



June 1, 2026

Administrator Mehmet Oz, MD
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1851-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS-1851-P - Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements; published at Vol. 91, No. 65 Federal Register 17338-17382 on April 6, 2026.

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Oz,

UnityPoint Hospice appreciates this opportunity to provide comments on this proposed rule related to hospice rates and quality reporting. Our parent organization, UnityPoint at Home, is the home health agency affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. Through more than 31,000 employees and our relationships with more than 420+ physician clinics, 35 hospitals in urban and rural communities, and 13 home care areas of service across our 8 regions, UnityPoint Health provides care throughout Iowa, central Illinois, southeast South Dakota, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through more than 8 million patient visits. As its home health arm, UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment (DME), pharmacy, palliative care, and hospice care.

UnityPoint at Home has long recognized the importance of hospice services for our patients. UnityPoint Hospice is affiliated with 5 Medicare certified agencies in Iowa and Illinois and provides high-quality care in those service areas. In 2025, UnityPoint Hospice provided 121,000+ patient care days. In addition, we are committed to payment reform and are actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is participating in the Home Health Value-Based Purchasing (HHVBP) model in Iowa, was a former CMMI Medicare Care Choices Model (MCCM) awardee in three Iowa regions and was an accountable care organization (ACO) Participant in various CMS ACO models. The CMS Innovation Center found both HHVBP and MCCM reduced total Medicare expenditures, consistent with UnityPoint at Home's performance.

UnityPoint Hospice appreciates the time and effort of CMS in developing this proposed rule. **As a member of the National Alliance for Care at Home (The Alliance), we generally support the comments submitted by The Alliance to this rule.** Additionally, we respectfully offer the following input.

PROPOSED FY2027 HOSPICE WAGE INDEX AND RATE UPDATE

CMS proposes a FY2027 hospice payment update percentage of 2.4% (an estimated increase of \$785 million in payments from FY2026). This combines a 3.2% inpatient hospital market basket increase reduced by a 0.8 percentage point productivity adjustment. The proposed hospice cap amount for FY2027 is \$36,210.11.

Comment: UnityPoint Hospice supports increasing the market basket update, but a 2.4% increase is not enough to keep up with inflation and maintain wages for high-quality services. Costs for medications, medical supplies, equipment, labor, and travel continue to outpace the update increase. For 2025, healthcare cost increases averaged 12.7% for drugs,¹ 5.2% for supplies,² and 4.3% for labor.³ As a non-profit provider serving rural areas, this challenges our ability to serve rural beneficiaries because caseloads are smaller due to physical distance and travel and are not subject to economies of scale efficiencies. In the first four months of 2026, UnityPoint Hospice averaged 16.8 miles per home hospice visit across our 5 agencies, and one agency serves 14 counties. As gas prices have risen 40% since last year, this sharp increase was not anticipated and has disproportionately affected our costs.

We also urge CMS to reconsider using the hospital wage data for calculating the hospice benefit wage index. The inpatient hospital prospective payment wage index is not suitable for hospice or home health wage indices. CMS has other more appropriate wage information for these care settings. We appreciate that CMS has included a Hospice-Specific Wage Index Request for Information in this proposed rule, and we have provided more specific input there.

SERVICE AND SPENDING VARIATION INDEX (SSVI) & NON-HOSPICE SPENDING

In response to trends indicating a rise in non-hospice spending, CMS has developed a Service and Spending Variation Index (SSVI), using 9 metrics collected from claims data that can signal potential inappropriate utilization, quality of care, or compliance concerns. CMS seeks feedback on the metrics used to calculate the SSVI score as well as input regarding the threshold values and point assignments.

Comment: UnityPoint Hospice is concerned that this new tool does not differentiate inappropriate utilization, quality, and compliance concerns and is misaligned with the Hospice Care Index (HCI). SSVI is explicitly a surveillance tool designed to flag providers that deviate from expected patterns and may warrant review, while HCI is designed to approximate quality, focusing on whether key care processes are occurring. *Table 1 – SSVI and HCI Comparison* highlights some overlapping concepts and key differences, which are ripe for consumer/patient and provider confusion.

