DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1851–P]

RIN 0938–AV78

Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2027. This proposed rule also includes an analysis of Medicare non-hospice spending, including details regarding a hospice service and spending variation index (SSVI), and proposes to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election. Additionally, this rule proposes conforming regulation text changes to discharge from hospice care regulations; regulation text changes to the face-to-face encounter regulations; and includes requests for information on community palliative care services; the construction of a hospice specific wage index; and the overlap between hospice and medical aid in dying (MAID). Finally, this rule proposes changes to the Hospice Quality Reporting Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by June 1, 2026.

ADDRESSES: In commenting, refer to file code CMS–1851–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (choose *only one* of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-1156.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1851–P, P.O. Box 8010, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1851–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

For questions regarding the CAHPS® Hospice Survey, contact Lauren Fuentes at (410) 786–2290.

For questions regarding the hospice quality reporting program, contact Jermama Keys at (410) 786–7778.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this proposed rule may be found at *https://www.regulations.gov/.*

I. Executive Summary

A. Purpose

This proposed rule would update the hospice wage index, payment rates, and cap amount for FY 2027 as required under section 1814(i) of the Social Security Act (the Act). This proposed rule also includes an analysis of Medicare non-hospice spending under a hospice election, including details regarding a hospice spending variation index (SSVI). The SSVI includes a scoring system that monitors nine claims-based metrics in order to comprehensively assess hospice services and yield a provider ranking that can be utilized by beneficiaries to make more informed health decisions and support program integrity efforts. This rule also proposes to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election. Additionally, this proposed rule proposes conforming regulation text changes to allow a physician designee or physician member of the interdisciplinary group (IDG), in addition to the hospice medical director, to discharge a patient from hospice care. This proposed rule also proposes conforming regulation text changes to the hospice telehealth face-to-face policy for the sole purpose of hospice recertification codified at § 418.22(a)(4)(ii) to align with the end date and new requirement to include modifiers or codes for such encounters as set forth in statute at section 1814(a)(7)(D)(i)(II) of the Act, as well as a subclause that prohibits the use of telehealth to conduct the face-to-face encounter in specific situations related to moratoriums (section 1866(j)(7) of the Act), enhanced oversight (section 1866(j)(3) of the Act), or enrollment status (section 1866(j) of the Act). This proposed rule also includes requests for information (RFI) on enhancing community palliative care services under current Medicare benefits, the construction of a hospice specific wage index using Bureau of Labor Statistics (BLS) data, and the overlap between hospice and medical aid in dying (MAID). Finally, this rule proposes adding an icon to the Medicare.gov Compare Tool as part of the Hospice Quality Reporting Program (HQRP), in addition to other updates to the HQRP.

B. Summary of the Major Provisions

Section III.A.1. of this proposed rule includes proposed updates to the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care.

Section III.A.2. of this proposed rule includes the proposed FY 2027 hospice payment update percentage.

Section III.A.3. of this proposed rule includes the proposed FY 2027 hospice payment rates.

Section III.A.4. of this proposed rule includes the proposed update to the hospice cap amount for FY 2027 by the hospice payment update percentage.

Section III.B.1. of this proposed rule includes analysis of Medicare non-

hospice spending under a hospice election.

Section III.B.2. of this proposed rule includes details regarding a hospice SSVI.

Section III.C. of this proposed rule proposes to make the hospice election statement addendum mandatory for all hospice elections.

Section III.D.1. of this proposed rule proposes a clarifying regulation text change at § 418.26(b) that aligns the Conditions of Participation (CoPs) and payment regulations regarding who may discharge a patient from hospice care.

Section III.D.2. of this proposed rule proposes technical regulation text changes at § 418.22(a)(4)(ii) to extend the end date of the telehealth allowance for the face-to-face encounter until December 31, 2027, as set forth at section 1814(a)(7)(D)(i)(II) of the Act, and to include a new requirement to include modifiers or codes for such encounters, and prohibit the use of telehealth to conduct the face-to-face encounter in specific situations related to moratoriums (section 1866(j)(7) of the Act), enhanced oversight (section 1866(j)(3) of the Act), or enrollment status (section 1866(j) of the Act).

Section III. E.1. of this proposed rule includes a Request for Information (RFI) on ways to enhance the provision of community palliative care outside of hospice care.

Section III. E.2. of this proposed rule includes an RFI regarding the construction of a hospice specific wage index.

Section III. E.3. of this proposed rule includes an RFI on Medical Aid in Dying.

Section III.F. of this proposed rule proposes to provide updates to the HQRP to include public reporting timeframes, future measures and a proposal to add a data submission icon to the Care Compare tool.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be $785 million in increased payments to hospices in FY 2027.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''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 (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary- and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(c)(1), to be certified for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director, physician designee, or physician member of the hospice interdisciplinary group must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual has a medical prognosis that the individual's life expectancy is 6 months or less if the illness runs its normal course (§ 418.22(b)(1)). The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with the written certification. The regulations at § 418.22(b)(3) require that the certification and recertification forms, or an addendum to the certification and recertification forms, include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is a patient choice, and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of primarily home-based services. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice interdisciplinary group (as specified at § 418.56(a)(1)), which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return home for hospice care (routine home care) (RHC). Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care or nursing and aide care must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices covered by this rule must comply with applicable civil rights laws, including section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112, September 26, 1973), the Americans with Disabilities Act (Pub. L. 101–336, July 26, 1990), and section 1557 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, March 23, 2010), which prohibit covered entities from discriminating against individuals based on disability. This includes requiring covered entities to take appropriate steps to ensure that communication with applicants, participants, members of the public, and companions with disabilities are as effective as communications with others. Covered entities must also provide appropriate auxiliary aids and services when necessary to afford qualified individuals with disabilities, including applicants, participants, beneficiaries, companions, and members of the public, an equal opportunity to participate in, and enjoy

the benefits of, a service, program, or activity of a covered entity.[1]

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: nursing care; physical therapy; occupational therapy; speech-language pathology services; medical social services; home health aide services (called hospice aide services); physician's services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute and chronic symptom management); continuous home care during periods of crisis, and only as necessary to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before such care is provided by, or under arrangements made by, the hospice program; and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, Congress also expected hospices to continue to use volunteer services, although Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the Health Care Financing Administration's (now Centers for Medicare & Medicaid Services (CMS)) proposed rule: Medicare Program; Hospice Care (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit with the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected the benefit). This per diem payment is meant to cover all hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd)(1) of the Act.

While payment made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, Federal funds cannot be used for prohibited activities, even in the context of a per diem payment. For example, hospices are prohibited from playing a role in medical aid in dying (MAID) where such practices have been legalized in certain States. The Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12, April 30, 1997) prohibits the use of Federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including ''mercy killing, euthanasia, or assisted suicide.'' However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

The Medicare hospice benefit has been revised and refined since its implementation after various Acts of Congress and Medicare rules. For a historical list of changes and regulatory actions, we refer readers to the background section of previous Hospice Wage Index and Payment Rate Update rules.[2]

III. Provisions of the Proposed Rule

A. Proposed FY 2027 Hospice Wage Index and Rate Update

1. Proposed FY 2027 Hospice Wage Index

a. Background

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to Metropolitan Statistical Area (MSA) definitions.

In general, OMB issues major revisions to statistical areas every 10 years based on the results of the decennial census. On July 21, 2023, OMB issued Bulletin No. 23–01, which updated and superseded OMB Bulletin No. 20–01, issued on March 6, 2020. OMB Bulletin No. 23–01 established revised delineations for the MSAs, Micropolitan Statistical Areas, Combined Statistical Areas (CSAs), and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSAs). According to OMB, the delineations reflect the 2020 Standards for Delineating Core Based Statistical Areas (the ''2020 Standards''), which appeared in the **Federal Register** (86 FR 37770 through 37778) on July 16, 2021, and application of those standards to Census Bureau population and journey-to-work data (for example, 2020 Decennial Census, American Community Survey, and Census Population Estimates Program data). A copy of OMB Bulletin No. 23–01 is available online at *https://www.bls.gov/bls/omb-bulletin-23-01-revised-delineations-of-metropolitan-statistical-areas.pdf.*

[1] Hospices receiving Medicare Part A funds or other Federal financial assistance from the Department are also subject to additional Federal civil rights laws, including the Age Discrimination Act, and are subject to conscience and religious freedom laws where applicable. CMS must ensure that pursuant to 42 U.S.C. 1396a(w) facilities provide written information to residents of their rights to have and make advance directives and that care facilities must respect the conscience rights of providers and healthcare workers in caring for patients with respect to advance directives and under 42 U.S.C. 1396a(w)(3).

[2] Hospice Regulations and Notices. *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notices.*

The July 21, 2023 OMB Bulletin No. 23–01 contained a number of significant changes. For example, it designated new CBSAs, split some existing CBSAs, and changed some urban counties to rural and some rural counties to urban. We believe it is important for the hospice wage index to use the latest OMB delineations available to maintain the most accurate and up-to-date payment system, reflecting the reality of population shifts and labor market conditions. We further believe that using the most current OMB delineations increases the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. Therefore, in the FY 2025 Hospice final rule (89 FR 64208 through 64224), we finalized the implementation of new labor market areas based on the revisions in OMB Bulletin No. 23–01 beginning in FY 2025.

b. Hospice Floor and 5 Percent Cap Policies

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. The pre-floor, pre-reclassified hospital wage index values below 0.8000 are adjusted by a 15 percent increase subject to a maximum wage index value of 0.8000. For example, if CBSA ''A'' has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8000, the CBSA ''A's'' hospice wage index would be 0.4593. In another example, if CBSA ''B'' has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8000, CBSA ''B's'' hospice wage index would be 0.8000.

In the FY 2023 Hospice Wage Index and Rate Update final rule (87 FR 45673), we finalized for FY 2023 and subsequent years the application of a permanent 5 percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. When calculating the 5 percent cap on wage index decreases, we start with the current FY's pre-floor, pre-reclassification hospital wage index value for a CBSA or statewide rural area, and if that wage index value is below 0.8000, we apply the hospice floor as discussed previously in this section of the proposed rule. Next, we compare the current FY's wage index value after the application of the hospice floor to the final wage index value from the previous FY. If the current FY's wage index value is less than 95 percent of the previous year's wage index value, the 5 percent cap on wage index decreases would be applied and the final wage index value would be set equal to 95 percent of the previous FY's wage index value. If the 5 percent cap is applied in one FY, then in the subsequent FY, that year's pre-floor, pre-reclassification hospital wage index would be used as the starting wage index value and adjusted by the hospice floor. The hospice floor adjusted wage index value would be compared to the previous FY's wage index which had the 5 percent cap applied. If the hospice floor adjusted wage index value for that FY is less than 95 percent of the capped wage index from the previous year, then the 5 percent cap would be applied again, and the final wage index value would be 95 percent of the capped wage index from the previous FY. Using the example previously stated, if CBSA ''A'' has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. If CBSA ''A'' had a wage index value of 0.6200 in the previous FY, then we would compare 0.4593 to the previous FY's wage index value. Since 0.4593 is less than 95 percent of 0.6200, then CBSA ''A'''s hospice wage index would be 0.5890, which is equal to 95 percent of the previous FY's wage index value of 0.6200. In the next FY, the updated wage index value would be compared to the wage index value of 0.5890.

Previously, this 5 percent cap methodology was applied to all the counties that make up a CBSA or rural area. However, beginning in FY 2025, we finalized a policy that the 5 percent cap methodology also be applied to individual counties. In the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64202), as a transition to the adoption of the revised delineations from OMB No. 23–01, we finalized a policy applying the permanent 5 percent cap on wage index decreases at the county level. Specifically, counties that were impacted by the revised designations beginning in FY 2025 would receive a 5 percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior FY. Also, beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated due to the application of the 5 percent cap (including redesignated counties that will receive the 5 percent cap and redesignated counties that move into a CBSA or rural area where all other constituent counties receive the 5 percent cap) would use a wage index transition code. These special codes are five digits in length and begin with ''50''. The 50XXX wage index transition codes are used only in specific counties. Counties located in CBSAs and rural areas that do not correspond to a different transition wage index value will still use the CBSA number.

Finally, we finalized a policy to apply the 5 percent cap to a county that corresponds to a different wage index value than the wage index value assigned to the CBSA or rural area in which they are designated due to a delineation change until the county's new wage index is more than 95 percent of the wage index from the previous FY. To capture the correct wage index value, the county will continue to use the assigned 50XXX transition code until the county's wage index value calculated for that FY using the new OMB delineations is not less than 95 percent of the county's capped wage index from the previous FY. Once the county's wage index value calculated using the new OMB delineation is higher than 95 percent of their previous FY's wage index, the county will no longer use their assigned transition code. Instead, these counties will use the CBSA or rural county code of the area they were redesignated into based on OMB Bulletin No. 23–01. More information regarding these special codes can be found in the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64220 through 64224). Additionally, the list of counties that must use a 50XXX transition code for a given FY can be found as a separate tab in the hospice wage index file for that FY available on the CMS website at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-wage-index.*

c. Proposed FY 2027 Hospice Wage Index

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484) we finalized a policy to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2027, we are proposing that the hospice wage index would be based on the FY 2027 hospital pre-floor, pre-

reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2022 and before October 1, 2023 (FY 2023 cost report data). We note that the FY 2027 hospice wage index would not consider any geographic reclassification of hospitals, including those in accordance with sections 1886(d)(8)(B) or 1886(d)(10) of the Act. The regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for Inpatient Prospective Payment System (IPPS) hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33, August 5, 1997) provides that the area wage index applicable to any hospital located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This rural floor provision is also specific to hospitals. Because the reclassification and the hospital rural floor policies apply to hospitals only, and not to hospices, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems, for example, the skilled nursing facility prospective payment system (SNF PPS), the inpatient rehabilitation facility prospective payment system (IRF PPS), and the home health prospective payment system (HH PPS). However, the hospice wage index does include the hospice floor, which is applicable to all CBSAs, both rural and urban. The hospice floor adjusts pre-floor, pre-reclassified hospital wage index values below 0.8000 by a 15 percent increase subject to a maximum wage index value of 0.8000. We propose that the FY 2027 hospice wage index would continue to include the hospice floor as well as the 5 percent cap on wage index decreases.

The appropriate FY 2027 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 FY 2027 wage index value would be applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

There exist some geographic areas where there are no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2006 Hospice Wage Index and Rate Update final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all the CBSAs within the State would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2027, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville, Georgia. As such, we are proposing that the proposed FY 2027 hospice wage index for Hinesville, Georgia would be 0.8917.

In the FY 2008 Hospice Wage Index and Rate Update final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there is a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). In the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64207), as part of our adoption of the revised OMB delineations, rural North Dakota became a rural area without a hospital from which hospital wage data can be derived. Therefore, to calculate the proposed FY 2027 wage index for rural area 99935, North Dakota, we use as a proxy the average pre-floor, pre-reclassified hospital wage data (updated by the hospice floor and 5 percent cap) from the contiguous CBSAs: CBSA 13900-Bismark, ND, CBSA 22020-Fargo, ND–MN, CBSA 24220-Grand Forks, ND–MN and CBSA 33500, Minot, ND, which would result in a proposed FY 2027 hospice wage index of 0.8299 for rural North Dakota. Additionally, in the FY 2026 Hospice Wage Index and Rate Update final rule (90 FR 37410), using our established methodology for rural areas with no hospitals, we finalized that hospices that provide services in the Northern Mariana Islands and American Samoa should use CBSA 99965 (Guam) and should receive the wage index assigned to CBSA 99965 (Guam) of 0.9611.

Previously, the only rural area without a hospital from which hospital wage data could be derived was in Puerto Rico. However, for rural Puerto Rico, we did not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that of half of its urban areas). Instead, we used the most recent wage index previously available for that area, which was 0.4047, subsequently adjusted by the hospice floor for an adjusted wage index of 0.4654. For FY 2025, we noted as part of our adoption of the revised OMB delineations, there is now a hospital in rural Puerto Rico from which hospital wage data can be derived. Therefore, we finalized a wage index for rural Puerto Rico based on the hospital wage data for the area instead of the previously available pre-hospice floor wage index of 0.4047, which equaled an adjusted wage index value of 0.4654. The proposed FY 2027 pre-hospice floor unadjusted wage index for rural Puerto Rico is 0.2577 subsequently adjusted by the hospice floor to equal 0.2964. Because 0.2964 is more than a 5 percent decline in the FY 2026 wage index, the adjusted proposed FY 2027 wage index with the 5 percent cap applied would equal 0.95 multiplied by 0.4200 (that is, the FY 2026 wage index with 5 percent cap), which would result in a proposed FY 2027 wage index value of 0.3990.

The proposed hospice wage index applicable for FY 2027 (October 1, 2026 through September 30, 2027) is available on the FY 2027 Hospice Wage Index proposed rule web page at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notices.*

2. Proposed FY 2027 Hospice Payment Update Percentage

Section 4441(a) of the BBA of 1997, August 5, 1997) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus one percentage point. Payment rates for FYs since 2002 have been updated as required by section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45194 through 45204), we finalized the rebased and revised IPPS market basket to reflect a 2018 base year. In the FY 2026 IPPS/LTCH PPS final rule (90 FR 36859 through 36866), we finalized the rebased and revised IPPS market basket to reflect a 2023 base year, to begin in FY 2026.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is published by BLS as private nonfarm business total factor productivity (TFP) (previously referred to as multifactor productivity).[3] We refer readers to *https://www.bls.gov/* productivity for the BLS historical published TFP data. A complete description of IHS Global Inc.'s (IGIs) TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information.*

Consistent with our historical practice, we estimate the market basket percentage increase, and the productivity adjustment based on IGI's forecast, using the most recent available data. The proposed hospice payment update percentage for FY 2027 is based on the most recent estimate of the inpatient hospital market basket (based on IGI's fourth quarter 2025 forecast). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket percentage increase for FY 2027 of 3.2 percent is required to be reduced by a productivity adjustment as mandated by section 3401(g) of the Affordable Care Act. The proposed productivity adjustment for FY 2027 is 0.8 percentage point (based on IGI's fourth quarter 2025 forecast). Therefore, the proposed hospice payment update percentage for FY 2027 is 2.4 percent. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage in the FY 2027 final rule. We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data regarding differences in patient resource use and costs among hospices as required by the statute.

