



Home Care Association of New York State

June 10, 2025

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1835-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: File Code CMS-1835-P, Medicare Program; Federal Fiscal Year 2026 Hospice Wage Index and Payment Rate Update

To CMS Officials:

The Home Care Association of New York State (HCA) is a statewide not-for-profit organization representing approximately 150 home care and hospice providers, allied organizations, managed care providers and individuals committed to the advancement of quality hospice and home care services in New York State.

On behalf of our hospice provider members that serve many of the approximately 50,000 Medicare hospice beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare Program Federal Fiscal Year (FFY) 2026 Hospice Wage Index, Payment Rate Update, and Hospice Quality Reporting Requirements proposed rule.

General Overview of CMS's FY 2026 Proposed Rule

CMS's FY 2026 proposed rule updates the Medicare hospice payment rates and aggregate cap amount for hospices serving Medicare beneficiaries in FY 2026.

In addition to the payment updates, the rule contains some proposed changes or revisions which HCA is interested in providing comments and in some cases recommendations that include the following:

- Inadequacy of the proposed 2.4% FY 2026 Hospice Payment Update.
- FY 2026 Hospice Wage Index Update and 5 percent cap on any decrease to the wage index.
- Face-to-Face (F2F) Encounter Attestation Requirements.
- Hospice Quality Reporting Program (HQRP), including implementation of the Hospice Outcomes & Patient Evaluation (HOPE) Instrument.
- Request for Information (RFI) on Advance Digital Quality Measurement (dQM) in the HQRP



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Proposed 2.4% FY 2026 Hospice Payment Update Percentage

By statute CMS is required to utilize the inpatient hospital market basket update (currently projected at 3.2% for FY 2026) less a productivity adjustment (currently estimated to be 0.8 percentage point for FY 2026) to arrive at the annual payment update for hospice services. As a result, CMS projects the hospice payment update percentage for FY 2026 to be 2.4%.

This value may change if more recent data becomes available prior to publication of a final FY 2026 hospice payment rule. The 2.4% update is generally in keeping with update values over the last 10 years, which have trended between 2.4% and 3.0%. While we understand that CMS has limited discretion relative to calculation of the annual payment update, we are deeply concerned that the projected payment update for hospice (as well as home health) provider members will be inadequate to address the accelerating financial demands that hospices have been facing over the last five years. HCA hospice members have voiced numerous issues that are creating these financial strains, including:

- Severe workforce shortages caused by caregiver burnout and other reasons associated with the previous pandemic.
- Increased costs related to outsourcing, recruitment and staff retention.
- Raising prices and other inflationary pressures such as the increased costs for supplies, drugs, personal protective equipment (PPE) and other items essential to the delivery of high-quality hospice care; and,
- Lower payments will further strain hospice operations and risks compromising patient access to quality end-of-life care.

HCA Comments & Recommendations

HCA is very concerned that the market basket update factor is not sufficiently sensitive to appropriately reflect the rapid financial changes and challenges that hospice and home care providers have experienced over the past 5 years.

General inflation, particularly in the healthcare sector, continues to be higher than historical norms. According to the U.S. Bureau of Labor Statistics (BLS), the medical care price index rose 3.1% over the 12 months ending April 2025.

Labor costs—which typically comprise the majority of hospice operating expenses—have been under extraordinary pressure. The hospice community continues to grapple with a nationwide healthcare workforce shortage and intense competition for skilled staff, including but not limited to nurses, social workers, aides, among other professionals, driving wages upward. BLS data indicate that wages, salaries, and employer costs for health care and social assistance occupations increased by 4.4% on average over the most recent year (12 months ending March 2025). This





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follows even larger wage growth in post-acute and home-based care settings over the past few years.

We believe that the significant workforce challenges and other cost inputs being experienced by hospices warrant a higher rate increase that reflects the true costs hospices are facing and the value the program provides to patients, families, and taxpayers

HCA strongly encourages CMS to explore all options available to address the financial strains that providers are undergoing, including the following:

- Examine trends relative to HIS Global's forecasts to determine whether more recently available data than used for the final FY 2026 rule would result in a higher market basket update and determine whether additional updates could be made during the course of FY 2026 to provide additional support to hospice and other providers, such as through a one-time adjustment.
- Direct various divisions of CMS to examine potential options for hospice regulatory relief, with a particular focus on policies that could help to address issues that contribute to the existing workforce crisis, including reductions in paperwork and more appropriate utilization of various clinical personnel.

