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The national voice for **nonprofit** hospice & advanced illness care

June 1, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: Comments on the FY 2027 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements Proposed Rule [CMS-1851-P]

Dear Administrator Oz,

The National Partnership for Healthcare and Hospice Innovation (NPHI) is pleased to submit the following comments on CMS-1851-P, the U.S. Department of Health and Human Services (HHS) Fiscal Year 2027 (FY27) Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements proposed rule.

NPHI is a collaborative of 130 nonprofit, community-integrated hospice, palliative, and serious illness care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values, and preferences. Representing providers from across the nation, NPHI and its members help design innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs and build collaboration between national thought leaders and policy makers.

The proposed rule, issued by the Centers for Medicare and Medicaid Services (CMS) on April 2nd, would provide routine updates to the hospice base payment rates, wage index, and aggregate cap amount for FY27. The rule proposes to require the distribution of the Hospice Election Statement Addendum [Patient Notification of Hospice Non-Covered Items, Services, and Drugs] to all Medicare beneficiaries at the time of hospice election, proposes multiple regulatory text changes, and discusses the growing prevalence of non-hospice spending. The proposed rule also offers the opportunity for commentary on three Requests for Information (RFIs), including ways to enhance the provision of community palliative care outside of hospice care, construction of a hospice specific wage index and the provision of Medical Aid in Dying (MAID).

NPHI recognizes the important and timely changes made in the proposed rule and values the opportunity to offer the unique perspective of nonprofit providers with respect to these specific proposed changes. We offer additional details and comments below.

Proposed Routine FY 2027 Hospice Wage Index and Rate Update

NPHI appreciates the proposed 2.4 percent rate increase for FY27 included in this rule. However, NPHI's nonprofit member programs report that their average Medicare margins remain effectively negligible, as reflected in the most recent Medicare Payment Advisory Commission report.[1] This update continues to fall short of meeting inflationary pressures and adequately supporting providers that disproportionately care for high-acuity, short-stay patients. In fact, a significant number of our members are left with a budget deficit, based on the current reimbursement structure, that can only be made up for through philanthropic support. Despite these financial constraints, Medicare claims and Hospice Quality Reporting Program (HQRP) data consistently demonstrate that nonprofit providers incur higher costs due to greater clinical complexity, while also delivering higher quality care relative to their peers.

At the same time, CMS's analysis in this rule underscores growing concern around variations in utilization and spending patterns across the hospice landscape. NPHI shares CMS's commitment to ensuring program integrity and addressing inappropriate utilization. Unlike many for-profit providers that maintain substantial margins and access to capital, nonprofit hospices operate with limited financial flexibility while simultaneously facing sustained workforce pressures, among other persistent challenges.

The ongoing staffing crisis—particularly among nurses, social workers, and other interdisciplinary team members—continues to strain the ability of high-quality providers to deliver comprehensive, patient-centered care. Competition for staff is intense, with other health care entities in the community also searching for staff and often offering sign-on bonuses and flexible hours. Persistently inadequate payment updates exacerbate these challenges, accelerate consolidation, and risk reducing access to high-quality hospice care, particularly for patients with complex needs.

Absent more targeted reforms, this trajectory is unsustainable for both providers and the Medicare program. NPHI therefore urges CMS to consider payment approaches that better align reimbursement with patient acuity and resource needs, while discouraging care patterns that prioritize lower-cost, higher-margin patients. Such reforms would more effectively advance CMS's dual goals of strengthening program integrity and ensuring access to high-quality, person-centered end-of-life care.

Lastly, while NPHI would typically address the adverse impacts of the current hospice wage index methodology on mission-driven providers in this section, we defer those comments to our responses to the related RFI questions included in this proposed rule.

Non-Hospice Spending During a Hospice Election

Introduction: NPHI appreciates CMS's interest in better understanding patterns of non-hospice spending among beneficiaries who have elected the hospice benefit. We agree that improving transparency into total cost of care is an important long-term objective. However, the proposed

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[1] MedPAC Report to Congress, March 2026, Hospice Chapter, Table 10-9, p. 313

approach raises significant concerns regarding attribution, feasibility, and alignment with the statutory design of the hospice benefit.

Most fundamentally, the commentary within the proposed rule and the corresponding Service and Spending Variation Index (SSVI) proposal would hold hospices accountable for categories of spending over which they have little to no clinical, operational, or financial control. In fact, many of our members had never seen the non-hospice spending dollar amount attributed to their patients, and even when the number was available, there is no way for the hospice provider to take action to reduce or eliminate the non-hospice spending for beneficiaries enrolled in their hospice. When the FY24 and FY25 sample SSVI was posted on the CMS website, most hospice providers had never seen the total non-hospice spending associated with their hospice. They were also frustrated that there is no way to identify the sources of the spending, to determine whether it was legitimate, and which patients could it be attributed to. Seeing data in real-time to be able to identify the specific service and the provider submitting claims directly to Medicare is essential to beginning to address non-hospice spending. This is a Medicare system-wide problem, not one that can be pinned on the hospice provider.

The fact that the hospice provider can do little to address specific instances of spending from non-hospice Medicare providers and practitioners should be reason enough to consider every alternative to address this spending, including blocks and flags in the claims processing system that prevent claims from being paid to non-hospice providers when a patient is enrolled in hospice.

In 2015, industry stakeholders came to CMS leadership with concerns and recommendations to curtail spending outside the hospice benefit. Some of the recommendations included:

- Identify methods for a hospice to determine relatedness, including a “comprehensive medication review” that identifies and distinguishes between medications that are related and unrelated to the terminal prognosis,
- Develop a process for non-hospice Medicare providers to have knowledge of the hospice election, including the name of the hospice, and require providers to access the Common Working file to ensure accurate billing,
- When Condition Code 07 is used, require the hospital to communicate with the hospice and confirm that the patient’s hospitalization is unrelated,
- Develop clear guidance to physicians on billing requirements for GV and GW modifiers and reject claims without a GV or GW modifier when the beneficiary has elected hospice and;
- Implement flags in the claims processing system that notify other provider types that the patient has elected hospice.

While these recommendations were detailed in their scope, we have not seen adequate movement to address these concerns. Few flags exist in the claims processing system that indicate a Medicare beneficiary’s hospice election before a claim is paid – from a hospital, outpatient clinic, physician office, or other Medicare provider type. Hospice providers who have attempted to educate non-hospice Medicare providers about correct billing practices often get responses like “we have always done it this way and always get paid,” or “we don’t have to follow your instructions. We get paid by Medicare anyway.”

Hospices do not have authority over non-hospice providers: Hospice providers do not have authority over hospital admissions initiated by patients, families, or non-hospice clinicians without hospice knowledge; specialist services delivered outside the hospice plan of care; or care trajectories that are already in motion prior to hospice election. This creates a clear misalignment between accountability and authority. As many of our members have emphasized, evaluating hospices on non-hospice spending risks assigning responsibility for decisions and utilization patterns that are driven by external actors and broader system dynamics rather than hospices themselves.

Inclusion of GV and GW modifier in Part B non-hospice spending: In the analysis and summary of the non-hospice spending detailed in the proposed rule, billing in the carrier/physician supply area had an increase of 317.5% between FY 2020 and FY 2024, with almost half of the spending due to reimbursement for skin substitutes. Since there are already GV and GW modifiers for independent attending physicians, it is important to ensure that claims with those modifiers are not included in the carrier/physician category of non-hospice spending and included as correctly billed in Table 5.