In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42532), we rebased and revised the labor shares for RHC, CHC, GIP, and IRC using Medicare cost report data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) from 2018. The current labor portion of the payment rates are: RHC, 66.0 percent; CHC, 75.2 percent; GIP, 63.5 percent; and IRC, 61.0 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. The non-labor portion of the payment rates are as follows: RHC, 34.0 percent; CHC, 24.8 percent; GIP, 36.5 percent; and IRC, 39.0 percent.

3. Proposed FY 2027 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the hospice services provided. The base payments are 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. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP care is intended to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for day 61 and subsequent days. In addition, in that final rule, we 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 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occur on the day of service if certain criteria are met. To maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by an SIA budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate to ensure that SIA payments are budget neutral. At the beginning of every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment. For FY 2027, the proposed SIA budget neutrality factor is 0.9999 for RHC days 1–60 and 0.9999 for RHC days 61+.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2027 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we propose using FY 2025 claims data (as of January 15, 2026) for the FY 2027 payment rate updates. We note that the budget neutrality factors and payment rates would be updated with more complete FY 2025 claims data in the FY 2027 hospice final rule. The wage index standardization factor is calculated by simulating 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 compare it to our simulation of total payments using FY 2025 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 (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) 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, we obtain a wage index standardization factor for each level of care. The proposed wage index standardization factors using FY 2025 claims data (as of January 15, 2026) for each level of care are shown in Tables 1 and 2.

The proposed FY 2027 RHC payment rates are shown in Table 1. The proposed FY 2027 payment rates for CHC, IRC, and GIP are shown in Table 2.

[3] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

TABLE 1: Proposed FY 2027 Hospice RHC Payment Rates

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

TABLE 2: Proposed FY 2027 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2026 Payment Rates	Wage Index Standardization Factor	FY 2027 Hospice Payment Update	Proposed FY 2027 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,674.29	1.0079	1.024	$1,728.02 $72.00 per hour
655	Inpatient Respite Care	$532.48	1.0022	1.024	$546.46
656	General Inpatient Care	$1,199.86	1.0033	1.024	$1,232.71

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a Hospice Quality Reporting Program (HQRP) as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that for FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 makes a negative payment update more likely than the previous 2 percent reduction. This could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. We applied this policy beginning with the FY 2024 Annual Payment Update (APU), which we based on CY 2022 quality data. Therefore, the proposed FY 2027 rates for hospices that do not submit the required quality data would be updated by –1.6 percent, which is the proposed FY 2027 hospice payment update percentage of 2.4 percent minus 4 percentage points. The proposed payment rates for hospices that do not submit the required quality data are shown in Tables 3 and 4.

TABLE 3: Proposed FY 2027 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2026 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2027 Hospice Payment Update of 2.4% minus 4 percentage points = -1.6%	Proposed FY 2027 Payment Rates
651	Routine Home Care (days 1-60)	$230.83	0.9999	1.0009	0.984	$227.32
651	Routine Home Care (days 61+)	$181.94	0.9999	1.0013	0.984	$179.24

TABLE 4: Proposed FY 2027 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2026 Payment Rates	Wage Index Standardization Factor	FY 2027 Hospice Payment Update of 2.4% minus 4 percentage points = -1.6%	Proposed FY 2027 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,674.29	1.0079	0.984	$1,660.52 $69.19 per hour
655	Inpatient Respite Care	$532.48	1.0022	0.984	$525.11
656	General Inpatient Care	$1,199.86	1.0033	0.984	$1,184.56

4. Proposed Hospice Cap Amount for FY 2027

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185, Oct. 6, 2014). Specifically, we stated that for accounting years that end after September 30, 2016, and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the Consumer Price Index for All Urban Consumers (CPI–U). Division CC, section 404 of the CAA, 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42539), we finalized conforming regulation text changes at § 418.309 to reflect the provisions of the CAA, 2021. Division P, section 312 of the CAA, 2022 (Pub. L. 117–103, March 15, 2022) amended section 1814(i)(2)(B) of the Act and extended the provision that mandates the hospice cap be updated by the hospice payment update percentage (the inpatient hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2031. Division FF, section 4162 of the CAA, 2023 (Pub. L. 117–328, December 29, 2022) amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (the inpatient hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2032. Division G, section 308 of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118–42, March 9, 2024) extends this provision to October 1, 2033.Therefore, for accounting years that end after September 30, 2016, and before October 1, 2033, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI–U. In the FY 2025 Hospice Wage Index and Rate

Update final rule (89 FR 64202), as a result of the changes mandated by the CAA, 2024, we finalized conforming regulation text changes at § 418.309 to reflect the revisions at section 1814(i)(2)(B) of the Act.

Division J, section 6218 of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119–75, February 3, 2026) amended section 1814(i)(2)(B) of the Act and extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2035. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2033. Therefore, for accounting years that end after September 30, 2016, and before October 1, 2035, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI–U. As a result of the changes mandated by the CAA, 2026, we are proposing conforming regulation text changes at § 418.309 to reflect the revisions at section 1814(i)(2)(B) of the Act.

The proposed hospice cap amount for the FY 2027 cap year would be $36,210.11 which is equal to the FY 2026 cap amount ($35,361.44) updated by the proposed FY 2027 hospice payment update of 2.4 percent. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the hospice payment update percentage), we would use such data, if appropriate, to determine the hospice cap amount in the FY 2027 hospice final rule.

B. Non-Hospice Spending During a Hospice Election

1. Medicare Non-Hospice Spending

a. Background

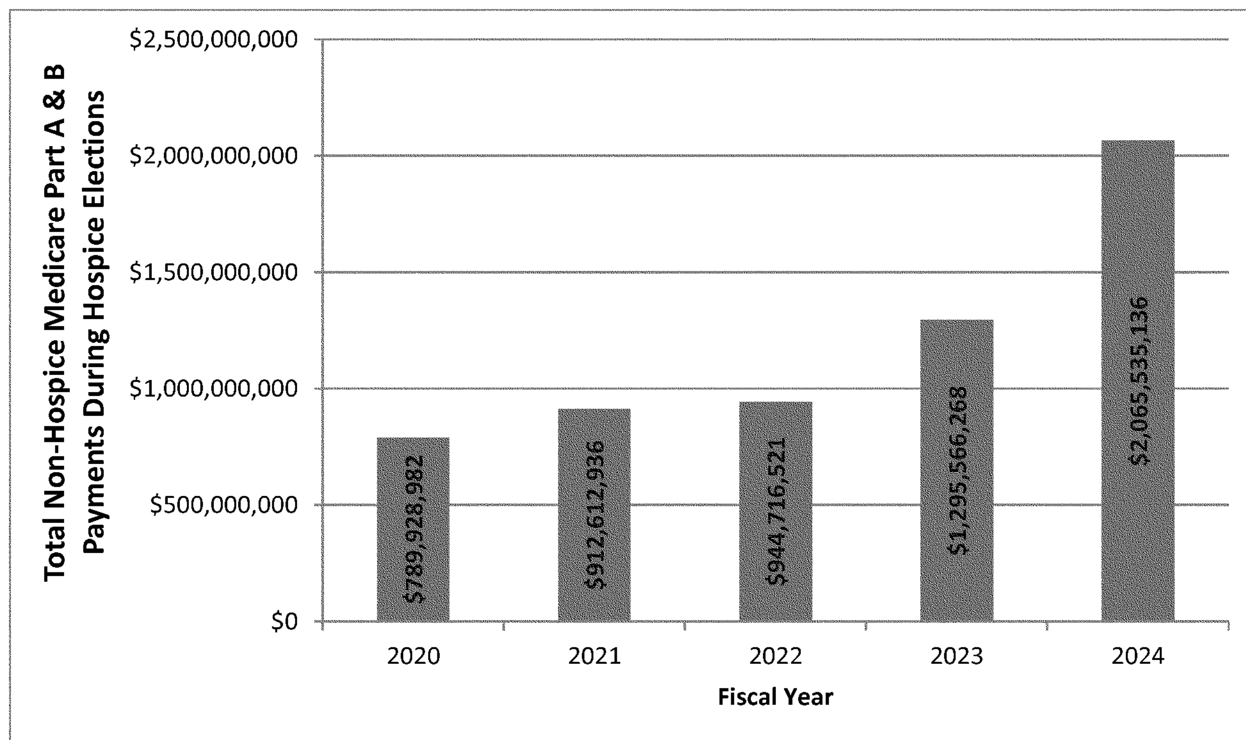
The Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Hospice services provided under a written plan of care (POC) should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments as outlined in the hospice CoPs at § 418.56. As referenced in our regulations at § 418.64, a hospice must routinely provide all core services directly by hospice employees and they must be provided in a manner consistent with acceptable standards of practice. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

Additionally, when a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the terminal illness and related conditions, except for services provided by the designated hospice and the attending physician. The comprehensive nature of the services covered under the Medicare hospice benefit is structured so that hospice beneficiaries would not have to routinely seek items, services, and medications beyond those provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life, and we have reiterated since 1983 that ''virtually all'' care needed by the terminally ill individual would be provided by the hospice (48 FR 56010, 84 FR 38509, 85 FR 47091, 86 FR 19713, 88 FR 20032, 89 FR 64202). Hospices are required to provide the individual (or representative) with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice, as codified in regulations at § 418.24(b)(3).

b. Medicare Non-Hospice Spending Since Implementation of the Hospice Election Statement Addendum

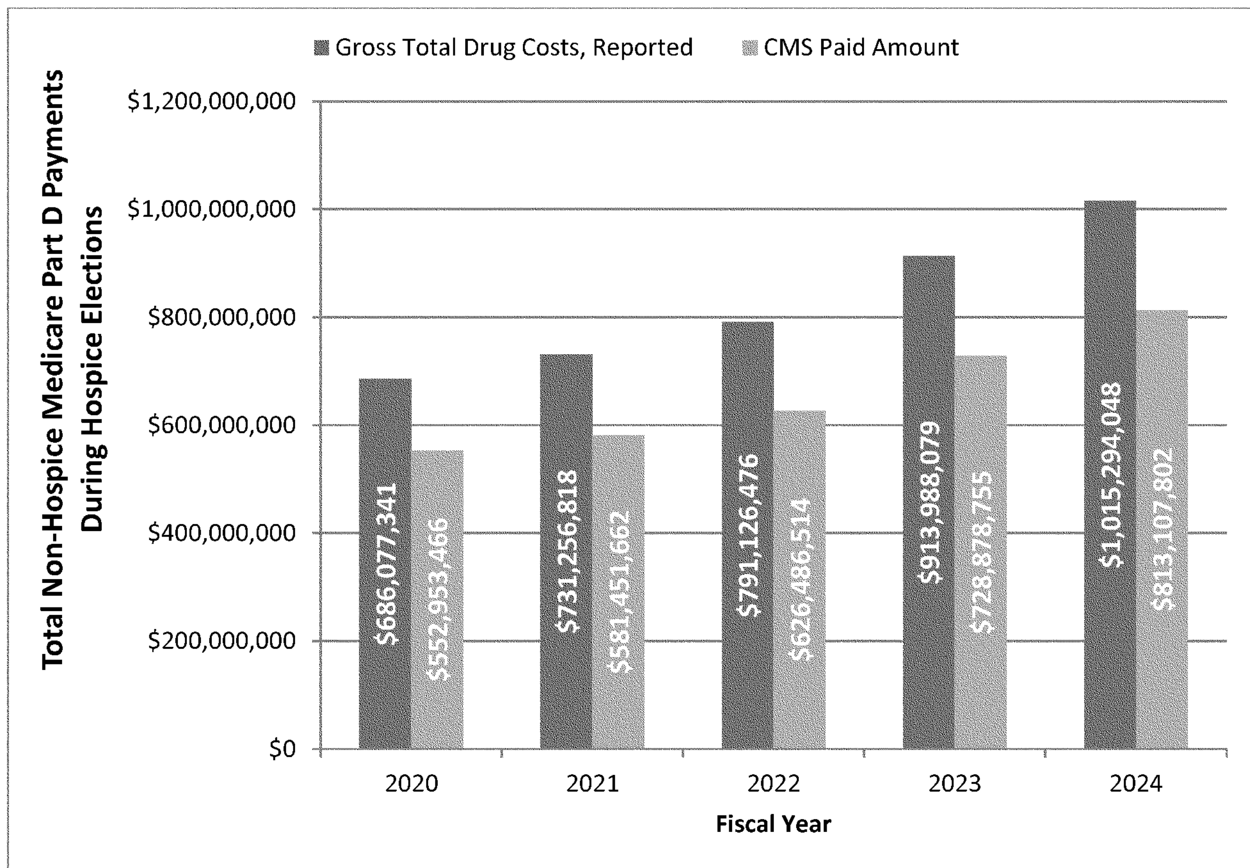
Since the implementation of the hospice election statement addendum requirement in FY 2020 (84 FR 38484), which must be provided upon request, Medicare non-hospice spending for beneficiaries who have elected the hospice benefit has shown substantial and consistent growth. Specifically, Medicare paid over $2.8 billion in non-hospice spending during a hospice election in FY 2024 for items and services under Parts A, B, and D (see Figure 1 and B).

Figure 1: Medicare Payments for Non-Hospice Medicare Part A and Part B Items and Services During Hospice Elections, FYs 2020–2024



Source: Analysis of 100 percent Medicare Part A and B claims analytic files, FYs 2020 – 2024, from the Chronic Conditions Data Warehouse (CCW), accessed May 09, 2025.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) payments per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are

Figure 2: Medicare Payments for Non-Hospice Medicare Part D Drugs During Hospice Elections, FYs 2020–2024



Source: Analysis of 100 percent Part D prescription drug events (PDEs), FYs 2020 - 2024 from the CCW Virtual Research Data Center (VRDC), accessed May 09, 2025.

Notes: The Medicare paid amounts were assigned to hospice days based on the service date on the PDE. Only service dates that fell within a hospice election and were not hospice admission or live discharge days were counted. The Medicare paid amount includes the low-income cost-sharing subsidy and covered drug plan paid amount on Part D PDEs. Payments are based on the total gross drug cost, excluding utilization on hospice admission or live discharge days.

Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during a hospice election increased from nearly $790 million in FY 2020 to over $2 billion in FY 2024 (see Figure B1). This represents an increase in non-hospice Medicare spending for Parts A and B of nearly $1.3 billion, or 160 percent. The most substantial increase in a single year occurred from FY 2023 to FY 2024, which demonstrated an increase in non-hospice Medicare spending for Part A and Part B items and services of $770 million, or 60 percent.

While there is minimal beneficiary cost sharing under the Medicare hospice benefit,[4] non-hospice services received outside of the Medicare hospice benefit are subject to beneficiary cost sharing. In FY 2024, the total beneficiary cost sharing amount for beneficiaries electing the hospice benefit was $510 million for Parts A and B.[5] In FY 2024, beneficiaries receiving hospice services from for-profit hospices had, on average, nearly 167 percent higher non-hospice spending per day compared to beneficiaries under non-profit hospice care. This represents a significant increase from FY 2022, when beneficiaries receiving hospice services from for-profit hospices had, on average, 60 percent higher non-hospice spending per day compared to beneficiaries under non-profit hospice care.

We also examined non-hospice spending during a hospice election by claim type for Part A and Part B items and services, as shown in Table 5. In percentage terms, we found the most dramatic increase in billing related to carrier/physician supply. From FY 2020 to FY 2024, non-hospice spending related to carrier/physician supply increased 317.5 percent with a notable single year spike from FY 2022 to FY 2023 of 63.5 percent, and the largest increase in one year occurred from FY 2023 to FY 2024 with an increase of 90.8 percent. The diagnosis code for carrier claims with the largest increase in spending in FY 2024 was for pressure ulcers, largely associated with skin substitutes, which accounted for 47 percent, almost half of the carrier claim spending. Carrier claims for ulcers from FY 2020 to FY 2024 increased by almost 4,000 percent, rising from $18 million in FY 2020 to $714 million in FY 2024. CMS is aware of the increased provision of skin substitutes overall and changes were made to the reimbursement for

[4] The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5. The amount of coinsurance for each respite care day is equal to five percent of the payment made by CMS for a respite care.

[5] Part A and B cost sharing is calculated by summing together the deductible and coinsurance amounts for each claim.

skin substitutes beginning in 2026. Effective January 1, 2026, CMS implemented major changes to skin substitute payments, transitioning most products to a single, national unified rate of approximately $127.14 per cm^2 (90 FR 49266, 90 FR 53448) in CY 2026, with the intent to propose payment rates that differentiate among three FDA regulatory categories in future years. This policy, applicable to both non-facility and hospital outpatient settings, classifies products as ''incident-to'' supplies to eliminate the Average Sales Price (ASP) + 6 percent model, aiming to significantly reduce Medicare spending. Additionally, it is not unusual for terminally ill patients to have skin breakdown as a result of their deconditioned state and where wound care would be appropriate for comfort. As such, we question why hospices would not be providing needed wound care for pressure ulcers (which could potentially require a skin substitute in certain circumstances) given that pressure ulcers generally develop from unrelieved pressure as a result of limited mobility and in terminally ill individuals who are chairbound or bedbound.

