MEDPAC | Medicare Payment Advisory Commission

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April 30, 2026

Dr. Mehmet Oz, M.D., M.B.A
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244–1850

Attention: CMS-1851-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Fiscal Year (FY) 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements" in the *Federal Register*, vol. 91, no. 65, p. 17338 (April 6, 2026). We appreciate CMS's ongoing efforts to administer and improve the payment system for hospice services, particularly given the many competing demands on the agency's staff.

Our comments focus on two issues:

- CMS's request for information on construction of a hospice-specific wage index, and
- hospice service and spending variation index.

Construction of a hospice-specific wage index

Since 1998, CMS has used general acute care hospital wage data to develop the hospice wage index. For FY 2027, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index"), with a hospice-specific national floor and a 5 percent cap on wage index decreases from one year to the next year.

The proposed rule solicits comments on whether CMS should consider using alternative data sources to construct a hospice-specific wage index for potential use in future years, citing MedPAC's prior recommendations for the Secretary to phase in new Medicare wage

index systems. CMS also hosted a Technical Expert Panel (TEP) on September 10, 2025, to seek feedback on a proposed alternative to the current hospice wage index.[1]

The agency describes a hospice-specific wage index approach that would use: (1) Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) all-industry data on wages by occupation and metropolitan statistical area (MSA), (2) a combination of data from freestanding hospice cost reports and hospice claims to construct national hospice-specific occupational mix weights, and (3) Census bureau county population data.

To derive the hospice-specific wage index, CMS would use these data sources to calculate:

- occupation-specific, core-based statistical area (CBSA)–level average hourly wage[2],
- cross-occupation CBSA-level average hourly wage (by weighting the occupation-specific CBSA-level average hourly wage by the hospice national average occupational mix), and
- cross-occupation national average wage (by weighting the occupation-specific CBSA-level average hourly wage by CBSA-level population and the hospice national average occupational mix).

CMS would calculate the raw wage index for each CBSA by dividing the cross-occupation CBSA-level average hourly wage by the cross-occupation national average hourly wage and then apply its standard adjustments (e.g., recalibrating the center of the distribution of the new wage index to match the prior year's wage index and applying the hospice floor and 5 percent cap on wage index decreases).

CMS seeks comment on the method to construct the hospice national occupational mix weights. CMS noted that the hospice cost reports do not include data on full-time equivalents (FTEs) by occupation. As an alternative, CMS describes constructing the hospice occupation weights as follows.

- For physicians, nurse practitioners (NPs), and nurse administration staff, occupation weights would equal the share of costs accounted for by each of these three types of staff based on freestanding hospice cost report data.
- For registered nurses; licensed practical nurses/licensed vocational nurses; medical social services; and physical, occupational, and speech therapy staff, occupation weights would equal the share of in-person visit minutes for each type of staff reported on hospice claims multiplied by 1 minus the share of total costs from the cost reports accounted for by physicians, NPs, and nurse administrators.

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[1] Plotzke, M., T. Christian, M. Knowles, et al. 2025. *Medicare Hospice Wage Index Technical Expert Panel notes.* https://www.cms.gov/files/document/hospice-wage-index-technical-expert-panel-meeting-summary-report-september-2025.pdf

[2] Because the publicly available BLS data are available at the MSA, non-MSA, and New England City and Town Area levels, and the hospice prospective payment system wage index is designated at the CBSA level, CMS would use the BLS data to assign wages at the county level and use Census Bureau county population data to calculate a population-weighted average wage at the CBSA level.

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[3] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, hospices), Medicare needs wage indexes that are less manipulable, more accurately reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor within a given market. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that:

- Uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- Reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- Smooths wage index differences across adjacent local areas.[4]

The approach CMS describes is generally consistent with the principles underlying the Commission's June 2023 recommendation, and we therefore support this direction. The use of BLS OEWS data for CBSA- and occupation-level wage estimates has numerous advantages: This data source is publicly available, recent, and includes all-employer mean wage data. These features would reduce CMS administrative burden, reflect more recent data than the current cost report data that is the basis of the unadjusted hospital wage index, acknowledge that employers in a market compete for similar types of workers, and decrease current circularity that causes deviation between the labor costs reported by hospitals and broader labor market wages. Establishing hospice-specific occupation weights is also an important feature of this approach and is directionally consistent with the Commission's recommendation; below, we comment on technical issues concerning the proposed construction of these occupation weights and offer alternatives CMS could consider.