Specific information to correct non-hospice spending: There is a persistent lack of any information that specifically ties a hospital, physician practice, or other non-hospice Medicare provider to non-hospice spending specifically for an individual enrolled as a hospice patient. Historically, even when CMS made limited data available through tools such as PEPPER—which included a Part D non-hospice spending target area —providers lacked the underlying detail necessary to validate findings, identify drivers of utilization, or take meaningful corrective action.

Referral source and practice style issues: Non-hospice spending patterns are heavily influenced by referral sources, physician practice styles, regional care norms, and the timing of hospice enrollment. For example, patients referred late in the course of illness or from highly medicalized settings often carry forward utilization patterns that predate hospice involvement. Similarly, variation in attending physician behavior, particularly when the attending is not employed by or closely integrated with the hospice, can materially affect service use and prescribing patterns. Physicians and other non-hospice Medicare providers may be unaware of the billing requirements when the patient has elected hospice. Even if the physician or other non-hospice provider is aware, the information is not transmitted to that provider’s billing staff which may be housed in another office at a corporate level. Assigning this variation to hospice and assuming that this is the “hospice’s fault,” risks oversimplifying complex care dynamics and may lead to misleading conclusions.

Complex patient populations: The proposed SSVI also introduces structural bias against providers serving higher-acuity or more complex patient populations. Hospices that care for patients with advanced disease, fragmented care histories, or significant comorbidities—often disproportionately nonprofit and community-based providers—are more likely to see elevated levels of non-hospice utilization. In this context, “doing the right thing” by enrolling and managing complex patients could inadvertently worsen a provider’s performance under the proposed framework. This dynamic raises serious concerns about equity and access, particularly in urban and high-need markets.

Perverse incentives: In addition, the proposal risks creating perverse incentives that could undermine patient-centered care. Tying evaluation or financial consequences to non-hospice spending may discourage providers from enrolling high-risk or high-acuity patients, or from engaging in situations where utilization is less predictable. Such incentives would be inconsistent with the goals of the hospice benefit.

Operational and financial feasibility: Feedback from NPHI members indicates that providers cannot reasonably absorb financial liability for services that have been determined by the hospice physician to be unrelated to the terminal diagnosis and outside their control. Moreover, if additional data collection and reporting are required, providers are concerned about increased administrative burden with limited opportunities for action or improvement.

Interactions with other Medicare provider types: Finally, there are important interactions with other parts of the Medicare program that warrant careful consideration. For example, in nursing facility settings, differing regulatory expectations between hospice and facility-based clinicians—such as required physician visits every 30 days—may result in services being counted as non-hospice spending depending on billing practices, even when those services are routine or duplicative.

Similarly, current incentive structures do not discourage skilled nursing facilities from facilitating non-hospice services, such as skin substitutes, that may ultimately be attributed to the hospice under this proposal. Without clearer guidance and alignment across settings, these dynamics could lead to unintended consequences, including duplicative visits, and competing regulatory requirements could lead to increased scrutiny or regulatory burden on hospice providers caring for nursing home residents.

NPHI Recommendation:

- If the expectation is that the hospice should be able to correct and reduce the amount of non-hospice spending, then patient-specific and provider-specific claims submission information must be available to the hospice for follow-up before this metric is approved and operationalized for use.

Part D and the Hospice N Transaction: Information on the Medicare beneficiary's hospice election, provided through the Part A Notice of Election (NOE) has not ever been available to Part D plan sponsors, as the databases for NOE and Part D data are not compatible. In 2019, hospice industry stakeholders and the National Council for Prescription Drug Programs (NCPDP) established a Hospice Task Group and began working to develop a structure and process to communicate the NOE information to Part D plan sponsors. In 2022, the workgroup met with CMS Part D representatives to review the problems with communication about the hospice election to Part D plan sponsors, after finding that the lag time ranged from 16 to more than 50 days. Based on 2024 data, the median number of days between the date when the hospice submitted an NOE and when the Part D sponsor received notification of the election was 30 days. Recoupment by the Part D sponsor from the hospice can take 2-3 years because Part D sponsors have delays in conducting audits.[2]

The Hospice Task Group began a pilot in August 2022 to design a hospice election notification system, and CMS virtual data center information was added in June 2024. The current pilot participants are NDCHealth Corporation/RelayHealth, as the Part D Transaction Facilitator (Facilitator); Express Scripts and Humana, as sponsors; Waystar and Inovalon, as clearinghouses; Axxess, MatrixCare, and Netsmart, as hospice Electronic Health Record (EHR) system providers; the National Alliance for Care at Home (the Alliance); and the Hospice Task Group.

The Hospice Task Group has developed an electronic notification called the Hospice N transaction that can be transmitted to the sponsors, which has shortened the time it takes for the sponsors to receive the NOE information from 65 days to between 20 and 30 days. CMS issued a Health Plan Management System (HPMS) memo[3] to Part D Plan Sponsors and Hospices in August 2025, entitled *"Alternative Method for Part D Plan Sponsors to Receive Hospice Notice of Election (NOE) Information."* However, Hospice Transaction N is still a transaction processing pilot, where CMS is requesting sponsors to participate. It is not a completed project with all sponsors and hospices using Hospice Transaction N for all Medicare beneficiaries enrolled in hospice.

NPHI Recommendations

- It is unfair and disingenuous for CMS to "blame" the hospice when so little information is available to the hospice about the specific details of the non-hospice claims. Transparency is essential to help identify practice or billing patterns that could be corrected by the hospice or the non-hospice providers. The data transmitted to hospices should include what medications are being billed to Part D, for what patient, and by what provider submitting the claim for payment. Hospices are being evaluated against what is effectively a "black box" metric — without the infrastructure necessary to understand the data and address or manage performance.

- CMS should continue to work with NCPDP to make the Hospice Transaction N pilot universally available and accessible to Part D plan sponsors and hospices. In the interim, more information on hospice enrollment should be available to sponsors to make real-time determinations of medication coverage either through the hospice or Part D.

- Until such time as the communication with sponsors about hospice enrollment is easily available, we recommend that any inclusion of Part D coverage after a hospice enrollment as a component of non-hospice spending be paused so that the seven years of work to design this communication system can be validated and implemented.

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[2] https://medifacd.mckesson.com/hospice/

[3] https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-august-11-15

Comments Specific to Part D and Hospice[4]

NPHI asked hospice pharmacy experts to review the Expanded Part D Non-Hospice Spending information posted as part of the FY27 Hospice Wage Index proposed rule, to provide context and analysis of the detailed data provided. When reviewing the additional data on Part D expenditures in hospice, three key main areas surface.

1. Perceived as Unrelated Medications or Outside of the Scope of Hospice

There are several categories of medications and therapies where hospices frequently struggle to determine whether they are truly unrelated to a patient's terminal prognosis. The core question often becomes: Is this condition or treatment meaningfully contributing to the patient's end-of-life trajectory? Many providers may reasonably conclude that some of these therapies are not directly related. At the same time, CMS has historically taken the position that few conditions or treatments are entirely unrelated to a patient's prognosis or overall wellbeing.

This creates significant operational and clinical tension and confusion. Even when a therapy may offer limited prognostic value, patients often wish to continue treatment because it supports symptom management, stability, quality of life, or peace of mind. Deprescribing these medications can be especially difficult as the industry continues efforts to engage patients earlier in the disease trajectory, when they may still be receiving or benefiting from more aggressive and costly therapies.

