Medicare Program; FY 2026 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements [CMS-1835-F]
Summary of Final Rule

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I. Introduction and Background

On August 5, 2025, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (90 FR 37404) a final rule updating the Medicare hospice payment rates, wage index and Hospice Quality Reporting Program (HQRP) for FY 2026. CMS also clarifies in its hospice payment regulations that the physician member of the interdisciplinary group (IDG) may recommend admission to hospice care, which will align with certification regulations and the Conditions of Participation (CoPs). In addition, CMS finalizes a clarification in its regulations that the hospice face-to-face encounter attestation must include the physician's/practitioner's signature and date. CMS also provides notification of several updates related to the HQRP.

CMS estimates that the overall impact of the final rule will be an increase of $750 million (2.6 percent) in Medicare payments to hospices during FY 2026.

CMS notes that wage index addenda for FY 2026 (October 1, 2025 through September 30, 2026) will be available only through the internet at https://www.cms.gov/files/zip/fy-2026-final-hospice-wage-index.zip.

In prior rules, CMS included data about hospice utilization trends. CMS will now include this information only on the CMS hospice center webpage at https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice.

II. Provisions of the Final Rule

A summary of key data for the final hospice payment rates for FY 2026 is presented below with additional details in the subsequent sections.

Summary of Key Data for Final Hospice Payment Rates for FY 2026			
Market basket update factor			
Market basket increase			+3.3%
Required total factor productivity (TFP)			-0.7%
Net TFP-adjusted update reporting quality data			**+2.6%**
Net TFP-adjusted update not reporting quality data			**-1.4%**
Hospice aggregate cap amount			$35,361.44
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2025 Federal Rates Per Diem**	**FY 2026 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$224.62	$230.83
Routine Home Care (days 61+)	66.0%	$176.92	$181.94
Continuous Home Care, Full Rate = 24 hours of care, $69.38 hourly rate	75.2%	$1,618.59	$1,674.29
Inpatient Respite Care	61.0%	$518.78	$532.48
General Inpatient Care	63.5%	$1,170.04	$1,199.86
Service Intensity Add-on (SIA) payment, up to 4 hours			$69.76 per hour
Notes: The Consolidation Appropriations Act of 2021 changed the payment reduction for failing to meet quality reporting requirements from 2 to 4 percent beginning in FY 2024.			

A. FY 2026 Hospice Wage Index and Rate Update

1. FY 2026 Hospice Wage Index

The hospice wage index is used to adjust payment rates to reflect local differences in area wage levels, based on the location where services are furnished. CMS requires each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management of Budget (OMB) to the Metropolitan Statistical Area (MSA) definitions (§418.306(c)). CMS discusses its prior adjustments to the delineations of the labor markets based on OMB MSA definitions. In the FY 2025 Hospice final rule (89 FR 64208 through 64224), CMS finalized the implementation of new labor market areas based on the revisions in OMB Bulletin No. 23-01 beginning in FY 2025.

For FY 2026, CMS finalizes its proposal that the hospice wage index will be based on the FY 2026 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2021 and before October 1, 2022 (FY 2022 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but includes a 5 percent cap on wage index decreases. Thus, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving routine home care (RHC) or continuous home care (CHC) and applied based on the geographic location of the facility for

beneficiaries receiving general inpatient care (GIP) or inpatient respite care (IRC). CMS notes that the pre-floor and pre-reclassified hospital wage index used as the raw wage index for the hospice benefit are subject to application of the hospice floor. The pre-floor and pre-reclassified hospital wage index below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.[1]

For FY 2026, the 5 percent cap on wage index decreases will continue to be calculated at the county level as well. While some counties that required a transition code for FY 2025 will continue to use the same transition code for FY 2026, other counties that required a transition code in FY 2025 will no longer require a transition code in FY 2026. For these counties, the FY 2026 wage index of the core-based statistical areas (CBSA) or rural area that they are designated into has a wage index higher than 95 percent of their previous FY's wage index. Therefore, these counties will use the CBSA or rural county code of the area they were redesignated into based on OMB Bulletin No. 23-01.[2]

CMS also will continue to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all CBSAs within the state will be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. For FY 2026, there is one CBSA without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The final FY 2025 wage index value for Hinesville-Fort Stewart, Georgia is 0.8894.