Proposed FY 2026 Hospice Wage Index

Background

On July 21, 2023, the Office of Management and Budget (OMB) issued Bulletin No. 23-01, which updates and supersedes OMB Bulletin No. 20-01, issued on March 6, 2020. OMB Bulletin No. 23-01 establishes revised delineations for the Micropolitan Statistical Areas (MSAs), Combined Statistical Areas, and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSAs). CMS proposes to implement these revised delineations for FY 2025.

Then as part of the FY 2023 Hospice Wage Index final rule, CMS finalized a permanent approach to smooth year-to-year changes in providers' wage indexes by placing a 5 percent cap on all wage index decreases in future years, regardless of the reason for the decrease. Under this change, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

CMS also finalized that if a geographic area's prior FY wage index is calculated based on the 5 percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index in the prior FY. The 5 percent cap will be implemented in a budget neutral manner and would be applied after the application of the hospice wage index floor. If there is a 5 percent decrease from the previous FY's wage index value after the application of the hospice wage index floor, then the 5 percent cap on wage index decreases



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would also be applied. CMS will be analyzing the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

For FY 2026, the proposed hospice wage index would be based on the FY 2026 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022 (FY 2022 cost report data).

HCA Comments & Concerns

While HCA supports a cap on losses in wage index values, we believe that CMS should consider lowering the cap to 2.5 or 3% in order to protect hospice providers who are already operating with negative or razor-thin operating margins and who are still experiencing multiple negative consequences due to the pandemic, such as increased costs and loss of staff. New York has 15 CBSAs and, for FY 2026, CMS is proposing to decrease 6 CBSA wages indexes, with one reaching the 5 percent cap and three other CBSAs proposed to see decreases of -4.03%, -3.37% and -2.86%. This will certainly make serving Medicare hospice beneficiaries in these areas of New York more challenging.

Although CMS has repeatedly dismissed HCA's longstanding request for wholesale revision and reform of the hospice and home health agency (HHA) wage index, we reiterate our support for more far-reaching reforms to the wage index methodology used under Medicare fee-for-service (FFS) programs.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting hospice and home health costs, particularly in states like New York, which has among the nation's highest labor costs and continues to increase.

Yet another ongoing concern for hospices and other small HHAs is the need for parity with other health care providers (i.e., hospitals, nursing homes, etc.) that draw from the same labor pool. While similar data is used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments).

This situation has already come to fruition specifically in New York's Albany-Schenectady-Troy Wage Index (CBSA 10580), where inpatient hospital facilities in this area have successfully appealed their wage index and CMS has implemented a Wage Index of approximately 1.20 for these providers, whereas hospice providers in the very same CBSA, are facing a proposed FFY 2026 Wage Index of 0.8556. This significant variance in the 10580 CBSA wage index makes it much more difficult for hospices and home health providers to recruit nurses and other professional and para-professional staff when hospitals can offer those same individuals a much higher salary and benefit package due to this large variance in Wage Index.



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HCA's Recommendations

The time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all providers have a level playing field from which to compete for personnel. Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation.

We encourage CMS to collaborate with stakeholders to address the shortcomings of relying upon hospital data to determine hospice payment rates.

Face-to-Face (F2F) Encounter Attestation Requirements

Section 3132(b) of the Affordable Care Act amended section 1814(a)(7) of the Social Security Act to add a new subparagraph (D). Subclause (i) of section 1814(a)(7)(D) requires that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a F2F encounter with a hospice patient to determine the patient's continued eligibility for hospice care prior to the 180-day recertification (implemented by CMS as the third and later benefit period recertifications), and prior to each subsequent recertification. Section 1814(a)(7)(D)(i) also requires that the hospice physician or NP attest that such a visit took place, in accordance with procedures established by the Secretary.