TABLE 1 – SSVI and HCI Comparison		
Topic	SSVI	HCI
Purpose	Risk detection	Quality measurement

¹ Tichy, E. M., Rim, M.H., Tadrous, M., Schumock, G.T., Cuellar, S., Johnson, T.J., Newell, M.K., Hoffman, J.M. "National trends in prescription drug expenditures and projections for 2026," American Journal of Health-System Pharmacy, zzag115, <https://doi.org/10.1093/ajhp/zzag115>

² For UnityPoint Hospice, supply costs per hospice day was over budget by 5.2% in 2025, which exceeded the 2025 baseline budget that estimated inflation of supply costs and was informed by our utilization of supplies for hospice patients.

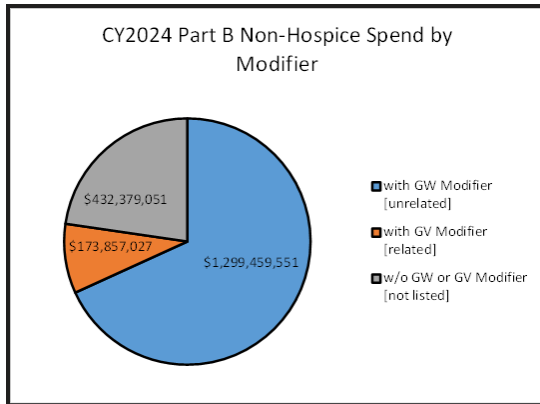
³ Labor refers to median base pay for health care staff positions. SullivanCotter, "2026 Health Care Staff Compensation Survey," <https://sullivancotter.com/surveys/health-care-staff-compensation-survey/>

Non-Hospice spend	Includes Parts A, B, and D	Spend = average hospice payments per beneficiary (proxy for length of stay)
Scoring		
• <i>Philosophy</i>	Penalty model (red flag index)	Reward model (quality achievement index)
• <i>Point range</i>	0-16	0-10
• <i>Interpretation</i>	“0” is ideal	“10” is ideal
Measure overlap		
• <i>Skilled nursing minutes</i>	Flags low performers (bottom quartile)	Rewards providers above a minimum threshold
• <i>Visits near death</i>	Flags lack of visits (no-visit rate high)	Rewards presence of visits
• <i>Live discharges</i>	Flags high rates (top quartile)	Penalizes only extreme values
• <i>CHC/GIP use</i>	Flags absence as potential concern	Treated as a quality indicator
Threshold approach	Distribution variation (25 th /75 th)	Outliers – fixed or benchmark-based
Endorsement	None	None

We urge CMS to pause use of this tool to collaborate with stakeholders. Among our suggestions:

- Reflect per-beneficiary spend in SSVI metrics, not total spend. As proposed, utilization disregards volume and patient census.
- Harmonize SSVI with HCl to clarify how they interact, if/why outlier thresholds should differ, and how potential public confusion can be minimized. UnityPoint Hospice offers suggestions to improve the HCl measure in this comment letter under “Hospice Quality Reporting Program (HQRP).”
- Validate the SSVI before implementation.
- Enable Hospice Agencies to manage their plans of care. Hospice Agencies are responsible for the totality of care for patients electing hospice (i.e. upon Notice of Election submission).

The last bullet is crucial. UnityPoint Hospice completely agrees that non-Hospice spend has spiraled out of control, but we have grave reservations with the methodology that CMS has selected to review non-Hospice spend. Foremost, **Hospice Agencies should not be penalized for non-Hospice spend that were not recognized by Hospice Agencies as unrelated to the Hospice Benefit.** As proposed, the SSVI will penalize Hospice Agencies for non-Hospice spend beyond their control. Without implementing the SSVI, CMS already has the tools to control non-Hospice spending. As the foundation, the Hospice Benefit provides that all items, services, and drugs should be the responsibility of the Hospice Agency unless a patient is assigned an Advance Beneficiary Notice (ABN) of Noncoverage that shifts financial liability to the patient. Hospice Agencies and other providers should be able to rely upon the Notice of Election (NOE) and submission to the Common Working File (CWF) as a trigger to commence the Hospice Benefit. The issue with non-Hospice spend and its growth lies with CMS payment approvals for items, services, and drugs outside the Hospice Benefit.