The proposed approach to construct hospice-specific occupation weights raises some technical concerns. First, establishing occupation weights using data measured in different units—costs for some occupations and visit minutes for others—can distort occupational shares because costs reflect both wages and time, while visit minutes reflect time only. Second, claims-based visit minutes reflect in-person patient care time only, which could skew occupation weights if occupations vary in the share of time they engage

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[3]Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC.
[4] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

in patient visits versus other activities. Finally, the set of occupations does not include certain hospice administrative staff (e.g., management or medical records).

Below are several alternative approaches CMS could consider to calculate hospice occupation weights, and there may be other reasonable approaches as well:

- *Use existing data on salaries from hospice cost reports or BLS*: As CMS noted, hospice cost reports currently report salaries for direct patient care occupations. Cost reports also have salaries for other cost centers, such as administrative staff, although not at an occupation level. Alternatively, while there is no North American Industry Classification System category that fully aligns with hospices, CMS could leverage BLS salary data from the two categories under which hospices currently report: home health care services (621610) for in-home hospices and nursing care facilities (623110) for inpatient hospices. Using salary information from either hospice cost reports or BLS would involve no new data collection and could be implemented soon.[5]

- *Collect FTE data*: CMS could collect data on hospice FTEs by occupation by adding these fields to the hospice cost reports (similar to ESRD and home health) or conduct an episodic occupational mix survey (similar to IPPS hospitals). Collecting additional data would increase administrative burden for some providers. However, according to the CMS TEP report, "multiple TEP members indicated that hospice cost reports should contain FTE information for staff so that the calculation of the national labor mix would be more accurate. TEP members indicated that FTE information would be straightforward to provide, since similar information is provided on the home health cost reports."[6]

Regardless of the alternative wage index data sources used, we urge CMS also to consider the two other parts of our June 2023 wage index recommendation: to account for differences in wages within metropolitan statistical areas (for example, by using data from the Census Bureau's American Community Survey), and to smooth wage index differences across adjacent local areas (such as county lines). We also encourage the agency to estimate the magnitude of changes under an improved wage index and contemplate phasing in larger changes over a period of time.

Hospice service and spending variation index

In the proposed rule, CMS describes a new measure it has constructed—the hospice service and spending variation index (SSVI). The SSVI is based on nine claims-based metrics: eight hospice utilization measures and one nonhospice spending measure. CMS stated that the goal of the SSVI is to (1) identify individual hospice vulnerabilities to help focus program integrity efforts and (2) provide enhanced transparency to the public and

[5] If CMS takes this approach of using salaries instead of time for occupational mix weights, the wage index calculation can be modified to accommodate that approach as described in our June 2023 report.
[6] Plotzke et al. 2025.

permit beneficiaries and their families the ability to make more informed choices regarding care at the end of life.

CMS released data on providers' scores on the SSVI measure and its components for FY 2024 and FY 2025, and indicates the agency seeks to release an additional year of data each year going forward. CMS seeks feedback on the metrics used to calculate the SSVI score as well as thoughts and suggestions regarding the threshold values and point assignments.

The SSVI score ranges from 0 to 16 with a higher SSVI score representing a potential higher level of concern. The SSVI is calculated as the sum of the provider's scores on each of the following nine measures.

- *Hospice utilization measures:* These eight measures capture potentially concerning patterns related to lack of higher-intensity care, nursing facility–based routine home care, low visit frequency or time, long stays, and live discharge patterns. Providers receive 1 point per measure if their utilization exceeds a specified threshold (generally set to identify 25 percent of providers for each measure with the most potentially concerning utilization)

- *Nonhospice spending measure:* CMS groups hospices into eight spending categories based on aggregate nonhospice spending incurred by their patients during hospice enrollment. Hospices with no aggregate nonhospice spending receive 0 points; those with spending receive 1 to 8 points, from lowest to highest spending.

CMS included in the proposed rule an analysis showing rapid growth in nonhospice spending for hospice enrollees. CMS reported that Medicare program spending on nonhospice services during hospice enrollment exceeded $2.8 billion in FY 2024. Hospice beneficiaries also incurred cost-sharing liability for these services—about $510 million for Part A and B services and $71 million for Part D drugs. Between FY 2020 and FY 2024, Medicare Part A and B nonhospice spending increased from $790 million to more than $2 billion, driven by a 317.5 percent increase in carrier/physician spending (nearly half of carrier spending in 2024 was for pressure ulcers, largely skin substitutes), followed by 40 percent and 27 percent increases in outpatient and inpatient spending, respectively. Over the same period, Part D nonhospice spending rose from more than $550 million to more than $810 million.