For rural areas without hospital wage data, CMS uses the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. As part of CMS' adoption of the revised OMB delineations in FY 2025, rural North Dakota became a rural area without a hospital from which hospital data can be derived. To calculate the wage index for rural area 99935, North Dakota in FY 2026, CMS will use as a proxy the average pre-floor, pre-reclassified hospital wage data (updated by the hospice floor) from the contiguous CBSA: CBSA 13900-Bismark, ND; CBSA 22020-Fargo, ND-MN; CBSA 24220-Grand Forks, ND-MN and CBSA 33500, Minot, ND. This results in a final FY 2026 hospice wage index of 0.8469 for rural North Dakota.

Previously, the only rural area without a hospital from which hospital wage data could be derived was Puerto Rico. For FY 2026, based on the adoption of the revised OMB delineations, there is a hospital in rural Puerto Rico from which hospital wage data could be derived. CMS finalizes that the wage index for rural Puerto Rico will be based on this hospital data. Specifically, based on updated data for the final rule, the pre-hospice floor unadjusted wage index for rural Puerto Rico will be 0.2443 with an adjusted wage index by the hospice floor of 0.2809. Because 0.2809 is

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

[2] 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.

more than a 5 percent decline in the FY 2025 wage index, the 5 percent cap will apply and the final FY 2026 wage index will be 0.4200.

Selected Comments/Responses. Some commenters urged CMS to explore alternatives to the current reliance on hospital-based wage data to set hospice payments. Reasons cited included that the inpatient hospital data fails to adequately account for unique and considerable hospice-specific circumstances and costs such as the costs associated with travel to patients' homes. In reply, CMS states that it may consider these recommendations in future rulemaking. Others expressed concern that hospice providers are unable to benefit from the Inpatient Prospective Payment System (IPPS) hospital wage index policies such as out-migration, reclassification, and the rural floor. CMS notes in its reply that the statutory provisions that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor or out-migration provisions that exist for IPPS hospitals.

2. FY 2026 Hospice Payment Update Percentage

CMS estimates the FY 2026 market basket percentage increase and the productivity adjustment based on IHS Global Inc.'s (IGI's) forecast using the second quarter 2025 forecast with historical data through the first quarter of 2025, the most recent available data. For FY 2026, the estimated inpatient hospital market basket update of 3.3 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the Affordable Care Act currently estimated to be 0.7 percentage points. This results in a final hospice payment update percentage for FY 2026 of 2.6 percent. Hospices that do not submit the required quality data under the HQRP will receive a payment update percentage for FY 2026 of -1.4 percent. CMS notes that in the FY 2026 IPPS/LTCH rule the IPPS market basket is being rebased and revised to reflect a 2023 base year.

CMS will update hospice payments by applying the 2023-based IPPS market basket percentage increase for FY 2026 of 3.3 percent, reduced by the statutorily required productivity adjustment of 0.7 percentage points along with the wage index budget neutrality adjustment to update the payment rates. For the FY 2026 hospice wage index, CMS will use the FY 2026 pre-floor, pre-reclassified IPPS hospital wage index.

CMS notes that in the 2022 final rule it rebased and revised the labor shares for the RHC, CHC, GIP, and IRC using cost report data for freestanding hospices. The labor portion of the hospice payment rates is currently as follows: for RHC, 66.0 percent; for CHC, 75.2 percent; for GIP, 63.5 percent; and for IRC, 61.0 percent.