To illustrate the issue, we reproduced a graph from The Alliance comment letter based on the Dobson DaVanzo & Associates analysis of CY 2024 non-Hospice spend. Related Part B spend (with the GV modifier) represents 9% of funding – leaving more than 90% funding (over \$1.7 billion), which is potentially questionable. The Hospice InterDisciplinary Team (IDT) determines whether an item, service, or drug is related or unrelated to the Hospice Benefit, yet it is our experience that Hospice Agencies are often unaware when GV modifiers are attached to bills from non-Hospice providers. In reviewing the CMS SSVI 16

April 2026 file, our 2024 and 2025 utilization scores ranged from 0 to 2, while our non-Hospice spending score ranges from 3 to 6. Under SSVI, Hospice Agencies have little to no recourse. Instead, **we recommend that CMS deny all unrelated claims with GW modifiers that do not include Hospice Agency documentation confirming these unrelated expenses.** This approach would add minimal burden to Hospice Agencies, as we anticipate that most claims would not meet unrelated standards, and it would appropriately shift burden to providers seeking to claim unrelated expenses. As for the 22% (~\$432 million) of paid claims that have neither a GV nor GW modifier, we are at a loss to explain why CMS would approve those claims. **We recommend that CMS simply deny those claims without a modifier.**

While Hospice Agencies must submit NOEs within 5 days, there are instances when a NOE is not immediately visible to non-Hospice providers. Delays in the visibility of the NOE across the CWF, HIPAA Eligibility Transaction System (HETS), Transaction Reply Report (TRR), and related systems can leave non-Hospice providers without timely awareness that a beneficiary is under an active hospice election. In those instances, the non-Hospice provider with a denied claim could resubmit the claim with documentation that CWF did not show hospice enrollment and CMS should process under Medicare FFS.

PROPOSED MANDATORY HOSPITAL ELECTION STATEMENT ADDENDUM

CMS proposes to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for hospice elections beginning on or after October 1, 2026. CMS specifies timeframes to furnish beneficiaries with addendums and addendum updates and mandates addendum availability to non-hospice providers and Medicare contractors.

Comment: UnityPoint Hospice opposes this proposal to require the election statement addendum to be provided to each beneficiary at admission. We agree with The Alliance that the addendum is fundamentally a clinical communication document tied to the comprehensive assessment and evolving plan of care. The addendum was never intended to be a substitute for payment enforcement against a provider that submits a non-hospice claim, the beneficiary should not serve as a coverage liaison between the Hospital Agency and non-Hospice providers, and CMS has existing tools to enforce appropriate Hospice Benefit payments, both related and unrelated.

CLARIFYING REGULATORY TEXT CHANGES

To conform to recent hospice updates, CMS proposes to expand authorizing physicians for purposes of discharge from hospice care and revise requirements for face-to-face encounters furnished using

telecommunications technology.

Comment: UnityPoint Hospice supports these changes.

HOSPICE QUALITY REPORTING PROGRAM (HQRP)

CMS proposes several changes. Due to the newness of the HOPE assessment, CMS will consider all HOPE assessments with a target date in 2025 to be timely. CMS adds a new icon for the agency’s Medicare.gov Care Compare site to identify hospices that do not meet HQRP reporting requirements. CMS is currently considering changes to the Hospice Care Index (HCI) measure for inclusion in the 2026 Measures Under Consideration (MUC) list.

Comment: The transition to HOPE has required considerable time and effort from providers as well as our electronic medical record (EMR) vendors. We are pleased that CMS will consider all HOPE assessments with a target date in 2025 to be timely. As for inclusion of a new icon on the Medicare.gov Compare Tool, we request that CMS differentiate between Hospice Agencies that choose not to participate versus Hospice Agencies that submit complete data late.

CMS noted that the HCI measure is being considered for revisions. We applaud this effort. In its current form, we believe that **HCI contains the correct indicators and targets important aspects of hospice care; however, HCI scoring fails in that weighting given or scoring stratification do not accurately reflect the care provided.** For consumers, HCI fails to distinguish between high-quality and low-quality providers, and its top-heavy distribution does not effectively aid in making informed choices. Table 2 illustrates how HCI scoring masks quality of care discrepancies at two Hospice Agencies.

