Medicare Hospice Wage Index

Technical Expert Panel Notes

Submitted by:

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About This Report

This report summarizes the content of the Medicare Hospice Wage Index Technical Expert Panel Meeting that was held at the Centers for Medicare & Medicaid Services on September 10, 2025.

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1. Meeting Overview

On September 10, 2025, the Centers for Medicare & Medicaid Services (CMS) and Abt Global convened a Technical Expert Panel (TEP) meeting to discuss potential changes to the Medicare Hospice Wage Index. The purpose of the meeting was to seek feedback from panelists on a proposed alternative to the current wage index, which would utilize new data sources. This work is part of an ongoing contract Abt Global has with CMS to analyze and support changes to the hospice payment system.

Members who participated in the TEP meeting are listed below:

Organization	Representative
Leading Age	Katy Barnett
Gentiva	Lori Braatz
Hospice of North Idaho	Shawna Cauley
California Hospice and Palliative Care Association	Sheila Clark
VITAS	Alex Fernandez
Harvard University	David Grabowski
Enhabit Home Health & Hospice	Jeanne Kalvaitis
The National Alliance for Care at Home	Hillary Loeffler
National Partnership for Healthcare and Hospice Innovation	Ethan McChesney
MedPAC	Kim Neuman
Essentia Health	Jill Rehl
Visiting Nurse Association Health Group	Robert J. Rosati
Amedisys	Michelle Ruff
University of North Carolina at Chapel Hill	Sally Stearns

1.1 TEP Feedback During Introduction

A TEP member asked if CMS was going to post a summary of the meeting on the website and whether TEP members would be able to provide further feedback after the meeting.

2. Overview of the Current Hospice Wage Index

Abt first described the current hospice wage index, how it is calculated, its range of values across providers, and some previously identified issues with its construction. Abt explained that wage indices across Medicare payment systems are intended to compensate for the disparate price of labor across localities. The wage index used for the Medicare hospice payment system is derived from the pre-floor, pre-classified hospital wage index. The hospice payment system adds its own floor and 5% cap on year-over-year wage index decreases within a geographic area. The wage index is incorporated into the final hospice payment rate through multiplication with both the labor-related share of payment and the per diem rates. This product is added to the product of the non-labor-related share and the per diem rate.

Abt explained how the wage index varies across Core-Based Statistical Areas (CBSAs) and rural areas, both of which are constructed from groups of counties. CBSAs are defined as core urban areas and surrounding counties with high levels of economic integration. Rural areas are defined as all counties outside of a CBSA within a state. Abt presented a map of the United States that distinguished, by color, counties located within CBSA versus non-CBSA areas. Abt went on to explain that the labor-related share of costs associated with a day of hospice service varies by level of care. In particular, the labor-related share is 66.0% for Routine Home Care (RHC), 75.2% for Continuous Home Care (CHC), 61.0% for Inpatient Respite Care (IRC), and 63.5% for General Inpatient Care (GIP).

Abt provided a series of tables and figures describing the empirical distribution of the FY2026 legacy hospice wage index values across CBSAs and rural areas. Abt displayed a table highlighting individual CBSAs and rural areas in key parts of the wage index distribution. Abt provided a histogram of wage index values that highlighted certain CBSAs and rural areas against the entire distribution of wage index values. Finally, Abt presented a heat map of the United States displaying the percentile rank of the wage index value in each CBSA and rural area.

Abt concluded with three concerns about the current hospice wage index that motivated CMS's alternative wage index approach. First, hospital wages may not reflect the wages faced by hospices for the same occupations. Second, the mix of occupations employed by hospices may be different than the mix employed by hospitals. Third, there is a significant time lag in the data used to calculate the hospital (and therefore hospice) wage index. Abt then gave an empirical example for two counties of how changing the occupational mix can dramatically change the final wage index values.

2.1 TEP Feedback on the Current Hospice Wage Index

- One participant said that RNs do not account for a lower share of labor in hospices compared to hospitals. Also, hospices cannot hire aides for less than $20 in Texas and were skeptical of the example wage data presented for the two CBSAs.
- A participant asked why Abt used California as an example, expressing doubt over its usefulness given California's minimum wage policies.
- There was concern that minimum wage changes may not be properly accounted for in the current wage index.

