National Alliance for Care at Home

June 10, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS–1835–P, Medicare Program; FY 2026 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements

Dear Administrator Oz:

The National Alliance for Care at Home (the Alliance) appreciates the opportunity to submit comments on the **fiscal year (FY) 2026 Hospice Wage Index and Payment Rate Update proposed rule** (Proposed Rule). The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with chronic and serious illnesses, as well as dying Americans who depend on those supports.

Our members serve some of the nation's most vulnerable patients, including those receiving hospice and palliative care. We applaud the Centers for Medicare & Medicaid Services' (CMS) ongoing commitment to hospice quality and program integrity. In particular, we support the proposal to clarify that a physician member of the hospice interdisciplinary group (ID) may recommend hospice admission to facilitate seamless transition of end-of-life care. At the same time, we are alarmed at the inadequacy of the

proposed FY 2026 payment rate update in light of current economic conditions and strongly urge CMS to revisit this update in the final rule. We also have serious concerns about the implementation of the Hospice Outcomes and Patient Evaluation (HOPE) tool, scheduled to begin on October 1, 2025. We recommend CMS revisit this implementation date in order to facilitate a seamless transition to HOPE while managing a transition to the Internet Quality Improvement & Evaluation System (iQIES). Further, we offer observations regarding the hospice monitoring report released by CMS in tandem with the Proposed Rule.

Our detailed comments are provided below.

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I. Payment Rate Update

For FY 2026, CMS proposes a hospice market basket percentage increase of 3.2 percent based on IHS Global Inc.'s (IGI's) fourth quarter 2024 forecast of the inpatient hospital market basket, before application of the productivity adjustment.[1] After application of a 0.8 percentage point projected productivity adjustment, CMS proposes a 2.4 percent payment update in FY 2026 for hospices who meet quality reporting requirements. Based on this update, CMS proposes a hospice cap amount of $35,292.51 for FY 2026, a 2.4 percent increase over FY 2025. CMS indicates these rate update calculations may be revised in final rulemaking if more recent data becomes available.

In the FY 2022 hospice wage index final rule (86 FR 42532 through 42539), CMS rebased and revised the labor shares for all hospice levels of care, based on 2018 Medicare cost report data for freestanding hospices. Notably, CMS proposes revising the hospital market basket for acute care hospitals from a 2018 base year to a 2023 base year in the FY 2026 hospital inpatient prospective payment system (IPPS) proposed rule (90 FR 18266). An outcome of the rebasing is a shift in the relative weight of labor costs. Using 2023 cost report data for salaries and wages, benefits, and contract labor expenses, CMS calculates a national labor-related share of 66.0 percent in the FY 2026 IPPS proposed rule, which is a decrease from the current 67.6 percent share (90 FR 18005). CMS is maintaining the existing labor shares in the FY 2026 hospice Proposed Rule.

A. Hospice Provides Value and Generates Program Savings

Hospice is more than a healthcare benefit—it is a compassionate, trust-based model of care that honors the dignity of every Medicare beneficiary at the end of life. Our members experience daily how hospice builds an interdisciplinary circle of support around patients and families during life's most vulnerable moments.

Through an interdisciplinary team—including physicians, nurses, hospice aides, social workers, spiritual counselors, and others—hospice delivers person-centered care that addresses the patient's physical, emotional, psychosocial, and spiritual needs. This holistic approach ensures that patients can spend their final days in comfort and with respect, supported by a team dedicated to affirming their wishes and values. Equally important, hospice achieves these human outcomes while adding significant value to the Medicare program through high-quality care that often reduces avoidable high-cost interventions.

[1] Section 3401(g) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) requires the annual payment update to be reduced by a productivity adjustment.

Hospice care has been consistently shown to enhance patients' quality of life at a time when they are most vulnerable—the end of life. By focusing on comfort and what matters most to the patient, hospice enables beneficiaries to live their last days as fully and pain-free as possible, surrounded by loved ones.

Hospice care is a clear example of how end-of-life care can also be cost-conscious. Research has shown that hospice use is associated with lower Medicare expenditures at the end of life. In fact, a recent study found that Medicare beneficiaries who enrolled in hospice had about 3.1% lower total cost of care in the last year of life compared to patients who did not—a reduction that amounted to approximately $3.7 billion in Medicare savings in a single year.[2] Hospice represents a treasured value proposition to the Medicare program and its beneficiaries. It preserves the dignity and quality of life of terminally ill patients and their families, and does so in a manner that saves our healthcare system money.

B. Market Basket Update

The proposed 2.4 percent payment update for FY 2026 will not sufficiently account for the cost increases that hospices continue to face. General inflation, particularly in the healthcare sector, continues to be higher than historical norms. According to the U.S. Bureau of Labor Statistics (BLS), the medical care price index rose 3.1% over the 12 months ending April 2025.[3]

Labor costs—which typically comprise the majority of hospice operating expenses—have been under extraordinary pressure. The hospice community continues to grapple with a nationwide healthcare workforce shortage and intense competition for skilled staff, including but not limited to nurses, social workers, aides, among other professionals, driving wages upward. BLS data indicate that wages, salaries, and employer costs for health care and social assistance occupations increased by 4.4% on average over the most recent year (12 months ending March 2025).[4] This follows even larger wage growth in post-acute and home-based care settings over the past few years. For example, employers

[2] https://www.norc.org/content/dam/norc-org/pdf2023/Value%20of%20Hospice%20in%20Medicare_Final%20Report.pdf
[3] https://www.bls.gov/news.release/cpi.nr0.htm
[4] https://www.bls.gov/news.release/pdf/eci.pdf

in home health care saw weekly average labor costs rise by 27.1% between February 2020 and January 2024.[5]