3. FY 2026 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[3] To calculate the wage index standardization factor, CMS simulated total payments using FY 2024 hospice utilization claims data with the FY 2025 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor and the 5 percent cap on wage index decreases) and FY 2025 payment rates and compared it to its simulation of total payment using the FY 2024 hospice 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 2025 payment rates. By dividing payments for each level of care using the FY 2025 wage index and FY 2025 payment rates for each level of care using the FY 2026 wage index and FY 2025 payment rates, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Tables 1 and 2 (reproduced below) list the final FY 2026 hospice payment rates by care category and the final wage index standardization factors.

Table 1: Final FY 2026 Hospice RHC Payments

Code	Description	FY 2025 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2026 Hospice Payment Update	FY 2026 Payment Rates
651	Routine Home Care (days 1-60)	$224.62	× 1.0005	× 1.0011	× 1.026	$230.83
651	Routine Home Care (days 61+)	$176.92	× 1.0001	× 1.0022	× 1.026	$181.94

Table 2: Final FY 2026 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2025 Payment Rates	Wage Index Standardization Factor	FY 2026 Hospice Payment Update	FY 2026 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care	$1,618.59 ($67.10 per hour)	× 1.0082	× 1.026	$1,674.29 ($69.76 per hour)
655	Inpatient Respite Care	$518.78	× 1.0004	× 1.026	$532.48
656	General Inpatient Care	$1,170.04	× 0.9995	× 1.026	$1,199.86

Tables 3 and 4 list the comparable FY 2026 payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $221.83; Routine Home Care (days 61+), $174.84; Continuous Home Care, $1,609.02; Inpatient Respite Care, $511.72; and General Inpatient Care, $1,153.08.

[3] CMS uses FY 2024 claims data as of January 13, 2025 to calculate the wage index standardization factor (the most recent available).

In the FY 2016 Hospice final rule (80 FR 47172), CMS implemented a Service Intensity Add-on (SIA) payment for RHC when direct patient care is provided by a registered nurse (RN) or social worker during the last seven days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. For FY 2026, the SIA payment is $69.76 per hour, up to 4 hours. In addition, for FY 2026, the final SIA budget neutrality factor is 1.0005 for RHC days and 1.0001 for RHC days 61+.

Selected Comments/Responses. Many commenters requested CMS make a one-time market basket adjustment of 4.9 percent to account for the cumulative shortfall in hospice payment rates due to forecast errors over FY 2021 through 2025. CMS in response notes that there is currently no mechanism to adjust for market basket forecast error in the hospice payment update. It also notes that the forecast error has been both positive and negative during past years , and over longer periods of time the cumulative forecast has not deviated significantly from the historical measures.

4. Hospice Cap Amount for FY 2026

By background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end of life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[4] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and was adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the IMPACT Act of 2014, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September 30, 2025 and revert to the original methodology, but this sunset provision was extended by the CAA, 2023 until September 30, 2032. The final hospice aggregate cap amount for the FY 2026 cap year (revised from the proposed rule based on updated data) will be $35,361.44 per beneficiary or the FY 2025 cap amount updated by the FY 2026 hospice payment update percentage ($34,465.34 * 1.026).

B. Finalized Regulation Change to Admission to Hospice Care

To align which physicians can make determinations for hospice admission with current certification requirements and conditions of participation (CoP), CMS finalizes refinements to its regulatory text. Specifically, to align with the current payment and CoP regulations at §§418.22(c)(1)(i) and 418.102(b), respectively, CMS finalizes its proposal to add the text "or 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

[4] If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days, then for inpatient care the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

IDG may also determine admission to hospice care. CMS believes aligning the language at §418.25(a) and (b) with the language at §§418.102(b) and 418.22(c)(1)(i) will allow for greater consistency between key components of hospice regulations and policies.

Selected Comments/Responses. Commenters overwhelmingly supported the proposal to add the physician member of the hospice IDG to §418.25(a) and (b). Several commenters requested clarification regarding whether the proposed regulatory changes to §418.25(a) and (b) would also apply to §418.26 (Discharge from hospice care) or whether CMS would be proposing this change (and include additional physician types) in future rulemaking. CMS replies that it is only finalizing the proposed changes to §418.25(a) and (b) and is not amending §418.26, but may consider this change in future rulemaking.