  - If higher minimum wages increase salaries for nurse aides, and the data informing the wage index are lagged by four years, then minimum wage increases will cause predictable discrepancies between the current wage index and actual salaries.

- There was a question from a participant about why rural Idaho and rural Montana have such different wage index values.
  - A different commentor mentioned that the wage index increased substantially in rural Montana over the past year.
- MedPAC and at least one other participant acknowledged the importance of having a hospice-specific occupational mix.
- One participant argued that some changes that are required by statute in other payment systems could be instituted by regulatory authority (e.g., reclassification).
- Participants noted that hospital reclassification hurts hospices by increasing cost of labor.
- A TEP member described a series of concerns over the current hospice wage index made in previous MedPAC reports.
  - Hospital wages are not necessarily representative of hospice wages.
  - High-wage index hospitals have seen their wage indices increase over time, and vice versa for low-wage index hospitals.
  - Occupational mix might be different between hospitals and hospices.
  - Intra-area variation in wages may be substantial in some cases.
- A participant noted that wage index cliffs between rural and urban areas make it difficult to serve rural areas when staff are primarily drawn from an urban area.
  - A different participant said that they do not think about wage index cliffs in the operation of their hospice.
- Multiple participants agreed that minutes on the claim do not fully track the time staff spend working.
- A participant voiced support for a wage index that would not need adjustments, like reclassification, to function properly and could instead provide a blanket policy for all hospices.
- One TEP member agreed with a 5% cap on wage index decreases but also advocated for a 5% cap on wage index increases.
  - Other TEP members agreed with the cap on decreases but not a cap on increase since wages have been increasing dramatically in recent years.
- A participant asked why the current wage index is not based on hospice wages instead of hospital wages.

- Participants generally agreed that adding a question to cost reports to collect wage data would be worthwhile.

- There was discussion across multiple TEP members on the unreliability of cost reports due to fraudulent providers.

3. An Alternative Approach: The BLS-Based Wage Index

This part of the presentation focused on an alternative methodology called the "BLS-Based Wage Index," which is constructed using wage estimates from the Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) surveys.

The key features and potential advantages of this new approach include:

- **More Timely Data**: The BLS data is more recent than the hospital cost report data used for the current legacy wage index. For example, a wage index for fiscal year (FY) 2027 could be built using BLS wage data from May 2025, whereas the current system would use data from FY 2023 hospital cost reports.
- **Hospice-Specific Labor Mix**: The BLS wage index uses a national labor mix developed from hospice claims and cost report data to weight the different occupations. This is an improvement over the current system, which is based on hospital data.
- **Relevant Cross-Industry Wages**: The model uses cross-industry wage estimates to better reflect the competitive labor market where hospices hire staff. This is considered an improvement over using only hospital-specific wages.
- **Methodological Consistency**: The proposed approach is similar to recent changes made to the Medicare End-Stage Renal Disease (ESRD) wage index.

It was noted that certain changes, such as reclassification and adjustments to the rural floor, are outside the scope of CMS's regulatory authority and were not part of the discussion.

3.1 Data Sources for the New Index

The construction of the BLS-based wage index relies on four primary data sources:

1. **BLS Occupational Employment and Wage Statistics (OEWS)**: This survey of over one million employers provides wage estimates for specific occupations at the national, state, metropolitan, and non-metropolitan levels.
2. **Freestanding Hospice Cost Reports**: These reports provide data on labor costs by occupation, which is used to help calculate the national labor mix. Only freestanding hospice cost reports are used to ensure cost accuracy, as facility-based reports may share costs with the larger facility.
3. **Hospice Claims**: Claims data provides information on the total minutes of care delivered by seven different disciplines (e.g., Registered Nurses, Aides), which is also used to construct the national labor mix.
4. **Census Bureau Population Data**: County-level population estimates are used to calculate weighted averages when aggregating wage data to the CBSA or national level.

3.2 Methodology for Constructing the BLS Wage Index

The fundamental calculation for a wage index is the ratio of the average wage estimate for a specific geographic area (a CBSA or non-CBSA rural area) to the national average wage estimate. The presentation outlined a six-step approach to calculate the final BLS wage index.

