of care (physical therapy, occupational therapy, speech language pathology, skilled nursing, medical social service, and home health aide) that are currently billed as visits on the claims form. Census Bureau population data is used to calculate weighted averages when aggregating wage data.

(2) Occupational mix weights

To determine how the occupation mix of the hospice specific wage index would be constructed, CMS is considering a fixed national set of weights based on the hours each occupation employed nationwide. The occupational mix determines how much weight each occupation's wage receives in the overall calculation of the wage level for each geographic area and the national level.

CMS' suggested approach uses expenses reported in hospice cost reports and minutes reported in hospice claims data for 10 occupational categories (hospice aide, registered nurses, nursing administration, physician services, licensed practical nurse, licensed vocational nurse, medical social services, nurse practitioner, physical therapy, occupational therapy, and speech language pathology) shown in Table 11 (reproduced below). Three occupations are identifiable on the cost report but not claims (Nursing Administration, Physician Services, Nurse Practitioner) and their share of the occupational mix was set to this percentage.

**Table 11: National Estimated Occupational Mix Using Hospice Cost Reports and Claims**

| Occupation | Share of Costs from Cost Reports | Share of Minutes from Claims | National Estimated Occupational Mix |
|---|---|---|---|
| **Hospice Aide** | 16.52% | 48.89% | 38.11% |
| **Registered Nurses** | 45.89% | 36.51% | 28.46% |
| **Nursing Administration** | 10.98% | N/A | 10.98% |
| **Physician Services** | 8.86% | N/A | 8.86% |
| **LPN/LVN** | 7.39% | 8.32% | 6.49% |
| **Medical Social Services** | 7.65% | 6.21% | 4.84% |
| **Nurse Practitioner** | 2.21% | N/A | 2.21% |
| **Physical Therapy** | 0.39% | 0.06% | 0.04% |
| **Occupational Therapy** | 0.09% | 0.01% | 0.01% |

**Note:** National occupational mix weight is derived by multiplying the share of minutes from claims by the 77.95% (the remaining shares of minutes from claims data excluding nursing administration, physician services, and nurse practitioner).

(3) Hospice Specific Wage Index Construction:

CMS states that it could construct a wage index for each CBSA by calculating an hourly wage for each CBSA (reflecting a weighted average of the occupational mix) and dividing by the aggregate hourly wage (reflecting a weighted average of the occupational mix). CMS provides detail on the following six specific computational steps it would use for constructing a potential hospice specific wage index: CMS seeks feedback on any steps that may need to be modified to be applicable to the data available for hospices and related occupations.

*Step 1: Estimate the Hospice National Average Occupational Mix.* CMS would use the combination of the share of costs from cost reports and share of minutes from claims to develop a hospice national occupational mix (as shown in Table 11 above).

*Step 2: Calculate Occupation-Specific, CBSA-Level Wage Estimates.* To determine how hourly wages in an area compare with national wage levels for specific occupations, CMS would calculate a CBSA-level wage estimate for each occupation included in the hospice labor mix.

*Step 3: Calculate Cross-Occupation, CBSA-Level Wage Estimates.* For each CBSA, CMS would calculate an average wage by multiplying the occupation-specific, CBSA-level wages by the hospice national occupational mix percentage (that is, registered nurse hourly wage times the 28.46 percent in Table 11) and then sum the wages for all occupations in Table 11. This is the numerator for the CBSA's hospice specific wage index value before adjustments.

*Step 4: Calculate the Cross-Occupation, National Wage Estimate.* CMS would calculate the cross-occupation, national wage estimate, which is the denominator of the hospice specific wage index value before adjustments. CMS would calculate a national weighted average of each occupation-specific wage estimate by weighting the occupation-specific wage estimate in each CBSA by the population in a CBSA. CMS would then weight the national averages by the share in the national occupational mix to obtain a cross-occupation, national wage estimate.

