



The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, DC 20515
Submitted electronically

Re: Comments on the discussion draft of the *Hospice Care, Accountability, Reform, and Enforcement Act of 2024*

Dear Representative Blumenauer,

Thank you for the opportunity to provide feedback on your draft legislation, the *Hospice Care Accountability, Reform, and Enforcement Act of 2024*. We thank you for your bold leadership in hospice and end-of-life care over the course of your career. That leadership is reflected in this draft legislation – through partnership with you and CMS over the past two years, we have made progress stemming the tide of fraud and abuse in hospice care. We submitted [34 program integrity recommendations](#) – some of which CMS has implemented, but more action is needed and this draft reflects that. Simultaneously, you asked us to provide you with ideas on the future of the hospice benefit. LeadingAge answered [that call](#) and we are thrilled to see many of our ideas reflected in this draft legislation. We look forward to continuing to work closely with you to strengthen the draft and move forward with reform.

LeadingAge represents more than 5,400 nonprofit aging services providers and other mission-driven organizations serving older adults that touch millions of lives every day. Alongside our members and 36 partners in 41 states (including our state partner in Oregon, LeadingAge Oregon), we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

PROGRAM INTEGRITY PROVISIONS

Section 2, Subsection (a). Mandatory Temporary Moratorium on Enrollment

LeadingAge supports the temporary moratorium on enrollment of new hospices and understands the rationale for making it nationwide.

We recommend that the conditions for exceptions be made more explicit in the legislative text. One concern our members raised is that access could be narrowly interpreted around the number of hospices that exist and their capacity. Our members could imagine trying to start a hospice in an area where they feel a quality option does not exist, even if there is not a dearth of actual providers.

Hospices could answer the following questions, based on what California put together in response to their licensure moratorium. The portion in red was added by LeadingAge due to feedback that sometimes, the goal would be to provide better *quality* care in an area that may have numerically sufficient hospices.

- The specific geographic area you plan to serve;



- Current hospice service availability in that area;
- Population demographics and projections;
- Evidence of unmet need (e.g., wait times, underserved populations; **other evidence that the existing providers are not delivering quality care even if there are sufficient numbers**);
- Your plan to address the identified gaps in service.

Some members suggested that Certificate of Need States (CON) be exempt from the moratorium. While we did not get consistent feedback on the CON issue, we do support that if CON states are exempt from the moratorium, the legislative text should be clear that if a state CON law were repealed during the 5-year time period, that state should be subject to the moratorium.

We support the proposal to revalidate all hospices, though recommend starting in the areas of greatest concern. We support the proposal on hospice ownership and control trends and the role of private equity in hospice. However, even though there is a process in place to correct demographic data including ownership it can take up to six months to process – and sometimes never is -- we suggest that CMS be instructed to prioritize these corrections so the cleanest data can be used for ownership and control trends.

We address the provision on prepayment review during the moratorium later in our comments – all of the audit/medical review provisions are grouped together for comment.

Section 2, Subsection (b). Authority to Extend Oversight of Newly-Enrolled Hospice Programs

LeadingAge supports this provision. We do not see why a PPEO would need to be active during the moratorium, but support CMS having this tool at their disposal after the moratorium ends.

Section 2, Subsection (c). Increase in Survey Frequency for Certain Hospice Programs

LeadingAge supports this provision. If CMS is behind on surveys, we fear a program remaining on the list waiting for a second survey and suddenly being up against a forthcoming standard survey – we could imagine a hospice being caught in a cycle of uncertainty and increased surveys unnecessarily. If the goal is for new hospices to receive 2 surveys in the first 5 years of their existence, we recommend that a program be allowed to graduate upon the completion of the second survey, if they did not receive any enforcement actions, and that the second survey marks the beginning of the timeframe for counting the next 36-month cycle.

We also recommend specifically defining what types of citations prevent graduation and how they would be counted. We recommend that programs be allowed to graduate if there are no condition level deficiencies cited on the quality-of-care conditions of participation.

Finally, we ask that CMS be instructed and funded to keep the QCOR system up to date, including a timeline for transitioning data from CASPER to QCOR, and to establish a better process to ensure the data is accurate, including allowing hospices to request edits that show inconsistencies with their own survey results.

Section 2, Subsection (d). Prohibition on Payment for Failure to Meet Quality Data Reporting Requirements



LeadingAge supports this provision. Given the high penalty, which is appropriate, we do recommend that potentially an extra layer of appeal is added to ensure that no hospice that is trying to submit data is left for a year without payment. Another potential guardrail could be that if the hospice has historically submitted quality data, they get an extra opportunity to amend their issue.

Section 2, Subsection (e). Independence of Attending Physician

LeadingAge opposes implementing this provision as drafted.