TABLE 2	Hospice A	Hospice B
HCI Score	10	10
Top Diagnosis	70.4% of patients have a primary diagnosis of circulatory or nervous system	66.5% of patients have a primary diagnosis of neoplasms, circulatory or respiratory system
Hospitalization Rate	3%	0.5%
Average Length of Stay (ALOS)	91.5 days	58.34 days
Mean Length of Stay (MLOS)	30 days	21 days
ALOS of Live Discharges	160.8 days	137.33 days
Burdensome Transitions, Type 1: Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission	9.3%	2.5%
Burdensome Transitions, Type 2: Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital	2.5%	0.8%
Percentage of Patient Days Provided in a Facility	83.13%	34.98%
Hospitalization Rate within 30 Days of a Hospice Discharge	5.2%	1.9%
Visits in the Last 3 Days of Life	Social Work: 0.51 Aide: 1.44 LPN/RN: 2.14	Social Work: 0.44 Aide: 1.39 LPN/RN: 2.24
Visits in the Last 7 Days of Life	Social work: 0.88 Aide: 2.8	Social Work: 0.82 Aide: 2.72

LPN/RN: 4.34

LPN/RN: 4.37

In Table 2, Hospice A and Hospice B have different patient populations with much different outputs, yet both hospices score 10 on the HCI. In this side-by-side, Hospice A should have a significantly lower HCI score than Hospice B. Hospice A represents a hospice that has a large population of lower acuity patients based on diagnosis category and a significant percentage (83.13%) of their care is provided to patients with 24/7 caregiving in a facility. Notables are the higher ALOS of live discharges, especially burdensome transitions, as well as elevated hospitalization rate within 30 days of a hospice discharge for Hospice A. These HCI indicators represent multiple behaviors that should prevent CMS from granting a perfect 10:10 HCI score to Hospice A. Collectively, these indicators could represent service which lacks after-hours nursing care that leads to patient hospitalization, provides inadequate nursing skill that requires patients to be hospitalized for symptom management, admits patients to hospice that do not have aligned goals of care with hospice philosophy, and/or discharges patients from hospice instead of incurring hospitalization expenses. At worst, the elevated rates of burdensome transitions or hospitalizations after discharge may point to diverting expenses back to the highest cost Medicare benefit instead of being managed by the Hospice Agency under the per diem (as expected when the Hospice Benefit was created). **UnityPoint Hospice urges CMS to revisit the HCI scoring methodology.**

REQUEST FOR INFORMATION – COMMUNITY PALLIATIVE CARE

CMS seeks stakeholder input on ways to enhance the provision of community palliative care outside of hospice care. CMS seeks to understand how Medicare providers currently support palliative care, how providers bill for these services, and where gaps persist are critical to strengthening community-based palliative care within today's regulatory and payment structure.

Comment: Palliative care is an important service focused on system relief and quality of life, but it is not synonymous with Hospice nor should it be limited to the Hospice Benefit. **CMS should recognize palliative care as a reimbursable service line for patients with chronic conditions within both the Home Health Benefit as well as the Physician Fee Schedule.** To include as a Home Health service, CMS should create a separate PDGM category for palliative care to establish a 30-day unit of payment and exclude those patients from the denominator of HHQRP measures. Under the Physician Fee Schedule, CMS should also consider a distinct service line, establishing standardized definitions, documentation requirements, and a bundled payment approach. Other considerations to meaningfully expand access to palliative care include authorizing telehealth service delivery and to remove barriers to interdisciplinary team payment, such as overlap with chronic care management billing.

REQUEST FOR INFORMATION – HOSPICE-SPECIFIC WAGE INDEX

CMS seeks stakeholder input on the construction of a hospice specific wage index. This includes input on source data for determining area wages, occupational mix weights, potential methodology constructs, and labor market areas.