Additionally, we found notable consistent increases in outpatient and inpatient services in recent years, as shown in Table 5. From FY 2020 to FY 2024, non-hospice spending related to outpatient services increased 40.4 percent and inpatient services increased by 26.9 percent in the same time frame. Additionally, we found that 30.1 percent and 25.9 percent of the non-hospice spending that occurred in FY 2024 was related to the primary hospice diagnosis of Alzheimer's disease/dementia/Parkinson's and heart conditions (Congestive Heart Failure and other heart disease), respectively. We also found that daily rates of non-hospice spending for services in FY 2024 are greater for every claim type, and 166.9 percent higher in total spending per day, for patients receiving hospice services in for-profit vs. non-profit hospices. We also noted that 67 percent of non-hospice spending occurred after hospice election day 60.

TABLE 5: Total Medicare Payments for Non-Hospice Medicare Part A and Part B Items and Services During Hospice Elections (Excluding Admission/Live Discharge Days) By Claim Type [All Beneficiaries], FYs 2020 – 2024

Claim Type	FY2020	FY2021	FY2022	FY2023	FY2024	Total
Durable Medical Equipment	$62,945,939	$53,064,592	$61,786,674	$70,599,597	$68,269,227	$316,666,029
Home Health	$17,193,724	$16,639,796	$16,370,072	$18,311,448	$20,575,467	$89,090,507
Inpatient	$152,295,116	$164,275,796	$157,318,180	$173,047,031	$193,298,218	$840,234,341
Outpatient	$144,508,467	$161,409,918	$163,125,008	$179,745,517	$202,855,467	$851,644,377
Carrier/Physician Supply	$374,328,285	$459,346,611	$500,910,102	$819,249,739	$1,562,873,679	$3,716,708,416
Skilled Nursing Facility	$38,657,451	$57,876,223	$45,206,485	$34,612,936	$17,663,078	$194,016,173

Source: Analysis of 100 percent Medicare Part A and B claims analytic files, FY 2020 – 2024, from the CCW, accessed May 9, 2025.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and related conditions while the patient is under hospice care. After a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriately continued, as they may offer symptom relief for the palliation and management of the terminal prognosis.[6] Similar to the increase in non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased from $552.9 million in FY 2020 to $813.1 million in FY 2024, which represents an increase of over a 47 percent (Figure B2).

Table 6 details the various components of Part D spending for patients receiving hospice care for FYs 2020 to FY 2024. The portion of the FY 2020 to FY 2024 Part D spending that was paid by Medicare is the sum of the Low-Income Cost-Sharing Subsidy and the Covered Drug Plan Paid Amount, approximately $3.3 billion. The beneficiary cost sharing amount was approximately $335.1 million.[7]

[6] Update on Part D Payment Responsibility for Drugs for Beneficiaries Enrolled in Medicare Hospice. November 2016. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.*

[7] Part D cost sharing is calculated by summing together the ''the patient pay amount'' and the ''other true out of pocket'' amount that are recorded on the Part D PDE.

TABLE 6: Drug Cost Sources for Hospice Beneficiaries' FY 2020-2024 Drugs Received Through Part D

Component	FY2020	FY2021	FY2022	FY2023	FY2024	Total
Patient Pay Amount	$62,477,174	$64,484,342	$67,806,189	$69,416,624	$71,000,446	$335,184,775
Low Income Cost-Sharing Subsidy	$152,706,016	$157,276,197	$170,289,423	$196,366,976	$206,193,896	$882,832,508
Other True Out of Pocket Amount	$1,408,537	$1,517,950	$1,569,171	$2,440,044	$2,354,151	$9,289,853
Patient Liability Reduction due to Other Payer Amount	$18,463,129	$21,121,595	$24,436,108	$28,588,193	$35,634,350	$128,243,375
Covered Drug Plan Paid Amount	$400,247,450	$424,175,465	$456,197,091	$532,511,779	$606,913,906	$2,420,045,691
Non-Covered Plan Paid Amount	$14,992,169	$19,290,227	$23,282,199	$31,204,341	$35,049,380	$123,818,316
Six Payment Amount Totals	$650,294,475	$687,865,775	$743,580,182	$860,527,958	$957,146,130	$3,899,414,520
Unknown/Unreconciled	$35,782,866	$43,391,043	$47,546,294	$53,460,121	$58,147,919	$238,328,243
Gross Total Drug Costs, Reported	$686,077,341	$731,256,818	$791,126,476	$913,988,079	$1,015,294,048	$4,137,742,762
CMS Paid Amount	$552,953,466	$581,451,662	$626,486,514	$728,878,755	$813,107,802	$3,302,878,199

Source: Analysis of 100% Part D PDEs, FY 2020-2024, from the CCW VRDC, accessed May 09, 2025.
Notes: The Medicare paid amounts were assigned to hospice days based on the service date on the PDE. Only service dates that fell within a hospice election and were not hospice admission or live discharge days were counted. The Medicare paid amount includes the low-income cost-sharing subsidy and covered drug plan paid amount on Part D PDEs.

We also note hospice beneficiaries with principal diagnoses of neurological and degenerative diseases, circulatory and cerebrovascular diseases, respiratory diseases, and neoplasms have received clinically indicated services for these conditions outside the hospice benefit. This issue may arise from hospices misclassifying conditions, referring patients to non-hospice providers, failing to coordinate care, or deliberately avoiding costs. We have examined principal hospice diagnoses on claims and identified Part B items and services paid outside the hospice benefit and have found concerning trends in non-hospice spending. Our intent in including data regarding non-hospice spending related to hospice principal diagnosis codes in this proposed rule is to highlight items and services we believe should be covered under the hospice benefit. For example, it is not clear why medications like bronchodilators or oxygen would be considered unrelated to a respiratory condition indicated as the primary hospice diagnosis.

As we discussed previously, the hospice model is interdisciplinary and focuses on symptom management rather than curative treatment. Covering related services under the hospice benefit reinforces this philosophy by ensuring that care for the terminal condition, including medications, equipment, supplies, and therapies, is managed and integrated by the hospice IDG. We question whether increased spending outside of the hospice benefit is indicative of diminishing comprehensive and patient-centered care. Covering all items and services related to the principal hospice diagnosis ensures that patients receive coordinated medical, nursing, psychosocial, and supportive services that address the full scope of a patient's end-of-life needs. This approach reduces fragmentation, prevents gaps in care, and supports comfort, dignity, and quality of life. Further, it reduces the burden of navigating additional coverage and cost sharing that the patient would not have under the hospice benefit.

As the hospice benefit requires hospice coverage of all items and services related to the terminal illness and any related conditions, the increase in non-hospice spending, particularly for items and services that appear objectively related to the principal diagnosis, may suggest non-compliance with statutory and regulatory requirements and inappropriate cost-

shifting to other Medicare benefits. Covering items and services related to the principal hospice diagnosis is essential to maintaining the integrity of the hospice benefit, ensuring coordinated and compassionate end-of-life care, protecting beneficiaries, and supporting responsible stewardship of Medicare resources. In the following section, we describe in more detail spending data on non-hospice services from FY 2024.

TABLE 7: Medicare Payments for Non-Hospice for Part B Items and Services During Hospice Elections Provided to Hospice Beneficiaries, FY 2024

Diagnosis Coding Group	DME and Carrier Claims Payments
Neurological/Degenerative	$575,587,784
Heart/Cerebrovascular	$589,991,573
Respiratory	$95,036,803
Cancer	$105,884,608
All Other Diseases	$265,444,840
Total	$1,631,945,608

Source: Analysis of 100 percent Medicare Part B claims analytic files, FY 2024, from the CCW, accessed May 9, 2025.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

Additionally, we analyzed the same principal diagnosis coding groups for Part D drugs paid outside of the hospice benefit.

TABLE 8: Medicare Payments for Non-Hospice for Part D During Hospice Elections Provided to Hospice Beneficiaries (Part D Claims), FY2024

Diagnosis Coding Group	Part D Payments
Neurological/Degenerative	$205,128,738
Heart/Cerebrovascular	$276,254,111
Respiratory	$100,380,848
Cancer	$86,405,092
All Other Diseases	$144,939,013
Total	$813,107,802

Source: Analysis of 100 percent Medicare Part D claims analytic files, FY 2024, from the CCW, accessed May 9, 2025.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

Neurological and Degenerative Diseases

We grouped claims in this diagnostic coding group using ICD–10–CM codes for G30, G31, and G20. This group includes Alzheimer's disease, Parkinson's disease, and other degenerative diseases of the nervous system. In FY 2024 claims, there are about 48,840,937 hospice days and 1,951,568 hospice claims in this diagnosis coding group. The non-hospice spending for this category for DME and carrier claim types was about $576 million. DME services that were billed during hospice stays related to these conditions during the same time included medical/surgical supplies, such as wound care supplies, catheters and incontinence supplies, tubing, masks, and needles, costing about $400 million, and wheelchairs, oxygen supplies, and hospital beds together cost about $0.5 million. Part D drugs that were billed during hospice stays related

to these conditions included (but are not limited to) about $44.5 million for common palliative drugs, such as analgesics, anxiolytics, antiemetics, and laxatives; $1.7 million for therapeutic nutrients and electrolytes; and $0.8 million for diuretics.

Circulatory and Cerebrovascular Diseases

We grouped claims in this diagnostic coding group using ICD–10–CM codes for I11, I25, I50, I63, I67, I69, and I13. This group includes circulatory and cerebrovascular diseases, such as heart failure, cerebrovascular diseases (stroke), ischemic heart disease, and hypertensive heart/kidney disease. In FY 2024 claims, there are about 47,380,977 hospice days and 1,938,372 hospice claims in this diagnosis coding group. The non-hospice spending for these conditions for DME and carrier claim types was about $590 million. DME services that were billed during hospice stays related to these conditions during the same time included (but are not limited to) medical/surgical supplies costing about $402 million; wheelchairs, oxygen supplies, and hospital beds together cost about $1.1 million. Part D drugs that were billed during hospice stays related to these conditions included about $177 million for anticoagulants, blood cell stimulations, beta blockers, vasodilators, and anti-hypertensives; $18.6 million for common palliative drugs, such as analgesics, anxiolytics, antiemetics, and laxatives; $3 million for therapeutic nutrients and electrolytes; and $2.2 million for diuretics.

Respiratory Diseases

We grouped claims in this diagnostic coding group using ICD–10–CM codes for J44 and J96. This group includes chronic obstructive pulmonary disease and respiratory. In FY 2024 claims, there are about 11,101,869 hospice days and 511,917 hospice claims in this diagnosis coding group. The non-hospice spending for this category for DME and carrier claim types was about $95 million. DME services that were billed during hospice stays related to these conditions during the same time included medical/surgical supplies costing about $50 million; wheelchairs, oxygen supplies, and hospital beds together costing about $0.5 million. Part D drugs that were billed during hospice stays related to this condition included (but are not limited to) about $24 million for bronchodilators; $7 million for common palliative drugs, such as analgesics, anxiolytics, antiemetics, and laxatives; $0.6 million for therapeutic nutrients and electrolytes; and $0.5 million for diuretics.

All Cancers

We grouped claims in this diagnostic coding group using ICD–10–CM codes for C00–D49. This group included all the diagnosis codes in the Neoplasms (C00–D49) Chapter in the ICD–10–CM. In FY 2024 claims, there are about 18,721,188 hospice days and 1,008,342 hospice claims in this diagnosis coding group. The non-hospice spending for this category for DME and carrier claim types was about $106 million. DME services that were billed during hospice stays related to these conditions during the same time included medical/surgical supplies costing about $46 million; wheelchairs, oxygen supplies, and hospital beds together cost about $0.3 million. Part D drugs that were billed during hospice stays related to these conditions included (but are not limited to) about $5.6 million for common palliative drugs, such as analgesics, anxiolytics, antiemetics, and laxatives; $0.5 million for therapeutic nutrients and electrolytes; and $0.4 million for diuretics.

For more detailed non-hospice spending data, the full file is available in the downloads section found at the FY 2027 hospice final rule link on the Hospice Center web page at *https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center.*

2. Service and Spending Variation Index (SSVI)

CMS currently monitors and publicly shares data related to hospice utilization. Using the most recent, complete claims data, CMS analyzes Medicare spending, utilization by level of care, lengths of stay, live discharge rates, and skilled visits during the last days of life. Interested parties report that such data is useful in highlighting certain issues and trends regarding Medicare policies. Additionally, we monitor a variety of other metrics from claims data including: percent of beneficiaries discharged with length of stay 180 days or more, percent of total discharges that were live discharges, total number of discharges (live or dead), average minutes of direct patient care per RHC day, average visits per RHC day, percent of RHC days on the weekend with at least one skilled visit, non-hospice spending per day, the percent of live discharges where a beneficiary returns to the same hospice within seven days, and total amount of non-hospice spending. By analyzing hospice utilization and other metrics, CMS can evaluate the behaviors of hospices to combat potential risks to the integrity of the Medicare program.

Analyzing these particular Medicare hospice metrics together is important because patterns across them can signal potential program integrity risks, inappropriate utilization, or quality of care concerns, especially when they deviate substantially between different hospices or from expected norms. For example, long lengths of stay combined with high live discharge rates may signal inappropriate enrollment of ineligible beneficiaries. Low number of visits, shorter visits, or fewer weekend visits may indicate minimal service provision. We recognize that patient census could vary year to year for each hospice (for example, in a given year, it may be possible that a hospice had a patient census that did not require any general inpatient level of care) and does not necessarily signal that a hospice is acting in an inappropriate manner. As such, we developed a scoring system, the SSVI, 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, we first determined a threshold for each of the nine metrics. For the non-hospice spending component of the SSVI score, we created eight separate thresholds for total non-hospice spending, as the degree to which a hospice spends outside of the hospice benefit can indicate varying levels of concern. For example, a hospice with higher non-hospice spending levels receives a higher number of points than a hospice with about 12.5 percent less non-hospice spending. Metrics related to utilization reflect visit and discharge patterns. The SSVI can be used to identify hospices that are outliers across many different utilization metrics and those that have a high level of non-hospice spending. We established thresholds using percentiles. For most of the individual measures, we established the threshold at the top or bottom 25 percent of the distribution. It is important to note that falling into this quartile on a single measure does not necessarily indicate poor performance or improper practices. There are often legitimate operational reasons for a hospice to be an outlier in an isolated area. Instead, this 25 percent threshold acts as a preliminary filter. 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 the 25 percent threshold on at least one metric is not uncommon. 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. Second, we add 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 below, we describe each of the nine metrics and the threshold values for those metrics. Given that we calculate a hospice's SSVI score using an evaluation of nine metrics, a high SSVI score indicates to CMS that a hospice might have more than one area of concern and may require additional targeted education or oversight, such as medical review, education, and investigations that could result in payment suspension, and revocation, if there is identified fraud, waste, or abuse. In other words, each score used to calculate the SSVI score can be used to identify a specific area of concern for a hospice, and the SSVI score itself provides an aggregate measure to evaluate a hospice as a whole. The SSVI can assist interested parties in comparing hospices on a holistic scale. Likewise, the SSVI is potentially another vehicle to target, and address fraud, waste, and abuse. For example, higher spending outside the Medicare hospice benefit may be indicative of abusive billing because a hospice is paid a comprehensive per diem to cover essentially all care at the end of life. Excessive non-hospice spending, for either unrelated care or services and supplies which should be the hospice's responsibility, may undermine the financial integrity of the hospice benefit.

BILLING CODE 4120–01–P

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

We plan to determine the SSVI for individual hospices each fiscal year using that applicable year's data. In this proposed rule, we are publishing the SSVI scores calculated from data for FYs 2024 and 2025 because these are our

most recent and complete years of claims data. We may update the FY 2024 and FY 2025 SSVIs with any revisions we deem appropriate from comments received on this proposed rule, when we publish the FY 2027 Hospice Wage Index and Rate Update final rule. In subsequent rulemaking cycles, we would publish the updated SSVI, using the most recent claims data, with the final rule. The FY 2024 hospice SSVI includes 6,409,155 hospice claims, representing 6,735 hospices and a total of 148,012,785 hospice days. The FY 2025 hospice SSVI includes 6,750,840 hospice claims, representing 6,642 hospices and a total of 156,514,386 hospice days. Table 10 shows the distribution of the number of hospices by their total score for hospices in FYs 2024 and 2025 claims.

TABLE 10: Distribution of SSVI Score for Hospices in FY 2024 and FY 2025 Hospice Claims

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

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

Note: The development of the FY 2024 Hospice SSVI included 6,409,155 hospice claims, representing 6,735 hospices and a total of 148,012,785 hospice days. The data used was pulled from the CCW VRDC on May 9, 2025. The development of the FY 2025 Hospice SSVI included 6,750,840 hospice claims, representing 6,642 hospices and a total of 156,514,386 hospice days.

BILLING CODE 4120–01–C

We 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 our Hospice Center web page at *https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center.* Our 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. We also believe the public will benefit from the enhanced transparency this data provides, allowing beneficiaries and their families the ability to make more informed choices regarding care at the end of life. We seek feedback on the metrics used to calculate the SSVI score as well as thoughts and suggestions regarding the threshold values and point assignments.