LeadingAge understands the intent of this provision and appreciates that physicians inappropriately certifying patients for hospice care – in fact, fraudulently certifying them – is a major concern of the Congress and of the Office of Inspector General. We note that we have heard about these issues in Los Angeles County and other areas with high incidents of reported fraud. However, LeadingAge is concerned that this provision, as written, would chill access to hospice which we do not believe to be consistent with the intent.

We outline below our concerns with the policy and how it might chill access and then propose some potential contours for solutions. We would ask to work with your staff to continue to outline the details of any solution but wanted to be responsive to the request to bring forth ideas that may achieve the same aim as the proposed policy.

Issues with the policy

1. Admissions from the community

As Mr. Blumenauer is well aware, despite a rise in utilization over time, 50% of Medicare beneficiaries never use hospice. Hospices have been working for decades to destigmatize end of life care and encourage people to elect hospice earlier. The most frequent phrase that our members here from their patients and families is “I wish we had come to hospice sooner.” Our members work in their communities day in and day out to explain, that if there is a person in your life – a patient, a family member, a church member, a neighbor – who is seriously ill and maybe in need of support – call hospice. Hospice will assess appropriateness and our members will either take the person on hospice, utilize one of their other programs (often philanthropy subsidized) like community based palliative care to serve the patient, or make an appropriate referral.

Often, these “self-referrals” or community referrals are not accompanied by an attending physician or a physician referral at all. Many of these people have not seen a doctor consistently in some time – they may not have a primary care doctor or other doctor who is particularly familiar with their case. They may have a specialist who sees them periodically or a number of specialists or simply goes in and out of the ER. If they are seriously ill, accessing care may have been a barrier to receiving it. In these cases, the hospice medical director often serves a dual role – as a hospice medical director and the attending physician. The hospice may add another practitioner on as attending after the person is enrolled. Some of our members reported that as high as 70% of their patients come to them with no attending.

We do not want people to stop calling hospice themselves and this provision as written would delay enrollment. It would also push even more “brink of death care” because these people who may have a community member or family member help with the referral may be waiting until an ER visit ends with a hospice referral – ER referrals are generally only for those very close to death.



2. “Conflicts of Interest”

Many of our hospices have contracted doctors in the community for a variety of reasons. In some states, corporate practice of medicine laws are such that hospice physicians set up their own medical practice and refer to hospice from that practice regularly. Physicians, especially those with hospice and palliative medicine expertise (whether a formal specialty or general experience) are in short supply so these physicians may be working in a practice but also serve as part time hospice physicians. In areas with particularly acute shortages, often rural, community physicians wear many hats – from nursing home medical director to FQHC doctor to oncologist. Our members need to contract with them as hospice physicians. These concerns are amplified in relation to employed physicians. We would be greatly concerned with a blanket policy excluding contracted and employed physicians from being the attending or from making a referral.

3. Referrals from the Hospital

Referrals from the hospital often come late in the game. As noted in the section on community admissions, any push that would increase the role of non-hospice physicians would likely delay hospice referrals. In the hospital, our members generally experience being called in to have the “hospice conversation” – others who have interacted with the patient prior to hospice getting involved are hesitant to do so. This is also true in the community, but given that hospital patients are often closer to death, the time between referral and admission in the hospital setting feels particularly fraught in terms of not delaying access. As we will discuss in our proposed solutions section, we could see a role for hospitalist, but it would have to be one that did not intersect with the role of attending. By the nature of their job, hospitalists are not well suited to be hospice attending physicians. There is also currently a probation on hospitalists signing the CTI.

4. Losing Access to Expertise and Pro Hospice Physicians

We have a member that contracts a hospice physician with specialty in neuropalliative care to work with their Huntington’s and ALS patients. This physician also makes a lot of referrals to said hospice. This type of behavior is good for patients and for the hospice – but would be lost if this policy were enacted as written. This is a particularly poignant example, but this would happen in many forms in communities across the country. The same concern arises with regards to referrals from palliative care physicians within the same organization – like inpatient palliative care specialists working in a hospital that owns the hospice.

5. Overwhelm

The general consensus from our members was that asking doctors in their communities to take any extra steps to get their patients to hospice would result in fewer referrals generally. If this policy went forwards as proposed, a mechanism to allow for these independent physicians to be reimbursed under Part B would have to be established in order to prevent some of the access concerns.

6. Fraudsters are going to commit fraud.

Our members are concerned that the policy as written will chill access and that fraudulent actors will still find a way around so that they will ultimately be faced with more burden and the policy might not be effective. For example, they’ll hide their kickback schemes in a new way while doctors pose as “independent.”