C. Finalized Clarifying Regulation Change Regarding Face-to-Face Attestation.

To correct an inadvertent omission from its regulatory text regarding face-to-face attestation, CMS proposed changes to §418.22(b)(4) the explicit requirements that the attestation include the accompanying signature of the practitioner who performed the face-to-face encounter, and the date signed. CMS also proposed that the attestation, its accompanying signature, and the date signed must be a separate and distinct section of, or an addendum to, the recertification form and must be clearly titled.

Accordingly, CMS finalizes its proposal, with modifications. In response to commenters' concerns regarding potential administrative burden, and CMS' goal to maintain the validity of the recertification process, CMS is finalizing a modification to the regulation text at §418.22(b)(4) to clarify that the attestation requirement may be fulfilled by not only a clearly titled section of or an addendum to the recertification form, but also by a signed and dated clinical note within the medical record that documents clear indication that the face-to-face encounter occurred and includes the date of the visit, the signature of the practitioner who conducted the face-to-face encounter, and the date of the signature.

Therefore, CMS is finalizing a revision to the regulation text at §418.22(b)(4) to state that the physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation must include the physician's or nurse practitioner's signature and the date it was signed. The attestation could be a separate and distinct section of, or an addendum to, the recertification or the signed and dated face-to-face clinical note itself, as long as said clinical note indicates the face-to-face encounter occurred and includes the clinical findings of the face-to-face encounter, the date of the visit, the signature of the physician or nurse practitioner who conducted the face-to-face encounter, and the date of the signature. If the attestation of the nurse practitioner or a non-certifying hospice physician is a separate and distinct section of, or an addendum to, the recertification, the attestation shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

D. Technical Regulations Text Change to Certification of Terminal Illness: Face-to-Face Encounter

In the final rule, CMS includes a technical change that conforms the regulatory text at §418.22(a)(4)(ii) with its underlying statute at section 1814(a)(7)(D)(i)(II) of the Act by changing the date "December 31, 2024" to "September 30, 2025". CMS inadvertently omitted this date change in the proposed rule. A discussion of this change is included in section IV of this final rule, Waiver of Proposed Rulemaking.

E. Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP)[5] includes the Hospice Item Set (HIS), administrative data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. New data collection through the Hospice Outcomes and Patient Evaluation (HOPE) tool was finalized in the FY 2025 Hospice Wage Index final rule. Section 1814(i)(5)(A)(i) of the Act[6] requires that hospices that fail to meet quality data submission requirements in a reporting year/data collection year[7] are subject to an annual payment update (APU) reduction, specifically a 4 percentage point reduction to the market basket update, for the payment FY to which that reporting year/data collection year corresponds.[8] Any such reduction applies for only the specified year. The reduction could result in the annual market basket update being less than zero and in payment rates that are less than rates for the previous fiscal year. In the FY 2026 Hospice Wage Index proposed rule, **CMS had not included any proposals related to the HQRP for FY 2026.** However, CMS is providing notification of a number of updates.

Table 5 (shown below, with slight formatting edits) lists the quality measures in effect for the FY 2026 HQRP.[9]

Table 5: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
Hospice Item Set (HIS) and Hospice Outcomes and Patient Evaluation (HOPE)
Hospice and Palliative Care Composite Measure–Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment

[5] The hospice quality reporting program is established under section 1814(i)(5) of the Act.
[6] The 4 percentage point reduction for failing to meet hospice quality reporting requirements, as well as completeness thresholds, are codified at §418.312(j).
[7] The "reporting year" (which is used in HIS and HOPE, once it is implemented) and the "data collection year" (which is used in CAHPS) are each based on a CY and correspond to each other. That is, if the HIS/HOPE reporting year is 2026, then the CAHPS data collection year is 2026.
[8] The Consolidation Appropriations Act of 2021 (CAA 2021; Public Law 116-260) changed the percentage point reduction for failing to meet these reporting requirements from 2 percentage points to 4 percentage points, beginning with FY 2024.
[9] Information on the current HQRP quality measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.