C. Proposed Election Statement Addendum Changes

1. Background

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of an individual may necessitate a transition from curative to palliative care if the individual so chooses. Medicare hospice care services are virtually all-inclusive, and are focused on meeting the physical, emotional, psychosocial, and spiritual needs of the terminally ill individual and his or her family. In order to make an informed choice about whether to receive hospice care, the patient, family, and caregiver must have an understanding of what services are going to be provided by the hospice and that, because there is no longer a reasonable expectation for a cure, care should now focus on comfort and quality of life. The services covered under the Medicare hospice benefit are comprehensive such that, upon election, the individual waives all rights to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except when provided by the designated hospice or attending physician. Because of the significance of this decision, the terminally ill individual must elect hospice care in order to receive services under the Medicare hospice benefit. Since we first implemented the Medicare hospice benefit in 1983, it has been our general view that the waiver required by law requires hospices to provide virtually all the care that is needed by terminally ill patients (48 FR 56010). In the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we 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 generally below and described in § 418.24(c):

- The addendum title (''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'');
- Hospice name;
- Individual's name and medical record identifier;
- Identification of the terminal illness and related conditions;
- A list of the individual's conditions 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;
- A written clinical explanation written in language that the beneficiary (or representative) can understand;
- References to relevant any clinical practice, policy, or coverage guidelines;
- 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;
- 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; and
- The date the hospice furnished the addendum.

2. Proposed Mandatory Hospice Election Statement Addendum for All Elections

We are proposing to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for hospice elections beginning on or after October 1, 2026. Section 1812(d)(1) of the Act requires beneficiaries to affirmatively elect hospice care, and the hospice election involves a significant waiver of Medicare rights, as beneficiaries waive all rights to Medicare payment for services related to the treatment of their terminal illness and related conditions, except for services provided by the designated hospice and attending physician, pursuant to section 1812(d)(2)(A) of the Act. Given the magnitude of this decision and its impact on beneficiary rights and access to care, it is essential that beneficiaries receive complete information about what services will and will not be covered by the hospice at the time of election to ensure truly informed consent.

Additionally, section 1871 of the Act provides the Secretary with broad authority to prescribe regulations necessary to carry out the administration of the Medicare program, including the authority to establish provider conditions of participation, payment requirements, and beneficiary rights and protections. Specifically, section 1871(f)(1) specifies that the Secretary should make efforts to reduce inconsistency or conflicts for individuals entitled to Medicare benefits. Under this authority, and consistent with our obligation to ensure beneficiary protection and program integrity, we require that hospices provide comprehensive disclosure of coverage determinations to all beneficiaries electing the hospice benefit.

In the FY 2020 Hospice Wage Index and Payment Rate Update proposed rule (84 FR 17570), CMS reiterated that hospice services should be providing virtually all the care needed by the terminally ill individual. CMS also reiterated that coverage decisions and treatment determinations should take into account multiple factors, including not only the opinion of the treating physician, but also other factors such as the condition of the patient upon admission, the nature of the principal diagnosis, and the existence of comorbid conditions, as these all play an important role in coverage determinations. Determinations about unrelated conditions, items, services, and drugs for each patient should take into account the needs, preferences, and goals of the terminally ill individual and his or her family; review of all of the beneficiary's conditions, related and unrelated to the terminal illness and related conditions; and current clinically relevant information

supporting all diagnoses as required by regulation at § 418.25. This process requires clinical judgment in which hospices need to consider clinical practice guidelines and relevant research when making determinations of whether items, services, and drugs are related or unrelated to the terminal illness and related conditions.

The significant increases in non-hospice spending patterns, as discussed in section III.B.1. of this proposed rule, suggest 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 comprehensive and holistic Medicare hospice benefit. Most notably, as discussed in section III.B.1., Medicare non-hospice spending for Parts A and B increased from nearly $790 million in FY 2020 to over $2 billion in FY 2024, representing a 160 percent increase, demonstrating that the voluntary nature of the current addendum requirement has not adequately addressed coverage transparency concerns or stemmed inappropriate billing of services outside of the hospice benefit. Additionally, 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.

Per the hospice CoPs at § 418.56(e)(5), hospices are required to develop and maintain a system of communication and integration among all providers furnishing care to the terminally ill patient. This includes the ongoing sharing of information with other non-hospice healthcare providers and suppliers furnishing services unrelated to the terminal illness and related conditions is necessary to ensure coordination of services and to meet the patient, family, and caregiver needs. Despite this CoP requirement, we continue to receive reports from non-hospice providers stating that they are not provided a beneficiary's addendum when requested from the hospice, are unable to reach, or do not receive communication from the hospice to discuss the hospice beneficiary's coordination of services that the hospice has determined unrelated to his or her terminal illness and related condition(s). Similarly, we have also received reports from non-hospice providers who state that hospices are requesting that services be billed to Medicare Part A and B, other inquiries where non-hospice providers are requesting payment from hospices for services that should be the hospices' coverage responsibility but where the hospices have not paid for such services or do not respond to these requests, and hospices who state they were unaware that patients had received care from non-hospice providers. Additionally, if a beneficiary receives services related to the terminal illness and related conditions and the hospice did not arrange for such care, the beneficiary, potentially unknowingly, would be liable for the costs related to those services. Likewise, Medicare would be making duplicative payments for care related to the terminal illness and related conditions if non-hospice providers bill Medicare for services that should have been the coverage responsibility of the hospice.

Additionally, the Office of Inspector General (OIG) has completed audits on non-hospice spending for outpatient services provided to hospice beneficiaries,[8] Medicare payments to non-hospice providers for items and services provided to hospice beneficiaries,[9] and improper Medicare payments for durable medical equipment, prosthetics, orthotics, and supplies provided to hospice beneficiaries.[10] These reports highlight vulnerabilities in the Medicare hospice benefit and describe fragmented care that beneficiaries may experience under a hospice election.

In the FY 2022 Hospice Wage Index and Payment Rate Update proposed rule (86 FR 42528), we requested feedback from interested parties as to whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to promote the care needs of hospice beneficiaries. The responses revealed that the FY 2020 addendum provisions (84 FR 38484) enhanced communication during the admission process and prompted hospice providers to ensure patients are receiving all services necessary for symptom management regardless of the primary diagnosis. However, the feedback also included reports that very few patients and their representatives had requested the addendum and that the burden of implementation of the addendum outweighed the benefit.

In the FY 2024 Hospice Wage Index and Payment Rate Update proposed rule (88 FR 20022), we solicited feedback on how to work with hospice providers to ensure Medicare beneficiaries and their families are aware of coverage under the hospice benefit and how to enhance transparency. Comments discussed in the FY 2024 Hospice Wage Index and Payment Rate Update final rule (88 FR 51164) emphasized the critical need for CMS education directed toward patients and families about transitioning from curative to palliative interventions at the time of hospice admission. Specifically, several commenters suggested that the hospice election statement addendum (titled ''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'') should be provided to all patients at the time of hospice election or as part of the care plan, rather than only upon request. Commenters noted that hospice providers, non-hospice providers, Medicare beneficiaries, and their families need more information to understand coverage distinctions and that hospice providers must share this information with patients at the time of, and throughout, hospice election.

Based on the FY 2022 feedback from interested parties indicating a low volume of requests, the continued growth in non-hospice spending, and the FY 2024 feedback from interested parties requesting mandatory provision of the addendum at the time of election, we are proposing to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for hospice elections beginning on or after October 1, 2026. We would require hospices to furnish the addendum within the first 5 days of a hospice election (that is, within the first 5 days of the effective date of the hospice election), and any updates to the addendum within 3 days of changes

[8] Medicare Improperly Paid Acute-Care Hospitals an Estimated $190 Million Over 5 Years for Outpatient Services Provided to Hospice Enrollees (A–09–23–03024). November 12, 2024. *https://oig.hhs.gov/documents/audit/10055/A-09-23-03024.pdf.*

[9] Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight (A–09–20–03015). February 14, 2022. *https://oig.hhs.gov/documents/audit/9604/A-09-20-03015-Complete%20Report.pdf.*

[10] Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries (A–09–20–03026). November 16, 2021. *https://oig.hhs.gov/documents/audit/9609/A-09-20-03026-Complete%20Report.pdf.*

to the plan of care that impact the addendum determinations, in writing, to the individual (or representative), and to make the addendum available for non-hospice providers and Medicare contractors. This proposal would modify the current requirement at § 418.24(b)(6), (c), and (d), which establishes the addendum as a condition of payment only when requested by beneficiaries, their representatives, non-hospice providers, or Medicare contractors. As such, we propose amending § 418.24 to include the previously stated provisions related to making the hospice addendum mandatory at the time of hospice election. We remind 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 web page at *https://www.cms.gov/Center/Provider-Type/Hospice-Center.*

As discussed in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), and again in section V.A. of this proposed rule, hospices are already required to make determinations about related versus unrelated conditions, items, and services as part of their comprehensive assessment and care planning processes. The mandatory addendum requirement would formalize and standardize the communication of these existing determinations to beneficiaries and their representatives. A one-time form development burden estimate was completed in FY 2020 hospice final rule (84 FR 38484). This burden estimate also accounted for the approximate amount of time it would take a hospice to complete the addendum and used the assumption that hospices would provide the addendum to all beneficiaries; it reflected an estimated $11.2 million in total costs to hospice providers. Despite the FY 2020 (84 FR 38484) burden estimates including the one-time addendum form development costs, the burden estimate reflected an estimated $5.2 million net reduction in total provider (that is, hospice provider and non-hospice provider) burden. In addition, the FY 2020 (84 FR 38484) burden estimates for all non-hospice providers (institutional, non-institutional, and Part D pharmacy providers) furnishing services to hospice beneficiaries were estimated to have an $8.2 million total reduction in burden with the availability of the addendum. In the FY 2020 hospice final rule (84 FR 38535), we stated that burden would be reduced for non-hospice providers, including institutional, non-institutional and pharmacy providers because less time would be spent trying to obtain needed information for treatment decisions and accurate claims submissions.

While the burden estimates completed in FY 2020 (84 FR 38484) already assumed that hospices would provide the addendum to all beneficiaries, we have updated the burden estimates, in section V.A.1. of this proposed rule, with more recent data that reflects the increase in hospices and hospice elections on the estimated hospice burden associated with the proposed mandatory election statement addendum for all elections; this includes a burden reduction estimate for non-hospice providers. The FY 2027 burden estimates continue to 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.

We solicit comments on this proposal.

D. Proposed Clarifying Regulation Text Changes

1. Discharge From Hospice Care

In the FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements final rule (89 FR 64202), we finalized conforming text changes to align the medical director CoP and the hospice payment requirements. Specifically, we amended § 418.102(b) by adding the physician member of the hospice interdisciplinary group (IDG), as defined in § 418.56(a)(1)(i), as an individual who may provide the initial certification of terminal illness. We also amended the medical director CoP in § 418.102(c) to include the medical director, or physician designee, as defined at § 418.3, if the medical director is not available, or physician member of the IDG among the specified physicians who may review clinical information as part of the recertification of the terminal illness. Further, to align payment regulations regarding the certification of the terminal illness and admission to hospice care under §§ 418.22 and 418.25 with the CoPs at § 418.102, we added ''physician designee (as defined in § 418.3)'' to clarify that when the medical director is not available, a physician designated by the hospice, who is assuming the same responsibilities and obligations as the medical director, may certify terminal illness and determine admission to hospice care. We clarified that this does not connote a change in policy; rather, we stated that we believe aligning the language at §§ 418.22(c) and 418.25 with the CoPs at § 418.102 allows for greater clarity and consistency between key components of hospice regulations and policies (89 FR 64231).

In response to comments received on the proposed amendments to §§ 418.22 and 418.25, in the FY 2025 proposed rule (89 FR 64202) to add physician designee to the hospice certification and admission payment policies, we again agreed with commenters who stated that our regulations at § 418.25 identifying which physicians can determine admission to hospice care should be consistent with those at § 418.22 identifying who can provide the certification of terminal illness. Accordingly, in the FY 2026 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements final rule (90 FR 37416), to align with the updated payment and CoP regulations at §§ 418.22(c)(1)(i) and 418.102(b), respectively, we finalized the addition of ''the physician member of the hospice interdisciplinary group'' at § 418.25(a) and (b) to indicate that, in addition to the medical director or physician designee, the physician member of the hospice IDG may also determine admission to hospice care. We stated that we believe aligning the language at § 418.25(a) and (b) with the language at §§ 418.102(b) and 418.22(c)(1)(i) would allow for greater consistency between key components of hospice regulations and policies.

We note 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, 418.102(b), and 418.25(a) and (b) and to create greater consistency between key components of hospice regulations and policies, we are proposing 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 IDG. We request comments on the proposed additions to § 418.26(b).

2. Face-to-Face Encounter

Section 6209(f)(1)(A) of the CAA, 2026 amended section 1814(a)(7)(D)(i)(II) of the Act to extend the use of telehealth by a hospice

physician or hospice nurse practitioner to conduct a face-to-face encounter for the sole purpose of recertifying the patient's eligibility for hospice, through December 31, 2027. Additionally, section 6209(f)(1)(B) of the CAA, 2026 amended section 1814(a)(7)(D)(i)(II) of the Act to include a prohibition on the use of telehealth to conduct the face-to-face encounter in the case of such an encounter with an individual occurring on or after January 31, 2026, if such individual is located in an area that is subject to a moratorium on the enrollment of hospice programs under this title pursuant to section 1866(j)(7) of the Act, if such individual is receiving hospice care from a provider that is subject to enhanced oversight under this title pursuant to section 1866(j)(3) of the Act, or if such encounter is performed by a hospice physician or nurse practitioner who is not enrolled under section 1866(j) of the Act and is not an opt-out physician or practitioner. Section 6209(f)(2) of the CAA, 2026 amended section 1814(a)(7)(D)(i)(II) of the Act to require (for face-to-face encounters conducted via telehealth occurring on or after January 1, 2027) that hospice claims include one or more modifiers or codes (as specified by the Secretary) to indicate that such encounter was conducted via telehealth.

In accordance with section 6209(f) of the CAA, 2026, we propose amending § 418.22(a)(4)(ii) to align with the provisions described previously. The regulatory language would require the hospice to collect data reflecting face-to-face encounters furnished using telecommunications technology, which includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner, and the hospice would do so by reporting a G-code identifying that a face-to-face encounter was furnished using such technology, that is, telehealth. We are soliciting comments on these proposed amendments and on the use of the new G-code identifying face-to-face encounters furnished via telehealth. The proposed coding requirement will enable CMS to enforce the prohibition on the use of telehealth to conduct the face-to-face encounter when the circumstances described in section 6209(f)(1)(B) of the CAA, 2026 are present because we will be able to identify those face-to-face encounters conducted via telehealth. We would not require that in-person face-to-face encounters for the purposes of recertification to be collected on claims. In accordance with section 6209(h) of the CAA, 2026, we would issue further subregulatory guidance on implementation of this provision, including the exclusion from this permissible use of telehealth, via a Change Request (CR).

E. Requests for Information on Medicare Services and Payment Structure

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

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). The Medicare hospice benefit provides comprehensive interdisciplinary palliative care once a patient is certified as having a life expectancy of 6 months or fewer; however, many palliative care patients are not yet ready or eligible for hospice. Therefore, as 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. In particular, community-based palliative care plays an essential role in improving the quality of life for individuals living with serious illness. The home is an ideal environment for individuals to receive palliative care services, as remaining in the home during a serious illness may help alleviate psychological and mental distress and allow for more intimate caregiving to be provided by family members. Although Medicare does not currently offer a dedicated palliative care benefit, because palliative services are offered across existing Medicare programs, we are interested in soliciting public feedback regarding ways in which we can optimize current coverage and billing practices under various outpatient or home-based benefits to result in more cohesive, integrated, person-centered care as beneficiaries approach hospice care. Understanding how Medicare providers currently support palliative care, how providers bill for these services, and where gaps persist is critical to strengthening community-based palliative care within today's regulatory and payment structure.

Although Medicare covers many services that are core to palliative care, coverage can be indirect. Most community palliative care services fall under Medicare Part B, which reimburses for reasonable and medically necessary outpatient care. Medicare Part B also supports 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. 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.

While Medicare Part A primarily covers inpatient services, it does provide limited outpatient-related support. Care delivered in hospital outpatient departments may be covered, as well as home health services for patients who are homebound and require skilled care. These benefits, though not palliative-specific, can provide essential nursing, social work, aide, and therapy support that aligns with palliative goals.

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

Understanding Billing Practices and Delivering Palliative Care

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. For example, ACP services are reimbursable through CPT codes 99497 and 99498, allowing providers to conduct structured discussions about patient values, goals, and treatment preferences. Similarly, chronic care management (CCM), complex CCM, principal care management (PCM), and transitional care management (TCM) codes 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. We are interested in understanding how community providers bill for palliative services, which CPT or HCPCS codes they rely on, and what barriers they face in using ACP, care management, or telehealth codes. Specifically:

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

Understanding Program and Beneficiary Needs

Gathering information from providers and beneficiaries is essential to identify how outpatient or community palliative care is currently provided under Medicare and where gaps remain. In addition to providing feedback on billing practices, interested parties can offer insight into broader systemic challenges, staffing limitations, claim denials, and palliative services they provide but cannot bill for under Medicare's current structure. Specifically:

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

The Path Forward

Medicare's current structure provides several pathways for delivering community palliative care; however, these programs may seem siloed, making it difficult for patients to understand how palliative services are provided outside of the hospice benefit. Interested party feedback is essential for guiding CMS toward policies that expand access to high-quality community palliative care without requiring legislative reform or the creation of an entirely new benefit. By gathering detailed input from those who deliver and manage palliative care services, we can better understand how to strengthen community palliative care under existing benefits. In addition to the questions previously listed, we are soliciting input on any additional targeted enhancements within current benefits, such as expanding billable services, simplifying documentation, standardizing definitions, or increasing beneficiary education that could meaningfully expand access to palliative care services. As the population ages and the prevalence of serious illness grows, refining how Medicare supports community palliative care, prior to hospice care, is both a practical necessity and an opportunity to enhance the well-being of millions of beneficiaries.