Compounding the issue, many newer therapies entering the market are clinically complex, expensive, and designed to extend or stabilize life, yet there is often little guidance regarding when discontinuation becomes appropriate in the context of hospice care. Hospices are increasingly being asked to navigate these grey areas without a reimbursement structure designed to support the cost of such therapies. As a result, providers frequently struggle to define the appropriate role of hospice within the broader continuum of care under the current payment framework.

- **Expensive drug examples that may be unrelated:** HUMIRA, LENBRE, STELARA, and SKYRIZI are very expensive drugs and most hospices, when looking at end-of-life and symptom management, don't see conditions like psoriasis of the skin as contributing to the terminal prognosis. It might contribute to overall symptom burden and wellbeing, but most likely will not be related to their end-of-life prognosis. It is very challenging for a hospice to discuss deprescribing these medications, especially for patients who have great success with them. Patients are struggling with decisions on whether to elect the hospice benefit or decide to stop these medications.

- **Expensive drug examples that may be outside the scope of hospice:** VYNDAMAX, OFEV, OPSUMIT are drugs that are used to slow disease progression, preserve lung function, or improve exercise capacity, respectively. While they may reduce disease-associated symptoms, they are intended to treat the disease and extend prognosis and are not

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[4] Analysis provided by Yellow Leaf Consulting, www.yellowleafconsulting.org, hospice pharmacist expertise

hospice covered medications. But since they are related, Part D does not cover them. The patient ends up having to decide to not elect hospice care, and expensive care continues.

- **Inexpensive examples may be unrelated:** COLCHICINE; LEVOTHYROXINE; METFORMIN; LUMIGAN: These are often not as expensive as biological examples referenced above, but hospices do not consider chronic diseases like diabetes (outside of pancreatic cancer and some cardiac/diabetes/renal metabolic combinations), gout, hypothyroidism (outside of thyroid cancer), or eye diseases such as glaucoma or macular degeneration as "end-of-life conditions" and the default is to deem those medications as unrelated. Some providers now consider diabetes contributing more to the end-of-life prognosis in some cases, but many providers still struggle, and that is indicated by the data showing a significant amount of spend in this category attributed to Part D.

2. Formulary and Advanced Beneficiary Notices (ABNs)

In our analysis, there are many clear-cut examples where medications are related to the terminal prognosis, including therapies that may be expensive and often fall outside standard hospice formularies. In these situations, some hospices inform patients that the medication will not be covered under the hospice benefit and that the patient may choose to discontinue or switch therapies, and that they cannot continue obtaining the medication through Part D, often with an ABN acknowledging financial responsibility.

In practice, overwhelmed patients and families frequently continue filling these prescriptions at the pharmacy. Because there is no real-time electronic coordination of benefits and each patient has an individualized plan of care, pharmacies and Part D sponsors often lack visibility into a patient's hospice election and continue billing the last payer on file that approves the claim.

- **Examples:** ELIQUIS; XIFAXAN; NUPLAZID; SANTYL; NUEDEXTA; BREO ELLIPTA; DONEPEZIL; MYRBETRIQ. The data shows there is a wide range of non-formulary cardiac, antipsychotics, COPD, dementia medications that are being paid by Part D. This is often seen in nursing facilities and assisted living facilities because their pharmacies do not understand the need to change billing practices and will continue billing Part D.

3. Medications Related to the Hospice Prognosis but Billed Incorrectly (Leakage):

These are medications that hospices generally would have covered. They are widely accepted as standard of care; they are on all national formularies but are leaking through the system. Reasons include prescription refills right before or after a hospice election or for patients in nursing homes where the point of sale and co-pay payment is not at the pickup transaction and instead done in arrears.

- **Examples:** SPIRONOLACTONE; METRONIDAZOLE; LACTULOSE; OXYCODONE; TRAZODONE; MIRTAZAPINE.

From the analysis, these three categories of non-hospice Part D spending account for the majority of spending outside the hospice benefit. We concur that there are hospices who are subpar organizations, purposefully not covering almost any medications other than narrowly defined comfort care kit items, but in reality, leakage is a real phenomenon and a systemic problem.

NPHI Recommendations on Part D and Hospice: For all the reasons detailed above, NPHI urges CMS to reconsider the role of non-hospice spending within the proposed SSVI framework. At a minimum, any future efforts in this area should be preceded by:

- Meaningful improvements in data transparency and access across Parts A, B, and D.
- Clearer guidance around expectations of the relationship between terminal prognosis and newer targeted therapies that previously did not exist.
- Development of more nuanced attribution methodologies that reflect shared accountability.
- Careful evaluation of potential unintended consequences on access, equity, and provider behavior.

We welcome the opportunity to work with CMS to develop approaches that advance transparency and accountability related to non-hospice spending while remaining aligned with the structure and intent of the Medicare hospice benefit.

Service and Spending Variation Index (SSVI)

NPHI appreciates CMS's effort to develop more comprehensive approaches to understanding variation in hospice utilization and spending patterns. We support the goal of identifying outliers and ensuring program integrity – particularly in the matrix-style approach that is a key component of what's being proposed in this section. However, as proposed, the SSVI raises significant concerns regarding conceptual clarity, methodological validity, and operational readiness.

At a foundational level, it remains unclear whether both of the two component parts of the SSVI — utilization and non-hospice spending — are intended to function as hospice performance metrics. In the comments that follow, we will provide feedback on each set of metrics.

We note again, with grave concern, that the hospice has little or no control over the non-hospice spending metrics, and the total amount billed for individual hospice patients enrolled with a particular hospice. The proposed metric is also problematic in that it aggregates spending at the hospice level without adjusting for patient volumes. As currently specified, the measure systematically disadvantages larger hospices, whose absolute spending total will appear inflated regardless of per-patient performance. This flaw is fundamental: without adjusting for hospice size, the metric cannot meaningfully distinguish high-cost outliers from providers who simply serve more patients.

A. Utilization Metric-Specific Feedback

We understand that the utilization metrics portion of SSVI is based on the Hospice Care Index (HCI), which is not currently endorsed by the national Consensus Based Entity (CBE). CMS has stated that there will be a thorough review of the HCI metrics, the measurement framework, and the individual metrics that make up the HCI. While we support the use of these utilization metrics, we believe that the SSVI utilization metrics should be finalized after the HCI-based metrics have been considered and approved by the CBE. Implementing the SSVI utilization metrics at this time, before review and approval by the CBE will cause upheaval and confusion about their use among hospice providers and likely result in the need for future changes after the CBE approval.

- **Continuous Home Care (CHC) and General Inpatient (GIP) Utilization**

NPHI is generally supportive of the concept that a provider who delivers zero days of either GIP or CHC is generally deserving of heightened scrutiny given that providing genuine access to all four levels of care is a core condition of participation in the benefit. However, we also note that while we understand the rationale for monitoring GIP and CHC utilization, the absence of these levels of care does not necessarily, in all cases, indicate poor performance.

The proposed metric presupposes an open and equal healthcare marketplace which does not exist. Many hospices operating in limited or highly consolidated markets find themselves excluded from any opportunity to secure GIP contracts with existing hospitals in the area. To meet the requirement for a GIP contract, some hospices have contracts with skilled nursing facilities (SNFs) at some distance from their service area because hospitals have refused to provide a contract. Accordingly, if CMS moves forward with this measure, it may be worthwhile to explore these issues more closely, as the challenges of contracting could create a burdensome transition for beneficiaries and an unnecessary administrative burden on a well-intentioned provider.

