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Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements [CMS-1851-F]
Final Rule Summary

I. Introduction and Background

On August 3, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 49118) a final rule updating the Medicare hospice payment rates, wage index and Hospital Quality Reporting Program (HQRP) for FY 2027. This final 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, CMS finalizes its proposal to require hospices to provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election, rather than upon request. This final rule also summarizes comments received from requests for information on enhancing community palliative care services, the development of a hospice-specific wage index, 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 finalizes its proposal 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 final rule will be an increase of $755 million (2.3 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 Hospice Wage Index | CMS.

II. Provisions of the Final Rule

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

Summary of Key Data for Final Hospice Payment Rates for FY 2027			
Market basket update factor			
Market basket increase			+3.2%
Required total factor productivity (TFP)			-0.9%
Net TFP-adjusted update reporting quality data			**+2.3%**
Net TFP-adjusted update not reporting quality data			**-1.7%**
Hospice aggregate cap amount			$36,174.75
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2026 Federal Rates Per Diem**	**FY 2027 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$230.83	$236.35
Routine Home Care (days 61+)	66.0%	$181.94	$186.35
Continuous Home Care, Full Rate = 24 hours of care	75.2%	$1,674.29	$1,726.50
Inpatient Respite Care	61.0%	$532.48	$545.98
General Inpatient Care	63.5%	$1,119.86	$1,231.63
Service Intensity Add-on (SIA) payment, up to 4 hours			$71.94 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 finalizes its proposal to use the hospice wage index 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 will 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 final FY 2027 wage index value for Hinesville-Fort Stewart, Georgia is 0.8915.

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 uses 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 final FY 2027 hospice wage index of 0.8297 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. The wage index for rural Puerto Rico will be based on this hospital data. Specifically, the 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 FY 2027 wage index is 0.3990.

Selected Comments/Responses. Commenters broadly supported the concept of updating the hospice wage index but opposed the current hospital-based methodology as fundamentally misaligned with hospice labor markets. Reasons cited included that the inpatient hospital data fails to adequately account for unique and considerable hospice-specific circumstances such as the costs associated with travel to patients' homes and a workforce mix dominated by nurses, social workers, and aids rather than hospital occupational categories. Another commenter recommended several smoothing methodologies that better reflect shared labor markets and reduce artificial payment cliffs such as regional rural smoothing across contiguous states. A commenter also requested a technical improvement to the Wage Index file to create an additional column to distinguish those counties that completed their transition in a prior FY from those newly entering or continuing transition in FY 2027.

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

CMS replies that it did not propose any changes to the FY 2027 hospice wage index methodology in the proposed rule but did request information on changes to the hospice wage index methodology and may consider these recommendations and the comments received on the RFI in future rulemaking. With respect to the technical improvement to the Wage Index file, CMS has updated the FY 2027 Wage Index File with a new column labeled "Transition Code Status". This column outlines whether the transition code should continue to be used for FY 2027 or the FY that the code was phased out.

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 second quarter 2026 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 0.9 percentage points (0.1 percentage points higher than in the proposed rule). This results in a final hospice payment update percentage for FY 2027 of 2.3 percent (slightly lower than the 2.4 percent proposed). Hospices that do not submit the required quality data under the HQRP would receive a payment update percentage for FY 2027 of -1.7 percent.

Thus, CMS updates 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 0.9 percentage points along with the wage index budget neutrality adjustment to update the payment rates. For the FY 2027 hospice wage index, CMS finalizes its proposal 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.

Selected Comments/Responses. Numerous commenters, including national associations, state hospice associations, large health systems, and individual providers, expressed strong concerns that the proposed 2.4 percent FY 2027 hospice payment update was insufficient to keep pace with the actual cost of delivering high-quality hospice care. Commenters specifically stated that this proposed update would not sufficiently account for the cost pressures, including rising labor costs, transportation expenses, and medical supply inflation. Several commenters also recommended that CMS continue to evaluate whether the inpatient hospital market basket remains an appropriate proxy for hospice cost structures and supported the development of a hospice-specific market basket as a long-term policy priority. In addition, commenters believed that the productivity adjustment does not reflect hospice-specific workforce realities, and that CMS should work with the Congress to repeal or suspend the productivity adjustment for hospice, or at minimum moderate its application for FY 2027.

