AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

June 10, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1835-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; FY 2026 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements [CMS-1835-P]

Dear Administrator Oz:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Fiscal Year (FY) 2026 Hospice Wage Index and Payment Rate Update proposed rule. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below:

1061 American Lane, Suite 310, Schaumburg, IL 60173-4973 • 847.375.4712 • Fax 847.375.6475
aahpm.org • palliativedoctors.org • info@aahpm.org

- **FY 2026 payment update.** CMS should pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2026. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, CMS should work with Congress to address this need.
- **Admission to hospice care.** CMS should finalize its proposal to update regulations to clarify that, in addition to the medical director or physician designee, the physician member of the hospice interdisciplinary group may also determine admission to hospice care.
- **Face-to-face attestation requirements.** CMS should finalize its proposal to update regulations to clarify requirements for attesting to the completion of the face-to-face recertification visit.
- **Hospice Outcomes and Patient Evaluation (HOPE) tool.** CMS should delay implementation of the HOPE tool for at least 1 year, as well as delay public reporting of measures that rely on HOPE data, in order to ensure that public reports reflect actual hospice performance.
- **Digital quality measurement.** CMS should work with Congress to secure funding for a new incentive payment program that supports hospices in adopting certified electronic health record (EHR) technology (CEHR)T. Until such time that hospices receive such payments and have sufficient time to adopt modernized systems, CMS should refrain from imposing new CEHRT-related requirements on hospices, such as through quality reporting programs. And when that time comes, CMS should adopt a transparent, thoughtful, and long-term transition that offers sufficient lead time for preparation and minimizes burden.
- **Potential future measure concepts.** AAHPM agrees that the adoption of one or more measures addressing the concept of well-being could be beneficial in supporting high-quality patient care for hospice patients, and we offer suggestions for potential measures in our comments below. However, we question the need for a measure addressing nutrition. Finally, AAHPM encourages CMS to explore mechanisms to collect quality data directly from hospice patients, rather than only from family members and caregivers.

Proposed FY 2026 Hospice Payment Update Percentage

CMS proposes a net hospice payment update percentage of 2.4 percent for FY 2026. As with previous years, AAHPM continues to hear that the proposed payment update is insufficient to keep pace with hospices' rising costs. To begin, hospices continue to report increased costs associated with recruiting and maintaining staff with the experience and training to support hospice care. These challenges are exacerbated by the fact that hospices must compete with other major health care employers in their markets for the same pool of candidates, including hospitals and health systems with substantially more hiring resources at their disposal. As a result, hospices must increase compensation to retain qualified physicians and clinical staff, contributing to sustained increases in costs. Furthermore, hospices' revenues are also challenged by reductions to Medicare payments under the Medicare Physician Fee Schedule, which often help to offset the costs associated with hospice physicians' services. Troublingly, Physician Fee Schedule payment rates have decreased by more than 10 percent since 2020, and the effects of these reductions are passed on to hospice providers. ***AAHPM therefore again urges CMS to pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2026. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, we also ask CMS to work with Congress to address this need.*** Protecting hospices' financial viability is critical for ensuring patient access to appropriate end-of-life care. Notably, hospice care is associated with reduced

rates of emergency department visits and readmissions,[1,2] which further underscores the value of hospice care and the importance of supporting hospice sustainability.

Proposed Regulation Change to Admission to Hospice Care

AAHPM supports CMS' proposal to update regulation text at 42 CFR § 418.25(a) and (b) to indicate that, in addition to the medical director or physician designee, the physician member of the hospice interdisciplinary group may also determine admission to hospice care. This change would align regulations with those at §§ 418.22(c)(1)(i) and 418.102(b), which specify that all three physicians may provide the written certification of terminal illness, which would help to provide clarity and consistency in regulatory requirements and protect hospices against inappropriate citations when physician members of the interdisciplinary group provide certification.

Proposed Clarifying Regulation Change Regarding Face-to-Face Attestation

Statute requires that a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with a hospice patient to determine the patient's continued eligibility for hospice care prior to the 180-day recertification, and prior to each subsequent recertification. CMS proposes to amend § 418.22(b)(4) to set forth that the physician or NP who performs a face-to-face encounter attest that the face-to-face encounter occurred, and the attestation must include the signature of the physician or NP who conducted the face-to-face encounter and the date it was signed. Further, CMS proposes 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.

