DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1835–F]

RIN 0938–AV49

Medicare Program; FY 2026 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: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2026. This rule also finalizes changes to the admission to hospice regulations and the hospice face-to-face attestation requirements under the certification of terminal illness regulations and includes technical changes to the hospice telehealth policy and wage index. This final rule also includes a technical correction to the regulatory text and provides updates to the Hospice Quality Reporting Program requirements.

DATES: These regulations are effective on October 1, 2025.

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:

I. Executive Summary

A. Purpose

This final rule updates the hospice wage index, payment rates, and cap amount for FY 2026 as required under section 1814(i) of the Social Security Act (the Act). In addition, this final rule amends the payment regulations to specify that the physician member of the hospice interdisciplinary group (IDG) may recommend admission to hospice. This final rule also amends the attestation requirements at 42 CFR 418.22(b)(4) to align with the original intent of the CY 2011 Home Health Prospective Payment System (HH PPS) final rule and statutory requirements under section 1814(a)(7) of the Act for the certification of terminal illness to include the physician's or nurse practitioner's signature and the date of the signature on each face-to-face encounter attestation, and incorporate commenter suggestions on the proposed policy. This rule also includes a waiver of proposed rulemaking making a technical correction to conform the end date of the allowance of telehealth to perform the face-to-face encounter for the sole purpose of hospice recertification codified at § 418.22(a)(4)(ii) to the end date set forth in statute at section 1814(a)(7)(D)(i)(II) of the Act and setting the wage index for hospices that provide services in the Northern Mariana Islands and American Samoa to the wage index for CBSA 99965 (Guam).

This final rule corrects an error in the regulations text at § 418.312(j). This rule also reinforces updates on the Hospice Quality Reporting Program (HQRP) and the Hospice Outcomes and Patient Evaluation (HOPE) instrument and public reporting, future quality measures (QMs), and the transition of hospice providers from the Quality Improvement and Evaluation System (QIES) to the internet Quality Improvement and Evaluation System (iQIES). The proposed rule (90 FR 18568) also included RFIs related to the transition to digital measures, nutrition, and well-being concepts.

B. Summary of the Major Provisions

Section III.A.1. of this final rule includes 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 final rule includes the final FY 2026 hospice payment update percentage of 2.6 percent.

Section III.A.3. of this final rule includes the final FY 2026 hospice payment rates.

Section III.A.4. of this final rule includes the final update to the hospice cap amount for FY 2026 by the hospice payment update percentage of 2.6 percent.

Section III.B. of this final rule specifies that the physician member of the interdisciplinary group is among the types of physicians who can recommend a patient's admission to hospice care and adds the physician member of the interdisciplinary group to the regulatory text at § 418.25.

Section III.C. of this final rule re-aligns the attestation requirements in the regulatory text at § 418.22(b)(4) with the original intent of the statutory requirements under section 1814(a)(7) of the Act and CY 2011 HH PPS final rule for the certification of terminal illness regulations to include the physician's or nurse practitioner's signature and the date of the signature on each face-to-face encounter attestation. This section also incorporates suggestions from commenters to allow the actual face-to-face encounter clinical note to satisfy the statutory requirement for the hospice physician or nurse practitioner to attest to the encounter.

Section III.D. of this final rule includes a technical correction to the regulatory text at § 418.22(a)(4)(ii) that was not proposed. This technical correction extends the use of telehealth by a hospice physician or hospice nurse practitioner to conduct a face-to-face encounter for the sole purpose of hospice recertification through September 30, 2025 in accordance with section 1814(a)(7)(D)(i)(II) of the Act, as amended by section 2207(f) of the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119–4).

Section III.E. of this final rule includes a technical correction to a typographical error in the FY 2024 Hospice final rule at § 418.312(j). This section provides updates on the HOPE instrument, HQRP measures, and the transition to iQIES. This section also provides RFIs related to the transition to digital measures, nutrition, and well-being concepts.

Section IV. of this final rule includes a Waiver of Notice of Proposed Rulemaking for technical corrections to the regulatory text at § 418.22(a)(4)(ii) and to include, in the FY 2026 hospice wage index, the wage indexes for the Northern Mariana Islands and American Samoa. While we do not believe that either the corrections to § 418.22(a)(4)(ii) or the addition to the wage index requires notice and comment rulemaking, as explained in section IV, of this final rule, there is good cause to waive such rulemaking if it were required.

C. Summary of Impacts

The overall economic impact of this final rule is estimated to be $750 million in increased payments to hospices in FY 2026.

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 (or designee) or physician member of the 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 (42 CFR 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 final rule must comply with applicable civil rights laws, including section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which prohibit covered entities from discriminating against individuals based on disability. This includes requiring covered entities to take appropriate steps to ensure that communications 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

[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.

''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 Final Rule

A. Final FY 2026 Hospice Wage Index and Rate Update

1. Final FY 2026 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.*

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 in order 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

[2] Hospice Regulations and Notices. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.*

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. In order 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.

While we did not propose any changes to the hospice floor or 5 percent cap policies for FY 2026, we did receive a few comments on these finalized policies. A summary of the comments and our responses to those comments are as follows:

Comment: Several commenters expressed support for the continued application of the 5 percent cap on wage index decreases. A commenter stated that the 5 percent cap policy provides an important protection for hospices in areas experiencing wage index volatility due to the adoption of revised OMB statistical area delineations. This commenter also expressed support for the application of the cap at the county level, stating that the county-level application of the 5 percent cap represents a thoughtful approach to mitigating the financial impact of geographic reclassifications while maintaining the integrity of the wage index system.

Response: We thank the commenters for their support.

Comment: Other commenters recommended changes to the 5 percent cap policy. While MedPAC recommended that CMS also apply a cap to the wage index increase that a provider can experience in a given year, other commenters expressed concern that the 5 percent cap on wage index decreases may not be sufficient and recommended lowering the cap threshold. A commenter stated that even a 5 percent cut year-over-year can significantly strain hospice operations, especially amid rising costs. In addition, a commenter stated that a 5 percent cap on wage index decreases may stabilize some regions but still leaves many providers undercompensated, compromising access and quality. A few commenters expressed concern with the financial impact of wage index decreases in high cost of living areas, specifically in New York state and Northern California. A commenter stated that decreases to 6 of the 15 New York CBSAs for FY 2026 (with one reaching the 5 percent cap and three other CBSAs proposed to see decreases of 4.03 percent, 3.37 percent, and 2.86 percent), will make serving Medicare hospice beneficiaries in these areas of New York more challenging. Another commenter stated that the wage index for Sacramento has decreased since FY 2022 (from 1.7072 in FY 2022 to 1.631 in FY 2025, with CMS now proposing a further decrease to 1.5690 for FY 2026) and as a result, the projected payment for Hospice payments in FY 2026 will be less than the payment received in 2022 despite a cumulative nationwide inflation of 15.98 percent over the same period. The commenter expressed concern that hospice programs in Northern California cannot sustain 4 years with no increase in payment given the ongoing inflationary trends. This commenter stated they believe that in order to ensure stability, CMS should cap wage index decreases to the level of the market basket update.

Additionally, a commenter recommended that CMS consider lowering the cap to 2.5 or 3 percent to protect hospice providers who are operating with negative operating margins and are still experiencing multiple negative consequences due to the COVID–19 pandemic, such as increased costs and loss of staff. Another commenter recommended that CMS cap wage index reductions to the level of the market basket update or only permit upward adjustments in CBSA wage index values in order to ensure stability in hospice payments. Finally, a commenter recommended that CMS apply a zero percent floor to wage index adjustments in CBSAs with demonstrably increasing labor costs.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule as we did not propose any changes to the wage index cap. Regarding MedPAC's suggestion that the wage index cap policy should also be applied to wage index increases, the purpose of the 5 percent cap policy is to help mitigate the significant negative impacts of wage index decreases. Therefore, we do not

believe it would be appropriate to also cap wage index increases.

Furthermore, with respect to commenters' recommendations about lowering the cap on decreases, we continue to believe that the 5 percent cap on wage index decreases is sufficient to effectively mitigate any significant decreases in a hospice's wage index for a fiscal year, while still balancing the importance of ensuring that area wage index values accurately reflect relative differences in area wage levels. We continue to believe that a 5 percent cap on wage index decreases is sufficient because it provides a degree of predictability in payment changes for providers and allows providers time to adjust to any significant decreases they may face year to year. Also, while we appreciate the concerns raised by commenters on the financial impact of wage index decreases on high cost of living areas we believe that 5 percent is a reasonable level for the cap because it effectively mitigates any significant decreases in a hospice's wage index for future FYs, while still balancing the importance of ensuring that area wage index values accurately reflect relative differences in area wage levels. Therefore, we do not believe that it would be appropriate to lower the cap percentage, to apply a zero percent floor to wage index adjustments or to only permit upward wage index adjustments.

Comment: A few commenters expressed concern with the hospice floor policy. A commenter recommended that CMS reevaluate the hospice floor policy to ensure adequate reimbursement in persistently underserved rural regions, especially with declining wage index adjustments. Another commenter stated that even with the hospice-specific floor (capped at 0.8000), providers in rural areas receive substantially lower reimbursement for delivering the same services, limiting their ability to retain staff, cover operating expenses, and invest in care quality. Additionally, a commenter stated that without a wage index floor or multi-year transition strategy, many hospices, regardless of location, face abrupt and destabilizing reimbursement cuts.

Response: We appreciate these recommendations. However, these comments are out of scope as we did not propose any changes to the hospice floor policy. Regardless, we believe that the hospice floor, which adjusts the 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, and the 5 percent cap on wage index decreases is sufficient to mitigate any potential negative impact for hospices serving beneficiaries in these rural areas.

Final Decision: We did not propose any changes to finalized hospice floor and 5 percent cap policies. Therefore, the FY 2026 hospice wage index will continue to include the hospice floor as well as the 5 percent cap on wage index decreases. For FY 2026, the 5 percent cap on wage index decreases will continue to be calculated at the county level . 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 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.