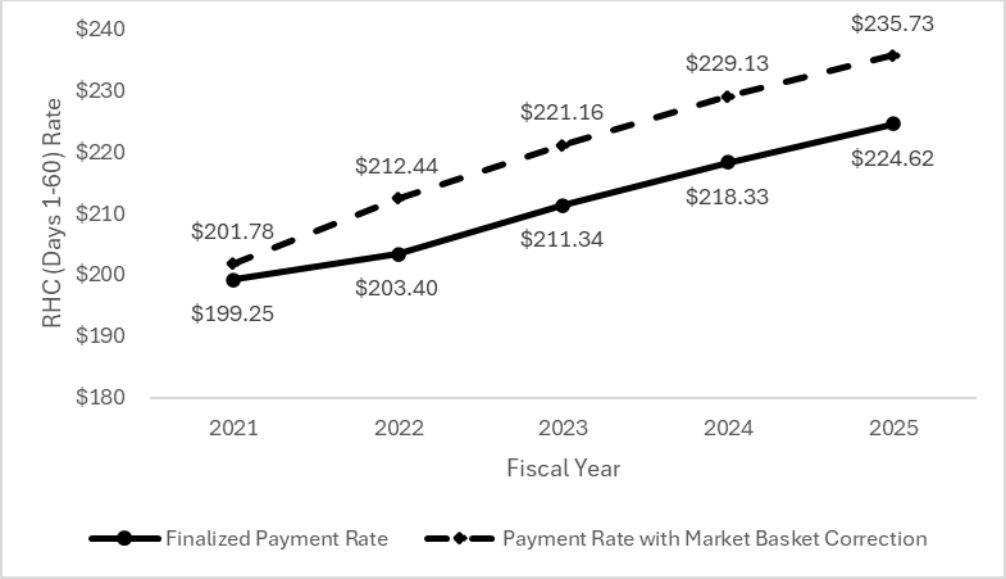
Hospices are experiencing rising wage growth as they strive to recruit and retain qualified staff in this competitive environment. For example, hospice nurses typically possess extensive experience and advanced skills due to the complex nature of their roles. They often work independently in challenging environments, requiring exceptional critical thinking and clinical assessment capabilities to effectively manage crises, transitions, and end-of-life care, while serving as the primary clinical link between the patient and physician. Labor cost increases for these professionals *far* outpace the market basket updates that hospices have received in recent years, and absent any adjustments, will fail to keep pace with the rising labor costs necessary to continue delivering quality care.

Hospice Forecasting Error

The Medicare hospice payment rate update is statutorily tied to the inpatient hospital market basket forecast. In recent years during the COVID-19 pandemic, these forecasts have significantly underestimated actual inflation, leading to payment rate updates that lagged behind actual cost growth. Figure 1 below compares the market basket percentage increase projected by CMS (used for the hospice Annual Payment Update each fiscal year) applied to the national routine home care rate versus the actual market basket realized for FY 2021 through FY 2025.

[5] https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-health-sector-employment/

Figure 1. Comparison of Actual and Corrected Payment Rates, FY2021-2025 (RHC 1-60 days as example)



Because annual payment updates compound, the impact of forecast errors is **cumulative**. A lower-than-needed update in one year leaves the base rate permanently smaller going forward. Based on the above data, the cumulative shortfall in hospice payment rates due to forecast error over FY 2021–2025 is approximately 4.9%. In other words, hospice base rates in FY 2025 are about 4.9% lower than they would be if CMS's market basket forecasts had perfectly matched actual cost inflation over 2021–2025.

A 4.9% payment rate gap is materially significant. Medicare hospice expenditures totaled about $27.5 billion in FY 2024.[6] A 4.9% shortfall equates to roughly $1.3 billion in annual underpayments relative to what payments would have been with accurate market basket updates. Over the FY 2021–2025 period, cumulative hospice underpayments likely amount to several billion dollars when each year's missed increase and compounding effects are considered. This missed increase does not go unnoticed: these were precisely the payments hospice providers needed to cover actual costs, such as, among other things, staff wages, medical supplies, equipment, pharmaceuticals, and transportation, but did not receive due to forecast underestimates. This is critical, because unlike other provider types, hospices are almost entirely dependent upon Medicare fee-for-service as a payer source, with Medicare paying for approximately 90 percent of hospice care in the United

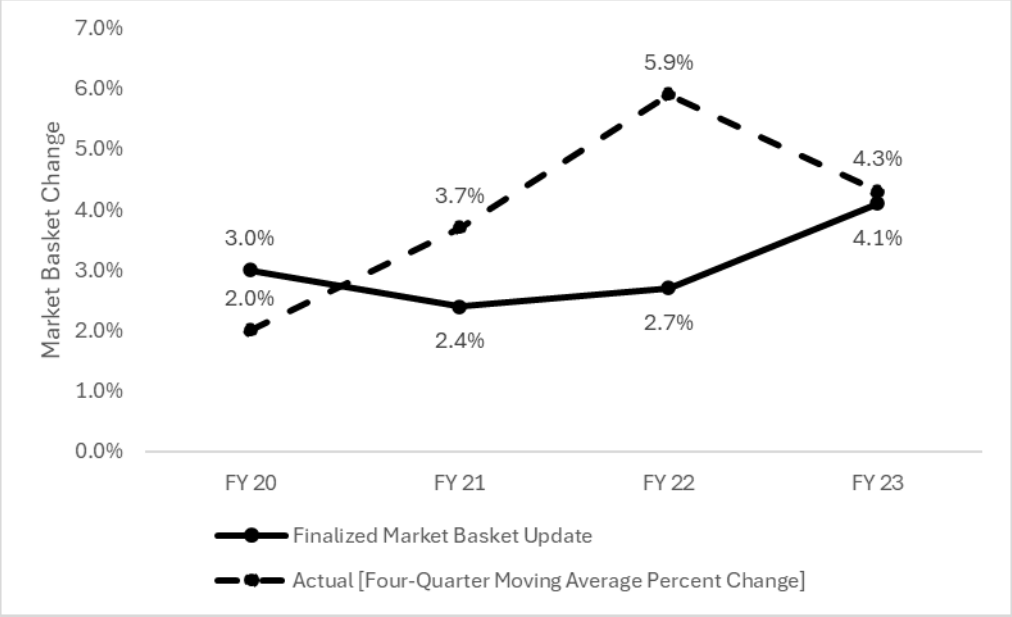
[6] https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf

States.[7] This persistent forecast error has important implications for hospice payment adequacy.