CMS states that while it appreciates the comments, CMS is statutorily required to update hospice PPS payments by the IPPS market basket percentage increase reduced by the productivity adjustment and does not have discretionary authority to deviate from this statutory formula. To the extent that commenters believe that the statutory productivity adjustment is inappropriate for

hospice, CMS encourages interested parties to engage with the Congress on potential legislative modifications to section 1814(i)(1)(C)(iv)(I) of the Act, which requires the reduction.

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 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 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) list the FY 2027 hospice payment rates by care category and the wage index standardization factors.

Table 1: FY 2027 Hospice RHC Payments

Code	Description	FY 2026 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2027 Hospice Payment Update	FY 2027 Payment Rates
651	Routine Home Care (days 1-60)	$230.83	× 0.9999	× 1.0010	× 1.023	$236.35
651	Routine Home Care (days 61+)	$181.94	× 0.9999	× 1.0013	× 1.023	$186.35

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

Table 2: Final FY 2027 Hospice CHC, IRC, and GIP Payment Rates					
Code	**Description**	**FY 2026 Payment Rates**	**Wage Index Standardization Factor**	**FY 2027 Hospice Payment Update**	**FY 2027 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,674.29	× 1.0080	× 1.023	$1,726.50 ($71.94 per hour)
655	Inpatient Respite Care	$532.48	× 1.0023	× 1.023	$545.98
656	General Inpatient Care	$1,199.86	× 1.0034	× 1.023	$1,231.63

Tables 3 and 4 found in the final rule preamble list the comparable FY 2027 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), $227.11; Routine Home Care (days 61+), $179.06; Continuous Home Care, $1,658.99; Inpatient Respite Care, $524.63; and General Inpatient Care, $1,183.47.

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 SAI payment is $71.94 per hour, up to 4 hours. In addition, for FY 2027, the SIA budget neutrality factor is 0.9999 for RHC days 1-60 and 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 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. Using updated hospice claims data, the hospice aggregate cap amount for the FY 2027 cap year will be $36,174.75 per beneficiary or the FY 2026 cap amount updated by the FY 2027 hospice payment update percentage ($35,361.44 * 1.023).

[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.

B. Non-Hospice Spending During a Hospice Election

1. Medicare Non-Hospice Spending

In the proposed rule and replicated in the final 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 final 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.

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 25th percentile (in FY 2025, the 25th percentile was 85.7%)	1
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

Table 9: Description of SSVI Metrics, Threshold Values, and Points Allocated		
Metric Description	**Threshold Value**	**Points**
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 the final 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 final 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 2025		**FY 2024**	
Total Score	**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	330	4.9%	334	5.0%
3	517	7.7%	564	8.4%
4	721	10.8%	760	11.3%
5	893	13.4%	838	12.4%

6	888	13.3%	918	13.6%
7	912	13.7%	862	12.8%
8	910	13.6%	920	13.7%
9	577	8.6%	629	9.3%
10	397	5.9%	366	5.4%
11	241	3.6%	255	3.8%
12	127	1.9%	116	1.7%
13	53	0.8%	48	0.7%
14	15	0.2%	28	0.4%
15	1	0.0%	0	0.0%
16	0	0.0%	0	0.0%
Total Hospices	**6,673**	**100.0%**	**6,735**	**100.0%**

Source: The data used was pulled from the CCW VRDC on May 12, 2026.

Note*:* The development of the FY 2025 Hospice SSVI included 6,773,919 hospice claims, representing 6,673 hospices and a total of 156,995,825 hospice days. The data used was pulled from the CCW VRDC on May 12, 2026. 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.

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 sought feedback on the metrics used to calculate the SSVI score, the threshold values and point assignments.