Table 5: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient Provided (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) - Live Discharges form Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Care preferences 8. Rating of this hospice 9. Willing to recommend this hospice

2. Update on Comprehensive Assessment at Admission Measure

CMS provides an update that the new CBE (Batelle) has extended the endorsement through Fall 2026 of the Comprehensive Assessment at Admission measure (CBE #3235), which assesses the proportion of patients for whom the hospice performed all 7 care processes (as applicable) at admission.

3. Update on Hospice Claims-based Measures

The Hospice Visits in the Last Days of Life (HVLDL) and Hospice Care Index (HCI) measures are claims-based measures that were adopted into the measure set in the FY 2022 Hospice Wage Index and Payment Rate Update final rule.[10] CMS provides an update that HVLDL has been re-endorsed through 2027 and the agency is considering respecifying HCI.

[10] 86 FR 42552

4. Update on HOPE Instrument and Public Reporting and Future Quality Measure (QM) Development

HOPE was developed as the new patient assessment tool to replace HIS and is to be implemented in FY 2026. Public reporting of the HOPE quality measures is to begin no earlier than FY 2028 (November 2027). Based on that anticipated timeline, the agency outlines that HOPE data collection would begin October 1, 2025. Data collected by hospices during the 2026 CY quarters will be analyzed starting in 2027. Based on the agency's findings of analysis of the 2026 data, CMS will decide whether it will report some or all of the HOPE quality measures publicly and will notify the public of its decisions through rulemaking. Providers will have the opportunity to preview HOPE data before it is publicly reported, with the first HOPE-based QM public reporting anticipated no sooner than November 2027 (FY 2028). Table 6 in the rule shows the anticipated schedule for HOPE public reporting. CMS notes that the schedule is subject to change based on the agency's analyses of the quality and reportability of the data and that it will provide updates in the FY 2027 Hospice rule.[11]

CMS encourages providers to complete a web-based training course "Introducing the HOPE Tool" available at https://www.cms.gov/medicare/quality/hospice/hqrp-training-and-education-library.

CMS notes that it is considering developing hybrid quality measures that could be calculated from multiple data sources. The agency also intends to develop measures based on information collected by HOPE after it is implemented.

Selected Comments/Responses. Many commenters expressed concerns about the transition to the HOPE, anticipated to begin October 1, 2025, including concerns regarding lack of technical readiness and additional financial burden. CMS provides updates for finding the HOPE Guidance Manual, HOPE Item Sets, and Data Submission Specifications. The agency also states that it will monitor the first quarter of HOPE data collection (Q4 of 2025) and provide subregulatory guidance on when public reporting of the two HOPE measures will begin. CMS further specifies that it expects providers to submit accurate and complete HOPE data beginning October 1, 2025.

5. Update on the Transition to iQIES

Hospices are required to submit HIS data using the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system and obtain reports in the Certification and Survey Provider Enhanced Reports (CASPER) system. As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update final rule, CMS is migrating to a new single CMS submission and reporting system. Beginning on October 1, 2025, the system will begin accepting data from HOPE and provider reports will also be available in the system. On February 15, 2026, the QIES system will stop accepting HIS records for admissions and discharges that occurred prior to October 1, 2025.

[11] Note that proposed or final rule is not specified.

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

Section 1814(i)(5)(A)(i) of the Act requires that each hospice submit data to the Secretary in a form and manner specified by the Secretary.