Comment: For several years, UnityPoint Hospice has called out shortcomings with the current wage index based on the inpatient hospital prospective payment wage index. A transition to a hospice-specific wage index will be welcomed, but the proposed BLS-based approach needs significant refinement before being adopted. In September 2025, The Alliance discussed this topic with the CMS-convened Technical Expert Panel and offered concerns, recommendations, and implementation requests. On September 29, 2025,

The Alliance, LeadingAge, and the National Partnership for Healthcare and Hospice Innovation (NPHI) provided a more detailed “stakeholder letter” with input and recommendations to CMS.⁴ **UnityPoint Hospice urges CMS’ strong consideration of this stakeholder letter and its recommendations for incorporation into any future hospice-specific wage index.**

REQUEST FOR INFORMATION – MEDICAL AID IN DYING (MAID)

*MAID is considered an end-of-life option for terminally ill adults to self-administer life-ending medication prescribed by a physician in 11 states and Washington, DC, under existing State laws. Medicare funds, including hospice payments, may **not** be used to facilitate MAID, including physician consultation services, prescribing, or dispensing of medications used for the purpose of causing death, or assistance with the ingestion of such medications. CMS seeks information about any issues that may arise when a Medicare hospice patient requests MAID.*

Comment: As CMS considers future guidance in this area, UnityPoint Hospice encourages CMS to reiterate that:

- MAID is not a covered Medicare hospice service;
- Federal funds may not be used for MAID;
- Hospice Agencies may continue to care for beneficiaries who have elected hospice care and who inquire about, consider, or pursue MAID under state law; and
- Hospice Agencies may provide bereavement care for family and loved ones of beneficiaries that ultimately choose MAID.

There is a distinction between caring for patients who may consider MAID versus participating in the MAID process. The Hospice Benefit covers the former.

ADDITIONAL INPUT – TREATMENT OF PASS-THROUGH PAYMENTS IN IOWA

The hospice reimbursement for the Nursing Facility room and board and basic Nursing Facility activities is a pass-through payment. When the Hospice Agency receives Medicaid reimbursement, the Hospice provider forwards the payment amount to the Nursing Facility.

Comment: **Pass-through payments shift reimbursement from states to Hospice Agencies, is the “poster child” of administrative burden for Hospice Agencies, and results in some Hospice Agencies not partnering with nursing facilities for hospice services.** Hospice Agencies are required to collect and pay the room and board component for patients who rely on the Hospice Benefit through Medicare but rely on Medicaid payment for their custodial care. As a result, Hospice Agencies are contracted with nursing facilities to pay this room and board pass-through regardless of when or whether Medicaid payment is made. As a result, Medicaid payment to Hospice Agencies for the room and board component has been inconsistent at best. **For UnityPoint Hospice, 36% of our hospice accounts receivable exceed 120 days due to outstanding room and board payments from Managed Care Organizations (MCOs) and state Medicaid programs in Iowa and Illinois.** As UnityPoint Hospice waits for reimbursement, we continue to pay facilities as their invoices come in. This creates a Hospice Agency cash flow issue in the short term and collection concerns overall. For care delivery, these are dollars we could be putting towards comfort

⁴ <https://allianceforcaareathome.org/wp-content/uploads/Letter-to-CMS-Regarding-Hospice-Wage-Index-Reform.pdf>

therapy and services for our hospice patients.

This delayed reimbursement is often exacerbated by a lack of understanding by MCOs of hospice coverage requirements. There is an overall failure of coordination between MCOs and state Medicaid agencies on hospice eligibility, facility rates, and client participation, resulting in incorrect payments to Hospice Agencies and increased administrative workload for a process where Hospice Agencies are the intermediaries. The burden is shifted to Hospice Agencies to coordinate with nursing facilities to administer billing and pass-through payments.

CMS should consider allowing room and board payment to be streamlined and managed directly between the state Medicaid program and/or MCOs and the nursing facilities. We urge CMS to eliminate or relax the federal requirement for the hospice room and board pass-through. This would enable each state to determine the best path forward for the coordination and payment of Medicaid nursing facility room and board when a patient is under hospice care. Presently, this federal mandate ties the hands of state policymakers and agencies in evaluating optimal and timely payment options for their state Medicaid program, nursing facilities, and Hospice Agencies.

We are pleased to provide input on this proposed rule and its impact on our patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,



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