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

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished, as determined by the Secretary, in accordance with sections 1814(i)(1)(A) and 1814(i)(2)(D) of The Act. As described in the FY 1998 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Additionally, our regulations at § 418.306(c) require that each labor market be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to Metropolitan Statistical Area (MSA) definitions.

However, CMS has received numerous comments regarding the use of the Inpatient Prospective Payment System (IPPS) wage index to adjust for the geographic variation of wages for hospice staff through the annual hospice rulemaking. Specifically, commenters have stated that the IPPS wage index uses data from four FYs prior to the current payment year and that the time lag may underestimate the changes in relative wages for hospice staff. Commenters have also stated that hospitals may have different labor costs and occupational mix than hospices and have requested that, like inpatient hospitals, hospices be able to reclassify their wage index in some instances. Additionally, we have received feedback opposing our proposals to adopt the new revised OMB CBSA delineations and the wage index values assigned to their geographic areas, wage index values assigned to rural areas, and adjusting wage index differences between high wage index and low wage index hospices in adjacent local areas through exceptions.

We have also received recommendations from MedPAC to include all-employer, occupation-level wage data to establish different weights for setting-specific occupational labor mix to capture labor costs faced by all employers of the related occupations. In 2007 and 2022, 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.[11] [12] Following the MedPAC analysis, a CMS-commissioned study issued in 2009 concluded that despite some limitations, BLS wage information is more accurate and reliable than the current source of wage information.[13] In a separate commissioned study from the Institute of Medicine (IOM), the committee examined ways to improve the accuracy of data sources and methods used for making the adjustments to payment to reflect geographic variation in labor prices.[14]

In response to these numerous, ongoing comments from interested parties regarding the hospice wage

[11] MedPAC, Report to Congress, 2007, p.124–125.

[12] MedPAC, Report to Congress, 2023, p.386.

[13] MaCurdy et al., Revision of Medicare Wage Index.

[14] Committee on Geographic Adjustment Factors in Medicare Payment; Board on Health Care Services; Institute of Medicine; Edmunds M, Sloan FA, editors. Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy, Second Edition. Washington (DC): National Academies Press (US); 2011 Jun 1. Available at *https://www.ncbi.nlm.nih.gov/books/NBK190070/* doi: 10.17226/13138.

index, we have examined possible alternatives to using the IPPS wage index for geographically adjusting hospice payments. We note that other non-hospital settings have also investigated using alternatives to the IPPS wage index, as hospital cost reports may not be representative of the occupations relative to the post-acute care settings. Most recently, in the CY 2025 End Stage Renal Disease (ESRD) PPS final rule (89 FR 89116), we finalized changes to the ESRD PPS wage index using BLS Occupational Employment and Wage Statistics (OEWS) data. Furthermore, in the 2023 Report to the Congress, MedPAC recommended using county-level wage data from the BLS with an occupational mix to construct a wage index that is more specific to the payment setting.[15]

CMS hosted a Technical Expert Panel (TEP) on September 10, 2025, inviting 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. We also provided a technical report for the TEP panelists that gave additional details regarding the potential methodology that could be used to construct a new hospice specific wage index and preliminary results for how specific hospices would be impacted. The TEP summary report, which summarizes the discussion and recommendations of the TEP, as well as the TEP technical report, which provides a detailed examination of the discussed alternative approaches, may be found at *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospice/hospice-educational-resources.* In this proposed rule, we are looking for feedback on how the BLS OEWS data, and other public data can be used to construct a hospice specific wage index.[16] CMS requests input to understand the advantages and limitations of the suggested approach in using BLS data and cost reports to support the construction of a hospice specific wage index. In addition, as discussed elsewhere in the **Federal Register**, we note that we are 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. We seek feedback on the unique considerations applicable to hospices that should inform how CMS considers the potential use of alternative data sources. We are seeking comment on the following suggested components of how a new hospice specific wage index would be constructed:

(1) Source data for determining area wages: When considering a source for wage data, we believe 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. The IPPS hospital wage index is updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals, as required by section 1886(d)(3)(E) of the Act. The final FY 2026 hospice wage index is based on the FY 2026 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2021 and before October 1, 2022 (using FY 2022 cost report data).

The BLS OEWS data provides MSA-level wage data for health professionals, including clinical and administrative office staff, that is updated annually using a pooled sample of six semi-annual surveys.[17] 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. We would only be using 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: In the IOM study, the committee recommended using a fixed national set of weights based on the hours of each occupation employed nationwide. When considering the construction of a hospice specific wage index, we need to better understand how hospices currently employ staff and determine what would be appropriate for using as fixed national weights. We want to gather feedback on relevant occupational categories to include in this calculation, which may include billable occupations, such as aides, registered nurses, licensed practical nurses, nurse practitioners, nurse assistants, medical social workers, physicians, occupational therapists, physical therapists, and speech pathologists. Since the full-time equivalent hours for the occupations are not reported in hospice cost reports, we would need to estimate using the most complete claims data available.

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. Our 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. Three occupations are available on cost reports but not claims (Nursing Administration, Physician Services, Nurse Practitioner). Those three occupations accounted for 22.05 percent of costs on the cost report and their share of the occupational mix was set to this percentage. The remaining 77.95 percent of the occupational mix was allocated among the other seven occupations based on their respective shares of minutes from claims data. We seek input on this suggested approach, as well as any other potential methodologies.

[15] MedPAC, Report to Congress, 2023, p.386.

[16] *https://www.bls.gov/respondents/oes/instructions.htm#online.*

[17] *https://www.bls.gov/oes/current/oes_tec.htm.*

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%
Speech/Language Pathology	0.02%	0.01%	0.01%

(3) Hospice Specific Wage Index Construction: Similar to as described in the CY 2025 ESRD PPS final rule (89 FR 89104), we 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). The specific computational steps used to calculate the new ESRD PPS wage index were provided in the supplementary document Addendum C of the CY 2025 ESRD PPS proposed rule.[18] In the following sections we present a potential methodology for constructing a potential hospice specific wage index:

Step 1: Estimate the Hospice National Average Occupational Mix

We 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).

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, we would calculate a CBSA-level wage estimate for each occupation included in the hospice labor mix. The hourly wages provided in areas available in the BLS data do not exactly align with the CBSAs and state-wide rural areas for which wage index values are calculated, therefore we would first map the BLS data to counties. We then impute missing wage estimates at the county-level. Wages for an area could be missing due to small sample size or data quality issues. Finally, we would aggregate county-level hourly wage estimates to the CBSA level using a county population-weighted average of the county-level wage estimates.

Step 3: Calculate Cross-Occupation, CBSA-Level Wage Estimates

For each CBSA, we 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 summing 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

We would calculate the cross-occupation, national wage estimate, which is the denominator of the hospice specific wage index value before adjustments. We 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. We 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

We would recalibrate to ensure center of distribution equals the center of the legacy wage index. We would then apply the hospice floor and 5 percent cap on decreases to calculate the final hospice wage index.

We seek feedback on any steps that may need to be modified to be applicable to the data available for hospices and related occupations.

(4) Labor market areas: 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. The appropriate 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. MedPAC recommended applying the wage index to a blend of MSA/statewide rural and counties as geographic delineation to set wage index values and smooth wage index differences greater than 10 percent between adjacent areas.[19] Currently, county information is not

[18] *https://www.cms.gov/files/document/addendum-c-cms-1805-p-esrd-pps-proposed-wage-index-construction-methodology.pdf.*

[19] *https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf.*

available to examine geographic variation of hospice labor costs.

For the purposes of constructing a hospice specific wage index, we are seeking feedback on the level of geographic delineation of labor market area to be applied to a new wage index and considerations for when neighboring areas have large differences in wage index values. In past rules, we have 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. While we continue to hold this belief, we seek feedback from interested parties on what other delineation would be appropriate and what data sources could be used to support the changes.

(5) Transition policy: We seek 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.

We appreciate hospices and national organizations sharing their support and commitment to offering meaningful comments for consideration. In addition to the methodological questions, we solicit 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 we appropriately compare wages between geographic areas that match the way hospice services are delivered? Should we maintain the use of CBSA, or consider other geographic delineation, such as county, census area, etc.?
- How should we reduce large differences in wage index values for adjacent geographic areas?
- How should we consider policy to support the transition between the current hospice wage index approach to a new one?

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

The Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12, April 30, 1997) prohibits the use of Federal funds (through Medicare, Medicaid, and other Federal programs) to provide or pay for any health care item or service, or health benefit coverage, for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide, sometimes referred to as ''medical aid in dying'' (MAID).[20] This law amended section 1862(a) of the Act (exclusions from coverage and Medicare as secondary payor) by adding a new paragraph (16) to the list of programs for which no payment may be made under Part A or Part B. CMS codified the exclusion of assisted suicide from coverage in regulation at § 411.15(q). This regulation clarifies that the prohibition does not pertain to the withholding or withdrawing of medical treatment or care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death. 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, DC, 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.

Because of State requirements (where MAID is allowed under State law) that a patient be terminally ill, we are interested in hearing from hospice providers and other interested parties about any issues that may arise when a Medicare hospice patient requests MAID. In particular:

- 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? We are especially interested in understanding what hospices do with any unused lethal medications prescribed for MAID.

We wish to reiterate 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, we are also requesting information on any additional CMS oversight mechanisms that should be in place to safeguard the use of Federal funds for the provision of MAID items and services. We welcome 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.

[20] CMS notes that entities must also comply with Section 1553 of the Affordable Care Act. Section 1553 prohibits the Federal Government, and any State or local government or health care provider that receives Federal financial assistance under the ACA, or any health plan created under the ACA from discriminating against an individual or health care entity on the basis that the individual or entity does not provide any health care item or service for assisted suicide, euthanasia, or mercy killing. Section 1553 clarifies it does not apply to withholding or withdrawing medical treatment or medical care, nutrition or hydration, abortion, or use of item or service to alleviate pain or discomfort withholding or withdrawing of medical treatment or care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing or assisting in causing, death, for any reason.

CMS also notes that covered entities violate 42 U.S.C. 14406 if they interpret 42 U.S.C. 1395cc(f) or 1396a(w) to require covered entities or their employees ''to inform or counsel any individual regarding any right to obtain an item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of the individual, such as by assisted suicide, euthanasia, or mercy killing; or to apply to or to affect any requirement with respect to a portion of an advance directive that directs the purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.'' 42 U.S.C. 14406.

The Office for Civil Rights investigates complaints related conscience statutes such as Section 1553, 42 U.S.C. 14406, or religious nondiscrimination provisions. See *https://www.hhs.gov/conscience/your-protections-against-discrimination-based-on-conscience-and-religion/index.html.*

E. Updates for the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. The Hospice Quality Reporting Program (HQRP), consisting of Hospice Outcomes and Patient Assessment Evaluation (HOPE) administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Hospice Survey, specifies reporting requirements that hospices complete and submit a standardized set of items for each patient to capture patient-level data, regardless of payer or patient age (§ 418.312(b)). Beginning with FY 2014, section 1814(i)(5) of the Act requires the Secretary to reduce the market basket update by 2 percentage points for those hospices failing to meet quality reporting requirements. Section 407(b) of Division CC, Title IV of the Consolidated Appropriations Act (CAA), 2021 amended section 1814(i)(5)(A)(i) of the Act to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points beginning in FY 2024 for any hospice that does not comply with the submission requirements provided for that FY. In the FY 2024 Hospice final rule (88 FR 51164), we codified the application of the 4-percentage point payment reduction for failing to meet hospice quality reporting requirements and set completeness thresholds at § 418.312(j).

Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year.

In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234, 48257 through 48262), and in compliance with section 1814(i)(5)(C) of the Act, we finalized a new standardized patient-level data collection vehicle called the Hospice Item Set (HIS). We also finalized the specific collection of data items that support eight consensus-based entity (CBE)-endorsed measures for hospice.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), we finalized national implementation of the CAHPS® Hospice Survey, a component of the CMS HQRP which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information about the development of the survey, originally called the Hospice Experience of Care Survey, may refer to the FY 2014 and FY 2015 Hospice Wage Index and Payment Update final rules (78 FR 48234 and 79 FR 50452, respectively) or to *https://www.hospicecahpssurvey.org/.* National implementation commenced January 1, 2015. We adopted eight CAHPS® survey-based measures for the CY 2018 data collection period and for subsequent years. These eight measures are publicly reported on the Care Compare website.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142, 47186 through 47188), we finalized the policy for retention of HQRP measures adopted for previous payment determinations and seven factors for removal. In that same final rule, we discussed how we would provide public notice through rulemaking of measures under consideration for removal, suspension, or replacement. We also stated that if we had reason to believe continued collection of a measure raised potential safety concerns, we would take immediate action to remove the measure from the HQRP and not wait for the annual rulemaking cycle. The measures would be promptly removed, and we would immediately notify hospices and the public of such a decision through the usual HQRP communication channels, including but not limited to listening sessions, email notifications and web postings. In such instances, the removal of a measure would be formally announced in the next annual rulemaking cycle.

On August 31, 2020, we added correcting language to the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Correcting Amendment (85 FR 53679) hereafter referred to as the FY 2021 HQRP Correcting Amendment. In the correcting amendment, we made updates to § 418.312 to correct technical errors identified in the FY 2016 Hospice Wage Index and Payment Rate Update final rule. Specifically, the FY 2021 HQRP Correcting Amendment (85 FR 53679) added paragraph (i) to § 418.312 to reflect our exemptions and extensions requirements for reporting, which were referenced in the preamble but inadvertently omitted from the regulations text. Thus, these exemptions or extensions can occur when a hospice encounters certain extraordinary circumstances.

In the FY 2017 Hospice Wage Index and Payment Rate Update final rule, we finalized the ''Hospice Visits When Death is Imminent'' measure pair (HVWDII, Measure 1 and Measure 2), effective April 1, 2017. We refer the public to the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52144, 52163 through 52169) for a detailed discussion.

As stated in the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622, 38635 through 38648), we launched the ''Meaningful Measures Initiative'' (which identifies high priority areas for quality measurement and improvement) to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers. The Meaningful Measures Initiative is not intended to replace any existing CMS quality reporting programs but would help such programs identify and select individual measures. The Meaningful Measures Initiative priority areas are intended to increase measure alignment across our quality programs and other public and private initiatives. Additionally, it would point to high priority areas where there may be gaps in available quality measures while helping to guide our efforts to develop and implement quality measures to fill those gaps. More information about the Meaningful Measures Initiative can be found at *https://www.cms.gov/medicare/quality/meaningful-measures-initiative.*

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also removed the HVWDII measure, as it was replaced by HVLDL. We also finalized a policy that claims-based measures would use 8 quarters of data, which would allow CMS to publicly report on more hospices. Additionally, the rule indicated that public data reflecting hospices' reporting of the two new claims-based quality measures (QMs), the HVLDL and the HCI measures, would be available on the Care Compare/Provider Data Catalogue (PDC) web pages as of the August 2022 refresh.

In addition, we removed the seven HIS Process Measures from the program as individual measures, and ceased their public reporting because, in our view, the HIS Comprehensive Assessment Measure is sufficient for measuring care at admission without the seven individual process measures. In the FY

2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. In the FY 2023 and FY 2024 Hospice Wage Index final rules, we did not propose any new quality measures. However, we provided updates on already-adopted measures. In the FY 2025 Hospice Wage Index final rule, the HQRP finalized two measures, including new data collection through the Hospice Outcomes and Patient Evaluation (HOPE) tool and plans for further development. The FY 2026 Hospice Wage Index final rule provided updates on the HOPE instrument and public reporting.

Table 12 shows the current quality measures in effect for the FY 2027 HQRP, which were updated and finalized in the FY 2025 Hospice Wage Index and Payment Rate Update final rule.

BILLING CODE 4120–01–P

TABLE 12: Quality Measures in Effect for the FY 2027 Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Outcomes and Patient Evaluation (HOPE)
Hospice and Palliative Care Composite Process 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 the Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (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 from 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 Patient 7. Care Preferences 8. Rating of this Hospice 9. Willing to Recommend this Hospice

BILLING CODE 4120–01–C

2. Updates Regarding the HOPE Measures

The HOPE assessment was developed as the new patient assessment tool to replace the HIS as part of the HQRP. HOPE was finalized in the FY 2025 Hospice Wage Index final rule (89 FR 64202) and implemented on October 1, 2025. Additional information regarding HOPE and its associated costs and burden can be found in the FY 2025 Paperwork Reduction Act of 1995 (PRA) submission (CMS–10390; OMB Control Number: 0938–1153).

As finalized in the FY 2025 Hospice Wage Index final rule (89 FR 64202), public reporting of the HOPE quality

measures would be implemented no earlier than FY 2028. CMS still expects to begin public reporting in November 2027, but this may change based on the quality and reportability of the data as determined by the CMS analysis of CY 2026 data, which would begin in CY 2027.