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. Final FY 2026 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 2026, we proposed that the hospice wage index would be 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 (FY 2022 cost report data). We noted that the FY 2026 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 of 1997 (Pub. L. 105–33) 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.

The appropriate FY 2026 wage index value will 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 2026 wage index value will 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 2026, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville, Georgia. As such, the proposed FY 2026 hospice wage index for Hinesville, Georgia was 0.8892. Based on updated wage index data, the final FY 2026 hospice wage index value for Hinesville, Georgia is 0.8894.

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 2026 wage index for rural area 99935, North Dakota, we used 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 resulted in a proposed FY 2026 hospice wage index of 0.8486 for rural North Dakota. Based on updated wage index data, the final FY 2026 hospice wage index value for rural North Dakota is 0.8469.

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 2026 pre-hospice floor unadjusted wage index for rural Puerto Rico was 0.2452 subsequently adjusted by the hospice floor to equal 0.2820. Because 0.2820 is more than a 5 percent decline in the FY 2025 wage index, the adjusted FY 2026 wage index with the 5 percent cap applied would equal 0.95 multiplied by 0.4421 (that is, the FY 2025 wage index with 5 percent cap), which resulted in a proposed FY 2026 wage index value of 0.4200. Based on updated wage index data, the final FY 2026 pre-hospice floor unadjusted wage index for rural Puerto Rico is 0.2443 subsequently adjusted by the hospice floor to equal 0.2809. Because 0.2809 is more than a 5 percent decline in the FY 2025 wage index, the adjusted FY 2026 wage index with the 5 percent cap applied would equal 0.95 multiplied by 0.4421 (that is, the FY 2025 wage index with 5 percent cap), which results in a final FY 2026 wage index value of 0.4200.

The final hospice wage index applicable for FY 2026 (October 1, 2025 through September 30, 2026) is available on the CMS website for the Hospice Wage Index page located at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-wage-index* as well as the FY 2026 Hospice Wage Index final rule web page at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notices.*

We received 24 public comments on the proposed FY 2026 hospice wage index. A summary of the comments and our responses to those comments are as follows:

Comment: Several commenters including MedPAC recommended more far-reaching revisions and reforms to the wage index methodology used under Medicare fee-for-service than the proposed wage index policies outlined in the FY 2026 Hospice Wage Index and Rate Update proposed rule. MedPAC recommended that the Secretary use existing authority to adopt the Commission's June 2023 wage index plan that calls for Congress to repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that: uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type; reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and smooths wage index differences across adjacent local areas.

Other commenters urged CMS to engage with interested parties in exploring alternatives to the current reliance on hospital-based wage data to set hospice payments. A few commenters stated that the hospice wage index, based on 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. Another commenter requested changes to the hospice wage index methodology and stated that the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting hospice and home health costs in states like New York, which has some of the nation's highest labor costs, and which continue to increase. Finally, a commenter requested CMS publish a state- and county-level wage index impact analysis and consider an alternative hospice-specific wage index methodology in future rulemaking.

Response: We thank the commenters for their recommendations. While we did not propose any changes to the wage index methodology in the proposed rule, we may consider these recommendations in future rulemaking.

Comment: A few commenters expressed concern that hospice providers are unable to benefit from IPPS hospital wage index policies such as out-migration, reclassification, and the rural floor. Specifically, some commenters expressed concern that hospices in Kootenai County, ID do not benefit from the hospital outmigration policy and stated that CMS has already acknowledged the labor market overlap through this county's eligibility for a hospital wage index out-migration adjustment. They stated that it is inconsistent and financially unsound to recognize this disparity for hospitals but not for hospice providers operating in the same environment and serving the same communities.

Other commenters recommended that the hospice wage index incorporate the hospital reclassification policy. A commenter recommended that the reclassification provision be extended specifically to provider-based home health and hospice agencies affiliated with hospital or health systems. A commenter stated that the inability to reclassify leaves hospices uniquely vulnerable in a competitive labor market with a limited pipeline of available workers.

Finally, a commenter requested that CMS reinstitute its prior policy that no hospice be paid below the rural floor for their State.

Response: We remind interested parties 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. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is

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. Section 1886(d)(13) of the Act outlines the adjustment that is applied to hospitals that experience a significant shift in their patient population due to patients seeking care outside their geographic area (out-migration). Because the reclassification provision, the hospital rural floor, and the out-migration provision apply only to hospitals, and not to hospices (even those hospices that are affiliated with a hospital or other health care system), we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. However, we note that hospices do receive the hospice floor which adjusts the 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 and the 5 percent cap on wage index decreases and these policies apply to both urban and rural areas.

Comment: A few commenters expressed concern with the CBSA designations and wage index values assigned to their specific geographic areas. Several commenters representing hospices in Coeur d'Alene, ID stated that the economy and cost-of-living of Coeur d'Alene, ID and Kootenai County, ID is not reflective of the rest of the Idaho region but rather is more reflective of the ''Pacific'' region that includes the Spokane, WA CBSA. A commenter stated that despite being part of a shared economic and labor market with neighboring counties in Washington and Montana, the Coeur d'Alene, ID reimbursement rate is falling behind at a time when costs are rising across the board. These commenters recommended that CMS align Coeur d'Alene, ID and Kootenai County's hospice reimbursement rate with that of the Spokane, WA metropolitan area.

Response: We thank the commenters for these recommendations. However, we have used CBSAs for determining hospice payments since FY 2006 and continue to believe that the 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. CBSAs provide a uniform and consistent basis for determining statistical area delineations, based on long-standing statistical standards maintained by OMB. Further, OMB conducts periodic review of the standards to ensure their continued usefulness and relevance. Additionally, other provider types, such as IPPS hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), and inpatient rehabilitation facilities (IRFs), all use CBSAs to define their labor market areas. Therefore, we believe it is important to apply this method consistently among providers. Using the most current OMB delineations provides an accurate representation of geographic variation in wage levels. For example, we do not believe it would be appropriate to allow Kootenai County, ID to be reassigned into a higher CBSA designation. However, if OMB redesignates Kootenai County, ID into the Spokane, WA, we would propose this change in future rulemaking consistent with our longstanding approach of adopting OMB statistical area delineations outlined in the most recent OMB bulletins.

Final Decision: After consideration of public comments, we are finalizing our proposal to use the FY 2026 pre-floor, pre-reclassified hospital wage index data as the basis for the FY 2026 hospice wage index. Additionally, using our established methodology for rural areas with no hospitals, we are including in the FY 2026 hospice wage index the wage indexes for the Northern Mariana Islands and American Samoa. Consistent with our established methodology, we compute an appropriate wage index for rural areas with no hospital using the average wage index values from contiguous CBSAs to represent a reasonable proxy. We believe that CBSA 99965 (Guam) represents a reasonable proxy because the islands are located within the Pacific Rim and share a common status of US territories. While Guam does not share a land border with either the Northern Mariana Islands or American Samoa, we believe that Guam's wage index is a reasonable proxy for the wage indexes of American Samoa and the Northern Mariana Islands under our contiguous CBSA policy given that those two territories cannot share a land border with others CBSAs Therefore, 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. Although we did not propose this in the proposed rule, we believe notice and comment rulemaking is not needed to add the wage indexes of the Northern Mariana Islands and American Samoa because their inclusion aligns with our current methodology, current law for establishing the wage index, and current practice. As stated previously, choosing Guam's wage index as the reasonable proxy for the wage indexes of the Northern Mariana Islands and American Samoa is the best application of CMS's contiguous CBSA policy to the anomalous situation of U.S. territories separated by the ocean, and applying the contiguous policy as described ensures that the Northern Mariana Islands and American Samoa have wage indexes per 42 CFR 418.306(c). The addition of the Northern Mariana Islands and American Samoa to the wage index would also have no effect on hospice payment because hospices in the two territories currently receive payment based on calculations using Guam's wage index. Moreover, there is good cause to waive rulemaking for the addition of the Northern Mariana Islands and American Samoa to the wage index. We explain why there is good cause for a waiver in section IV. of this final rule, Waiver of Proposed Rulemaking.

The wage index applicable for FY 2026 is available on our website at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-wage-index.* The hospice wage index for FY 2026 is effective October 1, 2025, through September 30, 2026.

2. Final FY 2026 Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) 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. For FY 2026, we proposed to rebase and revise the IPPS market basket to reflect a 2023 base year. For more information on this proposal, we refer readers to the FY 2026 IPPS/LTCH PPS proposed rule (90 FR 18237 through 18247).

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 statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) 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. We note that, previously, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and would not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as ''private nonfarm business total factor productivity.'' However, as mentioned, the data and methods are unchanged. We refer readers to *http://www.bls.gov* 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.* In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the ''productivity adjustment'' rather than the ''MFP adjustment''.

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 2026 was based on the most recent estimate of the inpatient hospital market basket (based on IGI's fourth quarter 2024 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 2026 of 3.2 percent was 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 2026 was 0.8 percentage point (based on IGI's fourth quarter 2024 forecast). Therefore, the proposed hospice payment update percentage for FY 2026 was 2.4 percent. We also proposed that if more recent data became 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 2026 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.

We received 37 public comments on our proposal for the FY 2026 hospice payment update percentage. A summary of the comments and our responses to those comments are as follows:

Comment: Several commenters expressed their appreciation for the proposed inpatient hospital market basket update for FY 2026; however, most commenters expressed their belief that the proposed 2.4 percent increase would not cover their increased operating costs. Specifically, these commenters stated that they have been facing unprecedented increases in labor costs which have far outpaced the market basket updates that hospices have received in recent years. They stated they continue to grapple with a healthcare workforce shortage causing intense competition for skilled staff (including but not limited to nurses, social workers, aides, among other professionals), driving wages upward. Several commenters noted that BLS data indicates that healthcare sector inflation continues to be higher than historical norms and wages, salaries, and employer costs for health care are increasing at higher rates. Several commenters noted that MedPAC reports nonprofit hospices have margins in the single digits which they stated makes it even more difficult for them in the midst of rising costs for medications, supplies, employee wages, and benefits.

