



Shaping the Future of Home Care

California Association for Health Services at Home

June 1, 2026

VIA ELECTRONIC SUBMISSION

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS–1835–P, Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements

Dear Administrator Oz,

The California Association for Health Services at Home (CAHSAH) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services regarding the **Fiscal Year (FY) 2027 Hospice Wage Index and Payment Rate Update proposed rule** (Proposed Rule).

CAHSAH is a nonprofit association representing California's licensed home health, home care, and hospice providers across the state. Established in 1966, CAHSAH is one of the oldest and largest state home care associations in the nation with a long tradition of service dedicated to promoting quality home care and enhancing the effectiveness of the home care industry. Throughout the past 60 years, CAHSAH has supported cost-effective models of home and community-based care, fiscally responsible federal spending, and policies that strengthen care delivery for Americans. CAHSAH is dedicated to advancing policies that support care in the home for millions of Californians at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

CAHSAH writes to express concern that the proposed rule includes an inadequate FY 2027 payment rate update, relies on a Service and Spending Variation Index (SSVI) methodology that raises significant validity concerns, and would require the mandatory provision of the hospice election statement addendum to all beneficiaries at the time of election without sufficient justification.

Payment Rate Update

The proposed FY 2027 payment update is insufficient to address the increasing costs of delivering hospice care and does not adequately reflect the inflationary and workforce pressures facing hospice providers. As a result, it will continue to erode the financial foundation necessary to recruit and retain the clinical workforce on which terminally ill patients and their families depend. This is particularly concerning because Medicare fee-for-service (FFS) remains the primary payer source for hospice providers, accounting for approximately 90 percent of all hospice payments nationally (see: Medicare Payment Advisory Commission (MedPAC), *March 2024 Report to the Congress: Medicare Payment Policy*. Washington, DC.).

California hospice providers continue to face significant workforce recruitment and retention challenges, particularly among registered nurses, social workers, chaplains, home health aides, and other members of the interdisciplinary care team. At the same time, providers continue to experience inflationary pressures affecting wages, employee benefits, transportation, medical supplies, and other operating expenses. Payment updates that fail to keep pace with these rising costs threaten providers' ability to maintain access to high-quality hospice care, particularly in rural, underserved, and high-cost areas of California. Without adequate reimbursement, providers may be forced to limit service capacity, reduce investments in workforce development, or scale back operations, ultimately reducing patient access to timely end-of-life care.

Based on this, CAHSAH recommends the following:

- CMS should use the most recent data available to more accurately align the FY 2027 payment update with rising cost pressures and actual inflationary increases.
- CMS should explore all available avenues to address the forecast error shortfall, such as through a one-time adjustment.
- CMS should continue collaborating with stakeholders to address the shortcomings of relying on outdated hospital data to determine hospice payment rates, and to identify ways to achieve parity across provider types with respect to geographic area wage adjustments.

Service and Spending Variation Index (SSVI)

The SSVI adds an unnecessary layer of public data that does not align with existing sources, creating confusion for policymakers and beneficiaries rather than providing clarity. The SSVI incorporates several claims-based measures similar to those used in the Hospice Care Index (HCI) to generate scores intended to identify potential areas of concern among hospice providers. It is important to note that the HCI was not accredited by the National Consensus-Based Entity (NCBE) due to concerns regarding its methodology and validity. Issuing SSVI with similar and more flawed versions of the same measures will only create more complexity that fraudulent actors will be able to exploit.

Based on this, CAHSAH recommends the following:

- CMS should pause any use of the SSVI for targeting oversight efforts (including medical reviews, education, and potential investigations that could lead to payment suspension or revocation) until the Agency undertakes a transparent and collaborative review of the index's methodology with the provider community. CMS should also improve transparency regarding the development, application, and intended use of the index.

The SSVI contains fundamental validity problems that make it unsuitable as an enforcement tool in its current form. Using a flawed index to target hospices for investigation or administrative action risks causing irreparable reputational and financial harm to providers acting in good faith, while potentially missing the bad actors it is meant to find. CMS should take the following steps before using the SSVI for any enforcement purpose:

- Engage the provider community in a structured technical review before drawing any conclusions from SSVI scores. CMS should be transparent about how scores have been used to date so stakeholders can assess whether the tool is functioning as intended.
- Adopt statistically defensible outlier thresholds, such as the 1st/99th percentile, one or more standard deviations from the mean, or 1.5 times the interquartile range - replacing the arbitrary 25th/75th percentile cutoffs.
- Risk-adjust for volume and patient census, so that larger hospices are not penalized simply for serving more patients.
- Exclude externally compromised billing categories - particularly high-cost skin substitutes - from the non-hospice spending metric until CMS can isolate hospice-attributable spending from fraud originating elsewhere.
- Validate the SSVI against existing CMS compliance data before expanding its use or reliance as a beneficiary transparency tool.

Election Statement Addendum

Requiring hospices to provide an election statement addendum to all beneficiaries at admission does not address the underlying causes of non-hospice spending, which are largely driven by unsupported non-hospice claims and the lack of meaningful enforcement against those billing providers. This proposal substantially increases administrative requirements for hospices and creates additional confusion and paperwork for beneficiaries, while not addressing the root cause of inappropriate non-hospice spending.

Hospices do not submit claims on behalf of hospitals, physicians, pharmacies, laboratories, ambulance suppliers, or other non-hospice providers, and they do not control how those entities code, document, or bill their services. Yet CMS proposes to respond to increased non-hospice spending not by requiring the billing provider to substantiate its claim that care was unrelated to the terminal condition, but by requiring the hospice to furnish more paperwork to the beneficiary at admission.

CMS already has the regulatory and programmatic tools necessary to address the unsupported non-hospice spend directly. Medicare documentation policy requires that the provider submitting the claim maintain sufficient documentation to support coverage, coding, and payment. CMS guidance states plainly that if the medical record does not support the billed services, there is no basis for payment, and any resulting payment may be denied or later recovered as an overpayment. In other words, Medicare already recognizes that the party seeking payment bears the burden of supporting that payment.

Based on this, CAHSAH recommends the following:

- CMS should focus enforcement efforts on the providers submitting non-hospice claims and require those providers to maintain and produce documentation supporting the medical necessity and hospice-unrelated nature of the services billed. CMS should enforce existing documentation requirements before imposing additional administrative burdens on hospice providers and beneficiaries.

CAHSAH appreciates the Centers for Medicare & Medicaid Services' consideration of these comments. CAHSAH stands ready to partner with the Centers for Medicare & Medicaid Services in advancing hospice quality, protecting program integrity, and ensuring beneficiaries continue to receive timely access to high-quality end-of-life care. For any questions, please contact CAHSAH's Director of Policy, Advocacy and Public Affairs, Tanya Bautista, at: tbautista@cahsah.org.

Best regards,



Soua Vang, President & CEO
California Association for Health Services at Home