Selected Comments/Responses. Commenters were largely critical of the metrics used to calculate the SSVI and whether the SSI framework would be able to distinguish between inappropriate utilization and clinically appropriate hospice care. Specifically, commenters opposed the use of the SSVI due to methodological concerns, such as thresholds used for the scoring assignment, the validity of the measures used, divergence between SSVI and the hospice care index (HCI), and the overemphasis on non-hospice spending in the scoring. Some commenters also recommended that CMS take down the SSVI from public view. Many commenters also opposed the use of the SSVI and the overall use of administrative data for oversight, stating that claims-based measures may not help target medical reviews and investigations related to fraud, waste, and abuse.

In response, CMS reminds commenters that the SSVI is a descriptive tool that uses a scoring system that represents different aspects of hospice utilization, as well as non-hospice spending, with the intent to score hospices comprehensively, rather than on a single care dimension. CMS continues to believe that the SSVI is a vital tool to provide information to interested parties, such

as beneficiaries and caregivers, and does not believe removing the SSVI from the CMS website is in their best interests. Providing this information publicly also supports CMS' efforts to provide transparent data to interested parties.

CMS was also unclear and highly skeptical of the many legitimate reasons for administrative discharge claimed by commenters. When FY 2025 claims show that more than 400 hospices have 90 to 100 percent live discharge rates and 25 hospices have 50 percent or more live discharge rates returning in 7 days, CMS states it is unclear whether the high live discharge rates are due to beneficiary choice or whether there is inappropriate enrollment and the hospices warrant further review. CMS states another concern highlighted by these data that over 100 hospices had no beneficiaries where skilled visits were provided in their last two routine home care days of life. CMS stresses that the SSVI is designed to complement the HCI's claim-based measures and is valuable tool to help patients, families, and caregivers choose hospice providers based on the factors that matter most to them. After consideration of the public comments, CMS is maintaining the design of the SSVI using the current measures and scoring assignments.

C. 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

Required Content of the Hospice Election Statement	
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. Mandatory Hospice Election Statement Addendum for all Elections

CMS finalize its proposal 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' policy will 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 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.

Selected Comments/Responses. Many commenters stated that the proposed mandatory statement addendum would not address the root causes of non-hospice spending, stated concerns that the addendum may confuse patients, cited claim denial concerns, and requested explanations as to why a mandatory election statement addendum is necessary. CMS also received comments that supported the proposed mandatory addendum for its potential to save Medicare program expenditures, reduce beneficiary cost-sharing, support more complete corrective architecture to help at-risk elderly populations, and to decrease non-hospice spending.

In its reply, CMS agrees that non-hospice spending is multifactorial problem with various contributing causes. However, CMS strongly disagrees that the proposed mandatory election statement addendum is unnecessary or ineffective. CMS states that the data documented in this proposed rule along with comments received in support of requiring the addendum to be provided at the time of hospice election, raises serious and specific concerns about whether hospices are fulfilling their existing statutory and regulatory obligations; obligations that exist independent of the proposed addendum requirement. Furthermore, CMS states that it is particularly concerned by the data showing that items, services, and drugs that are foundational to hospice care, and are not exceptional or unusual, such as, but not limited to, wheelchairs, hospital beds, oxygen supplies, wound care supplies, incontinence supplies, catheters, needles, and common palliative drugs, are being billed outside the hospice benefit for patients whose terminal diagnoses directly and foreseeably give rise to the need for these items.

In response to the comments that only 1 in 5 patients request the addendum and that 5 to 7 percent of admissions have completed addenda, CMS notes that the exceptionally low reported request rate raise concerns about whether hospices are fulfilling their required obligations and properly informing beneficiaries of their rights and coverage determinations. CMS emphasizes that hospice beneficiaries are among the most vulnerable Medicare population, and they, along with their entire care team, need to have access to complete information about what services will and will not be covered by the hospice at the time of election to ensure that the beneficiary is truly informed when providing consent to elect the hospice benefit, which waives significant Medicare rights.

CMS states that it further concerned by reports from all parties, including hospice providers, non-hospice providers, and patient advocates, describing the addendum as complex and not written in plain language. CMS reminds all hospices that the addendum is explicitly required under §418.24(c)(6) to include "a written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions." The requirement that the addendum be written in language that the beneficiary can understand is not a suggestion, it is a regulatory requirement. If hospices are producing addenda that are not written in language the individual (or representative) can understand, this represents a failure of compliance with the existing regulatory standard, not a reason to oppose the mandatory requirement.