The commenters also stated that the proposed payment update has not appropriately captured the inflation pressures experienced for non-labor operating expenses, specifically the increased costs for medical supplies, personal protective equipment, durable medical equipment, pharmaceuticals, rent and utilities. A commenter also noted that tariffs will only further increase the cost of doing business for hospice providers. A commenter stated that hospices incur substantial travel-related costs in their state. A commenter stated they believe the proposed payment update does not reflect the increased costs of the new EMR and information-technology management contracts to comply with the revised HIPAA Security Rule; the increased training and education requirements to meet new CMS hospice regulatory demands; and the additional administrative personnel required to manage medical reviews and investigations secondary to new CMS regulations, and payment issues from Managed Care and Medicare Advantage plans.

Several commenters recommended CMS increase the proposed FY 2026 hospice payment increase by a different update than the proposed IPPS market basket update. A commenter requested CMS to recognize the cost-saving value of hospice services to the Medicare program and implement a one-time catch-up adjustment to hospice payments to reflect the true cost of care. A commenter requested CMS examine trends relative to IHS Global Inc.'s forecasts to determine whether more recently available data could be used for the final FY 2026 rule, resulting in a higher market basket update. They also requested CMS determine whether additional updates could be made during the course of FY 2026 to provide additional support to hospice and other providers, such as through a one-time adjustment. A commenter requested that CMS continue to monitor profit margins, wage index variations, and the myriad of factors that impact nonprofit hospices as CMS moves forward with changes to the current methodology. Several commenters requested CMS pursue all possible administrative options available to support hospices and provide a higher payment update

for FY 2026. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, they requested CMS work with Congress to address this need. A commenter stated that the hospice payment updates rely on cost reports that are 2 to 3 years old, failing to reflect real-time operational cost increases which they say is particularly damaging in periods of economic volatility. They requested that CMS consider implementing a prospective payment model based on current-year data, perhaps utilizing real-time provider-reported financial data or a claims-based adjustment mechanism. A commenter requested CMS index the base payment update to actual medical inflation or provide a targeted supplemental increase for providers serving a high proportion of dual-eligible beneficiaries.

Response: We acknowledge concerns about recent inflation trends and requests for a higher FY 2026 hospice payment update or an alternative payment recommendation that differs from the statutorily required productivity-adjusted IPPS market basket update.

However, section 1814(i)(1)(C)(ii)(VII) of the Act requires CMS to update hospice payments by the IPPS market basket percentage increase (as defined in section 1886(b)(3)(B)(iii) of the Act) adjusted for productivity. We note that in the FY 2026 IPPS/LTCH proposed rule (90 FR 18237 through 18247), we proposed to rebase and revise the IPPS market basket to reflect a 2023 base year. Section 1886(b)(3)(B)(iii) of the Act states the Secretary shall update IPPS payments based on a market basket percentage increase estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services. The IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the IPPS market basket update would reflect the prospective price pressures described by the commenters during a high inflation period (such as faster wage growth or higher energy prices) but might not reflect other factors that could increase costs such as the quantity of labor used or any shifts between contract and staff nurses. We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period.

We understand that the market basket updates may differ from other overall inflation indexes such as the CPI for Medical Care; however, we would reiterate that these topline indexes are not comparable since they measure different mixes of products, services, or wages than the legislatively defined CMS IPPS hospital market basket. We would highlight that the market basket percentage increase is a forecast of the price pressures that hospitals are expected to face in FY 2026. We also note that when developing its forecast for the various price indexes used in the IPPS market basket, IGI considers industry-specific and overall economic conditions. More specifically for the ECI for hospital workers (which is used to measure compensation prices), IGI considers overall labor market conditions (including the impact of wage pressures on skill mix) as well as trends in contract labor wages, which both have an impact on wage pressures for workers employed directly by the hospital.

As stated in the FY 2026 IPPS/LTCH proposed rule (90 FR 18266) we proposed a FY 2026 applicable percentage increase of 2.4 percent, reflecting the proposed 2023-based IPPS market basket rate-of-increase of 3.2 percent and proposed productivity adjustment of 0.8 percentage point. We also proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2026 IPPS market basket update for the final rule. We appreciate the commenters' concerns regarding inflationary pressure and the request to use more recent data to determine the FY 2026 IPPS market basket update. For this final rule, we are using an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy. As published in the FY 2026 IPPS/LTCH final rule, based on more recent data available for this FY 2026 Hospice Wage Index and Rate Update final rule (that is, IGI's second quarter 2025 forecast of the 2023-based IPPS market basket rate-of-increase with historical data through the first quarter of 2025), we estimate that the FY 2026 IPPS market basket increase is 3.3 percent. Based on more recent data available as published in the FY 2026 IPPS/LTCH PPS final rule (that is, IGI's second quarter 2025 forecast of the productivity adjustment), the current estimate of the productivity adjustment for FY 2026 is 0.7 percentage point. Therefore, the final hospice payment update percentage for FY 2026 is 2.6 percent (0.2 percentage point higher than the proposed hospice payment update percentage). We note that while there are multiple offsetting factors contributing to differences in the forecasts underlying the proposed and final rules, the final FY 2026 IPPS market basket increase is slightly higher due to economic uncertainty.

Comment: 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 FYs 2021 through 2025. Commenters also stated that because annual payment updates compound, the impact of forecast errors is cumulative. They further stated that Medicare hospice expenditures totaled about $27.5 billion in FY 2024 and so a 4.9 percent shortfall equates to roughly $1.3 billion in annual underpayments relative to what payments would have been with accurate market basket updates. Commenters also noted that skilled nursing facilities have received forecast error adjustments, including a 0.6 percentage point correction in FY 2024 and a 1.7 percentage points correction in FY 2025.

Commenters urged CMS to consider any and all opportunities to implement a one-time catch-up adjustment for hospice payments, as has been done in the past for other provider types in extraordinary circumstances to rectify cost disparities. Several commenters stated that if CMS is limited by statutory requirements to implement an adjustment for updating hospice payments that CMS work with Congress to include funding for a one-time market basket forecast error adjustment for hospice providers as a component of any end of year legislation taken up by the 119th Congress.

Response: We thank the commenters for their recommendations. The inpatient hospital market basket percentage increases are required by law to be set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. There is currently no mechanism to adjust for market basket forecast error in the hospice payment update. Furthermore, beginning in 1989, Congress gave hospices their first increase (20 percent) in reimbursement since 1986 and tied

future increases to the annual increase in the hospital market basket through a provision contained in the Omnibus Budget Reconciliation Act of 1989. While the projected IPPS hospital market basket updates for FY 2021 through FY 2024 (the last historical fiscal year) were under forecast, this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID–19 PHE. 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. Only considering a forecast error for years when the final inpatient hospital market basket percentage increase was lower than the actual inpatient hospital market basket percentage increase does not consider the numerous years that providers benefited from a forecast error. We understand that the market basket updates may differ from other overall inflation indexes such as the topline ECI, CPI, or PPI; however, we would reiterate that comparisons between these topline indexes are not comparable since they measure different mixes of products, services, or wages than reflected in the legislatively defined CMS IPPS hospital market basket.

Comment: Commenters recognized that CMS is statutorily required to apply the productivity adjustment based on the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity; however, they expressed concerns about the magnitude and methodology of the adjustment. Commenters stated that the productivity adjustment largely reflects output growth driven by technology, capital investment, and process efficiencies—factors more applicable to industrial or tech-driven sectors. They remained concerned that this adjustment does not fairly reflect the nature of hospice care, which is fundamentally labor-intensive and not amenable to typical productivity gains. Other commenters expressed concern regarding the increase in the productivity adjustment for FY 2026 relative to prior years, noting that the average was 0.5 percent over the 2012 to 2025 time period as well as noting the upward trend with 0.2 percent in FY 2024, 0.5 percent in FY 2025, and 0.8 percent in FY 2026. They stated this volatility underscores the inconsistency of applying a uniform, economy-wide productivity factor across all sectors and highlights the financial strain it imposes on labor-intensive providers such as hospice and home health, which lack the ability to realize capital-based efficiencies.

A commenter stated CMS should elect to implement the most de minimis productivity adjustment that may be applied under current law as a component of the FY 2026 hospice rate update. Other commenters requested CMS reevaluate the productivity adjustment methodology to account for the unique structure of hospice care.

Response: 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 10-year moving average growth in economy-wide private nonfarm business multi-factor productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, we are required pursuant to section 1886(b)(3)(B)(xi)(II) of the Act to apply the specific productivity adjustment described here.

We have always made available on the CMS website the general method for calculating the productivity adjustment. This includes providing a link to the most recent BLS historical total factor productivity (TFP) (previously referred to as multifactor productivity) data (*http://www.bls.gov*), which allows interested parties to obtain historical TFP annual index levels for 1987 through 2024. We also provided the IGI projection model (*https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf*), which is used to derive annual TFP growth rates for 2025 and 2026. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2026 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2026 relative to the 40-quarter moving average projected level for the period ending September 30, 2025. We believe our methodology for the productivity adjustment is consistent with section 1886(b)(3)(B)(xi)(II) of the Act which states that the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

At the time of this final rule, the FY 2026 productivity adjustment reflects BLS historical TFP data through 2024 (released on March 21, 2025) and IGI's forecasted TFP growth for 2025 and 2026. The average annual growth rate of historical TFP published by BLS for 2017 through 2024 is currently 0.9 percent and IGI is projecting average TFP growth of about 0.0 percent for 2025 and 2026 based on IGI's second-quarter 2025 forecast. Combining the historical and projected TFP data over the entire 10-year time period results in a compound annual growth rate of TFP of 0.7 percent for 2026. The productivity adjustment (based on the 10-year period ending with FY 2026) for the FY 2026 IPPS/LTCH final rule is 0.1 percentage point lower than in the FY 2026 IPPS/LTCH proposed rule and primarily reflects the incorporation of a revised outlook from IGI that has lower projected economic growth over 2025 and 2026. The 0.7-percent productivity adjustment in the FY 2026 final rule is larger than the productivity adjustment in prior final rules for FY 2023 and FY 2024 mainly due to the incorporation of updated BLS historical data.