- **Percentage of RHC Days Provided in a Skilled Nursing Facility (SNF)**

NPHI recognizes CMS's interest in understanding site-of-service patterns but emphasizes that this metric must be interpreted with caution. For many patients, particularly those without adequate caregiver support, a nursing facility may be the only safe and appropriate care setting. Additionally, cultural preferences, geographic factors, and local infrastructure significantly influence site-of-care patterns. This is not a one-size-fits-all metric, and CMS should ensure that its use does not inadvertently penalize providers serving populations with legitimate facility-based care needs. That said, we believe the proposed threshold of 40% or more is appropriate.

- **Percent of the Last Two RHC Days with Visits**

NPHI generally supports this proposed metric.

- **Percentage of Total Discharges that are Live Discharges**

NPHI strongly encourages CMS to refine the treatment of live discharge metrics within the proposed SSVI. Many provider-initiated live discharges are inappropriate and deserving of heightened scrutiny. That said, not all live discharges are equivalent, and failure to distinguish between discharge types risks producing misleading conclusions. Specifically, CMS should consider:

- Differentiation between patient-initiated and provider-initiated discharges. Hospice providers do not have control over patient-initiated discharges (including transfers) which are considered a "patient right." In fact, details about revoking the election of hospice care are clearly spelled out in § 418.28. Guidance on the re-election of hospice benefits, spelled out in § 418.24(h), also state that the individual or their representative "may at any time file an election, in accordance with this section, for any other election period that is still available to the individual." Patient-initiated discharge data should be removed from the calculation of live discharges as they are a patient's right and a revocation or transfer can happen at any time during the course of care.
    - Patient-initiated discharges include:
        - Revocation
        - Transfer to another hospice
    - Hospice initiated discharges include:
        - No longer terminally ill
        - Patient moved out of the service area
        - Discharge for cause (e.g., safety concerns) should not be treated as a negative performance indicator
- Some hospices contract with a hospice with an inpatient facility (IPU) to ensure patients receive the GIP care their clinical condition indicates. The hospice can either transfer the patient to the IPU or contract with an eligible facility for GIP. In some situations, the hospice has sought a GIP contract in good faith with hospital(s) in the area and the hospital(s) refuses the contract.
- We note that data from patient transfers (both from another hospice and to another hospice) are not captured in the live discharge data and should be tracked. The live discharge rate is impacted when a hospice closes and must transfer all patients to other hospices. When a hospice receives a large number of patients as transfers from another hospice, the census of that hospice may increase quickly. Without the knowledge that the hospice accepted transfers from another hospice, the data may be considered suspect when it is in fact not.
- We also believe that tracking reasons for a live discharge may provide some additional clarity to CMS. We recommend the creation of more granular administrative discharge codes to enable accurate categorization and reporting.

Without these distinctions, hospices may be inappropriately penalized for clinically appropriate or unavoidable discharges, which could in turn create incentives to retain patients inappropriately or avoid certain patient populations altogether.

- **Percentage of discharges with a length of stay over 180 days**

NPHI generally supports this proposed metric.

- **Average skilled nursing minutes on Routine Home Care**

NPHI has concerns with the use of visit timing and intensity metrics—particularly those focused on minutes per visit—as proxies for quality or service adequacy. Hospice care is inherently individualized and driven by patient need as reflected in the interdisciplinary plan of care. The duration of a visit (e.g., five minutes versus one hour) is not a reliable indicator of quality or appropriateness. Instead, CMS should consider focusing on whether clinically appropriate visits were conducted when needed rather than the length of those visits. Metrics that emphasize minutes risk incentivizing volume over value and may distort care delivery in ways that are not aligned with patient-centered goals.

Relatedly, the use of average skilled nursing minutes as a utilization metric reflects an underlying assumption that more time equates to better care. This assumption is not supported by the realities of hospice practice. High-quality hospice care is defined by responsiveness to patient needs, not by standardized time thresholds. This metric should be reconsidered or significantly refined to avoid reinforcing a “time-based” model that is inconsistent with the hospice philosophy of care.

- **Weekend RHC Days with a Skilled Visit**

  NPHI generally supports this proposed metric.

- **Percentage of Live Discharges with Return to Same Hospice in Seven Days**

  There may be occasions when a hospice patient revokes their benefits to try one last treatment or medication that could be helpful. In this case, it would be important to separate the reasons for live discharge, so that a patient-initiated live discharge does not trigger a score for this metric.

NPHI Recommendations on Utilization Metrics:

- NPHI generally supports several of the proposed utilization metrics, including measures related to GIP/CHC availability, visit activity during the final days of life, weekend skilled visits, and long lengths of stay. However, we encourage CMS to apply these measures with appropriate context and refinement. Specifically, CMS should account for market-based barriers to GIP contracting, legitimate facility-based care needs in SNFs, distinctions between patient- and provider-initiated live discharges, and the individualized nature of hospice care when evaluating nursing visit intensity and timing metrics.

B. Non-Hospice Spending

As noted in comments above, hospices lack both the authority and visibility necessary to meaningfully influence non-hospice spending across Parts A, B, and D. Hospices cannot reasonably be held accountable for unrelated Part A, B, or D spending particularly when those services are delivered without hospice knowledge or involvement.

NPHI Recommendations on Non-Hospice Spending Metrics:

- Do not use non-hospice spending metrics at this time. Hospice providers cannot reasonably be held accountable for unrelated Parts A, B and D spending when there is no information available linking the spending to individual hospice patients and the billing Medicare provider. Services are being delivered and paid for without hospice's knowledge or involvement, and CMS has demonstrated a very limited ability to flag claims in the system when a Medicare beneficiary has elected their hospice benefit.

- Use the analytics available to match spending to individual patients and hospices with specific non-hospice providers who billed and got paid; provide this information to hospice providers. Develop a framework for the non-hospice provider to ensure clear communication with the hospice provider and a hold on claim submission and payment until the non-hospice provider and the hospice can determine who will pay for the claim and how it will be filed.

- Work with the Hospice PEPPER to ensure that the target measure for Part D is actionable. The current information related to the amount of Part D spend as a total for the year is not a useful metric and cannot be used for follow-up with non-hospice providers and practitioners, who have gotten paid regardless of the hospice election.

C. Cross-Cutting Concerns with SSVI Methodology

1. Signal vs. Noise & Provider Differences

A persistent concern with the SSVI is that it may not reliably distinguish between inappropriate utilization and clinically appropriate care. The methodology used must be carefully constructed to set appropriate thresholds and avoid misclassification of providers. This will require robust risk adjustment, contextualization, and validity and reliability testing of the index to ensure that it meaningfully differentiates high- and low-quality providers.

The proposed methodology does not appear to adequately account for differences in patient acuity, timing of referral, or disease complexity. Providers serving higher-acuity, short-stay, or medically complex populations will inherently exhibit different utilization patterns, including higher levels of non-hospice interaction.

2. Scale and Market Effects

The proposed SSVI may also introduce bias related to provider size and market presence. Larger hospices, by virtue of serving more patients and interacting with more parts of the healthcare system, are more likely to generate higher levels of observed utilization across multiple domains. This creates a structural correlation between census size and SSVI performance that is unrelated to care quality. CMS should carefully evaluate whether the index disproportionately impacts larger or more integrated providers – and take steps to address those discrepancies prior to advancing any index.