Alternatives



Better Targeting: In our 34 recommendations, we noted that CMS should establish red flags and share them with states and other oversight partners. We would like to note, upon looking at publicly available data, that CMS can see patterns that may indicate poor behavior. For example, in addition to being medical directors for large numbers of patients and hospices, fraudulent physicians also work with hospices displaying patterns such as:

- No burdensome transitions: while of course all hospices work to reduce burdensome transitions, no legitimate hospice has *none* or close to zero.
- High cost of care per beneficiary and long length of stay relative to state averages.
- Discharging between settings: Fraudulent providers are associating with both hospice and home health and patients are transferring between those settings – CMS should look at claims and see if there are claims being filed across both lines of business within a short period of time.
- Extremely high live discharge rate OR no live discharge: extremes indicate an issue. Extremely high live discharge rates are already an indicator that CMS looks at. However, some of the fraudulent providers are simply not discharging anyone alive because they have no intent to provide service so they never discharge. Consider the case of Anna written up in ProPublica. If Anna had never tried to seek a pacemaker, that hospice would have kept her on forever – they would not have bothered to live discharge her.
- High Risk Scores with low to no deaths: CMS calculates a risk score for each patient and then by agency - Hierarchical Condition Category (HCC) risk score of beneficiaries. This is reported in the PUF files.¹ Providers who have high risk scores with low to no mortality are a major red flag. A high-risk score indicates you are taking on patients who should be dying shortly – so huge numbers of those patients who are still alive at such a provider indicate a problem.
- No or low referrals from hospitals. There are high quality hospices who predominantly serve in nursing homes and assisted living – some of these are LeadingAge members serving their own campuses. But if there is a pattern of never taking referrals from hospitals or other community sources, this indicator should be considered in combination with others as a potential flag to take a closer look.
- Hospices that have low skilled nursing visits per routine home care day and high patient spend and long lengths of stay.
- Looking more closely at discrepancies in CAHPS and HCI scores. HCI scores should also be revisited to ensure they are capturing the scope of issues. For example, it is easy to get a “1” for providing GIP or CHC – because you get a “1” if you provide even one day of those services over 8 quarters of data.

There are other indicators that could be added to this “red flag” matrix. The legislation should instruct CMS to look at these indicators and others – including those submitted by stakeholders –

¹https://data.cms.gov/sites/default/files/2024-05/MUP_PAC_RY24_Methodology_2024_508.pdf



and focus program integrity action on these types of patterns first and foremost. CMS should also make it easier to look at these metrics through an easy to use, interactive interface such as is offered by private services.

This type of approach could lend itself to a pre-claim or prepayment review process. Our members do not feel comfortable with the concept of pre-claim or prepayment review given the current state of oversight. They would want to see the matrix and see CMS effectively implement a matrixed approach prior to any pre-claim or prepayment reviews going into effect. Their experience to date is that CMS simply chooses outliers on a particular metric and targets them and often, this targeting does not make sense. This pattern would have to change. But CMS should have enough information from these metrics to conduct effective, targeted audits.

Referring Physician Concept: If the existing data is really looked at appropriately, we believe that CMS could see trends of problematic hospices that might negate the need for the concept of an independent attending physician. However, if the intent is partially about a second opinion that the patient is truly terminal, we would recommend the following.

- **Distinguish “Attending” and “Referring” Physician.** Much of the issue with this provision stems from contemplating how you could get a second, independent physician to serve in that longitudinal attending role. It is simply not the experience of our members that there is a stable of nonaffiliated, truly independent physicians that are willing to serve in this role. Do not tie the idea of “independence” to the attending role in hospice.
- **Create a specific role called the “referring physician.”** This proposal would also need more work with staff to firmly establish parameters. However, in broad strokes, we envision something like:
 - Create a referral physician line on the claim where the hospice would be responsible for indicating who the referring physician is.
 - Referring physician’s referral must be documented by the hospice but it can done via a phone call – we do not favor a requirement for a wet signature unless the referring physician is signing the CTI.
 - Make the CTI signable by a hospice medical director/physician, an attending who is not employed by the hospice (but COULD be contracted with them), or this new category of referring physician. However, we would not want it to be mandatory that the referring physician sign the CTI – since many would not – but it should be an option.
 - If there is only one physician signature or no referring physician then CMS would create an exemption process where the hospice has to submit documentation as to why no referring physician or why a physician would not sign the CTI.
 - CMS should verify, through PECOS, all hospice physician relationships. We are looking into what, if any, changes need to be made to PECOS to do this, but we believe this is feasible. This could be reported publicly as part of the proposed transparency effort in the bill. Hospices could be required to have that list available



upon request and to submit it with recertification, but we hope to create a way that this could be tracked without hospices having to take an extra step.