AAHPM supports these clarifying regulation changes regarding face-to-face attestation requirements. Our members report that these requirements reflect best practice and align with how services are generally furnished. Furthermore, they are generally consistent with how hospices' electronic medical records are already programmed, so would result in little additional administrative burden.

Updates for the Hospice Quality Reporting Program

Hospice Outcomes and Patient Evaluation (HOPE) Tool Implementation

In the FY 2025 Hospice Final Rule, CMS finalized adoption of the HOPE tool, a new patient assessment tool, to replace the Hospice Item Set (HIS) in the Hospice Quality Reporting Program (QRP). Data collection through HOPE is set to begin October 1, 2025, and public reporting is scheduled to begin in the fall of 2027.

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[1] Kelley AS, Deb P, Du Q, et al. "Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay." Health Affairs, 2013. 32(3. https://doi.org/10.1377/hlthaff.2012.0851

[2] Holden TR, Smith MA, Bartels CM, et al. "Hospice enrollment, local hospital utilization patterns, and rehospitalization in Medicare patients." J Palliat Med, 2015. 18(7):601-12.

While AAHPM appreciates the benefits of transitioning to the HOPE tool, stakeholders have raised several challenges with the implementation timeline that raise concerns. A primary challenge is that technology vendors require additional guidance from CMS to effectively develop and update systems that support HOPE reporting. However, vendors have reported that some of this information will not be available until September, leaving them – and the hospices they support – with limited time to prepare. In addition, hospice providers would benefit further education and training on the HOPE tool, as well as additional time to familiarize themselves with data collection using the new tool and updated systems. With hospices facing a 4 percent payment penalty if 90 percent of data records are not received in a timely manner, the risks of moving forward with the current timeline are grave. ***Given these concerns, AAHPM recommends that CMS delay implementation of the HOPE tool for at least 1 year,*** or as long as necessary to ensure that vendors have sufficient time to implement necessary changes, and that hospices have sufficient time to receive training and become accustomed to utilizing the tool effectively and efficiently. Likewise, ***AAHPM recommends that CMS delay public reporting of performance on measures that rely on HOPE data, in order to ensure that public reports reflect actual hospice performance and not the challenges of implementing new systems.***

Request for Information (RFI) to Advance Digital Quality Measurement (dQM) in the Hospice QRP

CMS discusses its 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 (HIT) through Health Level Seven® (HL7®) Fast Healthcare Interoperability resources ® (FHIR®) standards." CMS also signals that it may in the future propose requirements around the use of such standards in the Hospice QRP – that is, for the submission of HOPE data. CMS also notes that it is considering opportunities to advance FHIR-based reporting of patient assessment data in settings that were not eligible to participate in the Medicare Electronic Health Record (EHR) Incentive Program, acknowledging that such providers may be at different levels of health IT adoption and readiness.

AAHPM appreciates CMS' interest in transitioning to the use of FHIR to collect quality data, which we agree would likely enable greater care coordination and information sharing. AAHPM also appreciates CMS' recognition of the disadvantage that hospice providers have experienced in achieving readiness to meet data exchange standards, namely as a result of their historic exclusion from the Medicare EHR Incentive Program. This oversight has led to few EHR vendors developing CEHRT that is applicable to hospice settings, and hospices being unable to make the substantial investments in core HIT necessary to support FHIR-based data exchange. AAHPM is therefore concerned that CMS is considering mandating the use of FHIR standards for submission of HOPE data; any such requirement would likely impose substantial costs to implement or upgrade HIT systems, which would serve as a significant barrier to success for many hospices across the country.

AAHPM cautions against CMS moving forward with FHIR-based data exchange without addressing these barriers. Instead, ***we urge CMS to work with Congress to secure funding for a new incentive payment program that supports hospices in adopting CEHRT.*** Such incentives would not only level the playing field and support hospices' quality assessment and improvement efforts, but also lead to improvements in interoperable data exchange that could facilitate seamless care coordination and more effective care management. ***Until such time that hospices receive such incentive payments and have sufficient time to***

adopt modernized systems, CMS should refrain from imposing new CEHRT-related requirements on hospices, such as through quality reporting programs.