To meet the assessment timeliness threshold under the Annual Payment Update (APU), hospices must achieve a timely submission rate of 90 percent or higher for FY2027. This means that 90 percent of all HIS and/or HOPE assessments must be submitted to, and accepted by, CMS within 30 days of the patient's admission or discharge date. For HIS assessments, the reporting period is based on the submission of HIS admission or discharge assessments between January 1, 2025, and September 30, 2025. HOPE assessments began submission on October 1, 2025; therefore, the reporting period is based on the submission of the HOPE admission, discharge, and/or HOPE Update Visit (HUV) assessments between October 1, 2025, and December 31, 2025.

Due to the newness of the HOPE assessment along with the migration to the iQIES platform, CMS has granted a waiver to all HOPE assessments dated October 1, 2025, through December 31, 2025, and as a result, all HOPE assessments with a target date in 2025 will be considered timely.

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

Since the creation of the Medicare.gov Compare Tool (*https://www.medicare.gov/care-compare/*) in 2020, CMS has made improvements to the information available to consumers to drive quality improvement among care settings. Due to the unique challenge of caring for patients in their last days of life, the HQRP has very few publicly reported measures compared to other care settings. Therefore, this lack of information in comparison can make it more challenging for consumers to differentiate between hospices when searching for end-of-life care. To help provide additional information and context to consumers, while also serving to highlight non-compliant hospices, we are proposing to add an icon identifying hospice facilities, on the Medicare.gov Compare Tool, that have failed to meet reporting requirements for the HQRP.

The proposed icon will identify hospices failing to submit any data or submitting less than the required 90 percent of HOPE submissions within 30 days of the patient's admission or discharge date within a year period. Despite the APU penalty increase from 2 percent to 4 percent in Fiscal Year (FY) 2024, we have not observed a significant improvement in the number of hospices meeting the QRP reporting requirements. In FY 2023, prior to the APU percentage increase to 4 percent, 20.07 percent of hospices were found to be non-compliant with the HIS reporting requirements. In FY 2024, the first year of the 4 percent APU penalty, 22.06 percent of hospices were found to be non-compliant. In FY 2025, the percentage of non-compliant hospices increased to 23.53 percent and in FY 2026 the percentage of non-compliant hospices was 20.37 percent. The consistent lack of data for approximately one-fifth of hospices limits the ability of CMS to accurately measure the quality of care provided by hospices and limits the amount of data available to a consumer. We are proposing to add an icon to provide an incentive for hospices to comply with the quality data submission requirements, while also communicating to consumers that CMS may not have enough data to adequately determine the quality of the hospice.

We propose to add the icon to the *Medicare.gov* Compare Tool no earlier than FY 2028 (October 1, 2027) to align with the addition of HOPE data to the *Medicare.gov* site, and the data will be based on CY 2026 APU submission data received from January 1, 2026, through December 31, 2026. The proposed icon will be added or removed on an annual basis to give hospices an ample amount of time to review and correct data, and to comply with the 90 percent threshold. The proposed icon would be visible both on the provider search page, as well as the individual hospice page on the Compare Tool, similar to how the icons appear for nursing homes and hospitals on the *Medicare.gov* site. Additional information will be added to the Compare Tool to ensure consumers are aware of what the icon means and how it should be taken into consideration. The aim of the icon would be to notify consumers that the hospice did not report sufficient data to CMS. Additional information about HQRP reporting requirements and APU penalty can be found on the HQRP Requirements and Best Practices website at *https://www.cms.gov/medicare/quality/hospice/hqrp-requirements-and-best-practices.* We invite public comment on our proposal to include an icon for hospices on the *Medicare.gov* Compare Tool to identify hospices that do not comply with the quality data submission requirements for the APU.

4. Future Measures Update

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) HVLDL; and (2) HCI. Our measure selection activities for the HQRP take into consideration input we receive from the CBE, as part of a pre-rulemaking process that we have established and are required to follow under section 1890A of the Act. The CBE convenes interested parties from multiple groups to provide CMS with recommendations on the Measures Under Consideration (MUC) list. This input informs how CMS selects certain categories of quality and efficiency measures as required by section 1890A(a)(3) of the Act. By February 1st of each year, the CBE must provide that input to CMS.

A Technical Expert Panel (TEP) convened in November 2024 provided input on potential new or potential HCI indicators and based on that feedback. This report can be found at *https://www.cms.gov/files/document/fall-2024-hqrp-tep-summary-report508c.pdf.* Based on this feedback, along with input from other interested parties and additional analysis of the measure and its indicators, CMS is currently considering making changes to the HCI measure and plans to submit the updated measure to the 2026 MUC list. The aim of re-specifying the HCI measure is to make it more useful and important to providers and consumers.

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

a. Statutory Penalty for Failure To Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA, 2021 and the payment reduction for failing to meet hospice quality reporting requirements was increased from 2 percent to 4 percent beginning with FY 2024. During FYs 2014 through 2023, the Secretary reduced the market basket update by 2 percentage points for non-compliance. Beginning in FY 2024 and for each subsequent year, the Secretary will reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality measure data submission requirements for that FY. In the FY 2023 Hospice

Wage Index final rule (87 FR 45669), we revised our regulations at § 418.306(b)(2) in accordance with this statutory change.

b. Compliance

HQRP Compliance requires understanding the different timeframes for both HIS (or HOPE) and CAHPS: The relevant Reporting Year, the payment FY, and the Reference Year.

- The ''Reporting Year'' (HIS or HOPE) or ''Data Collection Year'' (CAHPS) is based on the calendar year (CY). It is the same CY for both HIS (or HOPE) and CAHPS. If the CAHPS Data Collection year is CY 2025, then the HIS (or HOPE) reporting year is also CY 2025.
- In the ''Payment FY'', the APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year.
- For the CAHPS Hospice Survey, the Reference Year is the CY before the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS or HOPE).[21] For example, for the CY 2025 data collection year, the Reference Year is CY 2024. This means providers seeking a size exemption for CAHPS in CY 2025 will base it on their hospice size in CY 2024.

Submission requirements are codified at § 418.312. Table 13 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2025 through CY 2028 data collection periods and the corresponding APU application from FY 2027 through FY 2030. Please note that for the final quarter of CY 2025, CMS has granted a waiver to all HOPE assessments dated October 1, 2025 through December 31, 2025, and as a result, all HOPE assessments with a target date in 2025 will be considered timely.

TABLE 13: HQRP Reporting Requirements and Corresponding Annual Payments Updates

Reporting Year for HIS/HOPE and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (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

As illustrated in Table 13, CY 2025 data submissions compliance impacts the FY 2027 APU. CY 2026 data submissions compliance impacts the FY 2028 APU. CY 2027 data submissions compliance impacts FY 2029 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission of Data Requirements

As finalized in the FY 2016 Hospice Wage Index final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (that is, patient's admission or discharge). The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily mandated payment penalty.

We applied the same submission requirements for HOPE admission, discharge, and up to two hospice update visit (HUV) records. Hospices will continue to be required to submit 90 percent of all required HOPE records to support the quality measures 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).

Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website at *https://www.hospicecahpssurvey.org/.*

Table 14, HQRP Compliance Checklist, illustrates the APU and timeliness threshold requirements.

BILLING CODE 4120–01–P

[21] CAHPS Hospice Survey, Participation Exemption for Size. *https://www.hospicecahpssurvey.org/en/participation-exemption-for-size/.*

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 date (for example, patient's admission or discharge) for patient admissions/discharges occurring 1/1/25-12/31/25	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 or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient admissions/discharges occurring 1/1/26-12/31/26	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 admissions/discharges occurring 1/1/27-12/31/27	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 admissions/discharges occurring 1/1/28-12/31/28	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2028-12/31/2028

Note: The data source for the claims-based measures will be Medicare claims data that are already collected and submitted to CMS. There is no additional submission requirement for administrative data (Medicare claims), and hospices with claims data are 100-percent compliant with this requirement.

BILLING CODE 4120–01–C

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many trainings and educational opportunities through our websites, which are available 24/7, 365 days per year, to enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to visit the frequently updated HQRP website at *https://www.cms.gov/medicare/quality/hospice.* Available trainings can be found on the HQRP Training and Education Library web page at *https://www.cms.gov/medicare/quality/hospice/hqrp-training-and-education-library* and additional resources are located on the Requirements and Best Practices web page at *https://www.cms.gov/medicare/quality/hospice/hqrp-requirements-and-best-practices.* We also encourage readers to stay informed about HQRP by visiting the HQRP Provider and Stakeholder Engagement web page at *https://www.cms.gov/medicare/quality/hospice/provider-and-stakeholder-engagement* to sign-up for the Hospice Quality Listserv.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. Wage Data Used for the Proposed Mandatory Election Statement Addendum

To derive average (mean) costs, we are using data from the most current U.S. Bureau of Labor Statistics' (BLS's) National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, Table 15 below outlines BLS's mean hourly wage, our estimated

cost of fringe benefits and other overhead costs (calculated at 100 percent of salary), and our adjusted hourly wage. Table 15 contains our wage rate data for the proposed mandatory Election Statement Addendum: ''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'' discussed in section III.B. of this proposed rule.

TABLE 15: Adjusted Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Median Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Registered Nurse	29-1141	$39.34	$39.34	$78.68
Pharmacy Technicians	29-2052	$22.90	$22.90	$45.80

Source: Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics (OEWS), May 2024, NAICS 621600 – Home Health Care Services, https://data.bls.gov/oes/#/industry/621600.

B. Proposed Information Collection Requirements (ICRs)

1. Proposed Burden Related to Mandatory Election Statement Addendum: ''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'' (OMB Control Number: 0938–1067/Expiration date: 2/28/2029)

TABLE 16: Proposed Mandatory Election Statement Addendum: "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" Burden Estimate Assumptions

Number of Medicare-Billing Hospices from FY 2024 Medicare Enrollment Database, Provider of Service Files	6,732
Number of Hospice Elections in FY 2024	(1,873,148 × 0.81) = 1,517,250

Source: FY 2024 hospice claims data.

Notes: Nineteen percent of beneficiaries die within the first 5 days of hospice care. Hospices are exempt from completing the hospice election statement addendum if the beneficiary dies within the first 5 days of care.

Section 1814(a)(7) of the Act requires that for the first 90-day period of a hospice election, the individual's attending physician (as defined in section 1861(dd)(3)(B) of the Act) (which for purposes of this subparagraph does not include a nurse practitioner or a physician assistant), and the medical director (or physician member of the interdisciplinary group (IDG) described in section 1861(dd)(2)(B) of the Act) of the hospice program providing (or arranging for) the care, each certify in writing, at the beginning of the period, that the individual is terminally ill (as defined in section 1861(dd)(3)(A) of the Act). The regulations codified at §§ 418.22 and 418.25 provide the requirements regarding the certification of terminal illness and admission to hospice care. The hospice medical director must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. Additionally, clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification. The aforementioned regulations also require that the hospice medical director must consider both related and unrelated conditions and current clinically relevant information when making the decision to certify the individual as terminally ill. Likewise, the hospice CoPs at § 418.102(b) provide the requirements regarding the certification responsibility of the hospice medical director or hospice physician designee, which includes a review of the clinical information, including both related and unrelated conditions, for each hospice patient.

To receive hospice services under the Medicare hospice benefit, eligible beneficiaries must elect to receive hospice care by completing an election statement. By signing this election statement, the individual acknowledges that he/she waives all rights to Medicare payments for treatment related to the terminal illness and related conditions. The required content of the hospice election statement is outlined in part below and described in § 418.24(b):

- Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.

- The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.
- Acknowledgement that certain Medicare services, as set forth in § 418.24(d), are waived by the election.
- The effective date of the election, which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement.
- The signature of the individual or representative.

Once a beneficiary is certified as terminally ill and elects the Medicare hospice benefit, the hospice conducts an initial assessment visit in advance of furnishing care. During this visit, the hospice must provide the patient or representative with verbal and written notice of the patient's rights and responsibilities as required by the CoPs at § 418.52. Likewise, the regulations at § 476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review.

The beneficiary needs identified in the initial and comprehensive assessments drive the development and revisions of an individualized written plan of care for each patient as required by the hospice CoPs at § 418.56. The hospice plan of care is established, reviewed, and updated by the hospice IDG and must include all services necessary for the palliation and management of the terminal illness and related conditions. While needs unrelated to the terminal illness and related conditions are not the responsibility of the hospice, the hospice may choose to furnish services for those needs regardless of responsibility. However, if a hospice does not choose to furnish services for those needs unrelated to the terminal illness and related conditions, the hospice is to communicate and coordinate with those health care providers who are caring for the unrelated needs, as described in § 418.56(e). In accordance with the CoPs, the hospice must document the services and treatments that address how they will meet the patient and family-specific needs related to the terminal illness and related conditions in the plan of care, and those needs unrelated to the terminal illness and related conditions that are present when the patient elects hospice should also be documented. This documentation ensures that the hospice is aware of those unrelated needs and who is addressing them. This documentation provides the support for the hospices' financial responsibility for the hospice services they will be providing. There is limited beneficiary financial liability for hospice services upon election of the Medicare hospice benefit. However, for any services received that are unrelated to the terminal illness and related conditions, the beneficiary would incur any associated copayments and coinsurance.

Hospices already are required to review, determine, and document information on unrelated conditions per the hospice regulations and CoPs. The FY 2020 hospice final rule (84 FR 38484) finalized the requirement at § 418.24(b) and (c) for an election statement addendum titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" that must be issued to the patient (or representative), upon request, within 5 days of the hospice election date, or within 3 days of the request during the course of hospice care (that is, after the first 5 days of the hospice election date), to ensure that Medicare beneficiaries are fully informed whether or not all items, services, and drugs identified on the hospice plan of care will be furnished by the hospice. The addendum statement is not required if the beneficiary dies within the required timeframe for furnishing the addendum. This addendum accompanies the hospice election statement. This requirement for payment is codified in the regulations at § 418.24(b) and (c).

To ensure Medicare beneficiaries are provided disclosure of those conditions, items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions at the time of admission, we propose to make the issuance of the hospice election statement addendum, in writing, mandatory for all elections at the time of election, rather than upon request of the beneficiary (or representative). Currently, the regulations at § 418.24(b) and (c), require the election statement addendum titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" to be issued to the individual (or representative) upon request. We are proposing that the issuance of the hospice election statement addendum would be mandatory for all elections made on or after October 1, 2026, and would accompany the hospice election statement at the time of hospice election.

A one-time burden estimate for each hospice to develop and design their own addendum template to best meet their needs was completed in the FY 2020 hospice final rule (84 FR 38484). In the same rule, we also estimated the hospice's burden to complete the addendum; however, we will update these burden estimates to account for changes in the number of hospice elections and number of hospices. As mentioned in the FY 2020 final rule (84 FR 38484), we believe there is no associated burden for hospices to communicate/coordinate with non-hospice providers regarding the content of the addendum statement because the hospice CoPs, as described above, have always required hospices to have a system of communication with non-hospice providers in place. However, we believe that making the election statement addendum mandatory would reduce burden for non-hospice providers through a consistent and streamlined process by which non-hospice providers can make informed treatment decisions and accurately submit claims with the appropriate condition code or modifier. This requirement for payment is included in regulations at § 418.24(b) and (c).

The relevant information collection requirements are currently approved under OMB Control Number: 0938–1067/Expiration date: 2/28/2029.

C. Estimated Hospice Burden Related to Mandatory Election Statement Addendum

1. Estimated Time for Hospice To Complete Addendum

In accordance with the hospice CoPs at § 418.56(a), the hospice must designate a registered nurse that is a member of the IDG to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The hospice CoPs at § 418.54 require that a registered nurse conduct the initial assessment, therefore, the registered nurse would be responsible for completing the addendum for each hospice election as part of the routine admission paperwork. We estimate that there would be 1,873,148 hospice elections in a year based on FY 2024 claims data. However, if a beneficiary dies within the first five days of the hospice election, an addendum would not be required to be provided. Approximately, 19 percent (0.19) of hospice beneficiaries die within the first five days of hospice care. Therefore, the estimated total number of hospice elections in FY 2027 that would require the hospice election statement addendum would be (1,873,148 × 0.81)

= 1,517,250. There are 6,732 Medicare-certified hospices, so on average there would be (1,517,250/6,732) = 225 hospice elections per hospice. The estimated burden for the hospice registered nurse to extrapolate this information from the existing documentation in the patient's hospice medical record and complete this addendum would be 10 minutes (10/60 = 0.1667). At $78.68 per hour for a registered nurse over 10 minutes (0.1667 × $78.68 = $13.12), we estimate the total cost of RN time to complete the addendum per hospice in FY 2027 to be ($13.12 × 225) = $2,952.00, and the total cost of RN time to complete the addendum for all hospices in FY 2027 would be ($2,952.00 × 6,732) = $19,872,864.00. The estimated total per hospice and total annual hospice cost associated with the proposed mandatory addendum in FY 2027 are shown in Table 17. These total costs only include the cost for the RN to complete the addendum statement, as a one-time burden estimate for the addendum form development was accounted for in FY 2020 (84 FR 38484). Additionally, providing this information to the beneficiary is currently part of the routine admissions process and, as such, incurs no additional burden to that process.