In this context, the proposed 2.4% FY 2026 payment rate update is insufficient to keep pace with hospices' input costs. Indeed, without a more robust increase, many hospice providers will continue to operate under severe financial strain, ultimately threatening patient access to end-of-life care when individuals are most vulnerable.

Although CMS has previously indicated the absence of a mechanism to adjust for forecast errors in the hospice payment update (88 FR 51173), we urge CMS to consider any and all opportunities to implement 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. IHI Global forecasts are typically accurate, however the economic impacts of the COVID-19 Public Health Emergency appear to have generated a particularly severe forecast error, demonstrated in Figure 2 below.

Figure 2. Comparison of Finalized and Actual measured changes to the IPPS Market Basket, highlighting likely PHE-related forecast issues in FY21 and FY22



CMS's own Office of the Actuary data and recent industry analyses show that market basket projections have fallen short of actual inflation in recent years, resulting in a sizeable payment gap. Closing this gap is necessary to restore payment adequacy for

[7] The Medicare Payment Advisory Commission has observed that in 2022 "Medicare accounts for about 90 percent of hospice days[.]" Medicare Payment Advisory Comm'n, March 2024 Report to Congress, Ch. 9, at 22 (Mar. 15, 2024).

hospice providers. Ensuring that annual updates fully capture input price increases will help hospices maintain access to care for terminally ill patients and invest in workforce and quality improvement, consistent with Medicare's aims.

Productivity adjustment

We wish to raise broader considerations regarding the productivity adjustment as applied to the annual hospice payment update. We fully understand that CMS is statutorily required to apply this productivity adjustment under federal law. Notwithstanding the statutory application, we are concerned that the TFP adjustment does not accurately or fairly reflect productivity gains achievable in hospice care and similar labor-intensive services furnished in the home.

Section 3401(g) of the Affordable Care Act (ACA) requires that the yearly payment update for hospices and certain other providers be reduced by a productivity factor. Specifically, the law defines this productivity adjustment as the 10-year moving average of annual growth in economy-wide private nonfarm business productivity. The Bureau of Labor Statistics (BLS) calculates this metric, formerly termed "multifactor productivity," now known as total factor productivity (TFP). In practical terms, CMS's Office of the Actuary projects the 10-year average productivity growth (using BLS data) for the upcoming year, and that percentage (the TFP adjustment) is subtracted from the market basket update each FY.

Total factor productivity is an aggregate measure of output growth attributable to technological and efficiency improvements (after accounting for labor and capital inputs). It tends to be driven significantly by advances in technology, capital investment, and process improvements common in manufacturing and other industrial sectors. Hospice care, by contrast, is a highly personalized, hands-on service delivered by interdisciplinary teams of caregivers. Hospice services, such as nursing visits, pain and symptom management, personal care, spiritual counseling, and other supports, are inherently labor-intensive and centered on patient and family interaction. The nature of hospice—supporting patients and families with compassionate caregiving, clinical palliation, and psychosocial-spiritual support—offers limited opportunities for rapid productivity growth as measured by output.

Innovations like electronic health records and telehealth can help to an extent, but they do not fundamentally alter the delivery of compassionate end-of-life care provided to the patient and family. In short, hospice providers cannot reap the same productivity gains from technology or capital that other industries might.

Conversely, labor productivity changes regardless of technology are better representative of hospice and other healthcare services furnished in the home. This is due to the labor requirements of these fields and the fact that there are limits to how much more efficient these providers can become through technology, whereas technology is much more impactful elsewhere in healthcare, such as the use of artificial intelligence (AI) in vastly accelerating productivity in imaging and diagnosis.

Recommendations:

- We recommend CMS examine closely more recent data and increase final payment rates for FY 2026.
- We urge CMS to explore all available avenues to address the forecast error shortfall, such as through a one-time adjustment.

C. Hospice Wage Index

CMS proposes to continue applying the most recent inpatient hospital wage index, specifically, the FY 2026 hospital wage index prior to the application of any rural floor and geographic reclassifications to update hospice payment rates for FY 2026. Medicare hospice payments are adjusted for local wage costs, with a portion of the base rate treated as a labor portion subject to the wage index. In practice, this means hospices in high-wage regions receive higher reimbursement in consideration of the higher labor costs in the area, while those in lower-wage areas receive less for the same services. The intent is to reflect genuine cost differences, but in reality, the geographic wage index variation can be stark.

We appreciate CMS's efforts to blunt sharp wage index swings by continuing its 5% cap on any annual wage index decrease at the county level from year to year. This policy, finalized in the FY 2025 hospice final rule (89 FR 64223), has provided a measure of stability by ensuring no area's wage index falls to less than 95% of its previous year value. However, even a 5% reduction year-over-year will significantly strain hospice operations, especially in an era of rising costs. Any cut due to a lower wage index directly reduces funds available for staffing, patient care supplies, and other critical services. Over successive years, these index reductions compound.

Even with the hospice floor that boosts the lowest index values by 15%, capped at 0.8000 (82 FR 18571), many hospices in small or rural labor markets operate with wage index values far below 1.0 (the national average). This translates into significantly lower payments than their peers in higher wage index areas, directly affecting their ability to recruit and retain staff, cover operating expenses, and invest in quality improvements.

Geographic reclassification disparities exacerbate this problem. Hospitals can mitigate some wage index disparities by reclassifying into higher-wage index areas when appropriate, but hospices have no such recourse under current policy. As a result, providers in certain counties find themselves stuck with an index that often does not reflect their true labor cost environment. We have heard from members operating in urban- or metropolitan-adjacent counties who must contend with urban salary competition and costs, yet their hospice wage index remains arbitrarily low because their county is not included in the adjacent metropolitan CBSA.