*Step 5: Calculating Initial Hospice Wage Index Values*. The initial hospice wage index value for each CBSA would be calculated by dividing the cross-occupation, CBSA-level wage estimate from Step 3 by the cross-occupation, national wage estimate from Step 4.

*Step 6: Adjustments to the Initial Wage Index Values*. CMS would recalibrate to ensure center of distribution equals the center of the legacy wage index. CMS would then apply the hospice floor and 5 percent cap on decreases to calculate the final hospice wage index.

(4) Labor market areas

CMS notes that the final FY 2026 hospice wage index does not consider any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The final FY 2026 hospice wage index includes a 5 percent cap on wage index decreases.

CMS states that the calculated wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

For the purposes of constructing a hospice specific wage index, CMS is seeking feedback on the level of geographic delineation of labor market area to be applied to a new wage index and considerations for when neighboring areas have large differences in wage index values. In past rules, CMS has stated that OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments.

(5) Transition Policy

CMS seeks feedback on what an appropriate transition policy may be when shifting from a wage index using hospital IPPS wage data to a hospice specific wage index using BLS wage data. CMS appreciates hospices and national organizations sharing their support and commitment to offering meaningful comments for consideration. In addition to the methodological questions, CMS solicits public comment on the following questions:

- What data sources and changes should be considered to develop a wage index specific for hospices?
- What are the advantages of the suggested approach to constructing wage indexes, relative to the current system?
- What are the main limitations of the suggested approach?
- Can any limitations be addressed through changes to the data sources mentioned, such as cost reports and claims?
- What occupations should be included in the occupational mix to estimate geographic differences in expected prices to employ healthcare staff in hospices?
- What additional labor categories, if any, should be added to cost reports to support the revision of the hospice wage index? Are any other changes to the cost reports required for this purpose?
- How should CMS appropriately compare wages between geographic areas that match the way hospice services are delivered? Should CMS maintain the use of CBSA, or consider other geographic delineation, such as county, census area, etc.?
- How should CMS reduce large differences in wage index values for adjacent geographic areas?
- How should CMS consider policy to support the transition between the current hospice wage index approach to a new one?

3. Request for Information Regarding Medical Aid in Dying (MAID)

CMS is interested in hearing from hospice providers and other interested parties about any issues that may arise when a Medicare hospice patient requests "medical aid in dying" (MAID). MAID is not legal under Federal law; however, it is considered an end-of-life option for terminally ill adults to self-administer life-ending medication prescribed by a physician in certain states where it is allowed under State law. It is currently legal in 11 states and Washington, D.C., and under these existing State laws, strict criteria require a prognosis of 6 months or less to live. More states are passing laws allowing MAID, creating new challenges for hospices and other providers that participate in Federal health programs on how to navigate relevant State and Federal laws.

In particular, CMS is seeking information on:

- What information do hospice providers give to these patients and how often is there overlap when a patient pursues MAID? In other words, do hospices generally continue to provide clinical care while a patient seeks qualification for MAID and do patients generally remain on service until death?
- Conversely, do hospices encourage patients to revoke their election if they choose to utilize MAID?
- Is there confusion amongst hospices regarding visits or other comfort measures that can be provided during this process, especially on the day of death?
- Do hospices have written policies regarding caring for patients using MAID? CMS is especially interested in understanding what hospices do with any unused lethal medications prescribed for MAID.

CMS emphasizes that no Medicare funds, including hospice payments, may be used to facilitate MAID, including physician consultation services, prescribing or dispensing of medications used for the purpose of causing death, or assistance with the ingestion of such medications. As such, CMS is also requesting information on any additional CMS oversight mechanisms that should be in place to safeguard the use of Federal funds for the provision of MAID items and services. CMS welcomes any additional information regarding hospices' experience with patients choosing to utilize MAID, with the expectation that hospice providers and staff are adhering to Federal law.