TABLE 17: FY 2027 Estimated Per Hospice and Total Hospice Costs for Election Statement Addendum

	Average # of Elections Per Hospice	Total # of Hospice Elections (Based on FY 2024)
Number of Hospice Elections	225	1,517,250
Total # of Hospices		6,732
	Average Cost Per Hospice	Total Annual Costs for All Hospices
RN Form Completion per Hospice	$2,952.00	
Total Hospice Estimated FY 2027 Costs		$19,872,864.00

2. Burden Estimate Without Election Statement Addendum for Non-Hospice Providers

In order for non-hospice providers to make treatment decisions regarding services, items, and drugs for hospice beneficiaries and to submit the appropriate modifier or condition code on Medicare claims, they need supporting information from the hospice regarding related and unrelated conditions. As such, we first estimate the current burden associated with this communication and coordination in the absence of the election statement addendum. We believe this would require the non-hospice providers to contact the hospice and have a detailed phone call to obtain and document the information on unrelated conditions, items, services, and medications. For non-hospice providers submitting institutional claims (including inpatient acute care hospitals, SNFs, HHAs, and institutional outpatient providers), typically nurse case managers provide coordination of care for those beneficiaries in these settings who are receiving inpatient services or who are preparing to transition to a post-acute care setting or home. The estimated burden for the registered nurse to contact the hospice to obtain the needed information would be 15 minutes (15/60 = 0.25). The average number of hospice beneficiaries receiving services per institutional, non-hospice provider is 15.6 per year, which would mean each institutional, non-hospice provider would have an average of 15.6 communication encounters with hospice. The total number of institutional, non-hospice providers servicing hospice beneficiaries in FY 2024 was 24,086. At $78.68 per hour for a registered nurse (0.25 × $78.68) = $19.67, we estimate the total cost per institutional, non-hospice provider furnishing services to hospice beneficiaries in FY 2027 to be ($19.67 × 15.6) = $306.85 and the annual total cost for all institutional, non-hospice providers in FY 2027 would be ($306.85 × 24,086) = $7,390,789.10.

For non-institutional, non-hospice providers (including physicians), we also expect that a nurse would contact the hospice to obtain the needed clinical information on unrelated conditions, items, services and drugs. The estimated burden for the registered nurse to contact the hospice to obtain the needed information would be 15 minutes (15/60 = 0.25). The average number of hospice beneficiaries receiving services per non-institutional, non-hospice provider is 15.5 per year, which would mean each provider would have an average of 15.5 communication encounters with a hospice. The total number of non-institutional, non-hospice providers servicing hospice beneficiaries in FY 2024 was 135,407. At $78.68 per hour for a registered nurse (0.25 × $78.68) = $19.67, we estimate the total cost per non-institutional, non-hospice provider furnishing services to hospice beneficiaries in FY 2027 to be ($19.67 × 15.5) = $304.89 and the annual total cost for all non-institutional, non-hospice providers in FY 2027 would be ($304.89 × 135,407) = $41,284,240.23.

For pharmacies dispensing Part D drugs to hospice beneficiaries, the estimated burden for the pharmacy technician at the point of service to contact the hospice to obtain the needed clinical information regarding the drugs deemed by the hospice as unrelated to the terminal illness and related conditions would be 15 minutes (15/60 = 0.25). The average number of hospice beneficiaries receiving services per pharmacy dispensing Part D maintenance drugs is 18.6 per year, which would mean each pharmacy would have an average of 18.6 communication encounters with hospice. The total number of pharmacies dispensing Part D maintenance drugs to hospice beneficiaries in FY 2024 was 57,642. At $45.80 per hour for a pharmacy technician (0.25 × $45.80) = $11.45, we estimate the total cost per pharmacy dispensing Part D maintenance drugs to be ($11.45 × 18.6) = $212.97 and the annual total cost for all pharmacies dispensing Part D maintenance drugs to be ($212.97 × 57,642) = $12,276,016.74. The estimated total annual burden for

all non-hospice providers furnishing services, items and medications to hospice beneficiaries in FY 2027 without the availability of the hospice election statement addendum identifying unrelated conditions, items, services and drugs would be $60,951,046.07 ($7,390,789.10 + $41,284,240.23 + $12,276,016.74).

3. Burden Reduction Estimate With the Proposed Mandatory Election Statement Addendum for Non-Hospice Providers

With the availability of the ''Patient Notification of Hospice Covered/Non-Covered Items, Services, and Drugs'' election statement addendum, we believe the estimated burden would be reduced for non-hospice providers through a streamlining of the communication and coordination process. Following the same approach used in FY 2020 (84 FR 38484), we analyzed all Medicare Parts A and B non-hospice claims for beneficiaries under a hospice election in FY 2024. We also examined the Part D claims for drugs provided to hospice beneficiaries under a hospice election. Specifically, we analyzed the following:

- The total number of non-hospice, institutional claims with condition code 07 (to indicate the services were unrelated to the terminal illness and related conditions).
- The total number of non-hospice, non-institutional claims with ''GW'' modifier (to indicate the services were unrelated to the terminal illness and related conditions).
- The total number of Part D claims for beneficiaries under a hospice election.
- The average number of hospice beneficiaries per non-hospice provider with institutional claims with condition code 07.
- The average number of hospice beneficiaries per non-hospice provider with non-institutional claims with ''GW'' modifier.
- The average number of hospice beneficiaries per non-hospice provider with Part D claims.

To calculate the average number of hospice beneficiaries per non-hospice provider, we count the number of unique beneficiaries associated with each non-hospice provider as beneficiaries may receive services by more than one non-hospice provider. This means that some beneficiaries are double-counted. Because we double-counted beneficiaries, we expect that average to be larger than the ratio of unique beneficiaries to unique non-hospice providers. Table 18 summarizes Part A, B and D claims that overlap with hospice episodes in FY 2024.

TABLE 18: Summary of Part A, B, and D Claims That Overlap With Hospice Episodes, FY 2024

Non-Hospice Claim Type	Number of Hospice Beneficiaries	Number of Non-Hospice Providers	Number of Hospice Providers	Sum of Beneficiaries Across Non-Hospice Providers	Average Number of Hospice Beneficiaries per Non-Hospice Provider (Column 5 /Column 3= Column 6)
Part A & B, Non-Hospice Total	744,296	156,721	6,612	2,446,354	15.6
Institutional Claims with 07	285,457	24,068	6,238	375,835	15.6
Non-Institutional Lines with GW	711,483	135,407	6,601	2,101,062	15.5
Part D	806,709	57,642	6,648	1,072,624	18.6

Source: FY 2024 Part A/B claims and Part D PDEs data accessed from the CCW on May 9, 2025.

For institutional, non-hospice providers (those who would submit claims for unrelated services with condition code 07), the estimated burden for the registered nurse to contact the hospice to obtain the needed information would be reduced from 15 minutes in the absence of the addendum to 5 minutes (5/60 = 0.0833). The average number of hospice beneficiaries receiving services per institutional non-hospice provider is 15.6 per year. The total number of institutional non-hospice providers servicing hospice beneficiaries in FY 2024 was 24,068. At $78.68 per hour for a registered nurse (0.0833 × $78.68) = $6.55, we estimate the total cost per institutional non-hospice provider in FY 2024 to be ($6.55 × 15.6) = $102.18 and the annual total cost for all institutional non-hospice providers in FY 2024 would be ($102.18 × 24,068) = $2,459,268.24, an annual decrease in burden by ($7,390,789.10 − $2,459,268.24) = $4,931,520.86.

For non-institutional, non-hospice providers (those who would submit claims for unrelated services with modifier GW), the estimated burden for the registered nurse to contact the hospice to obtain the needed information would be reduced to 5 minutes (5/60 = 0.0833). The average number of hospice beneficiaries receiving services per non-institutional, non-hospice provider is 15.5 per year. The total number of non-institutional, non-hospice providers servicing hospice beneficiaries in FY 2024 was 135,407. At $78.68 per hour for a registered nurse (0.0833 × $78.68) = $6.55, we estimate the total cost per non-institutional, non-hospice provider in FY 2024 to be ($6.55 × 15.5) = $101.53 and the annual total cost for all non-institutional, non-hospice providers in FY 2024 would be ($101.53 × 135,407) = $13,747,872.71, an annual decrease in burden by ($41,284,240.23 − $13,747,872.71) = $27,536,367.52.

For pharmacies dispensing Part D drugs to hospice beneficiaries, the estimated burden for the pharmacy

technician at the point of service to contact the hospice to obtain the needed clinical information regarding the drugs deemed by the hospice as unrelated to the terminal illness and related conditions would be reduced to 5 minutes (5/60 = 0.0833). The average number of hospice beneficiaries receiving services from pharmacies dispensing Part D maintenance drugs is 18.6 per year. The total number of pharmacies dispensing Part D maintenance drugs to hospice beneficiaries in FY 2024 was 57,642. At $45.80 per hour for a pharmacy technicians (0.0833 × $45.80) = $3.82, we estimate the total cost per pharmacy dispensing Part D maintenance drugs to be ($3.82 × 18.6) = $71.05 and the annual total cost for all pharmacies dispensing Part D maintenance drugs to be ($71.05 × 57,642) = $4,095,464.10, an annual decrease in burden by ($12,276,016.74 − $4,095,464.10) = $8,180,552.64.

The estimated total annual burden for all non-hospice providers furnishing services, items, and drugs to hospice beneficiaries in FY 2024 with the availability of the hospice election statement addendum identifying unrelated conditions, items, services, and medication would be $20,302,605.05 ($2,459,268.24 + $13,747,872.71 + $4,095,464.10) for an overall burden reduction of ($60,951,046.07 − $20,302,605.05) = $40,648,441.02. The total reduction in burden for all institutional, non-institutional, and Part D pharmacy non-hospice providers is summarized in Table 19.

TABLE 19: FY 2027 Estimated Total Overall Burden Reduction for Non-Hospice Providers Using Election Statement Addendum

Non-Hospice Claims	Estimated Burden without Addendum	Estimated Burden with Addendum	Estimated Burden Reduction for Non-Hospice Providers with Use of the Addendum*
Institutional Claims with Condition Code 07	$7,390,789.10	$2,459,268.24	$4,931,520.86
Non-Institutional Claims with GW Modifier	$41,284,240.23	$13,747,872.71	$27,536,367.52
Part D Maintenance Drugs	$12,276,016.74	$4,095,464.10	$8,180,552.64
Total	$60,951,046.07	$20,302,605.05	
Total Burden Reduction for Non-Hospice Providers			$40,648,441.02

***Note:** Estimated burden reduction for non-hospice providers with use of the addendum=burden without addendum (column 2) minus burden with addendum (column 3).

The use of the ''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'' election statement addendum would result in an estimated, annual net reduction in burden of $20,775,577.02 ($40,648,441.02 − $19,872,864.00) in FY 2027. Table 20 summarizes the FY 2027 estimated total burden reduction.

TABLE 20: FY 2027 Estimated Total Provider Burden Reduction Using Election Statement Addendum

Item	Amount
FY 2027 Estimated Hospice Burden for Election Statement Addendum	$19,872,864.00
FY 2027 Estimated Non-Hospice Provider Burden Reduction	$40,648,441.02
FY 2027 Estimated Annual Net Reduction in Burden	$20,775,577.02

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections previously discussed, visit our website at: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html,* or call the Reports Clearance Office at (410) 786–1326.

We invite public comments on these information collection requirements. If you wish to comment, submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this proposed rule and identify the rule (CMS–1851–P) and, where applicable, indicate the ICR's CFR citation, CMS ID number, and OMB control number.

Comments must be received by the date and time specified in the **DATES** section of this proposed rule.

VI. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the Hospice Wage Index based on the most current available CMS hospital wage data, including any changes to the definitions of Core Based Statistical Areas (CBSAs) or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would update the payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2027 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Election Statement Addendum

This rule includes a proposal to make the hospice election statement addendum mandatory for all hospice elections. This proposal would require hospices to furnish the hospice election statement addendum within the first 5 days of a hospice election (that is, within the first 5 days of the effective date of the hospice election), and any updates to the addendum within 3 days of changes to the plan of care that impact the addendum determinations, in writing, to the to the individual (or representative), and to make the addendum available for non-hospice providers and Medicare contractors. If finalized, this change would become effective for hospice elections on and after October 1, 2026. The election statement addendum would add no additional burden for communicating with non-hospice providers, as this decision-making process has been a long-standing CoP requirement, as described in the preamble of this proposed rule. As reviewed in section V.B.1.of this proposed rule, hospices already are required to review, determine, and document information on unrelated conditions per the hospice regulations and CoPs. Additionally, our previous burden estimate, completed in FY 2020 hospice final rule (84 FR 38484), assumed that an addendum would be requested by every hospice beneficiary (or representative) receiving non-hospice services. While the number of hospice elections, and therefore the number of election statement addendums, have increased since our last burden estimate was completed, we continue to believe the actual burden would be less as hospices are already required to be comprehensive in their approach to covered services. As such, there would be hospices that would spend less time, than estimated, to complete the addendum as the hospice would be providing all items, services, and drugs. However, we believe that making the election statement addendum mandatory would reduce burden for non-hospice providers, including institutional, non-institutional and pharmacy providers because less time would be spent trying to obtain needed information for treatment decisions and accurate claims submissions.

3. Quality Reporting Program

This proposed rule would add an icon to the *Medicare.gov* Compare Tool to identify hospices that fail to meet the reporting submission requirements for the Annual Payment Update (APU). These requirements require hospices to submit 90 percent of HOPE assessments within 30 days of a patient's admission or discharge date. This new icon would allow consumers to identify hospices that may lack sufficient data to accurately gauge quality and provide another incentive for hospices to meet the 90 percent threshold.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) of E.O. 12866. Accordingly, we have prepared a regulatory impact analysis that presents the costs and benefits of the rulemaking to the best of our ability.

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of $785 million in payments to hospices, resulting from the proposed hospice payment update percentage of 2.4 percent for FY 2027. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2026 to FY 2027. Using the most recent complete data available at the time of rulemaking, in this case FY 2025 hospice claims data as of January 15, 2026, we simulate total payments using the proposed FY 2027 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 compare it to our simulation of total payments using FY 2025 utilization claims data, the final FY 2026 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 (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY

2026 wage index and payment rates for each level of care by the proposed FY 2027 wage index and FY 2026 payment rates, we obtain a wage index standardization factor for each level of care. We apply the wage index standardization factors so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time- period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

2. Hospice Election Statement Addendum

As a result of this election statement addendum, we estimate that this rule, if finalized, would generate $20.7 million in annualized cost savings to providers, beginning in FY 2027. The estimated burden reduction for this proposal is detailed in section V.C. of this proposed rule and the total annual estimated reduction is included in Table 20.

3. Hospice Quality Reporting Program

This proposed rule would add an icon to the *Medicare.gov* Compare Tool for hospices. There are no associated impacts for hospices with this proposal.

C. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2027

The FY 2027 hospice payment impacts appear in Table 21. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size) and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, and facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2027 updated wage index data with a 5 percent cap on wage index decreases. The aggregate impact of the change in column three is zero percent, due to the hospice wage index standardization factors. However, there are distributional effects of using the FY 2027 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act and is consistent for all providers. The hospice payment update percentage of 2.4 percent is based on the proposed 3.2 percent inpatient hospital market basket percentage increase reduced by a proposed 0.8 percentage point productivity adjustment. The fifth column shows the total effect of the updated wage data and the hospice payment update percentage on FY 2027 hospice payments. As illustrated in Table 21, the combined effects vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2025 as seen on Medicare hospice claims (accessed from the Chronic Conditions Warehouse (CCW) on January 15, 2026) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 21, the combined effects vary by specific types of providers and by location.