Additionally, hospices incur substantial travel-related costs, in consideration of, among other things, regulations that limit the delivery of inpatient care to no more than 20% of total hospice care days.[8] In other words, the vast majority of hospice care is delivered at the Routine Home Care (RHC) level in the patient's home. Unlike inpatient hospital care or other institutional settings, hospice clinicians frequently spend considerable portions of their day commuting between patient visits.

According to some reports, hospice clinicians may spend as much as 45-50% of their working hours on a typical day in transit between patient residences, depending on geographic factors such as population density and traffic conditions. While scheduling optimization software and redrawing team boundaries can help to an extent, given that patient referrals and residence locations are inherently variable and outside a hospice's control, significant travel time remains unavoidable. The hospice wage index, based on inpatient hospital data, fails to adequately account for these unique and considerable hospice-specific circumstances and costs.

While CMS has stated that the hospital reclassification authority in Section 1886(d)(10) of the Social Security Act applies only to hospitals, as does the rural floor wage index protection enacted by Congress in 1997 (90 FR 18572),[9] we believe that CMS has the authority to implement similar policies for purposes of the hospice wage index. Without such parity, hospice providers are effectively penalized for geography, an untenable situation that undermines the goal of equitable access to end-of-life care nationwide.

This inability to reclassify leaves hospices uniquely vulnerable in a competitive labor market with a limited pipeline of available workers. Where patients live should not determine the financial viability of accessing hospice care.

[8] *See* 42 CFR § 418.108(d).
[9] *See* Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105-33).

Recommendation:

- We encourage CMS to collaborate with stakeholders to address the shortcomings of relying upon hospital data to determine hospice payment rates, and ways to achieve parity across provider types with respect to geographic area wage adjustments.

II. Subpart B – Hospice Admission and Certification Proposals

A. Hospice Admission Recommendation

To align with the current payment and CoP regulations at §§418.22(c)(1)(i) and 418.102(b), respectively, CMS proposes 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. CMS states that aligning the language at §418.25(a) and (b) with the language at §§418.102(b) and 418.22(c)(1)(i) would allow for greater consistency between key components of hospice regulations and policies.
We support this proposal and agree that this change will align the regulations such that they will consistently describe the physicians that can certify terminal illness and determine patient admission to hospice care—helping to ensure that terminally ill beneficiaries can access hospice services.

B. Hospice Certification Face-to-Face Encounter Attestation

Section 3132(b) of the Affordable Care Act amended section 1814(a)(7) of the Social Security Act to add a new subparagraph (D). 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 (implemented by CMS as the third and later benefit period recertifications), 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.

CMS is proposing to amend the regulations at §418.22(b)(4) to clarify that the physician or NP face-to-face encounter attestation must include the signature of the physician or NP who conducted the face-to-face encounter and the date it was signed. Further, CMS is proposing 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. CMS stated that these changes are 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.

While the Alliance understands the need for a face-to-face requirement for hospice patients in their 3rd benefit period or later, we are concerned about the proposal that the "[face-to-face] 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." The current audit environment already places considerable pressure on hospices, and the proposed formatting requirements risks creating inadvertent compliance pitfalls.

Historically, CMS has supported the ability of hospices to format their paperwork in a way that best meet the hospice's needs, rather than prescribing specific formats for hospice forms.[10] We support this flexibility, especially in light of the administration's current focus on reducing regulatory burden.[11] Especially in the age of electronic medical records ("EMRs"), our concern is that a hospice provider may timely complete a valid face-to-face attestation, but that, due to EMR errors or other administrative burden, it may not be included directly on the recertification form or may not be obviously titled as a face-to-face attestation. Hospices should not be denied payment for hospice services over such minor clerical issues when there is clear documentation that the face-to-face was completed timely.

Additionally, we wanted to respond to CMS's comment that this measure "seek[s] to realign the regulatory text with the original intent of . . . the statutory requirement in section 1814(a)(7)(D)(i)(I) of the Act." Nothing in section 1814(a)(7)(D)(i)(I) of the Act states that the face-to-face attestation must be included on the certification document or sets any specific formatting requirements for the face-to-face attestation. Therefore, it is unclear how this added paperwork requirement supports the purpose of the Act.

Finally, we recommend that CMS allow a signed clinical note to serve as the attestation that the hospice physician or hospice nurse practitioner had a face-to-face encounter with that patient on a date specified to comply with the statutory requirements at 1814(a)(7)(D)(i). Indeed, there appears to be ambiguity under the proposal about whether the certifying physician is required to provide multiple signatures and dates—one for the attestation of the face-to-face encounter and another for the certification itself. Requiring

[10] See, e.g., CMS, Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 84 FR 38519 (stating that CMS allows hospices to "develop their own [election] addendums, in a format that suits them to best meet the requirements and patient needs while minimizing operational burden").
[11] *See* Executive Order 14192, 90 FR 9065.

duplicative signatures from the certifying physician when they perform their own face-to-face encounters introduces additional administrative complexity without any corresponding benefit.

Further, we also believe it is unnecessary for the physician or nurse practitioner to attest that the clinical findings of that visit were provided to the certifying physician (42 FR 418.22(b)(4)). The regulations at 42 CFR 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, meaning 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).

III. Hospice Quality Reporting Program (HQRP)

A. HOPE Data Collection Instrument Implementation

CMS is scheduled to implement the Hospice Outcome & Patient Evaluation tool (HOPE) on October 1, 2025, replacing the Hospice Item Set (HIS). The HOPE will be submitted via the internet Quality Improvement and Evaluation System (iQIES), the new submission and processing platform for quality data. The Alliance is fully committed to the Hospice Quality Reporting Program (HQRP), including the payment penalties for non-compliance, and recognizes the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. However, we have serious concerns about whether the HOPE tool can be successfully implemented on the current timeline.