## F. Updates for the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP)[5] includes the Hospice Outcomes and Patient Evaluation (HOPE) (which replaced the Hospice Item Set (HIS)), administrative data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. New data collection through the HOPE tool was finalized in the FY 2025 Hospice Wage Index final rule and the HOPE assessment was implemented on October 1, 2025. Section 1814(i)(5)(A)(i) of the Act[6] requires that hospices that fail to meet quality data submission requirements in a reporting year/data collection year[7] are subject to an annual payment update (APU) reduction, specifically a 4 percentage point reduction to the market basket update, for the payment FY to which that reporting year/data collection year corresponds.[8] Any such reduction applies for only the specified year. The reduction could result in the annual market basket update being less than zero and in payment rates that are less than rates for the previous fiscal year.

[5] The hospice quality reporting program is established under section 1814(i)(5) of the Act.
[6] The 4 percentage point reduction for failing to meet hospice quality reporting requirements, as well as completeness thresholds, are codified at §418.312(j).
[7] The "reporting year" (which is used in HIS and HOPE, once it is implemented) and the "data collection year" (which is used in CAHPS) are each based on a CY and correspond to each other. That is, if the HIS/HOPE reporting year is 2027, then the CAHPS data collection year is 2027.
[8] The Consolidation Appropriations Act of 2021 (CAA 2021; Public Law 116-260) changed the percentage point reduction for failing to meet these reporting requirements from 2 percentage points to 4 percentage points, beginning with FY 2024.

CMS proposes to add on the Medicare.gov Compare Tool an icon identifying hospices that have failed to meet HQRP reporting requirements. The agency also provides an update on the newly implemented HOPE assessment tool.

Table 12 (shown below, with slight formatting edits) lists the quality measures in effect for the FY 2027 HQRP.[9]

| **Table 12: Quality Measures in Effect for the HQRP** |
|---|
| **Hospice Quality Reporting Program** |
| **Hospice Outcomes and Patient Evaluation (HOPE)** |
| Hospice and Palliative Care Composite Measure–Comprehensive Assessment Measure at Admission includes:<br>1. Patients Treated with an Opioid who are Given a Bowel Regimen<br>2. Pain Screening<br>3. Pain Assessment<br>4. Dyspnea Treatment<br>5. Dyspnea Screening<br>6. Treatment Preferences<br>7. Beliefs/Values Addressed (if desired by the patient) |
| **Administrative Data, including Claims-based Measures** |
| Hospice Visits in Last Days of Life (HVLDL) |
| Hospice Care Index (HCI)<br>1. Continuous Home Care (CHC) or General Inpatient Provided (GIP) Provided<br>2. Gaps in Skilled Nursing Visits<br>3. Early Live Discharges<br>4. Late Live Discharges<br>5. Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission<br>6. Burdensome Transitions (Type 2) - Live Discharges form Hospice Followed by Hospitalization with the Patient Dying in the Hospital<br>7. Per-beneficiary Medicare Spending<br>8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day<br>9. Skilled Nursing Minutes on Weekends<br>10. Visits Near Death |
| **CAHPS Hospice Survey** |
| CAHPS Hospice Survey<br>1. Communication with Family<br>2. Getting timely help<br>3. Treating patient with respect<br>4. Emotional and spiritual support<br>5. Help for pain and symptoms<br>6. Training family to care for the patient<br>7. Care preferences<br>8. Rating of this hospice<br>9. Willing to recommend this hospice |

[9] Information on the current HQRP quality measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.

2. Updates Regarding HOPE Measures

HOPE was developed as the new patient assessment tool to replace HIS and was implemented October 1, 2025. Public reporting of the HOPE quality measures is to begin no earlier than FY 2028 (November 2027). CMS expects public reporting to begin in November 2027. Hospices must have a timely submission rate of at least 90 percent for FY 2027—meaning that 90 percent of all HIS and/or HOPE assessments would need to be submitted within 30 days of the admission or discharge date. Because of the HOPE implementation date, the reporting period is based on submission of HIS admission or discharge assessments between January 1, 2025 and September 30, 2025 and HOPE admission, discharge, and HOPE Update Visit (HUV) assessments between October 1, 2025 and December 31, 2025.