BILLING CODE 4120–01–P

TABLE 21: Impact to Hospices for FY 2027

Hospice Subgroup	Hospices	FY 2027 Updated Wage Data	FY 2027 Proposed Hospice Payment Update	Overall Total Impact for FY 2027
All Hospices	6,642	0.0%	2.4%	2.4%
Hospice Type and Control				
Freestanding/Non-Profit	777	0.1%	2.4%	2.5%
Freestanding/For-Profit	4,835	0.0%	2.4%	2.4%
Freestanding/Government	34	0.5%	2.4%	2.9%
Freestanding/Other	0	0.0%	2.4%	2.4%
Facility/HHA Based/Non-Profit	260	0.0%	2.4%	2.4%
Facility/HHA Based/For-Profit	3	1.2%	2.4%	3.6%
Facility/HHA Based/Government	94	1.0%	2.4%	3.4%
Facility/HHA Based/Other	0	0.0%	2.4%	2.4%
Subtotal: Freestanding Facility Type	5,646	0.0%	2.4%	2.4%
Subtotal: Facility/HHA Based Facility Type	357	0.1%	2.4%	2.5%
Subtotal: Non-Profit	1,048	0.1%	2.4%	2.5%
Subtotal: For Profit	5,144	0.0%	2.4%	2.4%
Subtotal: Government	128	0.8%	2.4%	3.2%
Subtotal: Other	8	0.4%	2.4%	2.8%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	201	0.9%	2.4%	3.3%
Freestanding/For-Profit	404	0.4%	2.4%	2.8%
Freestanding/Government	22	0.6%	2.4%	3.0%
Freestanding/Other	0	0.0%	2.4%	2.4%
Facility/HHA Based/Non-Profit	109	0.7%	2.4%	3.1%
Facility/HHA Based/For-Profit	0	0.0%	2.4%	2.4%
Facility/HHA Based/Government	68	1.1%	2.4%	3.5%
Facility/HHA Based/Other	0	0.0%	2.4%	2.4%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	576	0.0%	2.4%	2.4%
Freestanding/For-Profit	4,431	-0.1%	2.4%	2.3%
Freestanding/Government	12	0.4%	2.4%	2.8%
Freestanding/Other	0	0.0%	2.4%	2.4%
Facility/HHA Based/Non-Profit	151	-0.1%	2.4%	2.3%
Facility/HHA Based/For-Profit	3	1.2%	2.4%	3.6%
Facility/HHA Based/Government	26	1.0%	2.4%	3.4%
Facility/HHA Based/Other	0	0.0%	2.4%	2.4%

Hospice Subgroup	Hospices	FY 2027 Updated Wage Data	FY 2027 Proposed Hospice Payment Update	Overall Total Impact for FY 2027
Hospice Location: Urban or Rural				
Rural	851	0.6%	2.4%	3.0%
Urban	5,791	-0.1%	2.4%	2.3%
Hospice Location: Region of the Country (Census Division)				
New England	161	0.9%	2.4%	3.3%
Middle Atlantic	282	0.6%	2.4%	3.0%
South Atlantic	648	-0.1%	2.4%	2.3%
East North Central	657	-0.2%	2.4%	2.2%
East South Central	251	-0.3%	2.4%	2.1%
West North Central	443	0.4%	2.4%	2.8%
West South Central	1,293	-0.4%	2.4%	2.0%
Mountain	693	-0.2%	2.4%	2.2%
Pacific	2,134	0.2%	2.4%	2.6%
Outlying	80	1.2%	2.4%	3.6%
Total Hospice RHC Days				
0 - 3,499 RHC Days	1,588	0.2%	2.4%	2.6%
3,500-19,999 RHC Days	2,983	0.2%	2.4%	2.6%
20,000+ RHC Days	2,071	0.0%	2.4%	2.4%

Source: FY 2025 hospice claims data from CCW accessed on January 15, 2026.
Note: The overall total impact column reflects the addition of the individual impacts, which includes the wage index impact as well as the proposed hospice payment update of 2.4 percent. While the aggregate impact of the wage index is zero percent for all hospices due to the hospice wage index standardization factors, there are distributional effects of updating the proposed FY 2027 hospice wage index.

Due to missing Provider of Services file and Cost Report information (from which hospice characteristics are obtained), some subcategories in the impact tables have fewer agencies represented than the overall total (of 6,642). Subtypes involving ownership only add up to 6,328 while subtypes involving facility type only add up to 6,003.
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

BILLING CODE 4120–01–C

D. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with the regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. However, we acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed last year's proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. Despite these limitations, we believe that the number of commenters on last year's proposed rule is a fair estimate of the number of reviewers of this proposed rule. We welcome any comments on the approach to estimating the number of entities that will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the May 2024 National median hourly wage rate (doubled for benefits and overhead) for medical and health service managers (Code 11–9111); we estimate that the cost of reviewing this rule is $113.42 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/home.htm*). Assuming an average reading speed we estimate that it would take approximately 1.76 hours for staff to review half of this proposed rule. For each hospice that reviews the rule, the estimated cost is $199.62 (1.76 hours × $113.42). Therefore, we estimate that the total cost of reviewing this regulation is approximately $12,576 ($199.62 × 63 reviewers; which is based on last year's comments received).

E. Alternatives Considered

1. Hospice Payment

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider alternatives to updating the hospice payment rates by the proposed hospice payment update percentage. The proposed 2.4 percent hospice payment update percentage for FY 2027 is based on a proposed 3.2 percent inpatient hospital market basket percentage increase for FY 2027, reduced by a proposed 0.8 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage increase for that fiscal year. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. For FY 2027, since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we did not consider alternatives for the hospice payment update percentage.

2. Hospice Election Statement Addendum

An alternative to this proposal would be to not make the election statement mandatory but rather keep the existing policy where the addendum is only required when requested by the beneficiary, their representative, non-hospice providers or the Medicare contractors. However, as described in Section III.C. of this proposed rule, the intent of the election statement addendum is to increase coverage transparency for those seeking to elect the benefit. We believe that only requiring the provision of this addendum when requested does not fulfill this intent and that all beneficiaries deciding to elect hospice care in lieu of curative care should have all the information they need to make informed consent to elect. We also stated our concerns that the continued and increasing non-hospice spending during a hospice election may signal that beneficiaries are not being made aware of hospice coverage responsibility and this may result in increased beneficiary cost sharing and fragmented care which is counter to the comprehensive and holistic nature of hospice care.

3. Quality Reporting Program

CMS considered proposing an icon that would indicate if a hospice does not meet the submission requirements for HOPE, CAHPS, and claims. However, since claims are required for payment, there is high compliance, and, as many hospices are exempt from CAHPS due to size limitations, CAHPS submissions would be excluded for a large number of hospices so both CAHPS and claims were omitted. CMS also considered proposing an icon that would indicate if a hospice has met the submission requirements, however CMS is trying to induce the non-submitting hospices to change behavior and believe a negative icon will be more effective than a positive icon. Additionally, creating an positive icon would also cause, at times, hospices with poor quality indicators to receive this icon and possibly give mixed messages to the consumer as to whether the hospice provides good quality of care.

CMS considered proposing a star rating, similar to those seen in other care settings on the *Medicare.gov* Compare Tool. However, this change would require the need for more public feedback and additional analyses to create a star rating that would accurately reflect the care a hospice is providing. There was also a desire to not add something to the Compare Tool that may interfere with the changes that may be made by the Hospice Special Focus Program (SFP).

F. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), we have prepared an accounting statement in Table 22 showing the classification of the expenditures associated with the provisions of this proposed rule. Table 22 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 6,642 hospices in our impact analysis file, which was constructed using FY 2025 claims (accessed from the CCW on January 15, 2026). All expenditures are classified as transfers to hospices.

TABLE 22: Accounting Statement
Classification of Estimated Transfers to Medicare Hospices

	HOSPICE PAYMENT UPDATE (FROM FY 2026 TO FY 2027)
Category	**Transfers**
Annualized Monetized Transfers	$785 million*
From Whom to Whom?	Federal Government to Medicare Hospices
HOSPICE ELECTION STATEMENT ADDENDUM (FY 2027)	
Category	**Cost**
Net Burden for Completion of the Election Statement Addendum	-$20.8 million**

*The increase of $785 million in transfer payments is a result of the proposed 2.4 percent hospice payment update compared to payments in FY 2026.
**The estimated annual net provider burden reduction of $20.8 million is a result of the difference between the estimated hospice burden for completion of the election statement addendum and the estimated non-hospice provider burden reduction for obtaining the election statement addendum.

G. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS U.S. industry title ''Home Health Care Services'' and corresponding NAICS code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $19 million.[22] Table 23 shows the number of firms, revenue, and estimated impact per home health care service category. Table 24 shows the number of nonemployer establishments, total, and average revenue per nonemployer establishment.

[22] *https://www.sba.gov/sites/sbagov/files/2023-03/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%281%29%20%281%29_0.pdf.*

TABLE 23: Number Of Firms, Revenue, and Average Revenue Per Firm of Home Health Care Services for NAICS Code 621610

NAICS	NAICS Description	Enterprise Size ($1,000)	Number of Firms	Receipts ($1,000)	Average Receipts Per Firm ($1,000)
621610	Home Health Care Services	<100	6,361	232,967	37
621610	Home Health Care Services	100-499	7,099	1,869,713	263
621610	Home Health Care Services	500-999	3,866	2,829,374	732
621610	Home Health Care Services	1,000-2,499	5,218	8,370,496	1,604
621610	Home Health Care Services	2,500-4,999	2,560	8,833,076	3,450
621610	Home Health Care Services	5,000-7,499	885	5,275,636	5,961
621610	Home Health Care Services	7,500-9,999	450	3,789,016	8,420
621610	Home Health Care Services	10,000-14,999	466	5,256,982	11,281
621610	Home Health Care Services	15,000-19,999	235	3,621,448	15,410
621610	Home Health Care Services	>20,000	1,058	73,271,709	69,255
621610	Home Health Care Services	Total	28,198	113,350,417	4,020

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2022" (SOURCE: 2022 SUSB Annual Data Tables by Establishment Industry) Release Date: 4/10/2025: https://www2.census.gov/programs-surveys/susb/tables/2022/us_6digitnaics_rcptsize_2022.xlsx.

Notes: The 'Average Receipts Per Firm' column is calculated as the Receipts ($1,000)/Number of firms. The 'Total' row represents all the home health care services firms under NAICS 621610. Overall receipts (revenue) for the 28,198 firms (NAICS 621610) are approximately $113 billion.

TABLE 24: NUMBER, TOTAL, AND AVERAGE REVENUE OF NONEMPLOYER ESTABLISHMENTS OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS	NAICS Description	Establishments With Sales, Value of Shipments, or Revenue Size of Establishments Code	Number of Nonemployer Establishments	Total Nonemployer Sales, Value of Shipments, Or Revenue ($1,000)	Estimated Average Revenue ($1,000)
621610	Home Health Care Services	All Establishments	412,098	9,525,542	**$23,115**

Source: Data obtained from United States Census Bureau table title "All Sectors: Nonemployer Statistics by Legal Form of Organization and Receipts Size Class for the U.S., States, and Selected Geographies: 2023" (SOURCE: U.S. Census Bureau, 2023 Economic Surveys) Release Date: 05/15/2025: https://data.census.gov/table?q=NONEMP2023.NS2300NONEMP&codeset=naics~62161.

Notes: Estimated average revenue is calculated as Total Nonemployer Sales, Value of Shipments, or Revenue ($1,000)/Number of Nonemployer Establishments. For the total, this is the average estimated impact across all number of firms.

The Department of Health and Human Services' practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits, and therefore the majority of hospice agency revenue consists of Medicare payments. Based on our analysis, we conclude that the policies proposed in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has determined that this hospice proposed rule would have significant economic impact resulting in a net increase in positive revenue on a substantial number of small entities. We estimate that the net impact of the policies in this rule is 2.4 percent or approximately $785 million in increased revenue to hospices in FY 2027. The 2.4 percent increase in expenditures when comparing FY 2026 payments to estimated FY 2027 payments is reflected in the last column of the first row in Table 21 and is driven solely by the impact of the proposed hospice payment update percentage reflected in the fourth column of the impact table. In addition, hospices with less than 3,500 RHC days will experience a higher estimated increase (2.6 percent), compared to hospices with greater than 20,000 RHC days (2.4 percent) due to the proposed updated wage index. We estimate that in FY 2027, hospices in urban areas would experience, on average, a 2.3 percent increase in

estimated payments compared to FY 2026; while hospices in rural areas would experience, on average, a 3.0 percent increase in estimated payments compared to FY 2026. Hospices providing services in the Outlying region would experience the largest estimated increases in payments of 3.6 percent. Hospices serving patients in the West South Central region will experience, on average, the lowest estimated increase of 2.0 percent in FY 2027 payments. Further detail by hospice type and location is presented in Table 21. The statement of need for the various proposed policies in this rule are discussed in section VII.A. of the RIA. Additionally, the alternatives considered for the various proposed policies in this rule are discussed in section VII.E. of the RIA. We considered potential alternatives for the policies proposed in this rule, including the hospice payment update percentage and the hospice election statement addendum. Because the hospice payment update percentage is established annually in accordance with the statutory requirements of section 1814(i)(1)(C) of the Act, we did not evaluate alternative approaches for this provision. Similarly, we did not consider alternatives for the regulatory text revisions, as these changes either conform to policies already codified in regulation or are mandated by the Consolidated Appropriations Act, 2026. For the hospice election statement addendum, the proposed policy is expected to generate savings for all hospices, including small entities. We also considered an alternative under which the hospice statement addendum would be optional rather than mandatory. However, this approach would likely increase costs for hospices (we consider all hospices small entities) and would not fulfill the intended objective, as described in Section III.C. of this proposed rule, of enhancing transparency for beneficiaries seeking to elect the hospice benefit. We are soliciting comments on our proposed cost analysis.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. As this rule will only affect hospices, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 23).

H. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $193 million. This rule will not have an unfunded effect on state, local, or tribal governments, in the aggregate, or on the private sector that exceeds this threshold in any 1 year.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132 and have determined that it will not impose substantial direct costs on State or local governments.

J. E.O. 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' Therefore, this proposed rule, if finalized as proposed, is expected to be an E.O. 14192 deregulatory action. We estimate that this proposed rule would generate −$16.98 million in annualized cost savings at a 7 percent discount rate, discounted to relative to 2024, over a perpetual time horizon.

K. Conclusion

We estimate that aggregate payments to hospices in FY 2027 will increase by $785 million as a result of the 2.4 percent proposed hospice payment update, compared to payments in FY 2026. We estimate that in FY 2027, hospices in urban areas would experience, on average, a 2.3 percent increase in estimated payments compared to FY 2026; while hospices in rural areas would experience, on average, a 3.0 percent increase in estimated payments compared to FY 2026. Hospices providing services in the Outlying region would experience the largest estimated increases in payments of 3.6 percent. Hospices serving patients in the West South Central region will experience, on average, the lowest estimated increase of 2.0 percent in FY 2027 payments.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Mehmet Oz Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 30, 2026.

List of Subjects in 42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 418 as set forth below:

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 418.22 is amended by revising paragraph (a)(4)(ii) to read as follows:

§ 418.22 Certification of terminal illness.

(a) * * *

(4) * * *

(ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, or through December 31, 2027, whichever is later, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via telecommunications technology and is considered an administrative expense. Telecommunications technology means the use of interactive multimedia communications equipment that 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. For face-to-face encounters occurring on or after January 1, 2027, hospices must report any such encounters occurring via telecommunications technology on the claim, in accordance with guidance issued by CMS. Beginning January 31, 2026, telehealth may not be used for the face-to-face recertification encounter if any of the following conditions apply:

(A) The hospice patient is located in an area subject to a hospice enrollment moratorium under section 1866(j)(7) of the Act;

(B) The patient is receiving care from a hospice provider that is subject to enhanced oversight pursuant to section 1866(j)(3) of the Act; or

(C) The face-to-face encounter is conducted by a hospice physician or nurse practitioner who is not enrolled in Medicare under section 1866(j) and is not an opt-out physician or practitioner (as defined in section 1802(b)(6)(D) of the Act.

* * * * *

■ 3. Section 418.24 is amended by revising paragraphs (b)(6), (c) introductory text, (c)(9) and (10), and (d) to read as follows:

§ 418.24 Election of hospice care.

(b) * * *

(6) For Hospice elections beginning on or after October 1, 2026, the hospice must provide the individual (or representative) an election statement addendum, as set forth in paragraphs (c) and (d) of this section, which includes any conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice.

* * * * *

(c) *Content of hospice election statement addendum.* For hospice elections beginning on or after October 1, 2026, the hospice must provide the individual (or representative) an election statement addendum. The election statement addendum (and its updates) must include the following:

* * * * *

(9) Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (and its updates) is only acknowledgement of receipt of the addendum and not the individual's (or representative's) agreement with the hospice's determinations. If the individual (or representative) refuses to sign the addendum, the hospice must document on the addendum the reason the addendum was not signed and the addendum would become part of the patient's medical record. The addendum must also be available for non-hospice providers and Medicare contractors, although non-hospice providers and Medicare contractors are not required to sign the addendum.

(10) Date the hospice furnished the addendum to the individual (or representative).

(d) *Timeframes for the hospice election statement addendum.* (1) For hospice elections beginning on or after October 1, 2026, the hospice must provide the individual (or representative) an election statement addendum, in writing, as set forth in paragraph (c) of this section, at the time of the hospice election (that is, within the first 5 days of the effective date of the hospice election). The hospice must also file this information with the election statement, as set forth in paragraphs (a) and (b) of this section, to be available for the individual (or representative), non-hospice providers, and Medicare contractors.

(2) If there are any changes to the plan of care during the course of hospice care that impact the addendum determinations, the hospice must update the addendum, within 3 days, with the contents described in paragraph (c) of this section, and provide these updates, in writing, to the individual (or representative), as well as update the addendum on file in order to communicate these changes to the individual (or representative), non-hospice providers, and Medicare contractors.

(3) If the individual dies, revokes, or is discharged within the required timeframe for providing the addendum (and its updates) (as outlined in paragraphs (d)(1) and (2) of this section), and before the hospice has provided the addendum (and its updates), the addendum would not be required to be provided, in writing, to the individual (or representative). The hospice must note the reason the addendum (and its updates) was not completed and/or provided, in writing, to the individual (or representative) and this note would become part of the patient's medical record. If completed, the hospice must still file the addendum (and its updates) with the election statement, as set forth in paragraphs (a) and (b) of this section, to be available for the individual (or representative), non-hospice providers, and Medicare contractors.

(4) If the individual dies, revokes, or is discharged prior to signing the addendum (or its updates) (as outlined in paragraphs (d)(1) and (2) with the required contents described in paragraph (c) of this section), the addendum would not be required to be signed in order for the hospice to receive payment. The hospice must note (on the addendum itself) the reason the addendum (and any updates) was not signed and the addendum would become part of the patient's medical record.

* * * * *

■ 4. Section 418.26 is amended by revising paragraph (b) to read as follows:

§ 418.26 Discharge from hospice care.

* * * * *

(b) *Discharge order.* Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director (or physician designee, as defined at § 418.3) or physician member of the interdisciplinary group. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

* * * * *

§ 418.309 [Amended]

■ 5. Section 418.309 is amended in paragraphs (a)(1) and (2) by removing ''2033'' and adding in its place ''2035''.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–06604 Filed 4–2–26; 4:15 pm]

BILLING CODE 4120–01–P