The transition from the current quality reporting tool, the Hospice Item Set (HIS), to the HOPE tool is technically complex and represents a distinct change in the timing and content of the documentation of the care delivered to hospice patients; moreover, it carries significant financial risk for hospice providers. The HQRP is a "pay-for-reporting" program, which requires hospices to submit a high percentage (90%) of data records within a specified timeframe or receive an annual payment update penalty of four percent.

This penalty is twice that of other providers and a significant impact for hospice providers as many are small, independent businesses a great deal of which are not-for-profit. Providers and technology vendors have shared that there is a lack of information and clarity necessary to have a smooth, successful transition to the HOPE tool and to the new platform, iQIES, required for submission of HOPE records.

Technology Vendor Preparation for HOPE: Technology vendors are not sufficiently prepared for the implementation of the HOPE tool because of delays outside of their

control in necessary specifications and content. Hospice providers must utilize a third-party vendor to code the HOPE instrument responses. Vendors coding the HOPE responses are usually a hospice's Electronic Medical Record (EMR) vendor. These vendors report that necessary details for some of the data specifications were only recently made available (April 22, 2025) while other key pieces will not be available until September, which will be less than 30 days from HOPE implementation and will provide little time for essential programmatic testing.

Vendor Calls: There have also not been additional forums for vendors to have questions answered by the correct staff at CMS. CMS held a vendor call in January 2025 about HOPE implementation and indicated on this call that specification corrections need to be made. On the call, the team in charge of this transition area was not available to address associated questions or the necessary corrections. Also, during this call, CMS indicated a second vendor call would be scheduled soon. Despite the recent release of the final data specifications and persistent errors within these specifications, no follow up call or other information has been provided. The Alliance understands from the vendor community, based on what they have learned through the QIES Technical Support Office (QTSO) helpdesk, that CMS has not yet determined whether an additional vendor call will be scheduled. This is of great concern as there are outstanding questions about HOPE implementation and more information is needed before provider education can take place which is essential for the successful launch of the HOPE tool.

Validation Utility Tool: Of particular concern is the fact that the Validation Utility Tool (VUT), an essential tool used by vendors to ensure their software can successfully submit data, is not yet available. We understand vendors have been informed that the VUT and other reference materials for the QTSO website may not be available until September. Providers and vendors cannot be reasonably expected to prepare for this workflow change with only one month of lead time. Without sufficient time for testing to occur, we do not believe this will lead to a successful launch. On top of these missing technical pieces of information, a transition in the data submission and reporting platform are scheduled to occur at the same time as the transition to the new HOPE tool.

Transition to iQIES: While hospices are transitioning to a new data collection tool, they will also have a transition in data submission platform, from QIES to iQIES. This is necessary for hospices to submit their HOPE records. The Alliance supports this transition intended to strengthen the protection of data. However, we have significant concerns about the timing and how this transition would occur. CMS has indicated that additional information will be available in summer 2025 yet has not provided a specific month for publication nor communicated a firm date by which hospices must be transitioned.

Delay in iQIES Transition for Other Providers: Historically, CMS has experienced delays in transitioning other provider types to the iQIES platform. Most recently, on March 25, 2025, CMS announced another delay in moving skilled nursing facility (SNF) surveys to the

iQIES platform, with a previously scheduled February 2025 date delayed by an additional four months. The delay seems to be due to CMS moving the SNF surveys to the cloud-based version of iQIES. It is unclear whether hospices will also transition to this cloud-based version, and how the ongoing delays experienced by SNFs will affect the timeline for hospices.

iQIES Enrollment: There are numerous steps a hospice provider must take to enroll in iQIES. These include, among other things, having a privacy security official and other staff apply for iQIES access and undergo required background checks, a process that typically takes a minimum of 3-5 business days. A date has not yet been published for when hospices will have the ability to begin this process. This needs to be done well in advance of the HOPE implementation date as sufficient lead time for iQIES access is necessary for the transition to HOPE. It is assumed that hospices will have at least two individuals needing to enroll in iQIES with a large portion of hospices needing to enroll three or more individuals. This is estimated to result in 14,000+ individuals applying for enrollment at one time. Additionally, as with many software transitions, there are bound to be disruptions to the daily operational workflow due to technical issues. This is fully expected in the hospice iQIES transition, as this occurred with the home health transition in 2021. Due to the time it takes to process iQIES enrollment applications and the anticipated operational workflow and technical disruptions that are nearly impossible to plan for, a simultaneous transition from HIS to HOPE and QIES to iQIES could be disastrous for hospices as well as for CMS in terms of the amount and quality of data.

Hospice Financial Impact of Transition: In addition to the ordinary financial burdens of a software transition and transition to a new data collection tool, hospices are especially vulnerable to an adverse financial impact of this transition, as hospices are held accountable to the data submission timeliness thresholds immediately upon transition to iQIES and implementation of the HOPE. The Alliance previously recommended CMS finalize a policy to establish an incremental threshold for HOPE compliance over a three-year period. This was consistent with the implementation of the HIS, and while many of the items are the same between the tools, the HOPE includes two additional time points and a potential of three symptom reassessment visits. This is a considerable change from the original two time points in the HIS and could lead many agencies to have issues in timely reporting of data. Unfortunately, CMS did not agree with this request and moved forward with requiring full 90% compliance on October 1, 2025. Given the issues we have outlined regarding information and training barriers and delays, we feel hospices will struggle to meet these expectations, putting agencies at risk for a 4% annual payment reduction despite their best efforts. **The consequence of adverse outcomes cannot be understated. The risk of negative financial consequences for hospice providers is largely dependent this year on the success of two transitions—iQIES and HOPE—neither of which are within their control.**

Recommendations:

- Considering the volatility inherent in a reporting transition of this magnitude and the lack of clear information provided to date, we respectfully request CMS waive the HOPE timeliness submission requirement for two calendar quarters post implementation.
- We further respectfully request that CMS delay the HOPE implementation date until at least six months after CMS education and training, beyond that which is introductory and that is scheduled for spring/summer 2025, the final validation utility tool specifications are available and the application for iQIES access has been opened for hospices.