Step 1: Estimate a Blended National Labor Mix - The labor mix determines how much weight each occupation's wage receives in the overall calculation of the wage level for a geographic area. This method combines cost data for 10 occupations from hospice cost reports with minutes-of-care data for seven disciplines from hospice claims. Three occupations are available on cost reports but not on claims (Nursing Administration, Physician Services, Nurse Practitioner). Those three occupations accounted for 22.05% of costs on the cost report and their share of the labor mix was set to this percentage. The remaining 77.95% of the labor mix was allocated among the other seven occupations based on their respective shares of minutes from claims data.

Step 2: Determine Occupation-Specific, CBSA-Level Wage Estimates - The goal of this step is to establish an average wage for each of the 10 occupations in every CBSA and rural area using information from the BLS. This first involves mapping BLS wage data to counties and then imputing values where wage data is missing due to small sample sizes or data quality issues. A hierarchical imputation method is used, starting imputation with the most local data available (e.g., a state-level rural average) before moving to a national average if necessary.[1] After imputation, the county-level wage estimates are aggregated to the CBSA/rural area level using a population-weighted average.

Step 3: Calculate Cross-Occupation, CBSA-Level Wage Estimates - Using the labor mix from Step 1 and the occupation-specific wages from Step 2, a single weighted-average wage is calculated for each CBSA and rural non-CBSA area. This value serves as the numerator in the wage index calculation (Step 5).

Step 4: Calculate the Cross-Occupation, National Wage Estimate - This step mirrors Step 3 but on a national scale to produce the denominator for the wage index. First, a national average wage for each occupation is calculated by taking a population-weighted average of all wages for that occupation. Then, these national occupation-specific averages are weighted by the national labor mix (from Step 1) to arrive at a single cross-occupation national wage estimate.

[1] When constructing the BLS wage indices, Abt imputed a wage estimate for Physicians, All Other (29-1229) using the wage estimate for General Internal Medicine Physicians (29-1216) whenever possible. Of the 516 counties with a missing wage estimate for Physicians, All Other, 131 had a wage estimate for General Internal Medicine Physicians. There were wage estimates for 11 other physician specialties in the OEWS data that could possibly be used to impute for missing wage estimates for Physicians, All Other. However, for most of the physician specialties, the wage estimates are missing for more than two thirds of counties and are often missing whenever the wage estimate for Physicians, All Other is missing. There is a wage estimate for Family Medicine Physicians (29-1215) for 2,594 counties (80.5%) and of the 516 counties with a missing wage estimate for Physicians, All Other, 403 had a wage estimate for Family Medicine Physicians.

Step 5: Calculate the Initial Wage Index Values - The initial, unadjusted wage index for each location is calculated by dividing the location specific wage estimate (from Step 3) by the national wage estimate (from Step 4).

Step 6: Apply Final Adjustments - The final step involves several adjustments to the values from Step 5:

- **Recalibration**: The new BLS wage index values are adjusted to ensure their weighted average matches that of the legacy wage index, allowing for easier comparison.
- **Hospice Floor**: For any area with a wage index below 0.8000, the value is increased by 15%, up to a maximum of 0.8000.
- **5% Cap on Decreases**: A 5% cap is applied to limit any year-over-year decreases in a CBSA's wage index value relative to the prior year's legacy index.

Throughout the meeting, the presenters solicited feedback on the methodology, data sources, and potential alternative approaches, such as using hospice days instead of population for weighting, using different imputation methods, or using median wages instead of mean wages.

3.3 TEP Feedback on General Concerns Regarding the BLS Wage Index

- A TEP member asked if the BLS wage index was being proposed for any other Medicare benefit. Abt clarified that a similar approach has been used for the Medicare ESRD Prospective Payment System.
- TEP members wanted to see several variations of the BLS wage index and to compare those variations to understand how robust and stable the wage index is. These variations included constructing the BLS wage index using:
  - Several years of data (e.g., BLS wage index data for 2024, 2023, 2022, etc.).
  - Hospice days instead of population to weight wage information.
  - A trimmed sample of cost reports to remove outliers.
  - A set of hospices that are known to be high quality (either through star ratings, CAHPS, number of years in operation, etc.).
- TEP members also wanted to know what the impact on hospices overall, and by certain types (size, ownership type, geographic location, those with a high concentration of nursing home patients, those in rural areas, etc.) would be for the different options described above.
- One TEP member suggested using the ratio of the local costs for an occupation over the national cost for an occupation as a better way of determining relative cost differences for the wage index.
- One TEP member indicated the goal of creating a new labor mix using hospice specific occupations was a good goal. TEP members liked the approach in general, except for

some of the data sources that are used (e.g., using minutes on hospice claims to help construct the national labor mix).