Many commenters requested that CMS delay implementation for up to 18 months and a few commenters requested that the proposed mandatory addendum timeframe to furnish the hospice election statement be extended; with requests ranging from beyond 5 days and up to 15 days. CMS disagrees and states that hospices have had since FY 2020, when the addendum was initially finalized, to implement the addendum requirements with the assumption that every beneficiary could request an addendum. CMS also does not believe additional time is needed beyond 5 days to furnish the mandatory addendum and reminds readers that it extended the timeframe in the 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484) from 48 hours to 5 days to align with the comprehensive assessment requirements, in response to commenters' requests for additional time and to align the addendum timeframe with existing hospice admission regulations.

D. Clarifying Regulation Text Changes

1. Discharge from Hospice Care

This rule finalizes 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 finalizes 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.

Selected Comments/Responses. All commenters supported this proposal, stating that they would welcome the clarification that hospices may obtain written physician discharge orders from a physician designee (as defined at §418.3) or a physician member of the interdisciplinary group. Commenters broadly noted that this change would reflect current real-world practice, align with other recent regulator language changes, and would allow hospices to complete discharge orders on a timelier basis.

2. Face-to-Face Encounter

This rule also finalizes 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 is amending §418.22(a)(4)(ii). The regulatory language requires 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 sought 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).

Selected Comments/Responses. The majority of commenters support the proposal to amend §18.22(a)(4)(ii) in alignment with the CAA 2026, agreeing that the requirement to report a G-code identifying telehealth-conducted face-to-face encounters would not be overly burdensome and is feasible for most hospice providers. No commenters directly opposed the proposal.

E. Requests for Information on Medicare Services and Payment Structure

The proposed rule included 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." These are described below along with a summary of the comments CMS received.

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 requested feedback 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 were able to 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?

Selected Comments/Responses. Commenters broadly support CMS' interest in expanding community-based palliative care, citing strong evidence that palliative care reduces avoidable hospitalizations, improves symptom management, and facilitates more timely and appropriate hospice elections. Many commenters stated that existing evaluation and management, care management, and advanced care planning codes do not capture the full interdisciplinary scope of palliative care, particularly services provided by nurses, aides, social workers, chaplains, and community health workers, leaving many programs financially unsustainable. Commenters suggested creating a new comprehensive palliative care assessment and care planning G-code. Other commenters, however, supported retaining the existing coding structure, stating that

existing codes (mainly the chronic care management, advanced care planning, and evaluation and management codes) are sufficient to capture palliative care services, and adding additional codes would likely introduce unnecessary complexity. Another commenter recommended implementing a modifier that designates services as palliative care and suggested that the modifier should also differentiate between inpatient and home-based services.

CMS states that it appreciates the feedback and will take all suggestions into consideration to the extent possible.

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.

CMS stated that it was 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 requested 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 sought feedback on the unique considerations applicable to hospices and the potential use of alternative data sources.

CMS sought 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)

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

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 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 sought 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 sought 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 sought 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 solicited 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?

Selected Comments/Responses. In general, commenters expressed support for a hospice-specific wage index that better captures the occupations used in hospices relative to hospitals. Many commenters were concerned whether the methodology would capture local geographic differences and reflect hospice occupational labor mix. Some commenters recommended that CMS account for rural travel, mileage, on-call coverage, provider-level impact modeling, and delay in implementation to avoid abrupt geographic disruptions.

CMS thanks commenters for raising their concerns and states that while it is not responding to specific comments in response to the RFI in this final rule, CMS will take this feedback into consideration as it examines possible alternatives to using the IPPS wage index for geographically adjusting hospice payments.

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

In the proposed rule, CMS sought feedback 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 sought 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 also requested 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.