We do not make these recommendations lightly, as the Alliance remains fully committed to the Hospice Quality Reporting Program and recognizes the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. Our recommendation reflects our goal to ensure hospices are appropriately prepared to meet this important requirement and facilitate a successful transition without jeopardizing the timely delivery and accurate documentation of patient care.

B. HOPE Burden Estimates

While hospices are generally supportive of the HOPE tool, we note that hospices must make real investments into implementation and ongoing compliance. The HOPE significantly increases the financial and human resource expenditures as well as the daily operations of a hospice. The Alliance has noted that CMS's cost estimates in the Fiscal Year (FY) 2025 Hospice Final Rule contained several errors that underrepresent the true cost of implementing the HOPE Tool.

First, without explanation and outside of precedent, CMS used ***median*** hourly wage rates rather than ***mean*** hourly wage rates, which resulted in an underestimation of the total costs to hospices of nearly $10 million per year or $1,650 per hospice.

Second, CMS chose to use utilization data from Fiscal Year 2022 and corresponding labor costs from May of 2022 in its estimates, even though more recent data was available at the time of rulemaking. Labor costs continue to climb, and between May 2022 and May 2024, the average hourly wage rate for a registered nurse and a medical secretary increased 11 percent and 10 percent, respectively. Using May 2022 versus May 2024 data represents an

underestimation of the total cost to hospices of $30 million per year, or $5,400 per hospice.

Third, CMS acknowledged in the final rule that the HOPE tool and associated quality measures, will likely result in the need for additional in-person symptom follow-up visits, but did not quantify the costs of these additional in-person visits and instead stated that it would "monitor the burden of in-person follow-up visits after HOPE implementation" (89 FR 64269).

The Alliance believes that these costs should be included in the cost estimates for the HOPE tool. Assuming just one additional symptom follow-up visit will occur as a result of the HOPE tool, an additional $262 million in costs would be incurred by hospice programs, or an estimated $46,000 per hospice.[12] CMS indicated in the FY 2024 Hospice Final Rule that approximately 18 percent of hospices (about 1,050 hospices) failed to submit required quality data in Calendar Year (CY) 2022, and the 4 percent payment penalty for these hospices in FY 2024 represents an estimated $82.4 million reduction in payments (88 FR 51196), or approximately $78,400 per hospice. The Alliance is concerned that if the additional burden of complying with the HOPE requirements is greater, overall, than the cost of non-compliance, there is an incentive for hospices to accept the annual payment update penalty.

IV. Requests for Information

In the Proposed Rule, CMS includes requests for information (RFIs) focused on digital quality measurement (dQM) and future quality measure concepts in the HQRP. CMS also references a separate Medicare deregulation RFI pursuant to Executive Order 14192,[13] "Unleashing Prosperity Through Deregulation," aiming to reduce regulatory burdens and enhance transparency. We appreciate CMS's efforts to reduce burdensome requirements and better streamline regulations to promote a more effective and efficient healthcare system. Indeed, the Alliance commented in response to the Office of Management and Budget's Deregulation RFI seeking public input on federal regulations that may be overly burdensome or outdated. We will echo many of these comments and other recommendations in the Medicare deregulation RFI.

[12] 2,763,850 million HOPE Hospice Update Visits (HUV) estimated for the HUV1 timepoint, assuming 1 corresponding symptom follow-up visit, multiplied by the cost for a registered nurse visit estimated at $96.64 (May 2024 BLS Average Hourly Wage Rate of $47.32 accounting for 100 percent fringe). Number of hospices = 5,640 per CMS (89 FR 64263).

[13] https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/

Our comments in response to the RFIs included in the Proposed Rule are provided below.

A. Advance Digital Quality Measurement (dQM) in the HQRP

The Alliance shares CMS' commitment to improving healthcare quality through measurement, transparency, and public reporting of quality data, and to enhancing healthcare data exchange by promoting the adoption of interoperable health information technology (IT) through Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standards. We further agree that the use of technology utilizing such standards within the HQRP in the future could potentially enable greater care coordination and information sharing, which is essential for delivering high quality, efficient care and better outcomes at a lower cost. CMS has previously sought feedback on promoting the adoption of interoperable health IT and facilitating nationwide health information exchange. The Alliance's legacy associations—the National Association for Home Care & Hospice (NAHC) and the National Hospice & Palliative Care Organization (NHPCO)—have responded to previous requests, and the Alliance now offers the following in response.

Although hospice agencies were not among the health care providers that were incentivized to adopt The Office of the National Coordinator for Health Information Technology (ONC)-certified Health Information Technologies (CEHRT), we have remained engaged in the pursuit of interoperability and the development of strong business cases for health information exchange. However, despite this commitment and desire to share health information quickly and easily across care settings, many hospices today still lack truly interoperable health information technology (HIT) and electronic health record (EHR) technology systems. The absence of dedicated federal investment to support and incentivize Post Acute Care (PAC) provider adoption of these tools is the primary reason that hospices (and other PAC providers) fall so far behind hospitals, other acute care settings, and physician practices in the use of interoperable data-sharing technologies.

The *Health Information Technology for Economic and Clinical Health* (HITECH) Act, enacted as part of the *American Recovery and Reinvestment Act of 2009*, has provided billions of dollars in funding to support hospital and physician uptake of interoperable HIT through the establishment of the "Meaningful Use" program. Hospices (and other PAC providers) were ineligible for HITECH incentive funding, and have thus continued to be financially constrained in their pursuit of expensive HIT products that support the kind of interoperability CMS is seeking to promote in this rule.