- One TEP member indicated that the methodology for the BLS wage index is difficult to understand, and CMS needs to determine a good way to explain it. Making some changes, like using full-time equivalents (FTEs) for labor-mix, might make the methodology easier to explain.

3.4 TEP Feedback on BLS Data and Other Data Used to Construct the Wage Index

- A TEP member asked if the BLS data was more recent than the data used for the current hospice wage index. Abt clarified that the BLS data uses six surveys over the prior three years, with recent results weighted more heavily, which is timelier than the data used for the current hospice wage index.
- A TEP member inquired about the specific weighting for each survey (i.e., how much is one survey weighted versus another).
- One TEP member raised concern with the BLS data and whether there may be data quality issues in the future, or a lack of funding to collect it. There was concern that the BLS data may be unstable in the long run. Another TEP member was concerned with some of the initial BLS data being used, which included missing data for some occupations and areas as well as new data from the state of Colorado being temporarily unavailable.
- A TEP member requested that CMS make it clear and transparent which data was used to create the wage index so the hospice industry could validate the calculations.
- A TEP member wanted to know how the rural BLS data looked and whether there was much wage variation across different rural areas within a particular state. Another TEP member was interested in knowing BLS's rationale for determining the delineations for certain rural areas.
- TEP members indicated they would prefer that the most recent BLS data be used for rulemaking, even if that meant different versions of the BLS data would be used for the proposed rule versus the final rule.
- One TEP member indicated that using the BLS data for the wages made sense, even if those wages were not hospice specific. This was because the relative wages between occupations in the BLS data are likely similar to the relative wage between occupations in hospice specific data.
- The TEP questioned whether the BLS data adequately measured contracted labor wages.
- Some TEP members indicated that the hospice cost report information should be audited, as there might be fraudulent providers reporting inaccurate information. The TEP indicated that data from hospices that are known to be involved in fraudulent practices should be excluded.
- TEP members were concerned about using Census Bureau population data to weight wages that are available at the county level instead of simply using hospice days to weight wages.

- TEP members also indicated that county of service information could be reported on the claims, which would bypass issues with needing to use the population data in those years there are delineation changes for CBSAs.

3.5 TEP Feedback on Labor-Mix and Wage Information

- Multiple TEP members mentioned that although information on chaplain costs is not included in the construction of the BLS wage index, it is a very important aspect of hospice costs. They also indicated that although information on chaplain visits is not included in hospice claims, CMS should collect that information in the future.
- TEP members were concerned that using minutes on hospice claims to determine the labor mix of hospices was not representative of hospice costs, especially since the minutes on the claim do not reflect the non-direct patient care part of staff time. TEP members also indicated that the information shown regarding minutes on the claim does not represent their own hospices' FTEs.
- TEP members also indicated that breakdowns in cost should consider onshore (domestic workers) versus offshore (international) workers doing administrative tasks. They were concerned that not controlling for that difference would distort costs and the national labor-mix.
- Multiple TEP members indicated that hospice cost reports should contain FTE information for staff so that the calculation of the national labor-mix would be more accurate. TEP members indicated that FTE information would be straightforward to provide, since similar information is provided on the home health cost reports. TEP members recommended that contracted staff should be included in the FTE information.
- One TEP member was concerned that the labor category from the BLS used to represent administrative staff may be diluted by non-nurse wages. The point was made that in hospice it is more likely those administrative roles would be performed by a nurse.
- A TEP member suggested using the labor categories of "Family Medicine" or "Internal Medicine" from the BLS data instead of "Physician Other," as family and internal medicine better reflect the type of physicians working in hospice and so may lessen imputation needs.
- One TEP member indicated that CMS should consider a larger list of occupations to determine the national labor-mix. TEP members suggested that all the labor categories on the cost report should be used to determine the national labor mix (e.g., Spiritual Counseling, Dietary Counseling, etc.). TEP members were concerned that transportation costs might not be included when determining the labor-mix, but that those costs are important. TEP members indicated that even if a smaller list of occupations accounts for the variation in wages currently seen by hospices, that may not be true in the future and CMS should just use a larger list of occupations. The TEP thought it was important to include more information rather than less information.
- TEP members indicated some occupations like Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) did not make sense to include in the labor-mix because they are infrequently used in hospice. Other TEP members said hospices still need to provide PT, OT, and SLP. Since many hospices have contracts to provide those services, CMS should account for the costs.