CMS is proposing to amend the regulations at §418.22(b)(4) to clarify that the physician or NP F2F encounter attestation must include the signature of the physician or NP who conducted the F2F encounter and the date it was signed. Further, CMS is proposing that the attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. CMS stated that these changes are to "realign" the regulatory text at §418.22(b)(4) with the original intent of the CY 2011 HH PPS final rule and the statutory requirement in section 1814(a)(7)(D)(i)(I) of the Act.

HCA's Concerns

While HCANYS understands the need for the F2F requirement for hospice patients in their 3rd benefit period or later, we are concerned about the proposal that the F2F attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled."

Historically, CMS has supported the ability of hospices to format their paperwork in a way that best meet the hospice's needs, rather than prescribing specific formats for hospice forms. HCANYS support this flexibility, especially in light of the administration's current focus on reducing regulatory burden. Especially in the age of electronic medical records ("EMRs"), our concern is that a hospice provider may timely complete a valid F2F attestation, but that, due to EMR errors or other administrative burden, it may not be included directly on the recertification form or may not be obviously titled as a F2F attestation. Hospices should not be denied payment for hospice services over such minor clerical issues when there is clear documentation that the



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F2F was completed timely.

Finally, we recommend that CMS allow a signed clinical note to serve as the attestation that the hospice physician or hospice nurse practitioner had a F2F encounter with that patient on a date specified to comply with the statutory requirements at 1814(a)(7)(D)(i). Further, we also believe it is unnecessary for the physician or nurse practitioner to attest that the clinical findings of that visit were provided to the certifying physician (42 FR 418.22(b)(4)). The regulations at 42 CFR 418.22(b)(3)(v) already require the certifying physician's narrative to include an explanation of why the clinical findings of the F2F encounter support a life expectancy of 6 months or less, meaning it would not be possible for the certifying physician to include this in the narrative if the physician was not provided with the clinical findings from the encounter (contained in the clinical note from the encounter).

Revisions to the Hospice Quality Reporting Program (HQRP) and the Hospice Outcomes & Patient Evaluation (HOPE) Tool

CMS is scheduled to implement the Hospice Outcome & Patient Evaluation tool (HOPE) on October 1, 2025, replacing the Hospice Item Set (HIS). The HOPE will be submitted via iQIES (internet Quality Improvement and Evaluation System), the new submission and processing platform for quality data. HCANYS very much supports CMS's Hospice Quality Reporting Program (HQRP), including the payment penalties for non-compliance, and recognizes the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. However, we have significant concerns about the potential for successful implementation of the HOPE tool.

The transition from the current quality reporting tool, the Hospice Item Set (HIS), to the HOPE tool is technically complex and represents a distinct change in the timing and content of the documentation of the care delivered to hospice patients; moreover, it carries significant financial risk for hospice providers. The HQRP is a "pay-for-reporting" program, which requires hospices to submit a high percentage (90%) of data records within a specified timeframe or receive an annual payment update penalty of four percent. This penalty is twice that of other providers and a significant impact for hospice providers as many are small, independent businesses a great deal of which are not-for-profit. Providers and technology vendors have shared that there is a lack of information and clarity necessary to have a smooth, successful transition to the HOPE tool and to the new platform, iQIES, required for submission of HOPE records.

Technology Vendor Preparation for HOPE

Many of technology vendors used by HCANYS members are not sufficiently prepared for the implementation of the HOPE tool because of delays outside of their control in necessary specifications and content. Hospice providers must utilize a third-party vendor to code the HOPE instrument responses. Vendors coding the HOPE responses are usually a hospice's Electronic Medical Record (EMR) vendor. These vendors report that necessary details for some of the data specifications were only recently made available (April 22, 2025) while other key pieces will not



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be available until September, which will be less than 30 days from HOPE implementation and will provide little time for essential programmatic testing.