- There would likely have to be coding modifications to ensure that referring physicians are not disincentivized from making referrals – for example, making sure that coding for a hospice referral does not prohibit billing for other services provided to that patient during the encounter.
- Remove the barrier that prohibits hospitalists from signing the CTI. Hospitalists should be able to be either the referring physician or the attending physician (though we imagine they would rarely be the attending).

Section 2, Subsection (f). Allowing Nurse Practitioners to Certify Terminal Illness

LeadingAge supports this provision. We would advocate that both APRNs and PAs could be the referring physician or the attending and could sign the initial CTI in those capacities.

Section 2, Subsection (g). Allowable Use of Supporting Material in Medical Review of Hospice Care

LeadingAge’s position on this provision is unclear because we need more information about how it would apply if the independent attending physician requirement were to change.

Given our comments around the independent attending physician, it seems like this proposal would have to evolve accordingly. Our understanding of this provision is that it was tied to the concept of the “independent attending.” Since we are proposing alternatives to that approach, we would like the opportunity to revisit this requirement with staff once a path forward on the independent attending concept is chosen. Otherwise, this provision generally reads to correspond with existing requirements – so we would want to understand if there were any other expectations associated with it.

Section 2, Subsection (h). Inclusion of Hospice Care as a Designated Health Service

LeadingAge supports the intent behind this provision but asks for modifications.

Our members are concerned about how Stark would be implemented in the context of hospice. Many of the concerns raised are similar to those raised around the independent attending physician. Hospices contract with a lot of providers in their communities who refer to the hospice program. Hospices may even employ physicians who do not work with hospice patients – for example, to provide palliative care or primary care services – but who frequently generate referrals. Our members want to be sure they can still rely on these important relationships, and these bona fide referrals intended to meet patients’ needs, without being in violation of the Stark law. We recommend that CMS be instructed that Congressional intent is to propose via notice and comment rulemaking how they would anticipate hospice fitting into the existing exceptions or propose a specific hospice related exclusion or clarification, if needed, that can address these issues and ensure that coordination and delivery of hospice services are not adversely affected. Additionally, hospices will have to engage in a detailed legal review, addressing a high number of relationships with physicians, to be sure they are in compliance with Stark. There should be time given for that – at least two years.



Section 2, Subsection (i). Prohibition on Certain Changes in Majority Ownership

LeadingAge supports the intent behind this provision but asks for modifications.

Once the moratorium is over, this could return to three years to align with other areas of Medicare. There should also be an exemptions process built into the CHOW provision. We can imagine a scenario where a new hospice or a CHOW occurred and the hospice is still struggling – and to ensure continued access, another CHOW needs to occur. We think that this scenario will not occur frequently but warrants the creation of an exemptions process – it could mirror that of the moratorium. We would also like to be sure that with both this provision and the moratorium, that there is no restriction on a hospice expanding its service area.

Section 2, Subsection (j)(2): Care Unrelated to the Terminal Illness

LeadingAge supports this policy but makes the following recommendations to strengthen it. Most of our recommendations in this area relate to our members' consistent experience that they have no insights into when unrelated care is taking place.

- Hospices should be held harmless from any payment disputes regarding unrelated care submitted by other providers – including payment recoupment.
- Hospices should not be required to update an addendum based on submission and approval of unrelated costs by other providers for which they have no knowledge.
- If the intent of this provision is to include unrelated items identified by the hospice as subject to prepayment review, the review should be only ONE time. If a hospice puts a drug on the addendum as unrelated, it needs to be approved for the duration of the hospice stay so the patient does not face barriers to getting the drug.
- After [2] years, CMS should be required to report, annually, on categories of unrelated submissions and their denials – and why they were considered unrelated and offer education to providers and suppliers on related and unrelated – this training should also be required of surveyors and auditors. We put the number of years in brackets pending technical assistance from the agency on feasibility.
- CMS should send hospices quarterly reports on unrelated claims for their patients and the resolution.
- This provision underscores the need for interoperability funding for hospices and other post-acute care providers. LeadingAge is part of the LTPAC Health IT Collaborative and we support the [recommendations](#) from this group.
- CMS should strengthen the Common Working File (CWF) system where the Hospice Notice of Enrollment (NOE) stops any other payment for services on those dates unless the provider billing non-related items uses a condition code or modifier that would indicate they overrode the barrier. The provider of that service should also be required to make a note detailing why the decision was made that the specific service was not related to the terminal illness during a patient's hospice election.



Section 2, Subsection (k). Required Provision of Addendum of Non-Covered Services

LeadingAge opposes requiring the provision of the addendum to every hospice patient. We hope that our approach to this draft overall shows that this was a provision that members genuinely felt strongly that we oppose.

