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Dear Director Slater and Deputy Director Vontran:

We write to provide our initial feedback on a Bureau of Labor Statistics (BLS)-based alternative wage index methodology for hospice payments following our participation in the Technical Expert Panel (TEP) discussions facilitated by Abt Global, on behalf of the Centers for Medicare & Medicaid Services (CMS), on September 10, 2025. While we conceptually support a transition from the current pre-floor, pre-reclassified hospital wage index to a more hospice-relevant methodology, we have concerns about specific aspects of the potential methodology that require attention before CMS moves forward with rulemaking for a new hospice wage index approach.

Our organizations have long expressed concerns with the use of the hospital wage index for wage-adjusting hospice payments. The wage data used from hospitals is non-representative, as it does not accurately reflect the staffing rates and occupational mix specific to hospice care. Additionally, there is a clear mismatch in service distribution; while hospital service patterns are based on discharges, hospice care is measured in days of care. There are also notable geographic coverage differences - hospices typically serve much broader areas and encounter greater variability in labor pool locations compared to hospitals, further complicating direct comparisons or reliance on hospital-based metrics. Finally, while hospitals are permitted by law to reclassify into more favorable geographic areas for wage index adjustments, which allows them to offer higher wages to clinicians, hospices do not have this option. As a result, hospices face a competitive disadvantage when trying to attract and retain qualified staff.

While we have concerns with the current wage adjustment approach for hospice, there are several aspects of the current methodology that we believe are beneficial to preserve under an alternative wage index approach. These include the use of standardized wage area definitions based on Office of Management and Budget (OMB) area delineations, which promote consistency across regions. The annual wage index reduction cap of 5 percent is another important feature, as it helps maintain payment stability from year to year. Additionally, the hospice floor policy, which provides a 15 percent increase for wage index values below 0.8000, supports hospices in lower-wage areas. Any changes to the hospice

wage index methodology should be carefully evaluated based on the extent to which they introduce large year-to-year fluctuations in wage index values, as increased volatility could significantly disrupt budgeting and staffing decisions.

During the TEP discussion held on September 10, 2025, Abt Global presented an alternative wage index constructed using wage estimates from the Occupational Employment and Wage Statistics (OEWS) surveys from the BLS. The OEWS surveys are used to calculate estimated average hourly wages for a set of occupations across all employers and by geographic area. These all-employer wage estimates reflect the price of labor for specific occupations at not only hospices but also other health care providers that hospices compete with for qualified staff. The alternative approach presented by Abt Global calculated weights for each of the relevant occupations by estimating the labor mix of a typical hospice using information from hospice claims and the cost reports submitted by freestanding hospices.

Feedback on the Alternative BLS-Based Hospice Wage Index Methodology

The alternative BLS-based wage index approach presented by Abt Global has several positive features, but also multiple areas of concern that need to be addressed before CMS moves forward with any changes or formal proposal. Incorporating a hospice-specific labor mix offers a more accurate representation of the occupational categories actually found in hospice settings, improving the relevance of the data. Additionally, the use of more recent BLS wage data represents a modest improvement in timeliness compared to the data lag with hospital cost report data, allowing for wage index calculations that may better reflect current labor market conditions. The use of cross-industry data included in a much larger BLS dataset is also an improvement over using only hospital data for hospice wage index adjustment purposes.

There are several significant concerns with the alternative BLS-based hospice wage index methodology that require resolution. First, issues related to data representativeness and completeness raise questions about the accuracy of the alternative BLS-based wage index approach presented. Anecdotally, based on input from our members, approximately 34 percent of hospice wages were excluded from the calculation due to the omission of key occupational categories such as spiritual counseling, dietary counseling, medical records, volunteer coordination, and pharmacy services. Additionally, the categorization of hospice physicians under the broad "Physicians, All Other" label is problematic, as anecdotally hospice physicians are typically evenly split between Family Medicine and Internal Medicine. Furthermore, “Physicians, All Other” wage data is missing for 16 percent of counties, requiring substantial imputation and reducing data reliability. We also note that using hourly wage rates for home health aides from the BLS “Home Health and Personal Care Aides” category (31-1120) should be revisited as home health aides have specialized training for health-related tasks (e.g., monitoring vitals, assisting with the administration of medication, simple wound dressing changes, etc.) under the direction and supervision of a nurse that personal care aides are not qualified to perform. Hospices often compete with other occupations, like food service and retail, for entry-level home health aides.[1]

Second, there are concerns with the labor mix methodology. The use of unaudited cost report data introduces the risk of inaccurate allocations and potential data manipulation. In addition, the reliance on claims-based minutes for certain occupations does not accurately capture total paid hours or actual labor

[1] https://www.gao.gov/assets/gao-21-72.pdf

cost shares. Combining cost report data with claims data further complicates the methodology due to inconsistencies in data sources.