CMS has granted a waiver to all HOPE assessments dated October 1, 2025 through December 31, 2025 so that all HOPE assessments with a target date in 2025 will be considered timely.

3. Proposal to Add an Icon for Hospices on Medicare.gov Compare Tool to Indicate Failure to Meet Reporting Requirements

CMS proposes to include on the Medicare.gov Compare Tool an icon identifying hospices that have failed to meet HQRP reporting requirements. The icon would be added to the Medicare.gov Compare Tool no earlier than FY 2028 (October 1, 2027) and the data would be based on CY 2026 APU submission data. The icon would be added or removed on an annual basis.

The agency observes that there has not been much improvement in the number of hospices meeting the QRP reporting requirements, even with the APU penalty for noncompliance being increased from 2 percent to 4 percent. Approximately one-fifth of hospices are not meeting requirements, limiting the agency's ability to measure quality of care. The agency believes that its proposal to add the icon will provide an additional incentive for hospices to comply with reporting requirements as well as communicate to consumers that there may not be enough data for those hospices for CMS to measure quality of care.

4. Future Measure Updates

CMS is considering making changes to the Hospice Care Index (HCI) claims-based measure to make it more useful to providers and consumers. The agency plans to submit the updated measure to the 2026 Measures Under Consideration (MUC) list on which the consensus-based entity (CBE) will provide recommendations.

5. Form, Manner, and Timing of Quality Measure Data Submission

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary in a form and manner specified by the Secretary.

Three timeframes for both HIS/HOPE and CAHPS are important for HQRP compliance: (1) the reporting year for HIS/HOPE and data collection year for CAHPS; (2) payment FY (i.e., the consequence year during which the APU is applied to payment based on compliance in the

corresponding reporting year/data collection year); and (3) the reference year, which is used for hospices submitting a size exemption from the CAHPS survey. Table 13 (reproduced below) summarizes these three timeframes.

| Table 13: HQRP Reporting Requirements and Corresponding Annual Payment Updates | | |
|---|---|---|
| **Reporting Year for HIS/HOPE and Data Collection Year for CAHPS data (CY)** | **Annual Payment Update (APU) Impacts Payments for the FY** | **Reference Year for CAHPS Size Exception (CAHPS only)** |
| CY 2025 | FY 2027 APU | CY 2024 |
| CY 2026 | FY 2028 APU | CY 2025 |
| CY 2027 | FY 2029 APU | CY 2026 |
| CY 2028 | FY 2030 APU | CY 2027 |

Hospices must comply with CMS' submission data requirements. The same submission requirements that were applied to HIS are being applied to HOPE records. That is, hospices will continue to submit 90 percent of all required HOPE records within 30 days of the event or completion date (patient's admission, discharge, and based on the patient's length of stay up to two HUV timepoints). Though, note the waiver described in section E.2 above, which is being granted to all HOPE assessments dated October 1, 2025 through December 31, 2025.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to utilize a CMS-approved third-party vendor. A list of approved vendors is available on the CAHPS Hospice survey website.[10]

Table 14 summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. Information from the table is shown below. CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

| Table 14: HQRP Compliance Checklist | | |
|---|---|---|
| **Annual Payment Update** | **HIS/HOPE** | **CAHPS** |
| FY 2027 | Submit at least 90 percent of all HIS/HOPE records within 30 days of the event (for example, patient's admission or discharge) for patient admission/discharges occurring 1/1/2025 – 12/31/2025 | Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025 |
| FY 2028 | Submit at least 90 percent of all HOPE records within 30 days of the event date or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient admission/discharges occurring 1/1/2026 – 12/31/2026 | Ongoing monthly participation in the Hospice CAHPS survey 1/1/2026 – 12/31/2026 |
| FY 2029 | Submit at least 90 percent of all HOPE records within 30 days of the event or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient | Ongoing monthly participation in the Hospice CAHPS survey 1/1/2027 – 12/31/2027 |