Final Decision: We are finalizing the hospice payment update using the methodology outlined. Based on the more recent IGI second quarter 2025 forecast with historical data through the first quarter of 2025 the 2023-based IPPS market basket increase factor for FY 2026 is 3.3 percent. The FY 2026 productivity adjustment based on the more recent IGI second quarter 2025 forecast is 0.7 percentage point. Therefore, CMS is finalizing for FY 2026, a hospice payment update percentage of 2.6 percent (3.3 percent market basket percentage increase less a 0.7 percentage point productivity adjustment).

3. Final FY 2026 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 days 61 and beyond. 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 occurred 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 in order 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 2026, the proposed SIA budget neutrality factor was 1.0005 for RHC days 1–60 and 1.0001 for RHC days 61+. With updated FY 2024 claims data (as of May 9, 2025), the final SIA budget neutrality factor is 1.0005 for days 1–60 and 1.0001 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 in order to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2026 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we proposed to use FY 2024 claims data (as of January 13, 2025) for the FY 2026 payment rate updates. We noted that the budget neutrality factors and payment rates would be updated with more complete FY 2024 claims data for the final rule. With updated claims data (as of May 9, 2025), the wage index standardization factor was calculated by simulating 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 compare it to our simulation of total payments using FY 2024 utilization claims data, the 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 (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2025 wage index and FY 2025 payment rates for each level of care by the FY 2026 wage index and FY 2025 payment rates, we obtain a wage index standardization factor for each level of care. The final wage index standardization factors using FY 2024 claims data (as of May 9, 2025) for each level of care are shown in Tables 1 and 2.

The final FY 2026 RHC payment rates are shown in Table 1. The final FY 2026 payment rates for CHC, IRC, and GIP are shown in Table 2.

TABLE 1—FINAL FY 2026 HOSPICE RHC PAYMENT RATES

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	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.

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 beginning 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 final FY 2026 rates for hospices that do not submit the required quality data would be updated by −1.4 percent, which is the final FY 2026 hospice payment update percentage of 2.6 percent minus 4 percentage points. The final payment rates for hospices that do not submit the required quality data are shown in Tables 3 and 4.

TABLE 3—FINAL FY 2026 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2025 payment rates	SIA budget neutrality factor	Wage index standardization factor	FY 2026 hospice payment update of 2.6% − 4 percentage points = − 1.4%	FY 2026 payment rates
651	Routine Home Care (days 1–60)	$224.62	1.0005	1.0011	0.986	$221.83
651	Routine Home Care (days 61+)	176.92	1.0001	1.0022	0.986	174.84

TABLE 4—FINAL FY 2026 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2025 payment rates	Wage index standardization factor	FY 2026 hospice payment update of 2.6% − 4 percentage points = − 1.4%	FY 2026 payment rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,618.59	1.0082	0.986	$1,609.02 ($67.04 per hour).
655	Inpatient Respite Care	518.78	1.0004	0.986	511.72.
656	General Inpatient Care	1,170.04	0.9995	0.986	1,153.08.

We received two public comments on our proposals for the FY 2026 hospice payment rates. A summary of the comments and our responses to those comments are as follows:

Comment: A commenter expressed concern with the enforcement of the 4 percent payment reduction for hospices that fail to meet reporting requirements. This commenter stated that the strict enforcement of this penalty could disproportionately impact smaller or resource-limited providers and ultimately affect vulnerable patients.

Another commenter recommended that the Service Intensity Add-On (SIA) payment be expanded to include social work visits beyond the final 7 days to improve holistic end-of-life care.

Response: We appreciate the commenters' recommendations. However, these comments are outside the scope of the FY 2026 Hospice Wage Index and Payment Update proposed rule as we did not propose any changes to these policies. Furthermore, the 4 percent payment reduction for failing to meet hospice quality reporting requirements is required by statute. Any changes to these policies would need to be proposed through rulemaking or updated through statute.

Final Decision: We are finalizing the FY 2026 hospice payment rates, SIA budget neutrality factor, and wage index standardization factors. The final FY 2026 RHC payment rates are shown in Table 1. The final FY 2026 payment rates for CHC, IRC, and GIP are shown in Table 2. The final payment rates for hospices that do not submit the required quality data are shown in Tables 3 and 4.

4. Final Hospice Cap Amount for FY 2026

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) 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. 118–328) 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) extends this provision to October 1, 2033. 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, 2032. 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.

The proposed hospice cap amount for the FY 2026 cap year was $35,292.51, which was equal to the FY 2025 cap amount ($34,465.34) updated by the proposed FY 2026 hospice payment update of 2.4 percent. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of this 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 2026 final rule. Using the updated data, the final cap amount for the FY 2026 cap year will be $35,361.44 which is equal to the FY 2025 cap

amount ($34,465.34) updated by the final FY 2026 hospice payment update percentage of 2.6 percent.

We received eight public comments on our proposed update to the hospice cap for FY 2026. A summary of the comments and our responses to those comments are as follows:

Comment: A commenter expressed support for the proposed FY 2026 hospice cap amount.

Response: We thank this commenter for their support.

Comment: Most commenters opposed the proposed 2.4 percent update to the hospice cap amount for FY 2026. These commenters expressed concern that the proposed hospice cap update does not reflect the rising costs that hospices are currently facing. A commenter stated that the hospice cap warrants reevaluation to ensure it aligns with actual per-patient costs and does not disproportionately impact high-need populations. Another commenter recommended CMS reform the aggregate cap to account for patient mix, acuity, and regional cost differentials, ensuring that providers serving complex patients are not penalized. This commenter stated that the cap disproportionately penalizes providers caring for patients with non-cancer diagnoses; dual-eligible individuals requiring wraparound services and extended hospice stays; and vulnerable populations with limited access to caregivers or community support. The commenter also stated that even with the cap increase, many hospices will still exceed the limit due to factors beyond their control which creates disincentives to admit or retain high-need patients and exacerbates disparities in access to care. Finally, a commenter recommended that CMS abolish the hospice cap and stated that the hospice aggregate cap disincentivizes hospices from serving the most complex, high-need patients.

Response: We thank the commenters for their recommendations pertaining to the hospice cap; however, we are required by law to update the hospice cap amount from the preceding year by the hospice payment update percentage, in accordance with section 1814(i)(2)(B)(ii) of the Act. Therefore, we do not have the statutory authority to update the cap amount in a different manner nor account for patient mix, acuity, or regional cost differentials.

Final Decision: We are finalizing the update to the hospice cap amount for FY 2026 in accordance with statutorily mandated requirements.

B. Finalized Regulation Change to Admission to Hospice Care

The Medicare hospice benefit provides coverage for a comprehensive set of services described in section 1861(dd)(1) of the Act for individuals who are deemed ''terminally ill'' based on a medical prognosis that the individual's life expectancy is 6 months or less, as described in section 1861(dd)(3)(A) of the Act. As such, section 1814(a)(7)(A) of the Act requires the individual's attending physician (if the patient designates an attending physician) and hospice medical director (or physician member of the interdisciplinary group (IDG)) to certify in writing at the beginning of the first 90-day period of hospice care that the individual is ''terminally ill'' based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. In a subsequent 90- or 60-day period of hospice care, only the hospice medical director or the physician member of the IDG recertifies at the beginning of the period that the patient is terminally ill based on such clinical judgment.

Operation Restore Trust (ORT), a government initiative that began in 1995, coordinated with the Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG), and the Administration on Aging (AoA) to identify vulnerabilities in the Medicare program and to pursue ways to reduce Medicare's exposure to fraud and abuse. Through audits, ORT identified several areas of weakness in the hospice benefit, primarily in the area of hospice eligibility. In response to concerns raised by ORT regarding beneficiaries who had been receiving hospice care for more than 210 days but who were later determined to have not been eligible [3] and to reduce Medicare exposure to abusive practices, the FY 2006 Medicare Program; Hospice Care Amendments final rule (70 FR 70532, 70535, 70547) added a new § 418.25, ''Admission to hospice care,'' which established specific requirements that must be met before a hospice provider admits a patient to its care.

Section 418.25(a) requires that the hospice admit a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) in consultation with, or with input from, the patient's attending physician (if any). Section 418.25(b) sets out the information that the hospice medical director (or the physician designee, as defined in § 418.3) must consider in reaching a decision to certify that the patient is terminally ill. Section 418.25(b) is not the only regulation that discusses the certification of terminal illness. Section 418.22(c)(1) sets forth the sources of the certification of terminal illness and § 418.102(b) provides the standard for the initial certification of terminal illness in the condition of participation (CoP) for hospice medical directors. However, while each of these regulations pertains to the determination that a patient is terminally ill, they do not align regarding the physicians who can make these determinations.

In particular, § 418.25 only describes any of the two physicians on the recommendation of whom the hospice may admit a patient: the medical director or the physician designee (in addition to the patient's attending physician, if any). However, the payment certification of terminal illness and medical director CoP regulations at §§ 418.22(c)(1)(i) and 418.102(b), respectively, list any of three physicians who provide the written certification of terminal illness: the medical director of the hospice, the physician designee, or physician member of the hospice IDG.

Several out of scope comments were received regarding the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64231), specifically requesting that the physician member of the IDG be added to the hospice admission regulation at § 418.25. Specifically, commenters requested that the language regarding which physicians can make determinations for hospice admission align with current certification requirements and CoPs. We did not make a change to § 418.25 in the FY 2025 hospice final rule as we did not propose this change.

