CAPITOL STREET

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# Hospice Pay +2.4% in Proposed '27 Rule

New Tool Will Publicly Identify Hospices with High Non-Hospice Spend, 180+ Day LOS

Relevant Companies

## Our Take & Next Up

**Medicare hospice pay would increase +2.4% under Medicare's proposed FY27 rule, with increased focus on fraud, waste and abuse (FWA) in hospice practices nationwide.** Under the 111-page proposed rule (here), the overall rate increase is +2.4%, with rural for-profits +2.8%, and urban for-profits +2.3%.

**We have said that near-term policy changes to both home health and hospice would likely focus on program integrity, enforcement, and transparency requirements, as CMS generally lacks the authority to overhaul payment models without Congress.** Several policy headwinds are in play for hospice including (1) federal spending pressures weighing on all of healthcare, including post-acute and (2) continued regulatory program integrity efforts, which have targeted hospice specifically. In the near term, policymakers and regulators appear more focused on fraud enforcement and payment adjustments rather than major structural reform.

## Key Points

**PAYMENT HIGHLIGHTS**

**CMS proposes a pay raise for all hospices +2.4% for FY 2027.** All for-profit hospices will see pay +2.4%. This is based on the 3.2% inpatient hospital market basket increase reduced by a 0.8% productivity adjustment. As a reminder, last year's final 2026 rule provided rates of +2.5% to hospices. The impact of this rule will result in an estimated $785 M in increased revenue to hospices. Rural freestanding for-profits to see +2.8%, while urban freestanding for-profits would see +2.3%.

**CMS announces that hospice payments are subject to a limited statutory aggregate cap annually of $36,210.** For FY27, the final cap is $36,210.11, which is a 2.4% increase from the FY26 cap amount previously at $35,361.44.

**NEW HOSPICE SCORING SYSTEM TO ADDRESS FWA**

**CMS is proposing a new, publicly available hospice scoring system, the SSVI (service and spending variation index), to identify hospices with long LOS, high non-hospice spend, as well as other metrics.**

Scored on a 0-16 scale across nine claims-based metrics, the tool heavily weights non-hospice spending, which alone can account for up to 8 of the 16 possible points.

**Hospices with high scores face consequences including medical review, payment suspension, and revocation for identified fraud, waste, or abuse (FWA).** Scores will be publicly posted, creating accountability for bad actors.

**Other factors CMS will take into account:** percent of beneficiaries discharged with a length of stay of 180 days or more, average minutes per routine home care day, and percent of live discharges where beneficiaries return to the same hospice in seven days, among others. These metrics were chosen to compare spending and care delivery between hospices.

**CMS proposes a mandatory hospice election statement addendum, replacing the voluntary one.** This measure would require hospices to provide every Medicare beneficiary a written list of non-covered items, services, and drugs at the time of election, no longer only when requested. Non-hospice spending grew 160% since the voluntary, request-based addendum launched in FY 2020, with reports of hospices directing other providers to bill Medicare for services hospices were already paid to cover. Making the addendum mandatory forces transparency upfront and closes a significant duplicate payment vulnerability.

**The agency proposes extending telehealth recertification face-to-face encounters through Dec 31, 2027, but adds targeted FWA guardrails**. Hospices must now include specific modifiers or codes on claims identifying telehealth encounters, making audits clearer. Most significantly, telehealth is prohibited for face-to-face encounters when a hospice is already under a Medicare moratorium or enhanced oversight, directly blocking bad actors from using the flexibility as a shield.

**The agency develops these provisions due to questionable spending and trends -- skin subs, for-profit versus non-profit, non-hospice services -- in the Medicare hospice benefit over the past several years.** CMS noted that non-hospice services for hospice beneficiaries exploded 160% from FY 2020 to FY 2024, reaching over $2 B, money the hospice per diem is already supposed to cover. Skin substitute billing for pressure ulcers skyrocketed nearly 4,000%, from $18 M to $714 M, for conditions CMS argues hospices should be managing themselves. For-profit hospices drove 167% higher non-hospice spending per day than non-profits, and OIG audits confirmed hundreds of millions in improper payments to hospitals, physicians, and DME suppliers for services hospices were already paid to provide.

**BACKGROUND**

**The hospice industry is under scrutiny as Congress identifies hospice, DME and home health as industries to monitor.** On March 17, the House Energy & Commerce Committee (Guthrie R-KY) held a hearing specifically examining fraud, waste, and abuse in hospice, home health, and DME, signaling that congressional oversight of these sectors is needed, alongside broader health care cost concerns. These stakeholders are increasingly under scrutiny as policymakers turn greater attention toward providers in the broader health care cost debate (our take here).

**CMS is actively prioritizing program integrity in hospice, targeting newer providers and high-volume states where enforcement has identified improper patient enrollment, non-consensual admissions, upcoding, unbundling, and falsified documentation**. New hospices are bearing the brunt of enforcement.

Under CMS's Period of Enhanced Oversight for New Hospices (PEONH). At the March hearing, Chair Guthrie (R-KY) highlighted 89 hospice companies registered to a single address in Van Nuys, CA, a pattern CMS Deputy Administrator Kim Brandt confirmed is a primary enforcement focus.

**Separately, the agency has taken a targeted, data-driven approach to identify and address fraudulent activities at hospices, which has included unannounced hospice site visits nationwide and the revocation or deactivation of hundreds of hospice providers engaged in improper activity.** Enhanced oversight in four states with elevated fraud risk--Arizona, California, Nevada, and Texas--has resulted in more than 200 hospice Medicare enrollment revocations for failure to comply with CMS requirements. CMS has since expanded this targeted oversight approach to additional states, including Georgia and Ohio.

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