[10] www.hospicecahpssurvey.org

| Table 14: HQRP Compliance Checklist | | |
|---|---|---|
| **Annual Payment Update** | **HIS/HOPE** | **CAHPS** |
| | admission/discharges occurring 1/1/2027 – 12/31/2027 | |
| FY 2030 | Submit at least 90 percent of all HOPE records within 30 days of the event or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient admission/discharges occurring 1/1/2028 – 12/31/2028 | Ongoing monthly participation in the Hospice CAHPS survey 1/1/2028 – 12/31/2028 |

## III. Regulatory Impact Analysis

CMS states that the overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $785 million or 2.4 percent, for FY 2027. The proposed hospice payment update percentage of 2.4 is based on the proposed 3.2 percent inpatient hospital market basket percentage increase reduced by a proposed 0.8 percentage point productivity adjustment.

The impact analysis represents the projected effects of the changes in hospice payments from FY 2026 to FY 2027 using the most recent complete available data for this proposed rule (FY 2025 hospice claims data as of January 15, 2026). This includes the changes resulting from the updated wage data and the hospice payment update.

Table 21 in the proposed rule (recreated below) shows the overall total FY 2027 impact to hospices by facility type and area of country. In brief, proprietary (for-profit) hospices (about three-quarters of all hospices) are expected to have an increase in hospice payments of 2.4 percent compared with 2.5 percent for non-profit and an increase of 3.2 percent for government hospices. Hospices located in rural areas would see an increase of 3.0 percent compared with 2.3 percent for hospices in urban areas. The projected overall impact on hospices varies more among regions of country – a direct result of the variation in the annual update to the wage index. Hospices providing services in the Outlying and New England regions would experience the largest estimated increase in payments of 3.6 and 3.3 percent, respectively, in FY 2027 payments. By contrast, hospices serving patients in the West South Central and East South Central regions would experience, on average, the lowest estimated increase of 2.0 and 2.1 percent, respectively, in FY 2027 payments.

| Table 21: Impact to Hospices for FY 2027 | | | | |
|---|---|---|---|---|
| **Hospice Subgroup** | **Hospices** | **FY 2027 Updated Wage Data** | **FY 2027 Proposed Hospice Payment Update (2.4%)** | **Overall Total Impact for FY 2027** |
| **All Hospices** | 6,642 | 0.0% | 2.4% | 2.4% |
| **Hospice Type and Control** | | | | |
| **Freestanding/Non-Profit** | 777 | 0.1% | 2.4% | 2.5% |
| **Freestanding/For-Profit** | 4,835 | 0.0% | 2.4% | 2.4% |
| **Freestanding/Government** | 34 | 0.5% | 2.4% | 2.9% |