We agree with the commenters that our regulations should consistently describe the physicians who can certify terminal illness and determine patient admission to hospice care. Accordingly, to align with the current payment and CoP regulations at §§ 418.22(c)(1)(i) and 418.102(b), respectively, we proposed 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 IDG may also determine admission to hospice care. We noted 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

[3] Operation Restore Trust: Review of Medicare Hospice Eligibility at the San Diego Hospice Corporation *https://oig.hhs.gov/reports/all/1997/operation-restore-trust-review-of-medicare-hospice-eligibility-at-the-san-diego-hospice-corporation/.*

consistency between key components of hospice regulations and policies.

We received 31 public comments on our proposed changes to § 418.25(a) and (b). A summary of the comments and our responses to those comments are as follows:

Comment: Commenters overwhelmingly supported the proposal to add the physician member of the hospice IDG to § 418.25(a) and (b) and a few commenters expressed appreciation that CMS was responsive to the out of scope requests provided in the FY 2025 Hospice Wage Index and Rate Update final rule (89 FR 64231). Specifically, commenters stated that the regulation change would reduce ambiguity and improve clarity, leading to improved patient access to hospice care; reduce delays in services; improve timeliness of hospice services; improve accurate payment determinations; prevent inappropriate hospice citations; and align language with hospice certification payment requirements and CoPs.

Response: We thank commenters for their support.

Comment: We received a comment that opposed the addition of the physician member of the hospice IDG due to concerns that such a physician may materially benefit from recommending hospice if the physician has significant ownership in the for-profit hospice.

Response: We appreciate the concern raised; however, we would like to remind readers that § 418.25 simply aligns the admission process requirements with the certification requirements. The certification source for certifying a patient for hospice at § 418.22(c) includes the physician member of the IDG and also requires the individual's attending physician, if the individual has one, to certify the individual for hospice in the initial 90-day certification for hospice admission. Additionally, a patient must still meet eligibility requirements under § 418.20. The text change aligns language between payment policies and the CoPs in order to reduce ambiguity.

Comment: 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 we would be proposing this change (and include additional physician types) in future rulemaking. Some of these commenters requested that the same proposed physician language in § 418.25 be applied to § 418.26 for consistency and clarity, to improve timely discharge situations, and to further align hospice regulatory language.

Response: We thank commenters for their comments and recommendations. CMS is only finalizing the proposed changes to § 418.25(a) and (b) and is not amending § 418.26. We may consider adding ''physician member of the interdisciplinary group'' or additional physician types to § 418.26 in future rulemaking.

Comment: A commenter requested allowing nurse practitioners (NPs) and physician assistants (PAs) to certify a beneficiary as terminally ill.

Response: We thank this commenter for their suggestion; however, allowing NPs and PAs to certify a beneficiary as terminally ill is not permitted under the statute.

Final Decision: After consideration of public comments, we are finalizing our proposal to add the text ''or the physician member of the hospice interdisciplinary group'' to § 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.

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

The Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices final rule (CY 2011 HH PPS final rule) implemented the requirements in section 1814(a)(7)(D) of the Act, as added by section 3132(b) of the Affordable Care Act (75 FR 70435). Subclause (i) of section 1814(a)(7)(D) requires that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with a hospice patient to determine the patient's continued eligibility for hospice care prior to the 180-day recertification, and prior to each subsequent recertification. Section 1814(a)(7)(D)(i) also requires that the hospice physician or NP attest that such a visit took place, in accordance with procedures established by the Secretary. Additionally, as existing regulatory text at § 418.22 requires, if the face-to-face encounter was not performed by the certifying physician, the attestation of the physician or nurse practitioner who performed the face-to-face encounter shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care. These requirements were codified at § 418.22 to ensure that a hospice patients' continued eligibility is appropriately assessed through a face-to-face encounter conducted by either a hospice physician or NP.

As explained in the CY 2011 HH PPS final rule, the regulation at § 418.22(b)(4) set forth that the physician or NP who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient and, at that time, set forth that the attestation of the *nurse practitioner* shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. Further, the regulation set forth 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 (75 FR 70463).

In the FY 2012 Hospice Wage Index final rule (76 FR 47314), as a result of interested parties' concerns regarding access risks resulting from the policy implemented in the CY 2011 HH PPS final rule, we finalized that any hospice physician can perform the face-to-face encounter regardless of whether that physician recertifies the patient's terminal illness and composes the recertification narrative. Additionally, we amended the regulatory text at § 418.22(b)(4) to provide that the attestation of the NP *or a non-certifying hospice physician* shall state that the clinical findings of that encounter were provided to the certifying physician, for use in determining continued eligibility for hospice.

In that final rule, however, we inadvertently omitted from the regulatory text at § 418.22(b)(4) the explicit requirements that the attestation include the accompanying signature of the practitioner who performed the -face encounter, and the date signed. While the CY 2011 HH PPS final rule regulatory text required the hospice physician or the NP conducting the encounter to attest to its occurrence, including the date and their signature, the unintentional omission of this explicit requirement in the FY 2012 Hospice Wage Index final rule led to discrepancies in documentation practices and introduced potential ambiguity into compliance requirements along with inconsistencies in implementation among hospice providers. Specifically, the lack of clarity regarding the full attestation requirements complicated documentation standards and audit processes, led to confusion about the

expectations for what elements the attestation should minimally include, and thereby undermined of the intent of the original statute and rule to require verifiable documentation of appropriately assessed continued eligibility.

As such, we proposed to amend § 418.22(b)(4) to set forth that the physician, or NP who performs the face-to-face encounter attest that the face-to-face encounter occurred, and the attestation must include the signature of the physician or NP who conducted the face-to-face encounter and the date it was signed. Further, we 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. With these proposals, we sought to realign the regulatory text at § 418.22(b)(4) with the original intent of the CY 2011 HH PPS final rule and the statutory requirement in section 1814(a)(7)(D)(i)(I) of the Act.

Accordingly, we proposed to clarify the current regulation at § 418.22(b)(4) as follows: The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section 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, 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. If the face-to-face encounter was not performed by the certifying physician, the attestation of the physician or nurse practitioner who performed the face-to-face encounter shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

We noted that these additions would help to resolve current ambiguities, improve documentation standards, and promote consistent implementation across providers.

In total, we received 26 public comments on our proposed clarification of the regulation text regarding the face-to-face attestation. The following is a summary of the comments we received, our responses, and the final decision.

Comment: Several commenters supported the proposed regulatory text changes at § 418.22(b)(4), citing that a more detailed face-to-face encounter attestation process will strengthen program integrity. Commenters also stated the proposed attestation changes are already supported by hospice electronic medical records, reflect the current practice at many hospices, and are not expected to disrupt operations.

Response: We thank the commenters for this feedback.

Comment: A few commenters requested that CMS work with Congress to expand telehealth flexibility for face-to-face recertification.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule. Please note that section 2207(f) of the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119–4, March 15, 2025), amended section 1814(a)(7)(D)(i)(II) of the Act and extended the use of telehealth by a hospice physician or hospice nurse practitioner to conduct a face-to-face encounter for the sole purpose of hospice recertification through September 30, 2025.

Comment: A commenter stated Advanced Practice Registered Nurses (APRN) should be permitted to both perform and sign the attestation when conducting the face-to-face encounter to reduce redundancy, improve timeliness, and enhance access to care especially given access issues in rural areas and their scope of practice under state law. As such, this commenter strongly encouraged CMS to revise the regulation to authorize APRNs, within their scope of practice, to both conduct and sign the face-to-face encounter attestation for hospice recertification.

Response: We thank the commenter and acknowledge the critical role APRNs play in hospice care delivery. We remind commenters that in accordance with subclause (i) of section 1814(a)(7)(D) of the Act, a hospice physician or NP may conduct a face-to-face encounter with a hospice patient to determine the patient's continued eligibility for hospice care prior to the 180-day recertification, and prior to each subsequent recertification. However, the statute limits the practitioners who may conduct a face-to-face, and thereby does not permit other APRNs such as clinical nurse specialists (CNS), certified registered nurse anesthetists (CRNA), or certified nurse midwives (CNM) to perform this function.

Comment: A few commenters noted that the requirement for attesting that findings were shared with the certifying physician is redundant given existing narrative requirements. Specifically, commenters stated that § 418.22(b)(3)(v) already require the certifying physician's narrative to include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less, and that it would not be possible for the certifying physician to include this in the narrative if the physician was not provided with the clinical findings from the encounter (contained in the clinical note from the encounter).

Response: While we appreciate this comment, it is outside the scope of the proposal in the CY 2026 hospice proposed rule. We may consider this issue in future rulemaking.

Comment: While there was agreement that the proposed clarification to the regulation text at § 418.22(b)(4) requiring the signature and date of the signature be included with the face-to-face attestation will increase the integrity of this process, the majority of the commenters believe that implementation of this proposal would increase provider documentation burden. Commenters contend that the attestation process should prioritize appropriate clinical oversight rather than introduce administrative barriers that could delay care for vulnerable patients. Commenters suggested this proposal may result in a potential increase in delayed care for the most vulnerable patient populations. Additionally, several commenters remarked that the proposed attestation formatting requirements introduce an increase in audit vulnerability, compliance pitfalls and technical denials. They stated flexibility should be permitted, especially due to EMR constraints and costs, and that CMS should remove the proposed specific formatting requirement for face-to-face attestations.

Response: We appreciate these comments and agree that regulatory requirements should support, rather than hinder, timely access to appropriate hospice care. We also recognize the importance of balancing program integrity with administrative feasibility and remain committed to employing documentation requirements that do not impede care delivery. Additionally, we agree with commenters who pointed out that we have historically allowed hospices discretion in how documentation is structured, including for example, with the hospice election statement and addendum.