Transition to iQIES

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

Historically, CMS has experienced delays in transitioning other provider types to the iQIES platform. Most recently, on March 25, 2025, CMS announced another delay in moving skilled nursing facility (SNF) surveys to the iQIES platform, with a previously scheduled February 2025 date delayed by an additional four months. The delay seems to be due to CMS moving the SNF surveys to the cloud-based version of iQIES. It is unclear whether hospices will also transition to this cloud-based version, and how the ongoing delays experienced by SNFs will affect the timeline for hospices.

iQIES Enrollment

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

Hospice Financial Impact of Transition

In addition to the ordinary financial burdens of a software transition and transition to a new data collection tool, hospices are especially vulnerable to an adverse financial impact of this transition, as hospices are held accountable to the data submission timeliness thresholds



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immediately upon transition to iQIES and implementation of the HOPE. Our colleagues at The Alliance previously recommended CMS finalize a policy to establish an incremental threshold for HOPE compliance over a three-year period. This request was consistent with the implementation of the HIS, and while many of the items are the same between the tools, the HOPE includes two additional time points and a potential of three symptom reassessment visits. This is a considerable change from the original two time points in the HIS and could lead many agencies to have issues in timely reporting of data. Unfortunately, CMS did not agree with this request and moved forward with requiring full 90% compliance on October 1, 2025. Given the issues The Alliance has outlined regarding information and training barriers and delays, HCANYS believes many hospices will struggle to meet these expectations, putting agencies at risk for a 4% annual payment reduction despite their best efforts. The consequence of adverse outcomes cannot be understated. The risk of negative financial consequences for hospice providers is largely dependent this year on the success of two transitions—iQIES and HOPE—that are not within their control.

Because of these issues, HCA recommends the following:

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

HCANYS remains committed to the Hospice Quality Reporting Program and recognizes the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. Our recommendation reflects our goal to ensure hospices are appropriately prepared to meet this important requirement and facilitate a successful transition without jeopardizing the timely delivery and accurate documentation of patient care.

Request for Information (RFI) on Advance Digital Quality Measurement (dQM) in the HQRP

HCANYS agrees with CMS' commitment to improving healthcare quality through measurement, transparency, and public reporting of quality data, and to enhancing healthcare data exchange by promoting the adoption of interoperable health information technology (IT) through Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standards. We also agree that the use of technology utilizing such standards within the HQRP in the future could potentially enable greater care coordination and information sharing, which is essential for delivering high quality, efficient care and better outcomes at a lower cost.

However, HCANYS was disappointed that hospice agencies were not among the health care



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providers that were incentivized to adopt The Office of the National Coordinator for Health Information Technology (ONC)-certified Health Information Technologies (CEHRT), we encourage CMS to assist hospices and home health agencies in their pursuit of interoperability and the development of strong business cases for health information exchange. However, despite this wish to share health information quickly and easily across care settings, many hospices today still lack truly interoperable health information technology (HIT) and electronic health record (EHR) technology systems. The absence of dedicated federal investment to support and incentivize Post Acute Care (PAC) provider adoption of these tools is the primary reason that hospices (and other PAC providers) fall so far behind hospitals, other acute care settings, and physician practices in the use of interoperable data-sharing technologies.

While we understand that Congressional action may be needed for major new funding to incentivize more hospices (and other PAC providers) to adopt interoperable HIT, **we implore CMS to use its existing authority to support hospices' ability to purchase, implement, and maintain HIT that facilitates interoperable data exchange across all care settings.** Especially if CMS intends to require that hospices use certified electronic health record technology (CEHRT) in the future, it will be necessary to invest upfront financial and technical assistance resources in order to ensure broad adoption and successful implementation.

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

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

Before CMS requires hospices to collect, share, and/or report on data supporting interoperable quality measures, it must take steps to help hospices procure the tools necessary to make these efforts feasible and meaningful. And while helping hospices develop and implement interoperable systems that support this type of data sharing, it is not sufficient to achieve CMS' goals. **CMS must also begin to set more specific expectations for hospices (and other PAC providers), as well as HIT and EHR vendor organizations, regarding data collection and**



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sharing. Without a clear sense of how or if CMS plans to adopt more formalized HIT standards that govern this important process, there is a risk that, in the absence of guidance and education, individual providers develop their own unique approaches that make it extremely difficult for standards to be developed after-the-fact.

Conclusion

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS's consideration of our concerns and recommendations. I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,

A handwritten signature in black ink that reads "Patrick Conole". The signature is fluid and cursive, with the first name "Patrick" and last name "Conole" clearly legible.

Patrick Conole, MHA
Vice President, Finance & Management
Home Care Association of New York State, Inc.



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