3. Lack of Transparency and Operational Clarity

Providers currently lack clarity on how SSVI will ultimately be used by CMS. It is unclear whether the index will inform public reporting, payment adjustments, audit targeting, or other oversight activities – or some mix of these purposes. This lack of transparency undermines provider confidence and limits the ability to prepare for or respond to the measures. Additionally, most hospices have not historically had access to the full set of data inputs underlying SSVI, further complicating efforts to assess or improve performance.

4. Provider Burden and Consumer Utility

Feedback from NPHI members reflects significant concern about the operational feasibility of responding to the SSVI. Without actionable data, clear levers for improvement, or alignment with reimbursement structures, the index risks increasing administrative burden without delivering meaningful opportunities for quality improvement.

We believe that the SSVI, as proposed, would not be a useful or interpretable tool for patients and families without significant additional clarity. It is also unclear whether SSVI, as proposed, would provide meaningful or interpretable information to patients and families. The composite nature of the index, combined with its reliance on complex and sometimes opaque measures, may limit its value as a consumer-facing tool.

NPHI recommendations:

Given the concerns detailed in this section, NPHI urges CMS to:

- **Non-hospice spending:**
  - Enhance transparency around methodology, data sources, and attribution logic to ensure that non-hospice provider specific and hospice patient information is available to the hospice provider and is actionable to reduce non-hospice spending.
  - Delay the non-hospice spending component of SSVI until there is transparency and full access to non-hospice spending details and their connection to enrolled hospice patients. It is impossible to impact the amount of non-hospice spending when the hospice has no information on the spending and cannot act to improve it.
  - Ensure that providers are not held accountable for utilization and non-hospice spending outside their control.
  - Abandon the non-hospice spending metric or revise it to normalize for hospice size rather than relying on aggregate totals that systematically disadvantage larger providers.
- **Utilization metrics:**

    - Delay implementation of the SSVI utilization metrics until the Consensus Based Entity (CBE) has considered and approved revisions to the HCI, on which the utilization metrics are based.
    - Incorporate robust risk adjustments to account for provider size, patient acuity, referral timing, and regional variation.
    - Refine or reconsider specific component measures that rely on flawed assumptions (e.g., time-based visit metrics).
    - Differentiate among types of live discharges and develop more granular reporting categories, removing patient-initiated live discharges (revocation and transfer) from the metric.
    - Account for structural factors for some utilization metrics, such as access to CHC/GIP and variation in site-of-care availability.
- **Implementation:**
    - Delay implementation of the SSVI, both utilization metrics and non-hospice utilization metrics, until the CBE has reviewed and approved the utilization metrics for HCI and further analysis has been conducted on the appropriate metrics for non-hospice utilization.
- **Overarching:**
    - More broadly, NPHI encourages CMS to view SSVI as a conceptually promising but operationally premature construct. We welcome continued collaboration to refine the index in a way that accurately reflects hospice performance, supports program integrity, and avoids unintended consequences for patient access and provider behavior. If the intention of the SSVI is indeed to inform program integrity and audit oversight efforts, then we share CMS's goal creating and operationalizing tools like this that will help to ensure that limited resources are efficiently targeted at bad actors and poor-quality providers.

Proposed Mandatory Hospice Election Statement Addendum for all Elections

NPHI appreciates CMS's intent to improve transparency regarding services that are not covered under the hospice benefit. Ensuring that patients and families understand potential financial liability is an important objective. However, the proposed requirement to mandate a Hospice Election Statement Addendum for all elections raises significant concerns related to administrative burden, operational feasibility, patient experience, and overall effectiveness in addressing the underlying issue of non-hospice spending.

At a fundamental level, this proposal attempts to address challenges associated with non-hospice spending through additional documentation requirements imposed on hospices — despite the fact that hospices do not control or have full visibility into that spending. As discussed in comments above, the root issue lies in misaligned incentives, lack of data integration across Medicare Parts A, B, and D, and the absence of clear accountability mechanisms for non-hospice providers. Requiring a universal addendum at the point of hospice election does not resolve these structural challenges and may instead create additional administrative complexity without meaningfully improving outcomes.

Timing and Patient/Family Experience

The timing of this requirement is misaligned with the clinical realities of hospice care. Hospice elections often occur late in the disease trajectory, during periods of crisis or urgent symptom management. At this stage, patients and families are singularly focused on comfort, relief of symptoms, and a uniquely individualized plan of care that effectively supports the patient and family/caregivers — not on navigating complex coverage distinctions.

Requiring an additional, detailed piece of documentation (in addition to what is already required at the start of care) at this moment risks overwhelming patients and families, creating confusion, and detracting from the primary goal of establishing a patient-centered plan of care. Feedback from members consistently emphasized that patients are most concerned with out-of-pocket costs and practical implications of care — not with administrative distinctions regarding what Medicare will or will not cover in abstract terms.

Moreover, members questioned whether the proposed addendum would meaningfully improve patient understanding or informed consent. Without broader system alignment and clearer communication pathways across providers, the incremental value of this requirement appears limited relative to its administrative cost.

Administrative Burden and Operational Feasibility

The most consistent feedback from NPHI members relates to the significant administrative burden associated with this requirement, particularly the mandate to obtain patient or representative signatures. Hospice admissions frequently occur under time-sensitive and emotionally charged circumstances, often during periods of rapid clinical decline. Introducing an additional documentation requirement for all patients with prescribed timeframes risks slowing enrollment workflows and diverting staff attention away from immediate clinical needs and care planning.

For providers with high admission volumes, the requirement to obtain signatures on an addendum for every patient would represent a substantial operational strain. This burden is compounded by the proposal to require updated addends whenever there are changes to determinations of relatedness, which may not always be easily defined in real time.

Additionally, members expressed concern that technical non-compliance — such as minor timing discrepancies or missing signatures — could expose providers to significant audit risk. Hospices are receiving denials when an addendum is delivered one day late even if the patient or family request that the hospice staff visit the next day. Making this mandatory for every patient can further compound the risk of lost reimbursement. We strongly urge CMS to ensure that any documentation requirements are implemented with proportional compliance expectations and that minor administrative deficiencies do not result in denial of entire claims. At a minimum, CMS should consider limiting any associated payment impacts to discrete service days rather than the full claim.

Misaligned Incentives and Limited Effectiveness

A central concern is that the proposal does not address the behavior of non-hospice providers, who are often the drivers of non-hospice spending. Under current policy, there is little incentive for Part B providers or other clinicians to proactively engage with hospices to determine whether services are related to the terminal diagnosis. In some cases, providers may have a financial incentive not to inquire, as services can be billed and paid under existing mechanisms (e.g., with use of condition code 07).

Requiring hospices to furnish an addendum to patients does not create accountability for these external providers or ensure that they will seek or use this information. In practice, there is no clear mechanism compelling non-hospice providers to request or adhere to the addendum, limiting its effectiveness as a tool for managing non-hospice spending.

If CMS intends to influence non-hospice spending and utilization with the use of this addendum, more direct mechanisms — such as claims-based modifiers, real-time eligibility indicators, or requirements for provider-to-provider engagement — would be more appropriate and effective. For example, CMS could consider requiring non-hospice providers to obtain hospice confirmation of relatedness for certain services or establishing protections for providers who engage in good-faith coordination efforts. Given the efforts of CMS to align care across the continuum and the fact that the hospice benefit indicates the hospice oversees the plan of care, CMS should consider requiring non-hospice providers to obtain authorization before submitting a claim for an unrelated service to Medicare. This would add administrative burden to the hospice, but at least it would actually help address the root of the problem as opposed to penalizing the unknowing provider.

