GIP, CHC and respite: documentation checklist with FY2027 rates

What each Medicare hospice level of care needs in the chart, and what Medicare pays for it from October 1, 2026.

GIP in one look

- **Who decides:** the hospice physician, on medical necessity, with the interdisciplinary group; the need is reassessed every day.
- **Where:** a Medicare-participating hospital, skilled nursing facility or hospice inpatient unit under contract with the hospice, with registered nursing available 24 hours a day.
- **How long:** until the symptom is controlled or the patient can be managed in another setting; each day's note states why the patient still cannot be managed elsewhere.
- **What it is not:** caregiver breakdown alone (that is respite), imminent death without an uncontrolled symptom, custodial care, or a place to wait for a nursing facility bed.
- **When it ends:** once the symptoms are controlled, the patient returns to routine home care, and the record says when and why. See the 80/20 rule for how inpatient days are counted.

Medicare hospice rates, FY2027 (October 1, 2026 to September 30, 2027)

National base rates from the FY2027 hospice final rule (CMS-1851-F) as corrected by the September 30, 2026 correction notice (CMS-1851-CN), before the local wage index adjustment. A hospice that does not report quality data has its annual update cut by 4 percentage points. These are what Medicare pays the hospice; the patient's only Medicare cost shares are up to $5 per prescription and 5% of the respite rate.

Level of care	FY2026	FY2027
Routine home care, days 1 to 60	$230.83 a day	$236.33 a day
Routine home care, day 61 on	$181.94 a day	$186.33 a day
Continuous home care, full 24-hour day	$1,674.29	$1,726.16 (about $71.92 an hour)
Inpatient respite care	$532.48 a day	$545.93 a day
General inpatient care	$1,119.86 a day	$1,231.51 a day
Aggregate cap per beneficiary	$35,361.44	$36,174.75

The service intensity add-on pays the continuous home care hourly rate (about $71.92), up to four hours a day, for RN and social worker visits in the last seven days of life. Source: CMS fact sheet on the FY2027 hospice final rule.

What documentation does each level of care need?

Each hospice level of care needs documentation that shows why that level was needed. For continuous home care and general inpatient care, the record should show the precipitating symptom, what was tried, and hour-by-hour or daily evidence of continued need.

Level	The record should show
Routine home care	A current plan of care, visits that match the ordered frequencies, and ongoing eligibility documentation.
Continuous home care	The crisis that began the period: the symptom, its severity and what had been tried. Hour-by-hour entries showing who provided care, their discipline, the interventions and the patient's response. Total hours and nursing hours for each midnight-to-midnight day. Physician orders and contacts. The reason the period ended.
General inpatient care	The precipitating symptom and why it could not be managed in another setting. What was tried before the transfer. Daily documentation of interventions that require the inpatient setting, such as frequent titration, parenteral medicines and frequent skilled assessment, with the response. Daily interdisciplinary review of continued need. Discharge planning from day one.
Inpatient respite	The caregiver's situation and why respite is necessary. Start and end dates. The plan for return home.

Reviewed by the Beta Hospice medical director, 2026-11-04. A guide for clinicians, not a coverage determination: the physician's narrative and the hospice medical director decide eligibility. Sources: CMS FY2027 hospice payment rate update (CMS-1851-F, effective October 1, 2026, as corrected September 30, 2026 by CMS-1851-CN); 42 CFR 418.204 and 418.302; Medicare Benefit Policy Manual, chapter 9.

Reviewers look for specifics. Vague entries such as a note that the patient is declining or is actively dying do not by themselves support a higher level of care.