Here is a quote from one of our members that represents the general tenor of our conversations around the addendum:

*“I foresee providing every patient with an Addendum causing confusion. There are a lot of misperceptions about what the Addendum is and is not, even among industry professionals. Our EMR, for example, produces an Addendum that includes (1) all diagnoses marked “unrelated” in the diagnosis list (fine), and (2) all **non-covered medications**, including those that are marked “Part D” (unrelated, fine) and those are marked “patient responsibility” (some are “related” but have no real benefit, but still wants to take, should not go on the Addendum). So, we can create a manual, an accurate Addendum, but to do this for all patients would impose a burden.*

I would like to know how other hospices are producing these, because I have heard some are having admission nurses fill them out on the spot when patients request them (writing “everything is related” and “nothing is non-covered”), before the comprehensive assessment is completed or the physician has reviewed to determine relatedness. If there is no existing strong practice or standard among hospices, then trying to create a wider application will not support the intended effect. Perhaps an exploration of whether these documents are being completed correctly and accurately now would make sense.”

Another point that came up frequently in conversation around the addendum was that they were rarely requested – so it seemingly is not something that matters to patients and families.

If we were to move forward with a universal addendum, the following changes would be helpful but do not outweigh member feedback that they would prefer to see this provision removed.

- Extend the timeframe for submission of the addendum until after the first interdisciplinary group (IDG) meeting has occurred – two weeks is probably sufficient.
- If the beneficiary died within those two weeks, do not require the addendum
- Remove the beneficiary signature requirement – this involves taking a manual document, filling it out, mailing it, and often not receiving anything back.
- Require CMS to provide technical specifications and support to make the addendum electronic.

Section, Subsection (l). Provision of Explanation of Benefits Upon Hospice Election

LeadingAge supports this provision.

We recommend the name of the hospice physician, attending (if there is one), and referring physician (if created and if there is one) appear on this form. Also, the beneficiary should be instructed to report any concerns with the EOB to the hospice but also be provided another source since, if the hospice is fraudulent, they won’t respond to beneficiary concerns, and the beneficiary will not get relief. The EOB should also include the phone numbers of the appropriate state



agencies to report fraud. There should also be a fast-tracked mechanism for beneficiaries to get a new Medicare identification number.

Section 2, Subsection (a)(1). Mandatory Temporary Moratorium on Enrollment – specific focus on the prepayment review proposal and **Section 2, Subsection (j)(1). Medical Review of Hospice Outliers**

LeadingAge supports the intent of these provisions but has concerns regarding the metrics and approach that CMS and its audit contract partners have taken to review in the past. We offer the following recommendations:

- We would recommend that the review in subsection (j) only start once the moratorium and its related audit outlined in subsection (a) have ended – we are looking to decrease audit burden and these two audits seem to have similar targets. We also note it is likely not the best use of CMS’ resources to run two similar audits simultaneously.
- CMS should be explicitly instructed that being an outlier on one metric does not necessarily make the hospice a good target for review. For example, they should not only look at a percentile outlier for long length of stay – a hospice who is an outlier in that regard but who performs well in other areas should not be an automatic target. We outlined some targets in our response to subsection (e) but there are more that could be identified.
- There need to be clear and transparent criteria for review to end or to graduate from review.
- These reviews should not look at general inpatient care (GIP), continuous home care (if it remains), or respite care – levels of care that are not well utilized and over scrutinized, particularly GIP.
- Contractors must be held accountable for sticking to timelines and keeping communication open. We hear from members that months pass, and the contractors simply do not respond. This would not be acceptable for prepayment review.
- If prepayment review is going to occur, backend audits on these claims must be eliminated.

Section 2, Subsection (m). Medical Review of Hospice Care Contractor Requirements

LeadingAge strongly supports this proposal. We suggest the following additions:

- It should be required of all personnel involved in audits.
- Stakeholders should be consulted in the creation of the training, particularly experienced hospice clinicians.
- The training should be publicly available.
- The training must be completed prior to an auditor starting to perform audits and other oversight.



- There should be training created that is for new auditors and also a refresher training – think like CEUs. If hospice staff must take a certain number of CEUs per year to keep up to speed, auditors and surveyors should have a benchmark to attain as well.
- The trainings should be reviewed regularly by outside experts to ensure it is still up to date.
- A rotating panel of hospice experts should be available to auditors and surveyors to submit questions to ensure their understanding – the process by which this occurs could be anonymous to ensure no bias.
- We suggest the following additional metrics for the audit report:
 - Contractors must report their timeliness in response – e.g. how long did it take them to respond in each step of the process of an audit.
 - Contractors should also report on their communications with audit targets. We hear complaints from members regarding the ability to communicate with auditors – both being able to get a response and where to ask questions/get clarifications.
 - Contractors must disclose what metrics were used in past audits and show why they thought these metrics were good targets.
 - Contractors must show a random sample of hospices audited in each audit and the total billings for that hospice. The goal would be to gain transparency into whether hospices were being targeted based on their revenue or because they were truly good targets for oversight.
 - After the completion of the report, CMS should be required to post information, annually, in a public and user-friendly way, on these metrics.
- For technical audits, we recommend hospices should have the opportunity to amend the mistake and still get paid – this would save the system a lot of time and money.