While we understand that Congressional action may be needed for major new funding to incentivize more hospices (and other PAC providers) to adopt interoperable HIT, **we urge CMS to use its existing authority to support hospices' ability to purchase, implement,**

and maintain HIT that facilitates interoperable data exchange across all care settings. Especially if CMS intends to require that hospices use certified electronic health record technology (CEHRT) in the future, it will be necessary to invest upfront financial and technical assistance resources in order to ensure broad adoption and successful implementation.

While most hospices today use some kind of EHR, the costs of securing and maintaining these technologies have been borne entirely by the providers without federal funding support. As such, and because hospice and PAC EHR systems are not governed in the same way as hospital and physician systems that were developed primarily with HITECH resources, the majority of hospices are not operating ONC-certified systems. Should CEHRT be required at some point, providers already using EHR systems will inevitably incur additional costs, as vendors will be required to implement significant improvements to their solutions and, in turn, a percentage of these costs will inevitably be passed along to their provider customers.

In addition, providers will require additional staffing and training to support, administer, and configure new software solutions that support interoperability. Also, incentives to offset these newly imposed costs will help sustain adoption rates. Lastly, post-acute providers typically align with health systems, hospitals, and other provider types in various referral and care delivery relationships. Considerations for further incentives to provider partners (e.g., hospitals in a referral network) should be made, to ensure alignment with their interoperability strategies. This alignment also facilitates smoother care transitions and more seamless care coordination, which can result in better patient outcomes and improved quality of life for hospice patients and their families and caregivers.

Even with CEHRT, there are interoperability issues to be addressed. For instance, not all PAC providers can exchange information electronically due to a lack of standardized inputs and fragmented systems. For instance, records from hospitals, skilled nursing facilities, assisted living facilities and various home and community-based providers are delivered via FAX. Hospital systems can share information electronically within the system, but hospices and PAC providers are often not able to access these systems. Even if part of a Health Information Exchange (HIE), interoperability is often limited to those in the HIE only. Unique to hospices and other home- and community-based providers is the lack of internet connectivity / interrupted connectivity prohibiting the exchange of information in real time.

Before CMS requires hospices to collect, share, and/or report on data supporting interoperable quality measures, it must take steps to help hospices procure the tools necessary to make these efforts feasible and meaningful. And while helping hospices

develop and implement interoperable systems that support this type of data sharing, it is not sufficient to achieve CMS' goals. **CMS must also begin to set more specific expectations for hospices (and other PAC providers), as well as HIT and EHR vendor organizations, regarding data collection and sharing.** Without a clear sense of how or if CMS plans to adopt more formalized HIT standards that govern this important process, there is a risk that, in the absence of guidance and education, individual providers develop their own unique approaches that make it extremely difficult for standards to be developed after-the-fact.

B. Future Quality Measure Concepts for the HQRP

CMS is seeking input on the importance, relevance, appropriateness, and applicability of several concepts under consideration for future years in the Hospice QRP. These include:

- Interoperability – CMS is seeking comments on a measure of interoperability, focusing on systems readiness and capabilities in the Hospice setting.
- Well-Being – CMS is seeking feedback on a measure of well-being. Well-being is a comprehensive approach to disease prevention and health promotion, as it integrates mental, social, and physical health while emphasizing preventative care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting the well-being of hospice patients.
- Nutrition – CMS is seeking feedback on a measure of nutrition. Assessment for nutritional status may include various strategies, guidelines, and practices designed to promote nutrition at every stage of hospice care and ensure patients receive the necessary nutrients for maintaining their individual health needs and overall well-being.

Hospices earnestly work in collaboration with other providers to support interoperable exchange of health information. Efforts have focused on collecting robust, accurate and timely patient data, improving care coordination, promoting efforts that support longitudinal care planning and improving the quality of patient assessments. However, more work needs to be done on the alignment of technology, resources available to support the adoption of CEHRT by hospices, and specific expectations regarding data collection and sharing as stated above.

Hospices work with patients to develop patient-centered goals and interventions for the plan of care based on the assessment of the patient's needs and desires. As CMS identifies in this Proposed Rule, hospice care is patient-centered care. The Alliance supports the thoughtful expansion of the HQRP and the addition of measures that stem from this person-centered focus and are applicable to the end of life.

Well-being is defined at the individual level and encompasses a comprehensive assessment and review of the patient's physical, emotional, psychosocial and spiritual needs and desires. These are fluid and change throughout the course of a patient's hospice care and final days and months of life. For example, it is not uncommon for patients to have a goal to maintain pain at a moderate or severe level for reasons related to their cultural and/or religious beliefs. They may also wish to maintain a moderate to severe impact level for pain/non-pain symptoms due to not wanting to experience some of the trade-offs (increased hours of sleep/drowsiness; inability to carry on a conversation with family, etc.) that come with the treatments necessary to reduce the severity and impact level. Therefore, hospices struggle with finding the best tools to properly assess well-being. For instance, many of the existing survey instruments designed to detect depression are unsuitable for seriously ill patients, as questions addressing somatic, affective, and functional criteria often generate false positives.[14]

Relative to nutrition, the Alliance recommends that any nutrition measure incorporated into the HQRP be a process measure. While the nutritional status and desires of hospice patients are assessed, the focus is not on improving nutritional status. As individuals near the final days and months of life their appetite often decreases as their body prepares for death. Their organs have difficulty and eventually are not able to process the intake of foods, meal replacements or enteral or parenteral nutrition. Hospices assess the patient's nutritional status along with the role of food and nutrition in the patient's life, their cultural and religious beliefs, and develop interventions and plans of care that incorporate what is most important to the patient and their family. This may or may not involve goals and interventions for food intake and nutrition.

More work needs to be done in developing evidence-based tools for well-being at the end of life. These tools should incorporate principles of person-centered care and be specific to the end of life. Furthermore, incorporating a measure of well-being and nutrition in hospice will be difficult due to the nature of patients' conditions at the end of life. CMS saw at the beginning of the HQRP implementation that a measure requiring patient self-reporting could not be fully incorporated into the HQRP due to the fact that many hospice patients are not able to speak or self-report. Given the very short lengths of stay for some patients—20.6% of hospice patients receive care for fewer than five days, according to the April 2025 CMS Hospice Monitoring Report[15]—incorporating any type of measure of well-being or nutrition may be exceptionally difficult.