Selected Comments/Responses. Overwhelmingly, commenters opposed any potential CMS policy that would integrate MAID into Medicare-funded hospice care, primarily citing the Assisted Suicide Funding Restriction Act, ethical concerns rooted in the Hippocratic tradition, risks to vulnerable populations, and the importance of using different terminology ("assisted suicide," rather than MAID). Several physician commenters also raised concerns about billing fraud and the need for stronger CMS oversight, such as service audits. Another commenter stated that accreditation requirements should clearly outline how the hospice agency complies with Federal statutes on funding in those states where assisted suicide is allowed.

CMS emphasizes that this request for information was in no way intended to precede a proposal or to indicate that it is considering the integration of MAID into hospice care. CMS states its intent was to gain a better understanding of the landscape around hospice care and MAID to determine whether more oversight is required to safeguard the use of Federal funds from the provision of MAID items and services.

F. Updates to the Hospice Quality Reporting Program

1. Background and Overview

The Hospice Quality Reporting Program (HQRP)[5] includes the Hospice Outcomes and Patient Evaluation (HOPE) tool (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.

CMS finalizes its proposal 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]

[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 HOPE) 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 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.
[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.

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: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 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) 1. Continuous Home Care (CHC) or General Inpatient Provided (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) - Live Discharges form Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Care preferences 8. Rating of this hospice 9. Willing to recommend this hospice

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

CMS finalizes its proposal to include on the Medicare.gov Compare Tool an icon identifying hospices that have failed to meet HQRP reporting requirements (i.e., failed to submit any data or submitted less than the required 90 percent of HOPE submissions within 30 days of the target dates). The icon will be added to the Medicare.gov Compare Tool no earlier than FY 2028 (October 1, 2027) and the data will be based on CY 2026 APU submission data. The icon will 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 inclusion of 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 identified by the icon for CMS to measure quality of care.

CMS clarifies that the icon will only be based on HOPE admissions (admissions, HUVs, and discharges) and will not include CAHPS data submission compliance. Any hospice exempted from HQRP reporting requirements, such as due to extraordinary circumstances, will not be identified by the icon.

Comments/Responses. Several commenters supported the proposal, particularly for purposes of improving quality reporting compliance and promoting transparency. Some commenters requested CMS ensure the icon is presented in a consumer-friendly manner, including to explain the icon represents failure to meet reporting requirements and not quality of care or safety issues at the hospice. CMS responds that it will include a plain-language explanation of what the icon means. Other commenters were opposed to an icon representing a negative (rather than positive) aspect of a hospice and raised concerns about the icon being confusing or misleading. CMS points to nursing homes, which use a negative icon to indicate when a facility has been cited for abuse and states that a negative icon is a more effective incentive for hospices to meet HQRP requirements.

Many commenters requested that CMS distinguish between those hospices that do not submit any data and those that do submit data but fall below the 90 percent threshold. However, CMS believes that since the percentage of hospices not meeting HQRP reporting requirements has remained consistent (around 20 percent) since FY 2023 hospices are not improving and that there is not a concern that some are just falling short of the guidelines from time to time. Therefore, CMS does not believe a distinction between the two groups is needed.

4. Future Measure Updates

In the proposed rule, CMS noted that it 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.

Comments received generally supported efforts to refine and re-specify the HCI. Multiple commenters recommended reducing redundancies and enhancing transparency around CMS' methodology, testing, and impact analyses before finalizing changes. CMS responds that comments will be taken into consideration in the development of the revised HCI.

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 F.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.

[10] www.hospicecahpssurvey.org

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 admission/discharges occurring 1/1/2027 – 12/31/2027	Ongoing monthly participation in the Hospice CAHPS survey 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 final rule is an estimated net increase in Federal Medicare payments to hospices of $755 million or 2.3 percent, for FY 2027. The hospice payment update percentage of 2.3 is based on the 3.2 percent inpatient hospital market basket percentage increase reduced by a 0.9 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 final rule (FY 2025 hospice claims data as of May 12, 2026). This includes the changes resulting from the updated wage data and the hospice payment update.

Table 22 in the final 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) and non-profit hospices are expected to have an increase in hospice payments of 2.3 percent compared with an increase of 3.2 percent for government hospices. Hospices located in rural areas would see an increase of 2.9 percent compared with 2.2 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 3.4 and 3.1 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 1.9 and 2.0 percent, respectively, in FY 2027 payments.