NPHI Recommendation:

While NPHI has significant concerns with the proposed universal requirement, we recognize the importance of improving transparency and coordination. If CMS elects to move forward, we recommend several modifications to improve feasibility and impact:

- Remove the signature requirement and instruct hospices to attest via documentation the delivery of the addendum in the medical record,
- Avoid requiring updated addendums for every change in relatedness determination, given the fluid and evolving nature of patient care,
- Ensure consistent guidance across Medicare Administrative Contractors (MACs) to prevent variability in audit and enforcement practices and;
- Develop complementary policy solutions — such as claims modifiers or enhanced data-sharing mechanisms — to address the underlying drivers of non-hospice spending.

In summary, while NPHI supports CMS's goal of improving transparency around non-covered services, the proposed mandatory Hospice Election Statement Addendum for all elections is overly prescriptive and operationally burdensome relative to its likely impact. It does not resolve the core issues related to non-hospice spending and may instead introduce unintended consequences for providers and patients alike.

Accordingly, NPHI urges CMS to reconsider this proposal or, at a minimum, significantly modify its scope and implementation to better align with the realities of hospice care delivery. We welcome the opportunity to work collaboratively with CMS to develop more targeted, effective solutions that enhance transparency without imposing unnecessary burden or compromising patient experience.

Regulatory Text Change: Discharge from Hospice Care

NPHI thanks CMS for adding the physician language to the "Discharge from Hospice Care" section of Subpart B to align it with other references to the hospice medical director, physician designee, and hospice physician on the interdisciplinary group. NPHI is supportive of CMS's proposal to align the regulatory text related to discharge from hospice care.

Regulatory Text Change: Face-to-Face Encounter

NPHI is supportive of CMS's proposal to implement a code beginning January 1, 2027, to track telehealth visits for the hospice face-to-face. We believe that the G-code would be appropriate. We will watch for the notice and comment rulemaking opportunity to provide additional detail regarding implementation of this new code.

Request for Information (RFI) on Ways to Enhance the Provision of Palliative Care Outside of Hospice Care: Current Coverage, Billing Practices, and Opportunities for Improvement

1. Do the E/M codes, care management codes, and ACP codes represent the majority of the billing codes providers use to capture community palliative care services?

NPHI members generally agreed that E/M, care management, and ACP codes represent the primary reimbursement mechanisms currently used to support community-based palliative care services. Participants also noted increasing utilization of navigation-related services, including Principal Illness Navigation (PIN), particularly for care coordination, and patient engagement activities.

At the same time, members emphasized that the existing billing framework remains fragmented, administratively burdensome, and poorly aligned with the interdisciplinary, longitudinal nature of serious illness care. Many providers must navigate multiple overlapping billing pathways that can be difficult to operationalize consistently, particularly for smaller or resource-constrained programs.

Several participants also cautioned against drawing overly rigid distinctions between navigation and care management services, noting that these functions are often operationally integrated in practice. Members expressed concern that separating these activities too narrowly may fail to capture the true clinical complexity associated with caring for patients with advanced cancer, heart failure, dementia, and other serious illnesses.

2. What services are typically provided when Z51.5 is billed?

Members reported that Z51.5 is used to capture a broad range of palliative care services, including symptom management, goals-of-care discussions, advance care planning, interdisciplinary care coordination, and longitudinal support for patients with serious illness. However, utilization practices vary significantly across organizations and care settings.

Several participants noted that Z51.5 is not consistently applied at every encounter where palliative care services are being delivered, meaning the code alone underrepresents the true volume and scope of palliative care nationally. Members emphasized that use of the code is often driven more by EMR workflows, documentation practices, and organizational processes than by a standardized clinical approach.

Participants also highlighted meaningful variation between inpatient and outpatient/community-based settings. For example, some organizations consistently apply Z51.5 in inpatient settings but report more variable utilization in outpatient and home-based settings due to EMR limitations and workflow complexity.

Overall, members stressed that additional education, standardization, and operational guidance would be necessary if CMS intends to rely on Z51.5 for claims analysis, workforce identification, or future policy development.

3. Are there challenges in meeting documentation requirements or integrating nonbillable interdisciplinary team members, such as social workers, chaplains, or nurses who are crucial to palliative care delivery?

Members universally agreed that documentation complexity and inadequate reimbursement remain significant barriers to sustainable palliative care delivery. Participants emphasized that interdisciplinary team members including social workers, chaplains, nurses, navigators, medical assistants, and other community-based support staff are essential to high-quality serious illness care but are difficult to sustainably support under current fee-for-service reimbursement structures.

Several members noted that existing documentation requirements are overly complex, highly time-driven, and challenging to operationalize consistently across diverse patient populations and care settings. Providers frequently perform substantial care coordination and interdisciplinary work that is clinically necessary but ultimately does not meet billable thresholds. PIN services were specifically identified as administratively burdensome due to complex documentation and implementation requirements.

Members also emphasized that smaller and community-based programs face disproportionate operational challenges because they often lack the administrative infrastructure necessary to manage multiple overlapping billing pathways. As a result, members expressed strong support for simplifying documentation requirements, reducing reliance on narrowly defined discipline-specific billing structures, and exploring more flexible longitudinal or bundled payment approaches tailored to the realities of serious illness care.

Many members specifically supported adapting APCM-like concepts to palliative care in a way that would provide greater interdisciplinary flexibility, reduce implementation burden, and allow organizations to structure care teams around local workforce realities and patient needs rather than rigid billing categories.

4. Is there uncertainty about compliance requirements or concern that billing for palliative care will result in claims denials?

Yes, members expressed significant concern regarding compliance requirements, documentation standards, and the potential for claims denials. Members noted ongoing challenges documenting ACP and goals-of-care discussions in ways that consistently satisfy billing and audit requirements, particularly for nurse practitioners.

Members also raised concerns about provider specialty overlap within PECOS and uncertainty regarding responsibility for longitudinal care management when multiple clinicians are involved in a patient's care. Members emphasized that these issues may become more pronounced as additional providers adopt care management-based reimbursement models.

5. What non-medical services, such as caregiver training or spiritual care, would most benefit patients if reimbursed? What enhancements to existing benefits could strengthen palliative care?

Members emphasized that future palliative care reimbursement policy should prioritize flexible, interdisciplinary payment models rather than continued expansion of narrowly defined billing codes. Caregiver training, spiritual care, social work, navigation, and psychosocial support were all identified as critically important but inadequately reimbursed components of serious illness care.

Participants expressed strong support for bundled or longitudinal payment structures that would allow organizations greater flexibility to tailor staffing models and services to local workforce realities and patient needs. Members also highlighted the need to better support caregiver-focused services and interdisciplinary roles that do not fit neatly within existing fee-for-service billing frameworks but remain essential to high-quality palliative care delivery.

6. What aspects of palliative care are financially unsustainable for providers?

Members consistently identified telehealth instability, travel burden, and inadequate reimbursement as major contributors to the financial unsustainability of community-based palliative care. Members emphasized that current fee-for-service structures do not adequately support the interdisciplinary staffing, care coordination, and longitudinal management required for patients with serious illness.