- A TEP member thought it might be useful to study hospices that have inpatient units and to see what their labor mix looks like in comparison to hospices without an inpatient unit.
- A TEP member asked why only 50% of hospices seem to report costs for the category "Physician Services". Other TEP members indicated that some hospices may report their costs as "Physician Services" and other may report it as "Physician Administrative Services" and that overall, it is likely closer to 100% of hospices having physician costs in at least one of the two categories.
- One TEP member indicated that the imputation approach for areas and occupations with missing BLS wage information seemed to make sense, but it might be good to explore some alternatives (like a regression-based approach) to show whether the specific imputation approach made a significant difference in the construction of the wage index.
- A TEP member suggested using national wages from the BLS instead of weighting the CBSA and non-CBSA area wages by population (or using something else to weight, like hospice days).

4. Impacts on Hospices when Using a BLS-Based Wage Index

4.1 Impacts on the Wage Index

Abt walked-through several analyses describing patterns, trends, and findings from a simulated BLS wage index. Earlier presentations first provided an overview of how the current wage index works (see Section 2) and then walked-through how the BLS wage index would be constructed (see Section 3). The objective of the BLS simulation was to better illustrate implications of the described approach for the TEP.

Abt displayed a map with BLS wage index values nationwide (analogous to an earlier exhibit mapping the current wage index values). As with the current system, BLS index values are higher in the western areas, upper Midwest, DC into the northeast, Atlanta, and mid-Florida areas. This was followed by a table describing the distribution of BLS wage index values (showing particular percentiles and their associated CBSAs).

The next series of exhibits compared the current and simulated BLS wage index. It was clear that the BLS wage index values are higher on average (BLS mean average 0.9793 vs. 0.9340 current index) and Abt clarified this would not imply an overall payment increase as new wage indices are incorporated in a budget neutral manner (although individual hospices may receive higher or lower payments under one wage index versus another). There was also noticeably less variation in the BLS index. Abt noted that was not an objective of the BLS index but just a finding after the BLS methods were implemented. Less wage index variation in the BLS index was shown in both a table and a two-histogram figure (comparing the current and BLS index distributions). Abt also showed a distribution of the difference in current and BLS indices for each CBSA, noting that most CBSAs had BLS values within 10% of the current index.

Abt next provided a map showing where wage indices would increase versus decrease if the BLS were adopted. Areas with increases were the upper mid-west into the Great Lakes, upper New England, the Pacific Northwest, and southeast (especially Georgia). Areas with decreases were California, Nevada, Montana, the DC-Boston corridor, and many larger cities in areas otherwise receiving increases. Generally, it seemed that denser areas would incur a wage index reduction, and more rural areas would incur a wage index increase (these patterns persisted even after applying the floor and cap). Abt noted the calculated correlation between the current wage index and the BLS wage index is about 0.9.

4.2 Impacts on Payments

Wage indices are directly altered by the described methodology change, which by extension alters payments providers receive. Wage index changes imperfectly indicate actual payment changes due to labor share percentages, budget neutrality adjustments, floor and cap changes. To describe the financial implications more clearly, Abt presented results from payments that were simulated using the BLS methodology and claims from 2024 priced using the FY2026 payment parameters.

Abt began by showing tables with per diem rates under the current and BLS indices. As an example, under the current index, the FY2026 RHC rate for the first 60 days will be $230.83. If the BLS index had been adopted, the same rate would be $226.49. All other rates are lower under the BLS approach as well (since the BLS wage index went up on average, the rates must come down to maintain budget neutrality). Abt next showed histograms comparing

simulated FY2026 payments under both wage indices. As with the indices themselves, the payments from the BLS wage index showed less variation than the payments from the current wage index. Abt showed a histogram of the differences between the two payment amounts weighting by the total number of days, which illustrated that most per diem payments under the BLS index would be between within $20 of the current system.

