# FY 2027 Hospice Final Rule (CMS-1851-F)

The FY 2027 Hospice Final Rule includes updates to Medicare hospice payment rates, quality reporting requirements, beneficiary protections, and several operational regulations impacting hospice providers. CMS also finalized changes related to the Election Statement Addendum, face-to-face encounter requirements, public reporting, and oversight of hospice utilization and non-hospice spending.

## Payment Updates

The FY 2027 Hospice Final Rule includes a 2.3% payment increase for hospice providers, representing an estimated $755 million increase in Medicare hospice payments nationwide. CMS also updated the hospice wage index, finalized an aggregate cap amount of $36,174.75, and maintained the 4 percentage point quality reporting penalty for hospices that fail to meet HQRP requirements.

**FY 2027 Hospice RHC Payment Rates**

| Code | Description | FY 2026 Rate | SIA Factor | Wage Index Standardization Factor | FY 2027 Update | FY 2027 Rate |
|---|---|---|---|---|---|---|
| 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 |

**FY 2027 CHC, IRC, and GIP Payment Rates**

| Code | Description | FY 2026 Rate | Wage Index Standardization Factor | FY 2027 Update | FY 2027 Rate |
|---|---|---|---|---|---|
| 652 | Continuous Home Care (24-Hour Rate) | $1,674.29 | 1.0080 | 1.023 | $1,726.50 |
| 652 | Continuous Home Care (Hourly Rate) | $69.76 | 1.0080 | 1.023 | $71.94 |
| 655 | Inpatient Respite Care (IRC) | $532.48 | 1.0023 | 1.023 | $545.98 |
| 656 | General Inpatient Care (GIP) | $1,199.86 | 1.0034 | 1.023 | $1,231.63 |

**FY 2027 Hospice Aggregate Cap**

| FY 2026 Cap | FY 2027 Cap |
|---|---|
| $35,361.44 | $36,174.75 |

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## Hospice Election Statement Addendum—New Requirement Effective October 1, 2026

CMS finalized a significant change requiring hospices to provide the Hospice Election Statement Addendum to every Medicare beneficiary at the time of hospice election. Previously, the addendum was only required upon request. CMS believes this change will improve beneficiary understanding of hospice coverage, reduce unexpected cost-sharing, strengthen care coordination with non-hospice providers, and increase transparency regarding items, services, and medications determined to be unrelated to the terminal illness and related conditions.

**Why CMS Made This Change**

Increased focus on non-hospice spending

- Improved beneficiary transparency
- Better coordination of covered and non-covered services
- Enhanced program integrity oversight

What Hospice Providers Need to Know

⇒ Required for all hospice elections
⇒ Must be provided within 5 days of election
⇒ Must be updated within 3 days when coverage determinations change
⇒ Must clearly identify non-covered items, services, and medications
⇒ Must include a patient-friendly clinical explanation
⇒ Must be available to beneficiaries, representatives, providers, and Medicare contractors upon request

## Hospice Quality Reporting Program (HQRP)

**Continued Transition to the HOPE Tool**

The Hospice Outcomes and Patient Evaluation (HOPE) tool continues to be the foundation of the Hospice Quality Reporting Program after replacing the Hospice Item Set (HIS) on October 1, 2025. HOPE is designed to provide CMS with more comprehensive patient assessment data throughout the hospice stay and will support future quality measure development and public reporting. CMS currently anticipates public reporting of HOPE-based quality measures beginning in October 2027, following evaluation of data quality and measure reliability.

**HQRP Compliance Requirements**

To remain compliant with HQRP requirements and avoid payment penalties, hospices must submit at least 90% of all required HOPE assessments within 30 days of the assessment target date. This includes admission, discharge, and required Hospice Update Visit (HUV) records. CMS considers timely and complete data submission essential for measuring hospice quality and supporting public reporting initiatives.

**Financial Impact of Non-Compliance**

Hospices that fail to meet HQRP submission requirements are subject to a 4 percentage point reduction to their annual payment update. For FY 2027, hospices that meet all Hospice Quality Reporting Program (HQRP) requirements will receive the full 2.3% payment update. Hospices that fail to meet HQRP reporting requirements will be subject to a 4% reduction to their annual payment update, resulting in an overall 1.7% payment reduction rather than a 2.3% increase. CMS continues to emphasize quality reporting as a significant compliance and reimbursement priority.

**Additional HQRP Updates**

CMS also finalized a new Care Compare reporting icon that will identify hospices failing to meet HQRP reporting requirements. This initiative is intended to increase transparency for beneficiaries and encourage timely data submission. As CMS expands public reporting and quality oversight, hospices should prioritize HOPE education, monitoring of submission timeliness, and ongoing quality reporting compliance efforts.