Driving time and geographic dispersion were cited as particularly significant operational burdens for home-based programs, especially in rural areas. Members also noted that reimbursement frequently fails to reflect the clinical complexity and time intensity associated with palliative care delivery. Members expressed support for enhanced longitudinal payment models, including complexity-based or care management add-on payments, that better recognize ongoing provider responsibility for medically complex patients and interdisciplinary coordination activities.

7. What documentation requirements do providers typically use, or suggest using, to identify the provision of palliative care?

Members identified Z51.5 and palliative care consult note documentation as the primary mechanisms currently used to identify palliative care services. Members noted that some organizations also use palliative-specific EMR templates, note headers, and clinical forms to better distinguish serious illness care from other medical services.

However, members emphasized that inconsistent documentation workflows, EMR limitations, and variable adoption of Z51.5 continue to create operational challenges. Members also expressed concern that claims-based approaches alone may not accurately capture the true scope of the palliative care workforce or patient population without greater standardization in documentation and reimbursement practices.

8. Do providers commonly refer patients for home health services when a patient needs palliative care concurrently with curative or life-sustaining care?

Responses varied significantly across organizations and care settings. Members noted that home health coordination can be operationally cumbersome, particularly for patients receiving concurrent curative or life-sustaining treatment. Members emphasized that many patients needing palliative care services do not meet strict homebound eligibility requirements despite experiencing substantial functional limitations.

Several organizations reported leveraging internal home health divisions to improve coordination and continuity, while others rely on communication with primary care providers to facilitate referrals externally. Members also noted that access to home health services often depends on agency willingness to accept medically complex patients and that coordination challenges are frequently amplified when home health and palliative care providers operate separately.

9. What services do providers typically offer patients who are not eligible or ready to elect hospice care but require palliative services?

Members emphasized that many patients who are not yet hospice eligible still require substantial supportive services and interdisciplinary care. Organizations described providing a range of palliative and supportive services outside the hospice benefit, including symptom management, spiritual care, end-of-life doula support, care coordination, and transitional or rehabilitative services.

Some organizations also noted referring patients to short-term rehabilitation or hospital-based supportive services when hospice eligibility criteria are not yet met. Overall, members stressed the importance of maintaining flexible community-based serious illness care infrastructure capable of supporting patients earlier in their disease trajectory.

Request for Information Regarding Construction of a Hospice Specific Wage Index

1. What data sources and changes should be considered to develop a wage index specific for hospices?

NPHI supports CMS exploring a hospice-specific wage index methodology that more accurately reflects hospice labor markets and staffing patterns than the current hospital-based system. As noted in prior feedback following the CMS Technical Expert Panel (TEP) last fall, the current hospital wage index is fundamentally misaligned with hospice care delivery because hospital staffing patterns, service distribution, and labor markets differ significantly from hospice operations.

CMS should consider a blended methodology utilizing Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) data, revised hospice cost report data, hospice claims and utilization data, and potentially future payroll/FTE reporting. Any hospice-specific methodology should better capture the interdisciplinary hospice workforce, broader hospice service areas, travel burdens, and labor competition across healthcare sectors.

Importantly, CMS should first improve the underlying data infrastructure before implementing payment changes. Current hospice cost reports do not sufficiently capture contract labor, occupational mix, or workforce allocation detail necessary to support a highly accurate wage index methodology.

NPHI members also emphasized the need for a wage index that more accurately reflects regional cost-of-living differences, competition with other healthcare providers for workforce, and the unique staffing models utilized in hospice care. Some members specifically noted that current methodologies fail to capture the true cost of delivering hospice services in low-cost but highly competitive labor markets.

2. What are the advantages of the suggested approach to constructing wage indexes, relative to the current system?

NPHI believes the proposed hospice-specific BLS-based methodology has several important conceptual advantages over the current hospital-based wage index system.

Most importantly, it moves toward a labor market methodology that is more hospice relevant. The current hospital wage index relies on non-representative hospital staffing data that does not accurately reflect hospice occupational mix, service delivery patterns, or labor competition realities.

Potential advantages include incorporation of a hospice-specific occupational mix, use of broader cross-industry labor market data, more timely wage data compared to hospital cost report lag, and reduced dependence on hospital reimbursement structures and reclassification policies unrelated to hospice operations.

NPHI members consistently report that current wage index calculations produce anomalous and inequitable results that often bear little relationship to actual hospice labor costs. For example, HopeWest, an NPHI member on the Western Slope of Colorado, cumulatively received approximately $8.5 million less in hospice revenue from 2013–2023 for patients residing in Mesa County compared to adjacent rural counties solely because of wage index delineation issues tied to hospital classifications. Conversely, many rural providers face lower reimbursement rates despite substantially higher travel burdens and staffing challenges across broad service areas.

Additionally, a hospice-specific approach may better recognize that hospices compete for workforce against hospitals, health systems, home health agencies, and other industries that can frequently offer higher wages and more comprehensive benefits.

3. What are the main limitations of the suggested approach?

While supportive conceptually, NPHI believes the current proposed BLS-based methodology requires significant refinement before implementation.

Key concerns include data representativeness and completeness. Several important hospice occupational categories are currently excluded or poorly categorized, including spiritual care, volunteer coordination, pharmacy services, dietary counseling, and medical records personnel. During prior TEP discussions, stakeholders estimated that approximately 34 percent of hospice wages were excluded from portions of the methodology due to occupational categorization limitations.

There are also concerns regarding physician categorization. The use of the broad "Physicians, All Other" BLS category does not accurately reflect hospice physician staffing patterns, which are more commonly aligned with Family Medicine and Internal Medicine specialties.

Additional limitations include the exclusion of contract labor expenses, reliance on unaudited cost report data, and claims-based minutes that may not accurately reflect total labor costs, travel burden, interdisciplinary care coordination, or on-call staffing needs.

NPHI also remains concerned about geographic mismatch issues. Hospices frequently serve broad multi-county regions that do not align neatly with hospital-based labor markets or CBSA definitions. Finally, there are concerns about payment volatility and the potential for abrupt redistributive impacts that could destabilize nonprofit and rural hospice providers operating on extremely narrow margins.

4. Can any limitations be addressed through changes to the data sources mentioned, such as cost reports and claims?

Yes. NPHI believes several meaningful improvements could substantially strengthen the reliability and accuracy of a hospice-specific wage index over time.

CMS should revise hospice cost reports to include FTE reporting by discipline, separation of contract versus employed labor, more granular occupational categories, and improved reporting of interdisciplinary staffing and administrative versus direct care labor. This would align hospice reporting more closely with other provider types such as hospitals, SNFs, dialysis facilities, and home health agencies.

Claims data could also be strengthened through county-level reporting using FIPS codes and more precise service location reporting to better align labor market weighting with where services are actually delivered.

Before cost reports are formally integrated into payment methodology, CMS should implement stronger integrity measures including robust trimming methodologies, validity checks, audit protocols, and outlier analysis. NPHI strongly encourages CMS to test and publicly model these improvements extensively before implementation.

5. **What occupations should be included in the occupational mix to estimate geographic differences in expected prices to employ healthcare staff in hospices?**

The occupational mix should reflect the full interdisciplinary hospice care model rather than relying on hospital-centric staffing assumptions.