Comment: Several interested parties requested that CMS consider allowing a signed clinical note to serve as a substitute to a separate attestation that the face-to-face encounter occurred, highlighting that the statutory intent under section 1814(a)(7)(D)(i) of the Act is met if signed and dated clinical

documentation clearly demonstrates that the encounter occurred and is filed in the medical record.

Response: Section 1814(a)(7)(D)(i) of the Act specifies that the medical record must include evidence that a face-to-face encounter occurred prior to each recertification for hospice services. While CMS previously required a separate attestation to ensure that this statutory requirement was met, we recognize the burden in requiring a separate attestation when the information is already documented within a signed and dated clinical note. Therefore, we believe the statutory requirement is met through the signed and dated clinical note, without an additional attestation. CMS generally aims to reduce burden when appropriate, and we appreciate commenters bringing this to our attention.

Final Decision: In response to commenters' aforementioned concerns regarding potential administrative burden, and CMS' goal to maintain the validity of the recertification process, we are 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.

The proposed revisions to § 418.22(b)(4) align with our proposal to implement a revised attestation policy. As we stated in the proposed rule, our goal remains to resolve ambiguities that stem from prior rulemaking by clarifying that the attestation is identifiable and verifiable and therefore, must include the signature and date of the practitioner who conducted the face-to-face encounter in accordance with the statutory requirement at section 1814(a)(7)(D)(i) of the Act. The objective in the aforementioned revision to allow the face-to-face clinical note to serve as meeting the attestation requirement also achieves the regulatory intent that was first implemented in the CY 2011 HH PPS final rule and amended in the FY 2012 Hospice Wage Index final rule, as the clinical note still requires a dated signature from the practitioner who conducted the face-to-face encounter in order to allow clear identification of the attestation within the medical record. Moreover, a dated signature on the face-to-face clinical note serves to meet the definition of a medical attestation since it is a formal statement by a qualified practitioner verifying the accuracy of medical documentation which would include the clinical findings of the face-to-face encounter, the date of the visit, and the signature of the physician or nurse practitioner who conducted the face-to-face encounter, and the date of the signature. Given that these changes collectively address interested party concerns and provide increased clarity and standardization, while also preserving the statutory requirement at section 1814(a)(7)(D)(i) of the Act that a face-to-face encounter occur and be sufficiently documented by the practitioner who conducted said visit for each recertification for continued eligibility, these revisions fall within the scope of what a reasonable commenter would have understood from the FY 2026 Hospice proposed rule.

Therefore, we are finalizing a revision to the regulation text at § 418.22(b)(4) to state, 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 this final rule, we include 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''. We 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 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 Item Set (HIS), 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 above for that FY. In the FY 2024 Hospice final rule, 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, Open Door Forums, 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 will 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 will 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-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

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.

Table 5 shows the current quality measures in effect for the FY 2026 HQRP, which were updated and finalized in the FY 2025 Hospice Wage Index and Payment Rate Update final rule.

TABLE 5—QUALITY MEASURES IN EFFECT FOR THE FY 2026 HOSPICE QUALITY REPORTING PROGRAM

Hospice Quality Reporting Program
Hospice Items Set (HIS) and 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

TABLE 5—QUALITY MEASURES IN EFFECT FOR THE FY 2026 HOSPICE QUALITY REPORTING PROGRAM—Continued

Hospice Quality Reporting Program
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

2. Update on the Comprehensive Assessment at Admission Measure

We retained key items from the HIS in HOPE v1.0 and continue to collect data to inform the Comprehensive Assessment at Admission (CBE #3235) while gathering additional data to support new quality measures. The Comprehensive Assessment Measure assesses the proportion of patients for whom the hospice performed all seven care processes, as applicable, at admission.

First endorsed by the National Quality Forum (NQF) in July 2017, the measure was endorsed again by NQF in July 2021, and this measure endorsement has been extended through Fall 2026 under the new CBE, Battelle.

3. Update on Hospice Claims-Based Measures

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).

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. On July 26, 2022, the CBE endorsed the claims-based HVLDL measure. More information can be found on the HQRP Quality Measure Development web page at *https://www.cms.gov/medicare/hospiceequality-reporting-program/quality-measure-development* and the HQRP Current Measures web page at *https://www.cms.gov/medicare/quality/hospice/current-measures.* In November 2024, HVLDL was sent to the CBE advisory group for endorsement extension. HVLDL was re-endorsed with conditions in February 2025 and is endorsed through 2027. We are considering respecifying HCI, see the Hospice Technical Expert Panel (TEP) and Caregiver Report on this web page at *https://www.cms.gov/medicare/quality/hospice/provider-and-stakeholder-engagement.*

We received two public comments on the Hospice Claims-based Measures. The following is a summary of the comments we received and our responses.

Comment: A commenter urged CMS to re-evaluate HVLDL to evaluate correlation of the measure with other disciplines and the new CAHPS satisfaction surveys to allow time for provider and TEP engagement. Another commenter encouraged CMS to revisit the HCI scoring methodology to more accurately reflect the care provided by hospices.

Response: We thank commenters for their recommendations and will take them into consideration as we consider the re-specification of HCI and updates to HVLDL.

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

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 once implemented in FY 2026 (October 1, 2025), will provide value to hospice providers, patients, and families. 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).

HOPE will provide assessment-based quality data to enhance the HQRP

through standardized data collection, provide a better understanding of patient care needs, contribute to the patient's plan of care, and provide additional clinical data that could inform future payment refinements.

We encourage providers and vendors to visit the HOPE Technical Information web page at *https://www.cms.gov/medicare/quality/hospice-quality-reporting-program/hospice-outcomes-and-patient-evaluation-hope-technical-information* for the latest updates and resources related to HOPE data submission specifications and other technical information. More detailed comprehensive training will be available on the HQRP Training and Education Library web page linked previously in this section.

As finalized in the FY 2025 Hospice Wage Index final rule (89 FR 64202), public reporting of the HOPE quality measures will be implemented no earlier than FY 2028. Data collected by hospices during the four quarters of CY 2026 (for example, Q 1, 2, 3 and 4 CY 2026) will be analyzed starting in CY 2027. We will inform the public of the decisions about whether CMS will report some or all of the quality measures publicly based on the findings of analysis of the CY 2026 data through future rulemaking. Providers will have the opportunity to preview HOPE data before it is publicly reported, with the first HOPE-based QM public reporting anticipated to be no earlier than November 2027 (FY 2028). Table 6 shows the anticipated schedule for HOPE public reporting, should CMS decide that this information will be publicly reported.

TABLE 6—ANTICIPATED HOPE PUBLIC EDUCATION, DATA COLLECTION, AND REPORTING

Key event	Time period
Provider Trainings for HOPE Implementation	Spring/Summer 2025.
Data Collection Begins	October 1, 2025.
CY 2026 Data Analyzed to Assess Quality and Completeness	Winter/Spring 2027.
Provider Preview Reports for HOPE Measure(s) Provided to Hospices *	Summer 2027.
Public Reporting of HOPE Measure(s) Begins *	Fall 2027.

* These dates are subject to change based on the quality and reportability of the data as determined based on CMS analyses; updates will be provided in the FY 2027 Hospice Rule.

Lastly, as stated in the FY 2022 Hospice Wage Index final rule (86 FR 42528), we continue to consider developing hybrid quality measures that could be calculated from multiple data sources, such as claims, HOPE data, or other data sources (for example, CAHPS Hospice Survey). We also intend to develop several quality measures based on information collected by HOPE after HOPE is implemented. More information on measure development can be found on the HQRP Quality Measure Development web page at *https://www.cms.gov/medicare/hospice-quality-reporting-program/quality-measure-development.*

We received 30 public comments on the HOPE Instrument and Public Reporting and Future Quality Measure (QM) Development. The following is a summary of the comments we received and our responses.

Comment: Many commenters raised concerns about the transition from HIS to the HOPE tool, slated to begin October 1, 2025. Commenters expressed concerns about the lack of technical readiness among providers and vendors due to some final technical specifications not yet being released as of the publication of the proposed rule and only one vendor call occurring in November 2024. Some commenters expressed concern about additional financial burden and potential delays with the transition to the new CMS submission and reporting system, which is set to be implemented concurrently with the HOPE tool. To account for these issues, many commenters suggested delaying HOPE implementation until 6 months after the final specifications and trainings have been released, with a few suggesting delaying implementation by a year, and waiving timeliness penalties for providers for the first two quarters of HOPE. Some commenters also suggested phasing in penalties over the course of HOPE implementation, up to three years, to allow time for providers to adjust to HOPE. A few commenters were supportive of the transition to HOPE and noted no concerns with the implementation timeline.

A few commenters requested additional updates to or clarifications about HOPE, including that CMS consider allowing telehealth for HOPE, requesting that CMS collect data on chaplain services using the Healthcare Common Procedure Coding System (HCPCS) codes for chaplains, and asking for clarification around Medicare Advantage payer source coding.

Response: We appreciate interested parties' input regarding the transition to the HOPE tool. In this final rule we have provided updates as to where providers and vendors can find current information about HOPE, including the HOPE Guidance Manual, HOPE Item Sets, and Data Submission Specifications as well as training for HOPE implementation. Although most HOPE items are derived from the original HIS items, we recognize that providers will be acclimating to a new tool and submission system as of October 1, 2025, and will take this transition into consideration. For example, we will monitor the first quarter of HOPE data collection (quarter 4 of 2025) and provide sub-regulatory guidance on when public reporting of the two HOPE measures will begin. We will closely monitor the first quarter of HOPE data and expect providers to submit accurate and complete HOPE data beginning on October 1, 2025. Regarding other suggestions about the HOPE instrument, we will take them into consideration, and if modifications to the HOPE instrument or HOPE implementation are made, we will propose them in future rulemaking.