Comment

Over the years, the Commission has been concerned about aberrant patterns of care among some hospice providers (such as providers with high live discharge rates or long lengths of stay) and advocated for efforts to identify such patterns and bring focused program integrity oversight to those providers.[7] The Commission views CMS's efforts to

[7] Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC. Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC. Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

establish the SSVI as directionally consistent with that approach, and we commend the agency for pursuing these types of efforts.

We also have been concerned about the issue of nonhospice spending for beneficiaries enrolled in hospice, as we discussed in our March 2024 report to the Congress.[8] Under Medicare policy, a hospice provider is responsible for all services that are reasonable and necessary for palliation of the patient's terminal condition and related conditions. Services that are unrelated to the terminal conditions continue to be covered outside of the hospice benefit, though CMS has stated that "virtually all" services at the end of life are "related" and the responsibility of the hospice.

The issue of nonhospice service use and spending for beneficiaries enrolled in hospice is a concern for several reasons. If some services intended to be covered under the hospice benefit are furnished outside of hospice, the Medicare program is paying twice for those services. Beneficiaries' out-of-pocket costs may also increase because nonhospice services generally involve cost sharing while hospice services do not. In addition, the fragmented coverage of related and unrelated services may be confusing to beneficiaries, their families, hospices, other providers, pharmacies, and Part D plans.

In our March 2024 report, we discussed findings from our interviews with hospice providers that suggested several factors likely contribute to nonhospice service use and spending among hospice beneficiaries, including the following: policy guidance on what services are "related" is broad, and providers vary in their interpretations of what is related; hospices' efforts to educate beneficiaries and families about the hospice benefit can be unsuccessful; and hospices report challenges coordinating with other entities (other providers, pharmacies, and Part D plans) and gaps in information flow.[9] Given the variety of factors contributing to nonhospice service use and spending, we noted that a range of policies could be explored to address these issues, including administrative, payment, or penalty approaches.

The recent rapid growth in nonhospice spending for hospice enrollees that CMS has reported underscores the importance of this issue. As such, the Commission views including nonhospice spending in a public SSVI measure as a positive step, both in terms of enabling more focused program integrity oversight and enhancing transparency for patients and their families so that patients can choose hospice care that is consistent with their preferences without facing undue cost sharing.

As CMS implements the SSVI, it may be useful to consider whether there are ways to ensure the index is well suited to identify concerning patterns across a range of providers. For example, measuring a hospice provider's nonhospice spending in aggregate may miss smaller hospice providers that have high nonhospice spending on a per patient basis but low aggregate spending because they serve smaller patient populations. Structuring the measure to adjust for size of patient population in some way might better ensure providers of all sizes with aberrant patterns could be identified and help avoid creating incentives for providers to remain small to avoid scrutiny. In addition, because the SSVI combines

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[8] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

multiple utilization measures with a single nonhospice spending measure, some providers with several hospice utilization flags but relatively low nonhospice spending could still have a low (i.e., favorable) overall SSVI score. CMS has released files with the provider-level SSVI score along with the utilization and nonhospice spending component scores and we encourage the agency to continue to provide that granularity so that providers with concerning patterns along either dimension can be identified and beneficiaries and their families have more information to support informed decision-making.

Our forthcoming June 2026 report will include a chapter on access to hospice and complex palliative services for beneficiaries with end-stage renal disease or cancer. That issue is distinct from the growth in nonhospice spending that is discussed above. Substantial and growing nonhospice spending for beneficiaries enrolled in hospice raises concern about some hospice and nonhospice providers unbundling services that fall within the hospice bundle—such as wound care and palliative medicines—resulting in higher cost sharing and fragmented care for beneficiaries and additional spending by the Medicare program. By contrast, our June chapter focuses on access to certain complex services such as dialysis, radiation, and blood transfusions that may be palliative for some hospice patients. It also considers whether Medicare's hospice payment system pays appropriately for such care and whether policy changes are warranted to improve hospice payment accuracy or address potential access concerns.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair