STRATEGIC HEALTH CARE

FY 2027 Hospice Final Rule

Summary of the Most Consequential Changes to the Medicare Hospice Program

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Executive Overview

The final rule increases FY 2027 Medicare hospice payments by an estimated $755 million, but the 2.3 percent national update remains below the increases sought by many hospice organizations and does not include a catch-up adjustment for prior market-basket forecast errors. The rule also creates substantially greater transparency and program-integrity exposure through a mandatory election-statement addendum for every beneficiary, annual public SSVI scores, and a future Medicare.gov icon identifying hospices that do not meet HOPE reporting requirements.

The principal compliance dates are October 1, 2026, for the payment rates and mandatory election addendum; January 1, 2027, for claims coding of telehealth face-to-face recertification encounters; December 31, 2027, for the current statutory end of the telehealth recertification flexibility; and no earlier than October 1, 2027, for the new Medicare.gov quality-reporting icon.

Reference pages: 49118-49119.

1. FY 2027 Payment Increase, Rates, and Wage Index

Payment update. CMS finalized a 2.3 percent hospice payment update for FY 2027, calculated from a 3.2 percent inpatient hospital market-basket increase minus a 0.9 percentage-point productivity adjustment. This is slightly lower than the proposed 2.4 percent update because the final productivity adjustment increased from 0.8 to 0.9 percentage point. CMS estimates that the rule will increase aggregate hospice payments by approximately $755 million in FY 2027.

Final national base rates. Geographic wage adjustment will cause actual payment changes to vary by location. The final base rates are:

Level of care	FY 2027 rate	Rate if HQRP data requirements are not met
Routine home care, days 1-60	$236.35/day	$227.11/day
Routine home care, days 61+	$186.35/day	$179.06/day
Continuous home care	$1,726.50/day ($71.94/hour)	$1,658.99/day ($69.12/hour)
Inpatient respite care	$545.98/day	$524.63/day
General inpatient care	$1,231.63/day	$1,183.47/day

Quality-reporting penalty. Because the statutory HQRP penalty reduces the annual update by four percentage points, a noncompliant hospice receives a negative 1.7 percent update for FY 2027 rather

than the positive 2.3 percent update. This makes quality-data submission failures financially consequential in addition to the new public-reporting consequences described below.

Wage index. CMS continues to use the pre-floor, pre-reclassified hospital wage index, applies the hospice floor, and retains the permanent 5 percent cap on year-to-year wage-index decreases at the county level. The wage-index update is nationally budget neutral, but individual hospices may experience changes above or below 2.3 percent. CMS also added a "Transition Code Status" column to the wage-index file to identify counties that continue, enter, or complete a transition-code phase.

No catch-up adjustment. CMS declined requests for a one-time correction for cumulative market-basket forecast error, stating that the payment update is prospective and that there is no current mechanism to correct prior forecast errors. Thus, the final rule does not address the industry contention that recent inflation and labor costs have outpaced prior updates.

Reference pages: 49120-49128 and 49168-49171.

2. Hospice Aggregate Cap

CMS finalized an FY 2027 aggregate cap amount of $36,174.75 per beneficiary, an increase of 2.3 percent from the FY 2026 cap of $35,361.44. The aggregate cap remains a national, non-geographically adjusted limit on total Medicare payments to a hospice relative to the number of beneficiaries served during the cap year.

The rule also conforms the regulation to the Consolidated Appropriations Act, 2026, which extends through accounting years ending before October 1, 2035, the requirement that the cap be updated by the hospice payment-update percentage rather than the Consumer Price Index for All Urban Consumers. CMS declined requests to replace the cap, geographically adjust it, or substitute targeted program-integrity tools, explaining that it lacks statutory authority to make those changes.

Operational consequence. Hospices with long lengths of stay, significant inherited cap exposure, or high-cost market areas should continue to monitor projected cap liability closely; the rule provides no regional relief or methodological reform.

Reference pages: 49128-49129.

3. Mandatory Hospice Election Statement Addendum

Beginning with hospice elections on or after October 1, 2026, every hospice must furnish the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum to every beneficiary or representative. The prior policy required the addendum only when requested. This is the rule's most significant new day-to-day admission and documentation requirement.

Timing and updates:

- The written addendum must be furnished within the first five days of the effective date of the hospice election.
- An updated addendum must be furnished within three days after a plan-of-care change that affects the hospice's determinations about conditions, items, services, or drugs that are not covered by the hospice.
- The addendum must be available to non-hospice providers and Medicare contractors to support treatment decisions, coordination of care, and claims review.

Required substance. The addendum must identify the beneficiary's conditions and the associated items, services, and drugs the hospice has determined are unrelated to the terminal illness and related conditions, explain the clinical basis for those determinations in language the beneficiary or representative can understand, and explain appeal rights. If the hospice determines that all care is related and covered, the addendum must affirmatively state that determination; CMS rejects the view that such a document is a meaningless blank form.

Signature and format. The signature acknowledges receipt rather than agreement. If a signature cannot be obtained, the hospice may document the reason; the absence of a signature does not by itself require claim denial. CMS did not mandate a single standardized form, although a model is available. A written copy remains required, but a supplemental electronic copy may also be provided.

Program-integrity consequence. CMS expressly links the mandatory addendum to scrutiny of relatedness determinations, non-hospice claims, and cost shifting. The addendum creates an auditable record for beneficiaries, other providers, Medicare Administrative Contractors, and oversight entities. Hospices should ensure that EHR workflows, admission scripts, clinical review processes, translation and accessibility procedures, and update triggers are operational by October 1, 2026.