Regarding the comment about payer source coding, the intent of Item A1400 is to identify all of the payers that the patient has regardless of whether the payer is expected or likely to provide reimbursement during the hospice stay. We are not changing this guidance for HOPE, since it remains the same as long-standing HIS guidance.

Comment: Many commenters raised concerns about the HOPE burden calculated in the finalized PRA package (CMS–10390; OMB Control Number: 0938–1153), noting that CMS used the median wage rather than the mean wage and used 2022 Bureau of Labor Statistics (BLS) data [4] rather than more recent 2024 BLS data. Commenters also believe in-person follow-up visits should be included in the estimated

[4] May 2022 National Occupational Employment and Wage Estimates, United States. *https://www.bls.gov/oes/2022/may/oes_nat.htm.*

burden. Due to these concerns, commenters felt CMS underestimated the burden of the HOPE tool on providers.

Response: We thank commenters for their input regarding the HOPE burden calculations. When this PRA package was finalized for HOPE (CMS–10390; OMB Control Number: 0938–1153), no comments were received regarding these concerns. However, when comparing the finalized burden calculations using 2022 BLS Median wages, we find that using the 2022 BLS Mean wages instead would have resulted in a 9.5 percent increase in the additional annual cost per hospice. If the data were updated using the 2024 BLS Median wages, this would have resulted in a 15.3 percent increase in the additional annual cost per hospice and using the 2024 BLS Mean wages would have resulted in 21.1 percent increase. We recognize these differences may be significant for hospices and these concerns will be taken into consideration in anticipation of the next PRA package submission for the HOPE tool in 2026. We also understand commenters' concerns about the potential staffing burdens of in-person visits, but remind commenters that we selected this requirement based on expert input regarding hospice best practices during the beta test that noted these visits align with their usual practices (*https://www.federalregister.gov/d/2024-16910/p-224*).

5. Update on the Transition to iQIES

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we finalized migrating our systems for submitting and processing assessment data and the reporting system. Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system and obtain reports in the Certification and Survey Provider Enhanced Reports (CASPER) system. The FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484) finalized the proposal to migrate to a new single CMS submission and reporting system.

In the FY 2025 Hospice Wage Index and Payment Rate Update final rule (86 FR 64202), we finalized the HOPE tool to replace the HIS as part of the HQRP. Beginning on October 1, 2025, the new CMS submission and reporting system will begin accepting the data from HOPE, in line with the start of HOPE data collection. Provider reports will also be available in this system beginning October 1, 2025. The QIES system will stop accepting HIS records for hospice admissions and discharges that occurred prior to October 1, 2025, including any corrections, after February 15, 2026.

Although we did not propose the transition to the new CMS submission and reporting system in the proposed rule, we received 13 public comments. The following is a summary of the comments we received and our responses.

Comment: Commenters raised concerns about the feasibility of transitioning hospice providers to the new CMS system due to historical delays as other provider types transitioned into the new CMS system and the intensive process needed to enroll providers and staff members. As noted in the prior section, commenters also raised concerns around this transition occurring alongside the transition to the HOPE tool, creating additional burden for providers.

Response: We appreciate commenters' input regarding the transition to the new CMS submission and reporting system. We note that while providers and vendors will be submitting HOPE data to a new CMS system on October 1, 2025, we expect hospice providers to onboard successfully and as planned, as has occurred with the assessment submission and reporting migrations for other provider types. The submission process will be similar to the process for submitting data to QIES. In addition, we will provide a similar set of provider, APU, and QM reports to enable providers to monitor their data submissions.

We note that although there is a different enrollment process for the new CMS submission and reporting system, there are several benefits to the new system that are intended to provide a more streamlined user experience. The new system is web-based and accessible with a single login for submitting HOPE data and accessing HOPE-related reports, replacing the current two-step process that requires two different login credentials. In addition, the new system enables a provider to have unlimited users able to submit HOPE data and access reports, with user access managed internally by a provider's designated security official, which is designed to promote timely data submission and support APU compliance.

In this final rule we have provided updates as to where providers and vendors can find additional information about this transition. Providers and vendors should visit the HOPE Technical Information web page at *https://www.cms.gov/medicare/quality/hospice-quality-reporting-program/hospice-outcomes-and-patient-evaluation-hope-technical-information* for the latest updates and resources related to HOPE data submission specifications, including the final Hospice Outcomes and Patient Evaluation (HOPE) data submission specifications (V1.00.1) and other technical information. As noted in this final rule, providers must have access to iQIES by October 1, 2025, to submit HOPE assessments and the QIES system will no longer accept HIS records after February 15, 2026. Additional questions about the transition to iQIES can be addressed to the iQIES Help Desk at *iqies@cms.hhs.gov.*

6. 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, once implemented) 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, once it is implemented) 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).[5] 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 7 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2023 through CY 2026 data collection periods and the corresponding APU application from FY 2025 through FY 2028. Please note that during the first reporting year that implements HOPE, APUs may be based on fewer than four quarters of data. We will provide additional subregulatory guidance regarding APUs for the HOPE implementation year.

TABLE 7—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 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.

As illustrated in Table 7, CY 2024 data submissions compliance impacts the FY 2026 APU. CY 2025 data submissions compliance impacts the FY 2027 APU. CY 2026 data submissions compliance impacts FY 2028 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 will apply the same submission requirements for HOPE admission, discharge, and up to two hospice update visit (HUV) records. After HIS is phased out, 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 8 HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

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 (for example, patient's admission or discharge) for patient admissions/discharges occurring 1/1/24–12/31/24.	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 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.

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

TABLE 8—HQRP COMPLIANCE CHECKLIST—Continued

Annual payment update	HIS/HOPE	CAHPS
FY 2029	Submit at least 90 percent of all HOPE records within 30 days of the event date (for example, patient's admission date, HUV completion date or discharge date) for patient admissions/discharges occurring 1/1/27–12/31–2027.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2028–12/31/2027.

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.

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-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.* Available trainings can be found on the HQRP Training and Education Library web page at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-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.

7. Revision to § 418.312(j)(2) To Correct Regulatory Text

We proposed to revise the regulatory text at § 418.312(j)(2) to correct a reference to another part of the regulations. Specifically, we proposed replacing a reference to § 412.306(b)(2) with the correct reference to § 418.306(b)(2).

We received a comment in support of this proposal to revise § 418.312(j)(2) and we are finalizing as proposed.

IV. Waiver of Proposed Rulemaking

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Specifically, 5 U.S.C. 553 requires the agency to publish a notice of the proposed rule in the **Federal Register** that includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment for rulemaking to carry out the administration of the Medicare program under title XVIII of the Act. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the notice and comment and delay in effective date APA requirements. In cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act also provide exceptions from the notice and 60-day comment period and delay in effective date requirements of the Act. In this final rule, we are not waiving the delay in effective date of the finalized provisions, but rather we are exercising the waiver of notice and comment rulemaking for the provisions summarized in this section. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process are impracticable, unnecessary, or contrary to the public interest.

Here, we are making two technical changes to the regulations for which there is good cause to waive notice and comment rulemaking.

First, we are making a technical change to § 418.22(a)(4)(ii) that was not proposed to align the regulation with its underlying statute. We believe that there is good cause to waive advance notice and comment because public participation is unnecessary for this technical change that will conform the regulatory text at § 418.22(a)(4)(ii) with its underlying statute, that is, section 1814(a)(7)(D)(i)(II) of the Act. Section 2207(f) of the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub L. 119–4) 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 hospice recertification through September 30, 2025. However, the regulation at § 418.22(a)(4)(ii) continued to use ''December 31, 2024'' instead of ''September 30, 2025'' because we inadvertently omitted this date change in the proposed rule underlying § 418.22(a)(4)(ii). Given that this final rule simply conforms the regulation with its implementing statute, notice-and-comment rulemaking is unnecessary, and thus there is good cause to waive such rulemaking.

Second, as discussed in the comments and responses in section III.A.1.c. of this final rule, we are including in the FY 2026 hospice wage index the wage indexes for the Northern Mariana Islands and American Samoa using our established methodology for rural areas with no hospitals. The Northern Mariana Islands and American Samoa are rural areas with no hospital data from which a wage index can be calculated. Consistent with our established methodology, we compute an appropriate wage index for rural areas with no hospital using the average wage index values from contiguous CBSAs to represent a reasonable proxy. We believe that CBSA 99965 (Guam) represents a reasonable proxy because the islands are located within the Pacific Rim and share a common status of US territories. While Guam does not share a land border with either the Northern Mariana Islands or American Samoa, we believe that Guam's wage index is a reasonable proxy for the wage indexes of American Samoa and the Northern Mariana Islands under our contiguous CBSA policy given that those two territories cannot share a land border with other CBSAs. Therefore, 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.

While CMS believes that notice-and-comment rulemaking is not required for the addition of the wage indexes for the Northern Mariana Islands and American Samoa, were it required, there is good cause to waive such rulemaking as unnecessary. Notice-and-comment rulemaking is unnecessary because CMS is applying the existing methodology, that is, calculating the wage index of a rural area without a hospital based on the wage indexes of contiguous CBSAs, to the circumstances of the Northern Mariana Islands and American Samoa, and those two territories have historically and are currently receiving payment using Guam's wage index. As CMS is not altering a current wage index calculation methodology, there is good cause to waive notice and comment rulemaking to finalize the addition of the Northern Mariana Islands and American Samoa to the FY 2026 hospice wage index.

V. Collection of Information Requirements

In the proposed rule we noted that this rule, if finalized, would revise the attestation requirements at § 418.22(b)(4) to better align with the original intent of the statutory requirements under section 1814(a)(7) of the Act and CY 2011 HH PPS final rule for the certification of terminal illness regulations to include the physician's or nurse practitioner's signature and the date of the signature on each face-to-face encounter attestation. These underlying attestation requirements are collections of information that require approval under the PRA and were previously approved in the ICR for the Hospice Conditions of Participation (OMB Control Number 0938–1067). However, the revisions we proposed were minor and would not substantively change the scope of the attestation requirement or the burden that it would entail and thus do not require any additional approval that would go beyond the coverage provided by 0938–1067.