[14] https://pmc.ncbi.nlm.nih.gov/articles/PMC3509503/
[15] https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf

V. Hospice Monitoring Report

Though not specifically related to this rulemaking, the Alliance takes this opportunity to acknowledge concerns outlined in the CMS Hospice Monitoring Report (Hospice Monitoring Report), released concurrently with the Proposed Rule.[16] There are several issues of concern here, including the appropriateness of the measurement approach to live discharges given current claims coding guidance and on the recent trends in non-Medicare hospice spending for beneficiaries who have elected hospice. We note that the Hospice Monitoring Report aggregates data nationally but does not appear to break down spending or utilization by geography, such as by state or region. For example, if a large portion of non-hospice spending is concentrated in just a few markets, this may mischaracterize the issue.

Concerning the live discharge rate measurement, we caution CMS on the interpretation of reason for discharge codes and recommend that steps be taken in subsequent analyses to examine whether the beneficiary was immediately 'readmitted' to that or another hospice. For instance, the absence of clear guidance or specific coding to account for administrative discharges due to a technical error on a hospice election statement may inadvertently inflate live discharge rates. Typically, hospices have been instructed to administratively discharge patients to fix such errors, continue providing care, and then readmit them in accordance with Medicare requirements. However, the lack of appropriate discharge codes in these instances leads to such cases being inaccurately coded as patients no longer meeting terminal illness criteria as there is not a discharge code for claims that properly identifies an administrative discharge.

Given that election statement issues constitute a common denial reason across all three home health and hospice Medicare Administrative Contractors (MACs) as well as other auditing entities, this likely results in materially overstated live discharge rates. Administrative discharges like this are also necessary when there is a change in the patient's payer source and when a hospice is handling a late face-to-face encounter. In the latter situation, CMS considers the patient to not meet the qualifications of being terminally ill because there is not a valid certification of terminal illness; however, this is another situation where the technical requirements of a required document are not met rather than the patient not being terminally ill To this end, clear guidance and a discharge status code specific to administrative discharges is needed to accurately capture these situations and to help inform appropriate utilization and live discharge data.

[16] *Id*.

The rapid rise in high-cost Part B utilization is alarming. Hospice beneficiaries who reside in a congregate living or institutional care facility may be especially subject to receive additional services, outside of the ability for a hospice to exercise its obligations of expenditure management to the program. It is important to note that even outside a facility or congregate setting, spending outside the hospice benefit is often outside a hospice's control despite best efforts to educate patients and families. CMS indicates that "[t]he large increase in Part A & B spending is largely driven by a small percentage of Part B claims becoming more expensive[,]" but does not break this down further.[17] Anecdotally, we have heard from member hospice organizations and business partners that wound care, and especially application of new wound care technologies, may be a root cause of the change in expenditures. These practices of providing unnecessary care not only incur spending from the Medicare program, but also often carry copayments that may affect patients and families at a critical time.

The Alliance is now commissioning claims analyses to examine the root causes of these expenditures. We hope to further engage with the Agency to support the appropriate use of the hospice benefit and to protect the rights of beneficiaries who have entrusted hospice providers to achieve the highest possible quality of life during the transition to end of life.

VI. Conclusion

The Alliance values CMS's ongoing commitment to enhancing hospice care quality, ensuring program integrity, and improving patient outcomes. We appreciate your consideration of our comments and look forward to ongoing dialogue to achieve these shared objectives. If you have questions or would like to schedule a meeting, your staff should feel free to contact Scott Levy, chief government affairs officer, at slevy@allianceforcareathome.org.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home

[17] *Id.*

State association co-signers:

Arizona Association for Home Care
Association for Home & Hospice Care of North Carolina
California Association for Health Services at Home
Connecticut Association for Healthcare at Home
Delaware Association for Home & Community Care
Florida Hospice & Palliative Care Association
Georgia Association for Home Health Agencies, Inc.
Granite State Home Health & Hospice Association
Healthcare Association of Hawaii
Home Care & Hospice Alliance of Maine
Home Care Alliance of Massachusetts
Home Care and Hospice Association of Colorado
Home Care Association of Florida
Home Care Association of New York State
Home Care Association of Washington
Homecare and Hospice Association of Utah
Hospice & Palliative Care Network of Maryland
Hospice and Palliative Care Association of Iowa
Hospice and Palliative Care Association of New York State
Idaho Health Care Association
Illinois HomeCare & Hospice Council
Illinois Hospice and Palliative Care Organization
Indiana Association for Home and Hospice Care
Iowa Center for Home Care
Kentucky Association of Hospice and Palliative Care
Kentucky Home Care Association
Kokua Mau, a Movement to Improve Care
Louisiana Mississippi Hospice & Palliative Care Organization
Michigan HomeCare & Hospice Association
Minnesota Network of Hospice and Palliative Care
Minnesota Home Care Association
Mississippi Association for Home Care
Missouri Alliance for Care at Home
Missouri Hospice & Palliative Care Association
Nebraska Home Care Association
Ohio Council for Home Care and Hospice
Ohio Health Care Association
Oklahoma Association for Home Care & Hospice

Oklahoma Hospice & Palliative Care Association
Oregon Association for Home Care
Pennsylvania Homecare Association
Rhode Island Partnership for Home Care
South Carolina Home Care & Hospice Association
South Dakota Association of Healthcare Organizations
Texas and New Mexico Hospice and Palliative Care Organization
Texas Association for Home Care & Hospice
The Alliance for the Advancement of End of Life Care
The Hospice Council of West Virginia
Virginia Association for Home Care and Hospice
VNAs of Vermont
West Virginia Council for Home Care and Hospice