Table 22: Impact to Hospices for FY 2027				
Hospice Subgroup	**Hospices**	**FY 2027 Updated Wage Data**	**FY 2027 Hospice Payment Update (2.3%)**	**Overall Total Impact for FY 2027**
All Hospices	6,673	0.0%	2.3%	2.3%
Hospice Type and Control				
Freestanding/Non-Profit	782	0.0%	2.3%	2.3%
Freestanding/For-Profit	4,856	0.0%	2.3%	2.3%
Freestanding/Government	34	0.7%	2.3%	3.0%
Freestanding/Other	0	0.0%	2.3%	2.3%
Facility/HHA Based/Non- Profit	258	0.0%	2.3%	2.3%
Facility/HHA Based/For-Profit	3	1.2%	2.3%	3.5%
Facility/HHA Based/Government	94	1.0%	2.3%	3.3%
Facility/HHA Based/Other	0	0.0%	2.3%	2.3%
Subtotal: Freestanding Facility Type	5,672	0.0%	2.3%	2.3%
Subtotal: Facility/HHA Based Facility Type	355	0.2%	2.3%	2.5%
Subtotal: Non-Profit	1,050	0.0%	2.3%	2.3%
Subtotal: For Profit	5,172	0.0%	2.3%	2.3%
Subtotal: Government	128	0.9%	2.3%	3.2%
Subtotal: Other	6	0.7%	2.3%	3.0%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	203	0.9%	2.3%	3.2%
Freestanding/For-Profit	408	0.4%	2.3%	2.7%
Freestanding/Government	22	0.6%	2.3%	2.9%
Freestanding/Other	0	0.0%	2.3%	2.3%
Facility/HHA Based/Non- Profit	108	0.7%	2.3%	3.0%
Facility/HHA Based/For-Profit	0	0.0%	2.3%	2.3%
Facility/HHA Based/Government	68	1.1%	2.3%	3.4%
Facility/HHA Based/Other	0	0.0%	2.3%	2.3%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	579	-0.1%	2.3%	2.2%
Freestanding/For-Profit	4,448	-0.1%	2.3%	2.2%
Freestanding/Government	12	0.7%	2.3%	3.0%
Freestanding/Other	0	0.0%	2.3%	2.3%
Facility/HHA Based/Non- Profit	150	-0.1%	2.3%	2.2%

Table 22: Impact to Hospices for FY 2027				
Hospice Subgroup	**Hospices**	**FY 2027 Updated Wage Data**	**FY 2027 Hospice Payment Update (2.3%)**	**Overall Total Impact for FY 2027**
Facility/HHA Based/For- Profit	3	1.2%	2.3%	3.5%
Facility/HHA Based/Government	26	1.0%	2.3%	3.3%
Facility/HHA Based/Other	0	0.0%	2.3%	2.3%
Hospice Location: Urban or Rural				
Rural	857	0.6%	2.3%	2.9%
Urban	5,816	-0.1%	2.3%	2.2%
Hospice Location: Region of the Country (Census Division)				
New England	162	0.8%	2.3%	3.1%
Middle Atlantic	282	0.6%	2.3%	2.9%
South Atlantic	653	-0.1%	2.3%	2.2%
East North Central	661	-0.2%	2.3%	2.1%
East South Central	252	-0.3%	2.3%	2.0%
West North Central	446	0.4%	2.3%	2.7%
West South Central	1,302	-0.4%	2.3%	1.9%
Mountain	697	-0.2%	2.3%	2.1%
Pacific	2,137	0.2%	2.3%	2.5%
Outlying	81	1.1%	2.3%	3.4%
Hospice Sizes				
0 - 3,499 RHC Days (Small)	1,611	0.2%	2.3%	2.5%
3,500-19,999 RHC Days (Medium)	2,984	0.2%	2.3%	2.5%
20,000+ RHC Days (Large)	2,078	0.0%	2.3%	2.3%

Source: FY 2025 hospice claims data from CCW accessed on May 12, 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