CMS estimates that, after accounting for reduced time spent by non-hospice providers seeking coverage information, the policy will produce an annual net burden reduction of approximately $20.8 million. Hospice organizations nevertheless will bear the direct implementation burden of preparing, delivering, documenting, and updating an addendum for every election.

Reference pages: 49142-49148 and 49165-49168.

4. Service and Spending Variation Index (SSVI)

CMS is retaining and publicly deploying the SSVI as an annual claims-based hospice comparison and program-integrity tool. The SSVI assigns each hospice a score from 0 to 16 based on nine metrics. A higher score indicates more potential concern relative to peers, but CMS states that the score is one of several sources of information and is not, by itself, a finding of wrongdoing or poor quality.

The metrics examine:

- whether the hospice provided no continuous home care and no general inpatient care;
- the share of routine home-care days furnished in nursing facilities or skilled nursing facilities;
- skilled visits during the final two days of life;
- live-discharge rates;
- discharges after stays longer than 180 days;
- average skilled-nursing minutes on routine home-care days;
- weekend routine home-care days with a skilled visit;
- live discharges followed by return to the same hospice within seven days; and
- total non-hospice Medicare spending, scored by spending octile.

CMS will publish provider-level scores and related claims data for FYs 2024 and 2025 and plans to update the SSVI annually using the most recent complete claims data. For FY 2025, 69 hospices scored 13 or higher, a level CMS describes as above the 99th percentile of hospices.

Enforcement and reputational consequence. CMS intends to use the SSVI to focus education, medical review, and investigations. Where further review identifies fraud, waste, or abuse, actions could include payment suspension or revocation. Public scores also create reputational and referral risk. Hospices should therefore analyze their own performance on all nine metrics, especially non-hospice spending, live discharges, long stays, and visit intensity, and document legitimate clinical or case-mix explanations for outlier results.

Reference pages: 49135-49140.

5. Telehealth Face-to-Face Recertification Encounters

The rule extends the ability of a hospice physician or nurse practitioner to conduct the required face-to-face encounter by telehealth, solely for hospice recertification, through December 31, 2027. The telehealth encounter must include, at a minimum, two-way, real-time audio and video communication. The flexibility does not extend to physician assistants and does not make telehealth permanent.

Beginning January 1, 2027, hospice claims must include a CMS-specified modifier or code identifying a face-to-face recertification encounter conducted by telehealth. CMS plans to use a G-code and will issue implementing instructions through subregulatory guidance. In-person encounters will not require the telehealth code.

The rule prohibits telehealth for the face-to-face encounter when the beneficiary is in an area subject to a hospice enrollment moratorium, the hospice is subject to enhanced oversight, or the physician or nurse practitioner conducting the encounter is neither Medicare-enrolled nor an opt-out practitioner. Hospices should update eligibility checks, practitioner enrollment validation, clinical scheduling, and claims-edit processes before January 1, 2027.

Reference pages: 49149-49150 and 49175.

6. Broader Physician Authority for Hospice Discharge Orders

CMS amended § 418.26(b) so that the written physician order required before a hospice discharge may be obtained not only from the hospice medical director, but also from a physician designee or a physician member of the hospice interdisciplinary group. This aligns the discharge rule with prior changes concerning certification and admission decisions.

The change should reduce delays when the medical director is unavailable and gives hospices greater operational flexibility. It does not authorize nurse practitioners, physician assistants, or other non-physician clinicians to issue the discharge order. Policies, delegation documents, EHR permissions, and medical-staff workflows should be updated to reflect the expanded physician options.

Reference pages: 49148-49149 and 49175.

7. Public Icon for Failure to Meet HOPE Reporting Requirements

CMS finalized a new icon on the Medicare.gov Compare Tool identifying hospices that fail to meet Hospice Quality Reporting Program submission requirements. The icon will appear no earlier than FY 2028 (October 1, 2027) and will be based on CY 2026 HOPE submission performance. It will be displayed on both the provider search page and the individual hospice page and reassessed annually.

The icon applies when a hospice submits no HOPE data or fails to have at least 90 percent of required HOPE admission, Hospice Update Visit, and discharge records accepted by CMS within 30 days of the applicable event or completion date. It will not be based on CAHPS participation. Hospices exempt from HQRP reporting because of extraordinary circumstances, and certain newly certified hospices excluded from reporting, will not receive the icon.

Consequences. The icon adds a public-facing reputational consequence to the existing four-percentage-point annual payment-update penalty. CMS intends the accompanying explanation to make clear that the icon reflects insufficient reporting rather than a direct finding about quality or safety, but beneficiaries and referral sources may still view it negatively. CMS did not create a separate preview period; hospices must use the existing reconsideration process, generally within 30 days after a noncompliance notice.

The practical compliance focus is immediate: CY 2026 submission performance determines both the FY 2028 payment update and eligibility for the icon. Hospices should monitor iQIES acceptance reports, maintain a margin above the 90 percent threshold, and resolve rejected or late HOPE records promptly. The rule does not finalize a revised Hospice Care Index or a hospice star rating; those remain potential future policies.

Reference pages: 49158-49162 and 49168.

Primary source: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements, CMS-1851-F, 91 Fed. Reg. 49118-49176 (August 3, 2026).