| Table 21: Impact to Hospices for FY 2027 | | | | |
|---|---|---|---|---|
| **Hospice Subgroup** | **Hospices** | **FY 2027 Updated Wage Data** | **FY 2027 Proposed Hospice Payment Update (2.4%)** | **Overall Total Impact for FY 2027** |
| **Freestanding/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Facility/HHA Based/Non- Profit** | 260 | 0.0% | 2.4% | 2.4% |
| **Facility/HHA Based/For-Profit** | 3 | 1.2% | 2.4% | 3.6% |
| **Facility/HHA Based/Government** | 94 | 1.0% | 2.4% | 3.4% |
| **Facility/HHA Based/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Subtotal: Freestanding Facility Type** | 5,646 | 0.0% | 2.4% | 2.4% |
| **Subtotal: Facility/HHA Based Facility Type** | 357 | 0.1% | 2.4% | 2.5% |
| **Subtotal: Non-Profit** | 1,048 | 0.1% | 2.4% | 2.5% |
| **Subtotal: For Profit** | 5,144 | 0.0% | 2.4% | 2.4% |
| **Subtotal: Government** | 128 | 0.8% | 2.4% | 3.2% |
| **Subtotal: Other** | 8 | 0.4% | 2.4% | 2.8% |
| **Hospice Type and Control: Rural** | | | | |
| **Freestanding/Non-Profit** | 201 | 0.9% | 2.4% | 3.3% |
| **Freestanding/For-Profit** | 404 | 0.4% | 2.4% | 2.8% |
| **Freestanding/Government** | 22 | 0.6% | 2.4% | 3.0% |
| **Freestanding/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Facility/HHA Based/Non- Profit** | 109 | 0.7% | 2.4% | 3.1% |
| **Facility/HHA Based/For-Profit** | 0 | 0.0% | 2.4% | 2.4% |
| **Facility/HHA Based/Government** | 68 | 1.1% | 2.4% | 3.5% |
| **Facility/HHA Based/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Hospice Type and Control: Urban** | | | | |
| **Freestanding/Non-Profit** | 576 | 0.0% | 2.4% | 2.4% |
| **Freestanding/For-Profit** | 4,431 | -0.1% | 2.4% | 2.3% |
| **Freestanding/Government** | 12 | 0.4% | 2.4% | 2.8% |
| **Freestanding/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Facility/HHA Based/Non- Profit** | 151 | -0.1% | 2.4% | 2.3% |
| **Facility/HHA Based/For- Profit** | 3 | 1.2% | 2.4% | 3.6% |
| **Facility/HHA Based/Government** | 26 | 1.0% | 2.4% | 3.4% |
| **Facility/HHA Based/Other** | 0 | 0.0% | 2.4% | 2.4% |
| **Hospice Location: Urban or Rural** | | | | |
| **Rural** | 851 | 0.6% | 2.4% | 3.0% |
| **Urban** | 5,791 | -0.1% | 2.4% | 2.3% |
| **Hospice Location: Region of the Country (Census Division)** | | | | |

| Table 21: Impact to Hospices for FY 2027 | | | | |
|---|---|---|---|---|
| **Hospice Subgroup** | **Hospices** | **FY 2027 Updated Wage Data** | **FY 2027 Proposed Hospice Payment Update (2.4%)** | **Overall Total Impact for FY 2027** |
| **New England** | 161 | 0.9% | 2.4% | 3.3% |
| **Middle Atlantic** | 282 | 0.6% | 2.4% | 3.0% |
| **South Atlantic** | 648 | -0.1% | 2.4% | 2.3% |
| **East North Central** | 657 | -0.2% | 2.4% | 2.2% |
| **East South Central** | 251 | -0.3% | 2.4% | 2.1% |
| **West North Central** | 443 | 0.4% | 2.4% | 2.8% |
| **West South Central** | 1,293 | -0.4% | 2.4% | 2.0% |
| **Mountain** | 693 | -0.2% | 2.4% | 2.2% |
| **Pacific** | 2,134 | 0.2% | 2.4% | 2.6% |
| **Outlying** | 80 | 1.2% | 2.4% | 3.6% |
| **0 - 3,499 RHC Days (Small)** | 1,588 | 0.2% | 2.4% | 2.6% |
| **3,500-19,999 RHC Days (Medium)** | 2,983 | 0.2% | 2.4% | 2.6% |
| **20,000+ RHC Days (Large)** | 2,071 | 0.0% | 2.4% | 2.4% |

**Source:** FY 2025 hospice claims data from CCW accessed on January 15, 2026.

**Region Key: New England**=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
**Middle Atlantic**=Pennsylvania, New Jersey, New York;
**South Atlantic**=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
**East North Central**=Illinois, Indiana, Michigan, Ohio, Wisconsin
**East South Central**=Alabama, Kentucky, Mississippi, Tennessee
**West North Central**=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
**West South Central**=Arkansas, Louisiana, Oklahoma, Texas
**Mountain**=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
**Pacific**=Alaska, California, Hawaii, Oregon, Washington
**Outlying**=Guam, Puerto Rico, Virgin Islands-9q