Three timeframes for both HIS/HOPE and CAHPS are important for HQRP compliance: (1) the reporting year for HIS/HOPE and data collection year for CAHPS; (2) payment FY; and (3) the reference year. Table 7 in the rule (reproduced below) summarizes these three timeframes. CMS notes that during the first reporting year that implements HOPE, APUs may be based on fewer than four quarters of data. CMS will provide additional subregulatory guidance regarding APUs for the HOPE implementation year.

Table 7: HQRP Reporting Requirements and Corresponding Annual Payment Updates		
Reporting Year for HIS/HOPE and Data Collection Year for CAHPS	**Annual Payment Update (APU) Impacts Payments for the FY**	**Reference Year for CAHPS Size Exception**
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024
CY 2026	FY 2028 APU	CY 2025
CY 2027	FY 2029 APU	CY 2026

Hospices must comply with CMS' submission data requirements. After HIS is phased out, the current submission requirements applied to HIS will apply to HOPE records. That is, hospices will continue to submit 90 percent of all required HOPE records (patient's admission, discharge, and based on the patient's length of stay up to two hospice update visits (HUV) timepoints) within 30 days of the event or completion date.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to utilize a CMS-approved third-party vendor. A list of approved vendors is available on the CAHPS Hospice survey website.[12]

Table 8 in the rule summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. Information from the table is shown below. CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

Table 8: HQRP Compliance Checklist		
Annual Payment Update	**HIS/HOPE**	**CAHPS**
FY 2026	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2024 – 12/31/2024	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024 – 12/31/2024
FY 2027	Submit at least 90 percent of all HIS/HOPE records within 30 days of the event (for example, patient's admission or discharge) for patient	Ongoing monthly participation in the Hospice CAHPS survey

[12] www.hospicecahpssurvey.org

Table 8: HQRP Compliance Checklist		
Annual Payment Update	**HIS/HOPE**	**CAHPS**
	admission/discharges occurring 1/1/2025 – 12/31/2025	1/1/2025 – 12/31/2025
FY 2028	Submit at least 90 percent of all HOPE records within 30 days of the event date or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient admission/discharges occurring 1/1/2026 – 12/31/2026	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2026 – 12/31/2026
FY 2029	Submit at least 90 percent of all HOPE records within 30 days of the event (for example, patient's admission or discharge) for patient admission/discharges occurring 1/1/2027 – 12/31/2027	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2027[13] – 12/31/2027

III. Regulatory Impact Analysis

CMS states that the overall impact of this final rule is an estimated net increase in Federal Medicare payments to hospices of $750 million or 2.6 percent, for FY 2026. The final hospice payment update percentage of 2.6 is based on the 3.3 percent inpatient hospital market basket percentage increase reduced by a 0.7 percentage point productivity adjustment.

The impact analysis represents the projected effects of the changes in hospice payments from FY 2025 to FY 2026. Using the most recent complete available data for this final rule (FY 2024 hospice claims data as of May 9, 2025), CMS presents the effects of the changes in hospice payments from FY 2025 to FY 2026. This includes the changes resulting from the updated wage data and the hospice payment update.

Table 9 in the final rule (recreated below) shows the overall total FY 2026 impact to hospices by facility type and area of country. In brief, proprietary (for-profit) hospices (about three-quarters of all hospices) are expected to have an increase in hospice payments of 2.5 percent compared with an increase of 2.9 percent for non-profit hospices and an increase of 3.3 percent for government hospices. Hospices located in rural areas would see an increase of 3.0 percent compared with 2.6 percent for hospices in urban areas. The projected overall impact on hospices varies more among regions of country, a direct result of the variation in the annual update to the wage index. Hospices providing services in the New England region would experience the largest estimated increase in payments of 3.9 percent in FY 2026 payments. In contrast, hospices serving patients in the Pacific, Outlying and West South Central regions would experience, on average, the lowest estimated percentage increase of 1.5, 2.2, and 2.1, respectively in FY 2026 payments.

[13] Note that the table in the rule says 1/1/2028-12/31/2027, changed in this summary to 1/1/2027-12/31/2027, consistent with the timing for the prior years in the table.