Third, the approach to weighting for purposes of imputing missing values and calculating national average wage rates needs further study and potential refinement. The current census population-based weighting approach likely does not align with how hospice services are distributed, and there is a mismatch between where hospices pay for labor (provider location) and where services are delivered (beneficiary location). Lastly, the exclusion of contract labor costs from BLS data fails to account for a significant portion of hospice labor expenses, undermining the completeness and accuracy of the wage index.

We recommend improvements to the alternative BLS-based hospice wage index methodology. The occupational categories used in the alternative wage index calculations should be expanded to include all relevant hospice positions, particularly those involved in direct patient care (e.g., chaplains). Physician categorization should be revised to reflect the typical hospice blend, anecdotally Family Medicine and Internal Medicine, rather than using the overly broad "All Other" category which is also missing 16 percent of the time. Additionally, Abt Global should closely evaluate whether population-based weighting versus hospice days weighting using beneficiary location data derived from claims, more accurately reflects service distribution. Also, in calculating the national average wage rates, we believe the BLS has national wage rate data, so CMS should evaluate whether calculating weighted averages is even necessary. To improve data reliability, stronger integrity measures should be applied to hospice cost reports, including robust trimming and validity checks. This should occur prior to any formal introduction of them into the wage index methodology.

For longer-term structural improvements, several changes should be considered. Hospice cost reports should be revised to include full-time equivalent (FTE) reporting by contract versus non-contract staff, consistent with existing requirements for hospitals, dialysis facilities, skilled nursing facilities, and home health agencies. Claims data could be enhanced by requiring county code reporting using Value Code 85 with FIPS codes, allowing for more precise weighting based on where services are delivered. CMS should also evaluate how hospital reclassification policies impact the ability of other providers, such as hospices, to compete for qualified staff and consider policy approaches to help hospices and other providers compete more effectively with hospitals for staff in these higher wage areas. Finally, CMS should evaluate whether the hospice wage index floor policy should be modified given the policy goal of providing additional support for providers operating in low-wage regions, helping to ensure continued access to care.

Implementation Considerations

Implementation of any changes to the hospice wage index should be approached with careful consideration to ensure stability and transparency, including publicly publishing the methodology and resulting wage index values before notice and comment rulemaking to allow all providers to share feedback. This includes being transparent about the wage index values produced using the BLS-based approach before and after the application of the 5% cap on wage index decreases. During the transition period from using the hospital wage index to a BLS-based wage index for hospice, several protections should be put in place. These include implementing an aggregate cap hold-harmless provision to prevent significant reductions in overall payments if a hospice were to exceed their cap due to an increase in

their wage index, which is beyond their control. Additionally, the impact analysis by census region presented during the TEP discussion shows that CMS should carefully address the disproportionate effects of the BLS-based approach, limiting decreases to no more than 0.5% per year in any region to avoid destabilizing hospice care in affected areas. It is also important to assess the potential impact on state Medicaid budgets, as states must statutorily base Medicaid payment rates on the Medicare rates. Additionally, the revised methodology must be transparent, replicable, and capable of being validated by hospice providers.

To fully evaluate the alternative BLS-based wage index approach, additional data and analysis are needed. Specifically, it is necessary to examine the impact of a potential shift to hospice days-based weighting or using a BLS national wage rate on wage index values, and to compare labor cost shares derived from different data sources, such as from cost shares or eventual FTE counts following needed cost report changes. An analysis of missing data patterns and the effect of imputation is also critical to understanding the reliability of the alternative index. Finally, a thorough assessment of outlier impacts and changes in variance is required to ensure the new methodology produces fair and stable results across all hospice providers. Ample lead time before any changes to the hospice wage index are implemented is critical for hospices to effectively plan, adjust budgets, modify staffing strategies, and ensure continued access to quality care without disruption.

In summary, while we support the conceptual move towards a more hospice-relevant wage adjustment methodology, the current BLS-based approach requires significant refinement to accurately reflect hospice labor costs and service patterns. We strongly encourage CMS to solicit additional feedback, make necessary changes to the Medicare Hospice Cost Report form, address the methodological concerns outlined above, and provide additional data and analysis incorporating our recommended changes before moving forward with a new hospice wage index methodology in formal rulemaking. We appreciate the opportunity to provide this feedback and remain available for further discussion or clarification of these recommendations.

Sincerely,

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