At minimum, CMS should include registered nurses, licensed practical/vocational nurses, hospice aides/CNAs, social workers, chaplains/spiritual care providers, hospice physicians, nurse practitioners, bereavement staff, volunteer coordinators, clinical supervisors/managers, pharmacy support personnel, and administrative/care coordination staff.

NPHI particularly emphasizes the need to include occupations currently omitted or underrepresented in BLS categorizations, especially chaplaincy and other interdisciplinary care roles central to hospice delivery.

CMS should also carefully evaluate whether the “Home Health and Personal Care Aides BLS” category appropriately reflects the specialized clinical functions performed by hospice aides.

6. **What additional labor categories, if any, should be added to cost reports to support the revision of the hospice wage index? Are any other changes to the cost reports required for this purpose?**

CMS should consider adding reporting categories for contract labor by discipline, FTE counts by occupation, hospice physician specialty distinctions, spiritual care/chaplaincy, volunteer coordination, bereavement staffing, clinical management/supervisory staff, on-call staffing, and travel-related labor expenses.

NPHI also recommends separating direct patient care labor from administrative labor and distinguishing contract versus employed workforce categories. These additions would significantly improve the reliability and representativeness of any hospice-specific labor mix calculation.

7. **How should we appropriately compare wages between geographic areas that match the way hospice services are delivered? Should we maintain the use of CBSA, or consider other geographic delineation, such as county, census area, etc.?**

NPHI believes CMS should carefully evaluate alternatives to an exclusively CBSA-based methodology.

Hospices frequently operate across broad geographic areas that do not align with hospital labor markets. Rural providers especially experience substantial travel burdens and staffing challenges that are not adequately reflected under current geographic delineations.

CMS should evaluate continued use of CBSAs alongside county-level approaches, rural regional groupings, hospice service-area-based methodologies, beneficiary location weighting using hospice days, and hybrid approaches incorporating multiple geographic indicators.

At the same time, NPHI supports preserving standardized OMB geographic delineations where feasible for consistency and predictability.

8. How should we reduce large differences in wage index values for adjacent geographic areas?

NPHI strongly supports policies that reduce anomalous “cliff effects” between neighboring geographic areas.

CMS should consider geographic smoothing methodologies, multi-year averaging, rural floor protections, transition corridors, caps on annual decreases, and hold harmless protections. The HopeWest example in Western Colorado illustrates how adjacent counties can generate dramatically different reimbursement outcomes despite operating within highly integrated labor markets.

NPHI also generally supports CMS’s prior efforts to establish a 5 percent cap on year-over-year wage index decreases, which has improved payment stability. However, additional safeguards may still be necessary under a redesigned methodology.

9. How should we consider policy to support the transition between the current hospice wage index approach to a new one?

NPHI strongly encourages a cautious, transparent, phased transition.

CMS should publicly release modeled wage index values before formal rulemaking, allow extensive stakeholder review and comment, conduct robust regional impact analyses, and implement any changes over multiple years with limitations on annual payment reductions.

Additional protections should include hold harmless provisions, careful evaluation of aggregate cap implications, and assessment of downstream Medicaid payment impacts given states’ reliance on Medicare hospice payment structures.

NPHI also recommends substantial lead time prior to implementation to allow hospices to adjust staffing strategies, plan budgets, evaluate operational impacts, and preserve uninterrupted patient access to care.

Ultimately, while NPHI supports movement toward a more hospice-relevant wage adjustment methodology, additional refinement, testing, and data infrastructure improvements are essential before implementation. The revised methodology must be transparent, replicable, auditable, and capable of validation by external audiences.

Request for Information Regarding Medical Aid in Dying (MAID)

1. **What information do hospice providers give to these patients and how often is there overlap when a patient pursues MAID? In other words, do hospices generally continue to provide clinical care while a patient seeks qualification for MAID and do patients generally remain on service until death?**

Hospice providers care for patients with terminal illness, and therefore there is naturally significant overlap between hospice patients and individuals who may inquire about or pursue medical aid in dying where it is permitted under state law. In these instances, hospices generally continue to provide the full range of appropriate hospice care consistent with the patient's plan of care, applicable state law, and federal requirements.

Hospices may provide patients and families with general information about applicable state law, patient rights, available resources, and the distinction between hospice services and any separate process established under state medical aid-in-dying statutes. Importantly, hospice care remains focused on symptom management, psychosocial and spiritual support, family support, and high-quality end-of-life care. A patient's interest in or pursuit of medical aid in dying does not, in and of itself, change the hospice's obligation to provide appropriate care.

In general, patients who pursue medical aid in dying remain on hospice service if they continue to meet hospice eligibility requirements and wish to continue receiving hospice care. Any services or activities that fall outside the Medicare hospice benefit or that are considered participation in medical aid in dying under applicable state law are handled separately, consistent with state and federal requirements.

2. **Conversely, do hospices encourage patients to revoke their election if they choose to utilize MAID?**

Hospices should not encourage patients to revoke their Medicare hospice election solely because the patient has expressed interest in, is pursuing, or has elected to utilize medical aid in dying where permitted under state law. Interest in medical aid in dying is not, by itself, an appropriate basis for encouraging revocation or discontinuing hospice care.[5]

Hospice providers generally understand their responsibility to continue supporting eligible patients and families through the end of life, regardless of the patient's legally available choices under state law. Patients may choose to revoke hospice for their own reasons, but hospices should not treat pursuit of medical aid in dying as a reason to initiate or encourage revocation.

3. **Is there confusion amongst hospices regarding visits or other comfort measures that can be provided during this process, especially on the day of death?**

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[5] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.28?utm_source=chatgpt.com

Hospices generally understand that they must continue to provide appropriate hospice care consistent with the patient's plan of care, applicable state law, and Medicare requirements. This includes clinically appropriate comfort measures, psychosocial support, family support, and care at the time of death. That said, state laws vary in how they define participation in medical aid in dying, and what activities are permitted or prohibited for providers and staff.

4. Do hospices have written policies regarding caring for patients using MAID?

Many hospices in states where medical aid in dying is legal have developed written policies, procedures, or internal guidance addressing how they respond to patient inquiries, maintain neutrality, comply with applicable state law, support staff, document care planning, and continue providing hospice services. These policies vary because state laws differ significantly, including with respect to what constitutes participation in medical aid in dying; what activities are permitted for hospice clinicians, medical directors, and other staff; and what mechanisms are in place to allow providers as individuals or organizations to "opt out" of any participation. In general, hospice policies are designed to ensure that patients continue to receive high-quality end-of-life care while maintaining appropriate separation between Medicare-covered hospice services and any activities that fall outside the Medicare hospice benefit or constitute participation under state law.

Care Compare Icon for Reporting Noncompliance

NPHI is strongly supportive of this provision of the proposed rule. We take this opportunity to remind CMS that consumers will be overwhelming unaware of hospice quality data submission requirements, so any icon identifying failure to report will need to be carefully constructed to maximize public understanding and impact.

Conclusion

Thank you again for the opportunity to provide comments on CMS's proposed regulation regarding the FY27 Hospice Wage Index and Payment Rate Update. As always, NPHI appreciates the opportunity to provide insight and commentary into how various proposed regulatory, compliance, and quality reporting changes may impact the nonprofit hospice and palliative care provider community. If you have any questions concerning these comments or would like to discuss these issues further, please contact NPHI's Senior Policy Director, Ethan McChesney, at ethan@nphihealth.org.

Sincerely,

Tom Koutsoumpas

Tom Koutsoumpas
Founder and CEO
NPHI