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## Service and Spending Variation Index (SSVI)

**New Public Reporting & Oversight Initiative**

CMS finalized the Service and Spending Variation Index (SSVI), a new claims-based scoring system designed to evaluate hospice utilization patterns and Medicare spending outside the hospice benefit. The SSVI combines multiple indicators into a single score to identify hospices whose utilization patterns differ significantly from their peers.

**What Does the SSVI Measure?**

The SSVI combines multiple claims-based indicators into a single score that evaluates both hospice utilization and non-hospice spending patterns, including:

- Non-hospice Medicare spending
- Non-hospice spending per beneficiary day
- Length of stay trends
- Live discharge rates
- Beneficiaries readmitted to the same hospice within 7 days of discharge
- Skilled visits during the last days of life
- Weekend visit patterns
- Visit utilization and service intensity
- Other claims-based indicators associated with quality and program integrity concerns

CMS assigns points across these measures and calculates a total SSVI score. Higher scores indicate a greater concentration of utilization patterns that may warrant additional review.

**Why It Matters**

CMS intends to use the SSVI to:

- Identify hospice outliers
- Enhance program integrity efforts
- Support beneficiary decision-making
- Increase transparency
- Target potential fraud, waste, and abuse concerns

**What Hospices Should Expect**

- Public reporting of SSVI data and scores
- Continued CMS monitoring of non-hospice spending and utilization trends
- Potential use of high SSVI scores to prioritize medical review, education, investigations, and other oversight activities

**Key Takeaway**

The SSVI signals CMS's increasing focus on non-hospice spending, live discharges, visits near death, and overall hospice utilization patterns. Hospices should begin monitoring these metrics internally as they are expected to play a growing role in future compliance and program integrity initiatives.



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## Other Key Areas

### Hospice Discharges

CMS finalized clarification allowing discharge orders to be signed by:

- Hospice Medical Director
- Physician Designee
- Physician Member of the IDG

This aligns discharge regulations with certification and admission requirements.

### Telehealth Flexibility Extended Through December 31, 2027

- CMS finalized an extension allowing hospice physicians and nurse practitioners to conduct required face-to-face encounters for hospice recertification via telehealth through December 31, 2027. This continues the flexibility many hospices rely on to support patients in rural, underserved, and geographically challenging areas.

### New Reporting Requirement

- Beginning January 1, 2027, hospices must include a CMS-designated G-code/modifier on claims when the recertification face-to-face encounter is performed via telehealth. CMS will use this information to monitor telehealth utilization and ensure compliance with Medicare requirements.

### Key Takeaway

- Hospices should review recertification and billing processes, educate staff on the new coding requirements, and monitor future CMS guidance regarding telehealth face-to-face encounter reporting

### New Care Compare Icon

- Beginning no earlier than FY 2028: CMS will display an icon on Care Compare identifying hospices that fail HQRP reporting requirements.
- Purpose:
  - ⇒ Increase transparency
  - ⇒ Alert consumers to missing quality data
  - ⇒ Encourage compliance

### Requests for Information (RFI)

While CMS did not finalize policy changes in these areas, the FY 2027 Hospice Final Rule includes summaries of stakeholder feedback that may shape future hospice and palliative care regulations. CMS is seeking input on several emerging issues impacting end-of-life care delivery, access, reimbursement, and program integrity.

### Community-Based Palliative Care

CMS requested feedback on opportunities to improve access to palliative care services provided outside the hospice benefit. Topics included reimbursement challenges, care coordination, telehealth utilization, advance care planning, social worker involvement, interdisciplinary care delivery, and potential enhancements that could support beneficiaries earlier in the serious illness trajectory.

### Hospice-Specific Wage Index

CMS continues to explore alternatives to the hospital-based wage index currently used for hospice payments. Stakeholder feedback focused on the use of Bureau of Labor Statistics (BLS) wage data, hospice-specific staffing patterns, rural workforce challenges, geographic inequities, and development of a wage index more reflective of hospice operations and labor costs. No changes were finalized, but CMS signaled ongoing evaluation of potential future reforms.

### Medical Aid in Dying (MAID)

CMS sought information regarding hospice involvement when patients reside in states where Medical Aid in Dying is permitted. The agency reiterated that federal funds cannot be used for MAID-related services and requested feedback regarding hospice policies, care coordination, and operational challenges associated with these situations. CMS did not propose or finalize any policy changes related to MAID.



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