Further, even when that time comes, ***we urge CMS to adopt a thoughtful, long-term transition that recognizes the burden and operational challenges providers experience in updating their EHR systems to support interoperable data exchange.*** CMS should undertake these efforts in a transparent manner that offers providers sufficient lead time for preparation and minimizes unnecessary burden on the provider community.

RFIs on Future Quality Measure Concepts for the Hospice QRP

CMS seeks input on the importance, relevance, appropriateness, and applicability of several measure concepts under consideration for future years in the Hospice QRP, including the concepts of well-being and nutrition.

AAHPM agrees that the adoption of measures addressing well-being could be beneficial in supporting high-quality patient care for hospice patients. The emphasis on mental, social, and physical health aligns well with a palliative care approach and would reflect on the extent to which care is being delivered in accordance with patients' and caregivers' needs, goals, and preferences. In particular, we believe that an assessment such as a distress thermometer could identify the extent to which patients' well-being is impaired as a result of psychological distress. Distress scales have been validated across different populations and geographies in measuring and quantifying levels of distress.[3,4,5,6]

We also call attention to the quality measure *Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood ("Feeling Heard and Understood").* This patient-reported outcome performance measure (PRO-PM) focuses on palliative care patients' experience and encompasses physical, mental, social, and emotional aspects of well-being. It was developed by AAHPM in partnership with the National Coalition for Hospice and Palliative Care (Coalition) and RAND Health (RAND) under a CMS-awarded cooperative grant (Cooperative Agreement #1V1CMS331639-01-00), and it is currently included in the quality measure inventory for the Merit-based Incentive Payment System (MIPS). We believe this measure could be readily adapted for the Hospice QRP to develop a clearer picture of the quality of care hospices deliver and the impact of such care on patients' well-being, and we would be pleased to share additional information on the measure, including evidence to support the measure's effect on improving quality of care processes in applicable settings.

However, AAHPM questions the need for or value of a measure focused on nutrition under the Hospice QRP. Notably, there is wide variability in how patients receive nutrition and what their nutrition priorities are in their overall plan of care when they are receiving hospice services. As a result, we question whether a measure would be meaningful across the spectrum of circumstances patients experience. To the extent that CMS does pursue a measure focused on nutrition, we suggest considering a measure

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[3] Donovan KA, Grassi L, McGinty H, Jacobsen PB. "Validation of the distress thermometer worldwide: state of the science." Psychooncology, 2014. 23(3):241-50.

[4] Baken DM, Woolley C. "Validation of the distress thermometer, impact thermometer and combinations of these in screening for distress." Psychooncology, 2011. 20(6):609-14.

[5] Ransom S, Jacobsen PB, Booth-Jones M. "Validation of the distress thermometer with bone marrow transplant patients." Psychooncology, 2006. 15(7):604-12.

[6] Mitchell AJ, Morgan JP, Petersen DP, et al. "Validation of simple visual-analogue thermometer screen for mood complications of cardiovascular disease: the Emotion Thermometers." J Affect Disord, 2012. 136(3):1257-63.

assessing whether patients or their caregivers have the information they need and/or sufficient support to address any nutrition-related concerns. Such an approach would not dictate specific interventions, but rather be flexible in how it considers patients' individual needs and preferences.

Finally, to the extent CMS moves forward with measures in the above domains, ***AAHPM encourages CMS to explore mechanisms to collect data from hospice patients, rather than only from family members and caregivers.*** While we recognize that there are often challenges with collecting data from hospice patients who are near the end of life, we highlight the importance of hearing directly from patients about their own experiences of care whenever possible.

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Thank you, again, for the opportunity to provide feedback on the FY 2026 Hospice Wage Index and Payment Rate Update proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,

Kristina Newport, MD, FAAHPM, HMDC
Chief Medical Officer, American Academy of Hospice & Palliative Medicine