Section 2, Subsection (n). Requiring Face-to-Face Encounters Before Recertifications of Terminal Illness

LeadingAge supports the intent of this policy. However, we have found that the ability to utilize telehealth for face-to-face visits has been useful and we would like that flexibility to continue, including if a new recertification at 90 days is added. We propose the following guardrails in exchange for being able to conduct these visits either in person or via telehealth.

- Someone else from the hospice is in the home during the face-to-face (e.g. nurse, social worker, aide)
- The physician or provider performing the recertification participates regularly in that patient’s IDG so there would be knowledge of the patient. This could be documented with an agenda or roster of those who are participating in the IDG meetings.
- Allowing the new 90-day recertification to be completed up to 30 days prior to the recertification timepoint.

If this provision moves forward without the option for telehealth, we request that the face-to-face be billable rather than administrative.



Section 2, Subsection (o). Ensuring Medical Director and Physician Availability

LeadingAge supports this provision.

We would recommend defining “immediate” or saying what the intent is. We fully support physician availability 24/7, 365, but if immediate is meant to mean something more than that, we would want to discuss what that looks like.

We also recommend that the number of hospices that a medical director is able to oversee be slightly higher than 2. We recommend it be less than 5. Alternatively, or in addition, there could be a waiver process that allows CMS to approve a medical director to serve more hospices based on community need (e.g., if there is a physician shortage).

Section (3), Subsection (a). Adjusting Payments for Routine Home Care

Paragraph (1): Per Visit Proposal

LeadingAge supports the intent of this payment reform proposal and agrees that the current per diem methodology provides opportunity for profiteering in the benefit. Our members are wary of the per visit structure as they do not have all the information needed to access how it would work – some felt that it might be workable, others are not sure – but generally, we are not able to commit to a consensus position on that proposal.

Members were concerned about the source of the data to establish per visit rates – presumably the cost reports would have to be utilized in the creation of this new payment system – and there was consensus amongst our members that the cost reports are not accurate. In addition to ensuring better accuracy in reporting, there might be opportunities to consider amendments to the current cost reports and new cost centers that should be on the cost reports as we consider payment reform. For example, there could be buckets to reflect staffing for safety. We have members that send out extra staff in order to ensure staff safety and these costs are not reflected in the cost report. Given the higher utilization of technology, there may be a need to amend reporting around technology to ensure that the costs are fully covered.

Our members suggested that a tiered per diem reform could be considered instead of the per visit reform. CMS could consider “tiering” by setting of care and/or by length of stay (like a more intensive U-Curve). CMS could closely monitor high percentage of live discharges and revocations at per diem cutoffs points to red flags for oversight.

If the per visit model moves forward, we offer the following thoughts:

- In terms of a potential data source, we would ask that CMS be instructed to run multiple options – like for example, using Bureau of Labor Statistics data, cost report data, and any other variations that make sense and put those models out for notice and comment. We ask that CMS be instructed that getting the reform right is more important than the speed of the reform to ensure the best possible outcome. In this vein, our members generally thought that if per visit were adopted, they would want to see a base rate of a couple hours and the ability to bill for hours thereafter to give them the ability to maximize time with complex patients. However, they would want to see options for how the per visit could be structured, with the possible data sources, before committing to any approach.



- The per visit payments should be tiered based on the setting of care. There would need to be higher payments for at home patients – to account for drive time and not being able to see as many patients in a day as in a nursing home or an assisted living facility. Any proposed caps would also have to be varied to account for this difference to ensure access to home-based hospice care.
- Any proposed caps on services may need to have exceptions in order to preserve access to services and to avoid the optics of potentially “maxing out” hospice care.
- Chaplains should be billable – they are a core component of the hospice benefit and leaving them out of the per visit payment structure disincentivizes their use. The CMS HCPCS code committee established hospice chaplain codes for use in the VA and in Medicare Advantage, but we have not been able to get those codes added to the hospice claim form. If there is a list of disciplines for new per-visit payment amounts, chaplain and spiritual counselor should be added.
- The legislation should spell out that licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) could be billed per visit – not just an RN.
- If the service intensity add on remains as part of the new payment structure, CMS should be instructed to include physicians, nurse practitioners, LVN/LPNs, spiritual care professionals, and aides as billable professionals for that add-on and to count for the hospice visits in the last days of life quality measure.