Table 9: Impact to Hospices for FY 2026

Hospice Subgroup	Hospices	FY 2026 Updated Wage Data	FY 2026 Hospice Payment Update (2.6%)	Overall Total Impact for FY 2026
All Hospices	6,735	0.0%	2.6%	2.6%
Hospice Type and Control				
Freestanding/Non-Profit	791	0.2%	2.6%	2.8%
Freestanding/For-Profit	4,654	-0.1%	2.6%	2.5%
Freestanding/Government	34	0.9%	2.6%	3.5%
Freestanding/Other	0	0.0%	2.6%	2.6%
Facility/HHA Based/Non- Profit	266	0.6%	2.6%	3.2%
Facility/HHA Based/For-Profit	4	0.3%	2.6%	2.9%
Facility/HHA Based/Government	97	0.5%	2.6%	3.1%
Facility/HHA Based/Other	0	0.0%	2.6%	2.6%
Subtotal: Freestanding Facility Type	5,479	0.0%	2.6%	2.6%
Subtotal: Facility/HHA Based Facility Type	367	0.6%	2.6%	3.2%
Subtotal: Non-Profit	1,067	0.3%	2.6%	2.9%
Subtotal: For Profit	5,131	-0.1%	2.6%	2.5%
Subtotal: Government	132	0.7%	2.6%	3.3%
Subtotal: Other	12	0.6%	2.6%	3.2%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	206	0.5%	2.6%	3.1%
Freestanding/For-Profit	392	0.3%	2.6%	2.9%
Freestanding/Government	24	0.8%	2.6%	3.4%
Freestanding/Other	0	0.0%	2.6%	2.6%
Facility/HHA Based/Non- Profit	112	1.2%	2.6%	3.8%
Facility/HHA Based/For-Profit	0	0.0%	2.6%	2.6%
Facility/HHA Based/Government	71	0.1%	2.6%	2.7%
Facility/HHA Based/Other	0	0.0%	2.6%	2.6%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	585	0.2%	2.6%	2.8%
Freestanding/For-Profit	4,262	-0.2%	2.6%	2.4%
Freestanding/Government	10	1.0%	2.6%	3.6%
Freestanding/Other	0	0.0%	2.6%	2.6%
Facility/HHA Based/Non- Profit	154	0.5%	2.6%	3.1%
Facility/HHA Based/For- Profit	4	0.3%	2.6%	2.9%
Facility/HHA Based/Government	26	0.7%	2.6%	3.3%
Facility/HHA Based/Other	0	0.0%	2.6%	2.6%

Hospice Subgroup	Hospices	FY 2026 Updated Wage Data	FY 2026 Hospice Payment Update (2.6%)	Overall Total Impact for FY 2026
Hospice Location: Urban or Rural				
Rural	849	0.4%	2.6%	3.0%
Urban	5,886	0.0%	2.6%	2.6%
Hospice Location: Region of the Country (Census Division)				
New England	159	1.3%	2.6%	3.9%
Middle Atlantic	280	0.1%	2.6%	2.7%
South Atlantic	650	0.4%	2.6%	3.0%
East North Central	654	0.4%	2.6%	3.0%
East South Central	252	0.3%	2.6%	2.9%
West North Central	441	0.8%	2.6%	3.4%
West South Central	1,251	-0.5%	2.6%	2.1%
Mountain	701	0.2%	2.6%	2.8%
Pacific	2,270	-1.1%	2.6%	1.5%
Outlying	77	-0.4%	2.6%	2.2%
Hospice Size (RHC Days)				
0 - 3,499 RHC Days (Small)	1,751	-0.8%	2.6%	1.8%
3,500-19,999 RHC Days (Medium)	3,014	-0.4%	2.6%	2.2%
20,000+ RHC Days (Large)	1,970	0.1%	2.6%	2.7%

Source: FY 2024 hospice claims data from CCW accessed on May 9, 2025.

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