We received public comments on the attestation requirements regarding collection of information requirements, which are summarized in section III.C. of this final rule, stating that implementation of some of the proposed regulatory language would increase provider documentation and administrative burden. Therefore, we are finalizing only the proposed signature and date requirement of the attestation (which would not substantively change the scope of the attestation requirement) and not finalizing the proposed language stating that the attestation must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. This language accounted for the part of the proposal that commenters stated would increase provider burden. Additionally, we clarified that if the signed and dated face-to-face encounter clinical note is included in the medical record, this could substitute for a signed and dated attestation, with the belief that this will further decrease administrative burden.

We are seeking approval from OMB to reinstate Control Number 0938–1067 separately from this rulemaking via the standard PRA process. The revisions to the attestation requirements that are being finalized in this rule will take effect once OMB approves the reinstatement.

VI. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This final 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 CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This final rule updates the payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2026 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.

B. Overall Impact

We have examined the impacts of this 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); and the Congressional Review Act (5 U.S.C. 804(2)).

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.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. 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. Furthermore, pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has determined that this rule meets the criteria set forth in 5 U.S.C. 804(2). Therefore, OMB has reviewed this final rule and the Department has provided the following assessment of its impact.

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this final rule will result in an estimated increase of $750 million in payments to hospices, resulting from the final hospice payment update percentage of 2.6 percent for FY 2026. The impact analysis of this final rule represents the projected effects of the changes in hospice payments from FY 2025 to FY 2026. Using the most recent complete data available at the time of rulemaking, in this case FY 2024 hospice claims data as of May 9, 2025, we simulate total payments using 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 compare it to our simulation of total payments using FY 2024 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 (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2025 wage index and payment rates for each level of care by the FY 2026 wage index and FY 2025 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 Quality Reporting Program

There were no new proposals related to the Hospice Quality Reporting Program for FY 2026; accordingly, there are no impacts.

C. Detailed Economic Analysis

1. Final Hospice Payment Update for FY 2026

The FY 2026 hospice payment impacts appear in Table 9. 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 2026 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 2026 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 2.6 percent is based on the final 3.3 percent inpatient hospital market basket percentage increase reduced by a 0.7 percentage point productivity adjustment. The fifth column shows the total effect of the updated wage data and the hospice payment update percentage on FY 2026 hospice payments. As illustrated in Table 9, the combined effects vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2024 as seen on Medicare hospice claims (accessed from the CCW on May 9, 2025) 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 9, the combined effects vary by specific types of providers and by location.

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

TABLE 9—IMPACT TO HOSPICES FOR FY 2026—Continued

Hospice subgroup	Hospices	FY 2026 updated wage data (%)	FY 2026 hospice payment update (2.6%)	Overall total impact for FY 2026 (%)
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 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	1,751	−0.8	2.6	1.8
3,500–19,999 RHC Days	3,014	−0.4	2.6	2.2
20,000+ RHC Days	1,970	0.1	2.6	2.7

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

Note: The overall total impact reflects the addition of the individual impacts, which includes the wage index impact as well as the hospice payment update of 2.6 percent.

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 6,735). Subtypes involving ownership only add up to 6,342 while subtypes involving facility type only add up to 5,846.

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.

We received a comment on the detailed economic analysis and impact table. A summary of this comment and our response follows:

Comment: A commenter recommended enhanced data transparency regarding the files used to categorize hospice provider types by ownership and facility type in the FY 2026 hospice impact table. This commenter requested further information about the differences in the two files used to source this data and stated that CMS must be transparent about this measure.

Response: Ownership and facility type have typically been sourced from the provider of services (POS) file *(https://data.cms.gov/resources/pos-file-iqies-for-hha-asc-and-hospice-providers-methodology*). In recent years, ownership and facility type have increasingly been missing from the POS. Starting with the FY 2026 proposed rule, we also incorporated cost report data. We first assign ownership and facility type using information from the cost reports. Then, if there is missing data, we use the POS data to determine ownership and facility type. This improved our ability to assign ownership and facility type, with 6,305 hospices having ownership type information and 5,788 having facility type information. We encourage all hospices to review their POS and cost report data to ensure information on ownership and facility type are available and accurate. Missing information on ownership or facility type only impacts the rows of the impact table that are associated with ownership or facility type. Other calculations throughout the rule are not impacted by missing data on ownership or facility type.

D. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final 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 this year's proposed rule will be the number of reviewers of this final rule. However, we acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed this 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 this year's proposed rule is a fair estimate of the number of reviewers of this final rule. We received no comments on the approach to estimating the number of entities that will review this final rule. We also recognize that different types of

entities are in many cases affected by mutually exclusive sections of this final rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

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/current/oes_nat.htm*). Assuming an average reading speed we estimate that it would take approximately 1.76 hours for staff to review half of this final 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 $11,977.20 ($199.62 × 60 reviewers; which is based on the number of comments received for the proposed rule).

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 hospice payment update percentage. The final 2.6 percent hospice payment update percentage for FY 2026 is based on a final 3.3 percent inpatient hospital market basket percentage increase for FY 2026, reduced by a final 0.7 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 2026, 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.

F. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 10 showing the classification of the expenditures associated with the provisions of this final rule. Table 10 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this final rule. This estimate is based on the data for 6,735 hospices in our impact analysis file, which was constructed using FY 2024 claims (accessed from the CCW on May 9, 2025). All expenditures are classified as transfers to hospices.

TABLE 10—ACCOUNTING STATEMENT CLASSIFICATION OF ESTIMATED TRANSFERS TO MEDICARE HOSPICES

Hospice payment update	FY 2025 to FY 2026
Category	Transfers
Annualized Monetized Transfers.	$750 million*.
From Whom to Whom?.	Federal Government to Medicare Hospices.

*The increase of $750 million in transfer payments is a result of the 2.6 percent hospice payment update compared to payments in FY 2025.

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.[6] Table 11 shows the number of firms, revenue, and estimated impact per home health care service category.

TABLE 11—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	36.62
621610	Home Health Care Services	100–499	7,099	1,869,713	263.38
621610	Home Health Care Services	500–999	3,866	2,829,374	731.86
621610	Home Health Care Services	1,000–2,499	5,218	8,370,496	1,604.16
621610	Home Health Care Services	2,500–4,999	2,560	8,833,076	3,450.42
621610	Home Health Care Services	5,000–7,499	885	5,275,636	5,961.17
621610	Home Health Care Services	7,500–9,999	450	3,789,016	8,420.04
621610	Home Health Care Services	10,000–14,999	466	5,256,982	11,281.08
621610	Home Health Care Services	15,000–19,999	235	3,621,448	15,410.42
621610	Home Health Care Services	>20,000	1,058	73,271,709	69,254.92
621610	Home Health Care Services	Total	28,198	113,350,417	4,019.80

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.*

[6] *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.*

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.

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 finalized in this rule will 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 final rule will 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 2.6 percent or approximately $750 million in increased revenue to hospices in FY 2026. The 2.6 percent increase in expenditures when comparing FY 2025 payments to estimated FY 2026 payments is reflected in the last column of the first row in Table 9 and is driven solely by the impact of the 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 lower estimated increase (1.8 percent), compared to hospices with 3,500–19,999 RHC days (2.2 percent) and hospices with greater than 20,000 RHC days (2.7 percent) due to the final updated wage index. We estimate that in FY 2026, hospices in urban areas would experience, on average, a 2.6 percent increase in estimated payments compared to FY 2025; while hospices in rural areas would experience, on average, a 3.0 percent increase in estimated payments compared to FY 2025. Hospices providing services in the New England region would experience the largest estimated increases in payments of 3.9 percent. Hospices serving patients in the Pacific region will experience, on average, the lowest estimated increase of 1.5 percent in FY 2026 payments. Further detail is presented in Table 9 by hospice type and location. The analysis in this section along with the rest of the regulatory impact analysis in this final rule constitutes our final regulatory flexibility analysis. We did not receive any 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 604 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 9).

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 $187 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 final rule is not an E.O. 14192 regulatory action since it does not impose any more than *de minimis* regulatory costs.

K. Conclusion

We estimate that aggregate payments to hospices in FY 2026 will increase by $750 million as a result of the 2.6 percent final hospice payment update, compared to payments in FY 2025. We estimate that in FY 2026, hospices in urban areas would experience, on average, a 2.6 percent increase in estimated payments compared to FY 2025; while hospices in rural areas would experience, on average, a 3.0 percent increase in estimated payments compared to FY 2025. Hospices providing services in the New England region would experience the largest estimated increases in payments of 3.9 percent. Hospices serving patients in the Pacific region will experience, on average, the lowest estimated increase of 1.5 percent in FY 2026 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 July 21, 2025.

List of Subjects in 42 CFR Part 418

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, 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 paragraphs (a)(4)(ii) and (b)(4) 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 September 30, 2025, 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 a 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.

(b) * * *

(4) The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section 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 a clinical note that 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.

* * * * *

■ 3. Section 418.25 is amended by revising paragraphs (a) and (b) introductory text to read as follows:

§ 418.25 Admission to hospice care.

(a) The hospice admits a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) or the physician member of the hospice interdisciplinary group, in consultation with, or with input from, the patient's attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director (or the physician designee, as defined in § 418.3) or the physician member of the hospice interdisciplinary group, must consider at least the following information:

* * * * *

■ 4. Section 418.312 is amended by revising paragraph (j)(2) to read as follows:

§ 418.312 Data submission requirements under the hospice quality reporting program.

* * * * *

(j) * * *

(2) A hospice must meet or exceed the data submission compliance threshold in paragraph (j)(1) of this section to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as described under § 418.306(b)(2) of this chapter.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–14782 Filed 8–1–25; 4:15 pm]

BILLING CODE 4120–01–P