Paragraph (1): Specified Hospice Services

LeadingAge supports this proposal with the following suggested modifications.

For the first five years, we believe that the reimbursement should be higher than what is currently proposed. We base this recommendation on a few facts. Members report that their costs for offering these services now exceed 200% of routine home care (RHC). One illustrative example:

“A patient was referred to hospice after receiving 6 years of treatment for recurrent metastatic cancer. Patient was admitted to hospice post-hospitalization for GI bleeding & pain due to metastatic disease invading the abdomen and a treatment-related colostomy site. After evaluation by the hospice physician and the hospice’s Radiation Oncology consultant, the hospice authorized a 5-day course of palliative radiation to reduce pain & bleeding and reduce the risk of impending intestinal obstruction. The treatment and transportation was provided within 2 weeks of hospice admission with the cost to the hospice for Radiation Oncology services was \$7,475. The hospice also incurred additional transportation costs.”

While there might be more opportunity to negotiate with a consistent reimbursement stream, the delta between what some are paying today and 200% of routine home care is very high and the legislation should reduce that delta to ensure more beneficiaries are accessing specified hospice services.

We imagine that one consideration was that the costs might vary amongst the four proposed services – for example, radiation might be more expensive than a blood transfusion. This might be true – but given that this is a proposal intended to increase access to hospice services, we would



advocate erring on the side of providing overpayment for some services to ensure that all are used. We also do not have insight into the universe of real costs – that is work CMS will undertake to create the outlier policy.

For these reasons, we recommend that the reimbursement rate for specified hospice services for the first five years be set at something like 500%-600% of RHC – closer to the GIP or CHC rates.

Paragraph (2): Plan of Care Oversight, Specified Hospice Services

LeadingAge supports this provision and makes the following suggestions.

We heard from multiple members that blood transfusions are important palliative interventions for diagnoses besides cancer. We recommend adding, at a minimum, primary care physician, nephrologist, and gastroenterologist to the list that can sign off on the plan of care for transfusions. Additionally, we ask that the phrasing around “significant ownership interest” and “significant financial interest” be narrowly defined – we understand that you are trying to prevent untoward referrals for unnecessary services. However, as written, it would likely be impossible for many hospices to contract to provide these services in their communities.

Paragraph (3): Removes coverage of home health aide services from the hospice benefit for individuals residing in a skilled nursing facility or nursing facility.

LeadingAge supports the intent of this provision and understands the concerns of the Congress and the OIG. However, our members have a few concerns. First, they were concerned about access to care – while it may be true that many of the duties of the hospice aide should be taken care of by the nursing home, that is not always the case. Our members note that sometimes the hospice aide carries out specialized tasks related to the palliation of the patient even in appropriately staffed nursing homes. Second, there are concerns that providers will continue to use aides even without payment – which is the environment many of our members operate in today and fear the imbalance would only increase without payment for aide services. We suggest capping aide services at 12 visits/month in nursing homes and creating a process to access more visits if appropriate for that patient.

Paragraph (4): Outlier Policy

LeadingAge supports the intent of the creation of an outlier policy to allow for more treatments and therapies to be offered as specified hospice services in the future. We are concerned that, as written, the caps would advantage larger hospices who could spread costs out over a larger hospice population. For example, one small hospice wanted to offer someone with a neuroendocrine tumor a high-cost drug that assists with palliation – our members told us that the drug they are thinking of costs about \$17,000/month. A small hospice would reach that 10% of total payments to their hospice with that one patient – or would never be able to offer a drug like that at all. A per hospice cap may not make sense for this reason but rather simply to have the cap on total hospice payments. We would also give the Secretary some flexibility to adjust that cap based on experience as real costs come in.

Finally, the outlier policies must be accompanied by instructions to create clinical pathways and ultimately, national coverage determinations that are created through stakeholder groups consisting of hospice and non-hospice clinicians. One theme we heard from members in discussing this policy was that the amount of treatment or therapy that might be appropriate for a



hospice patient might be different than a patient seeking curative therapy or treatment. For example, the number of fractions of palliative radiation appropriate for the patient in the example above might be different than if that patient were still seeking to cure their cancer. Establishing those guidelines collaboratively will help hospices have those conversations with potential partners. It will also help CMS in thinking about establishing payments.

Paragraph (5): Adjusts the cap amount in fiscal year 2027 to reflect the estimated percentage change in the total amount of payment made under this part for hospice care attributable to the amendments in paragraph 1, and also updates the cap amount from the previous fiscal year by the market basket percentage increase reduced by a productivity adjustment.

LeadingAge supports amending the cap to align with payment changes – but our comments in paragraph (1) may change how this provision would be written. We recommend adding a Medicare Payment Advisory Commission (MedPAC) report to the bill that looks at the effectiveness of the cap.