Next, Abt showed a series of impact tables, which showed average percentage changes in total annual payment amounts if the BLS index were implemented. Highlights of the findings are as follows:

- *All hospices nationwide:* collectively no impact (due to budget neutrality).
- *Facility-based status:* freestanding hospices had no impact on payments, facility-based hospices had an average of a 0.7% increase in payments.
- *Tax status:* non-profits had a 0.7% increase in payments and for-profits had a 0.4% decrease in payments.
- *Geography (Census division):* Hospices in most divisions would average increases in payments, in particular South Central (Alabama/Mississippi) and South Atlantic, but especially in the outlying territories, where hospices averaged a 24% payment increase.
- *Urban/rural status:* As expected from the maps, urban hospices averaged a 0.3% decrease in payments and rural hospices had a 3.2% increase in payments.
- *Hospice size/volume:* Hospices with fewer than 3,500 RHC days annually had a 2.7% decrease in payments, hospices with 3,500-19,999 RHC days had a 1.2% decrease in payments, but hospices exceeding 20,000 RHC days had a 0.4% increase in payments.

Lastly, Abt showed that more hospices would have had had a positive impact on payments of 5% or more if the BLS were hypothetically adopted in FY2026 (n = 885) compared to if the current wage index continued (n = 75).

Following this discussion, the TEP provided feedback on the impacts as well as general feedback based on other topics discussed during the meeting.

4.3 TEP Feedback Regarding the Impacts on Hospices when Using a BLS-Based Wage Index and General Feedback

- Generally, the TEP thought reading too much into the results yet was premature, since the findings follow the methodological approach that was reviewed, for which the TEP had recommendations for revisions – in other words, because changing the method will change the results, they wanted the methods to be revised first, before the results were reviewed in earnest.
- One TEP member said the methods and approach made sense and were good, they just were more concerned about the data sources (i.e., using claims instead of solely using cost reports for the labor mix). When reviewing results, the TEP was more interested in the payments simulation than results describing the wage index changes.
- When showing results, Abt indicated that differences between the BLS and current indices were clustered near “0”; however, one TEP member noted that small changes in a

wage index adjusted per diem rate will add-up over many patients and service days. This feedback suggests future analyses should also account for total payments.

- One TEP member was interested in whether Abt could decompose how much various factors were leading to changes in the wage index values (e.g., how much having more recent data versus other parts of the methodology were driving results).
- The TEP questioned whether the national labor mix was truly representative of the labor mix of hospices, when the map describing wage index changes was displayed, members of the TEP hypothesized how a different mix may lead to different results. Some points that were raised included:
  - Outside of the staffing mix, one TEP member thought the rural/urban changes seen in the BLS wage index might be due to physician compensation differences in rural/urban areas and hospitals using more physician FTEs than hospices.
  - At another point, a TEP member suggested hospices are competing against hospitals for staff (in dense markets), and paying higher wages to do so, so using a non-hospital wage index would not always account for that increased competition.
- When looking at impacts, the TEP suggested CMS also consider Medicaid programs, which use Medicare rates in hospice. That is, any wage index change causing increases in payments may have an unintentional adverse impact on Medicaid.
- The TEP also suggested considering sites of service in impact assessments (e.g., whether hospices with a high percentage of hospice days in a nursing home are disproportionately impacted), impacts on the aggregate cap, and for CMS to consider a grace period in the wage index transition where hospices would be exempt from cap overpayments due to a new wage index.
- Some TEP members indicated a desirable characteristic of the wage index is that it should compensate for good care. If the methods do not directly take quality and value into account, impact tables should include quality metrics like CAHPS star ratings (some TEP members noted many hospices do not have CAHPS scores, so more general outcomes, such as live discharge rates, could be used instead).
- The TEP also brought up that CMS should consider:
  - Whether fraudulent hospices were impacting national staffing mix estimations.
  - Whether a floor (or cap for positive index increases) is needed.
  - Whether travel time and related costs were being accounted for in the BLS wage index.