ChatGPT Executive Summary of CMS' FY 27 Hospice proposed rule

April 3, 2026

The biggest policy story here is that CMS is pairing a routine payment update with a much more aggressive transparency, compliance, and program-integrity agenda for hospice.

Overall takeaway

This proposed rule gives hospices a modest payment increase, but the more important changes are not financial. CMS is signaling deeper concern about fraud, waste, abuse, under-reporting of quality data, and hospice providers shifting care or costs outside the hospice benefit. The rule's center of gravity is oversight.

1) Payment update is positive, but not the real story

CMS proposes a 2.4% hospice payment update for FY 2027, which it estimates would increase hospice payments by about $785 million. The proposed FY 2027 hospice cap amount would rise to $36,210.11. CMS also estimates rural hospices would see a somewhat larger average increase (3.0%) than urban hospices (2.3%), with smaller hospices seeing slightly larger gains than very large hospices.

Why this matters: financially, this is helpful but not transformative. The more important implication is that CMS is not using this rule mainly to cut base rates; instead, it is tightening accountability around how hospice providers operate, document coverage decisions, and report quality.

2) The biggest policy shift: CMS is targeting non-hospice spending during hospice elections

CMS devotes major attention to Medicare non-hospice spending while a beneficiary is enrolled in hospice. The agency says such spending has continued to rise from FY 2020 through FY 2024, especially Part A and Part B spending, even though the hospice benefit is supposed to cover virtually all care related to the terminal illness and related conditions.

To address this, CMS describes a new Service and Spending Variation Index (SSVI) built from nine claims-based measures tied to hospice utilization and non-hospice spending. CMS says the index is meant to identify hospices with patterns that may suggest program-integrity risks, inappropriate utilization, quality problems, or compliance concerns. Higher scores indicate more concerning patterns.

Why you should pay attention: this is one of the most consequential parts of the rule even though it is not yet a direct payment penalty. It gives CMS a structured surveillance tool for identifying outlier hospices. In practice, this could lead to more audits, targeted oversight, reputational pressure, and eventually future enforcement or payment policy built on these measures. The rule is telling the industry that CMS views high non-hospice spending during hospice enrollment as a warning sign.

3) Mandatory hospice election addendum for all patients

CMS proposes to require the hospice election statement addendum for all hospice elections, instead of only when requested. The addendum explains which conditions, items, services, or drugs the hospice has determined are not related to the terminal illness and therefore not covered under the hospice benefit. Under the proposal, the addendum would have to be furnished within the first 5 days of the hospice election, with updates within 3 days of care-plan changes that affect those determinations. The proposal would apply to elections beginning on or after October 1, 2026.

Why this matters: this is a major operational and legal-risk issue. It will force hospices to be much more explicit, early, and consistent in their coverage determinations. That improves beneficiary transparency, but it also creates a clearer paper trail that contractors, regulators, beneficiaries, and non-hospice providers can scrutinize. If a hospice excludes items that CMS later believes should have been covered, that could become an enforcement vulnerability.

4) Quality reporting pressure is rising beyond the payment penalty

Hospices that fail HQRP requirements already face a 4-percentage-point reduction to the annual payment update. CMS says compliance still has not improved enough: about 22.06% of hospices were non-compliant in FY 2024, 23.53% in FY 2025, and 20.37% in FY 2026.

CMS therefore proposes a new public-facing consequence: an icon on Medicare.gov Care Compare to identify hospices that fail to submit any data or submit less than the required 90% of HOPE quality data on time. CMS says this would begin no earlier than FY 2028 (October 1, 2027) and would be updated annually.

Why this matters: this could be more damaging than the payment penalty for some providers. A visible compliance marker on Care Compare creates reputational risk with hospitals, referral sources, families, and managed-care partners. It also fits CMS's broader shift from private compliance problems to public transparency tools.

5) HOPE implementation remains a major operational issue

CMS reiterates that HOPE replaced HIS as the hospice patient assessment tool and was implemented on October 1, 2025. CMS still expects public reporting of HOPE-based measures no earlier than FY 2028, and hospices must hit the 90% timely submission threshold for assessments submitted within 30 days of the admission or discharge date.

Why this matters: many hospices may focus on the payment update and miss the operational burden here. HOPE readiness, timeliness, and data quality are now central compliance issues. The proposed Care Compare icon makes HOPE submission performance a visible business issue, not just a back-office issue.

6) Telehealth for face-to-face recertification is extended, but narrowed

The rule proposes technical changes to align hospice telehealth policy with the Consolidated Appropriations Act, 2026. It would extend telehealth for the face-to-face encounter used for hospice recertification through December 31, 2027. But it also adds guardrails: telehealth would be prohibited in certain situations involving hospice enrollment moratorium areas, providers under enhanced

oversight, or physicians/practitioners who are not properly enrolled or opted out. Starting January 1, 2027, claims would also need modifiers or codes identifying telehealth face-to-face encounters.

Why this matters: this is not simply a telehealth flex extension. CMS is preserving the option while making it much easier to monitor and enforce. Hospices using telehealth recertification will need tighter billing, enrollment, and compliance controls.

7) Discharge authority becomes more flexible

CMS proposes to align its regulations so that a hospice discharge order could come not only from the hospice medical director, but also from a physician designee or the physician member of the interdisciplinary group.

Why this matters: this is mainly an administrative flexibility change, and it should reduce friction for providers. But it also reflects CMS's broader effort to clean up inconsistencies across payment rules and Conditions of Participation. This is not the biggest policy issue in the rule, but it is operationally useful.

8) The RFIs matter because they signal where CMS may go next

CMS includes RFIs on three forward-looking topics: improving community palliative care outside hospice, creating a hospice-specific wage index, and understanding issues around hospice and medical aid in dying. On palliative care, CMS specifically asks about billing pathways, barriers, and what could be improved without creating a new statutory benefit.

Why this matters: the palliative-care RFI is especially important. It suggests CMS is exploring whether serious-illness care can be better supported before hospice election, potentially reducing pressure on the hospice benefit as the only meaningful Medicare pathway for advanced illness care. The hospice-specific wage-index RFI could also become very important if CMS decides the current wage-index framework does not reflect hospice labor patterns well.

What I would watch most closely

The top issues to monitor are the SSVI and non-hospice spending framework, because that appears to be the strongest signal of future program-integrity action. Right behind that is the move to make the election addendum mandatory for all beneficiaries, because it will reshape admission workflow, beneficiary notice practices, and documentation exposure. Third is the Care Compare icon tied to HOPE/HQRP compliance, because public visibility can have outsized market impact. The payment update matters, but it is not the core policy development here.

If you want, I can turn this into a cleaner Hill-style memo or a stakeholder comment letter outline keyed to the provisions most worth supporting or opposing.