Section 3, Subsection (b). Wage Adjusting Caps.

LeadingAge supports this provision. We would ask that MedPAC be instructed to look at hospice specifically in its ongoing evaluation of a new wage index. We recommend restoring the rural floor to hospice so that no hospice is paid below the rural floor.

Section 3, Subsection (c). Modification of Requirements Relating to Short-Term Inpatient Care

LeadingAge strongly supports this provision.

We recommend the follow enhancements:

- Transitional respite be available to anyone with a preceding GIP stay at any time during the hospice stay. A high intensity change in a person’s condition is often connected to caregiver overwhelm and may signal a point at which the caregiver may consider other options. Being able to use transitional respite would be helpful in those considerations.
- We also recommend being able to use this benefit more often – potentially once per 6 months or once per year – to account for patients that may discharge from hospice and come back.
- If either of these recommendations are adopted, then the legislative language should be amended to reflect that transitional respite can be used outside of the first benefit period.

The legislative text should be amended to make it clear that an identified caregiver is not necessary to use transitional respite.

Our members felt that inpatient respite, as it exists today, should be allowed more frequently than once per benefit period. It is often how caregivers can sustain a patient at home. We recommend keeping it as it is now or creating a higher limit, like 2-3x a benefit period with the ability to authorize more respite if needed (e.g. a caregiver gets sick).



We recommend that the Secretary's authority around the inpatient cap be reversed so that the cap remains at 20% while the impacts of the changes to the inpatient cap take effect and that the Secretary be given the authority to lower the cap if necessary.

Section 3, Subsection (d). Hospital Discharge Planning Requirements

LeadingAge supports this provision. Hospitals play a crucial role in educating patients and caregivers on the availability of hospice services in their area and destigmatizing hospice use.

Section 3, Subsection (e). Payment for Respite Care Furnished in the Home

LeadingAge supports this provision. We would ask that it be clear that a hospice can use contracted staff to provide in-home respite care.

Also, we do not want to recreate the current billing issues related to continuous home care (CHC) and the definition of a "day." We ask that CMS be instructed that a hospice will be reimbursed fully in cases where the care occurs over 2 calendar days but within a 24-hour period (e.g. in-home respite starts at 10pm on Thursday and lasts until 7am Friday). We ask for this change to be applied to CHC as well if that level of care remains (we could see it being eliminated in a per visit environment, explained further below). We also would ask that Congress clarify that any member of the hospice team can provide the in-home respite if that is consistent with the patient's plan of care.

Finally, we ask that assisted living be a site of care for in-home respite. Since assisted living varies in what services are offered, there are people who are residing in an assisted living who are still receiving substantial help from family members. Since in-home respite is limited to one time per benefit period, it is less likely that it would be inappropriately utilized. We would support that the hospice has to document who is being relieved by the in-home respite care and that it would have to be a family or other unpaid caregiver, akin to the requirements for inpatient respite currently.

OTHER IDEAS NOT INCLUDED IN THE DRAFT

Congressional Intent on Timeliness vs Execution

We recommend instruction that Congressional intent prioritizes getting these policies *right* rather than done *fast*. While there are dates in the bill, if CMS does not feel the program or policy is ready, it can be delayed based on stakeholder feedback and/or their own assessment of readiness. The idea behind this recommendation is that we've learned from the SFP that pushing a program out because of time constraints may result in a good idea not being well executed.

Secret Shopper

We recommend that both the Center for Program Integrity and the Center for Clinical Standards and Quality receive funding to operate a "secret shopper program." Calling a hospice to try to get services with a standard set of questions would inform efforts from both of these Centers. For example, the data received could show that a hospice does not exist at all. It could also show poor quality of service and violations of the CoPs such as not offering DME, not having true 24/7 availability, and more. Hospices and others should be able to submit anonymous tips that could be investigated by secret shoppers (or the appropriate part of the agency).

Marketing Conditions of Participation

In our 34 recommendations from 2023, we included recommended changes to the hospice Conditions of Participation (CoPs) to address inappropriate marketing practices and provide



guidance to surveyors on reviewing marketing materials as part of the survey efforts. Many fraudulent hospices inappropriately market their services to individuals who do not qualify by simply excluding key details regarding hospice such as the waiver of curative care. Additionally, unscrupulous hospices use marketing to induce referrals and inappropriately compensate marketers for the recruitment of hospice patients who may or may not be eligible. We recommend including the following CoP changes in the legislation to address inappropriate marketing of hospice services:

Each hospice must develop a policy on ethical marketing practices that will be followed in all marketing materials. The policy must contain info on:

- Prohibition of kickbacks and inappropriate inducements for referrals (e.g. bonuses for longer stay patients or those more likely to be longer stay)

- Disclosure about any incentive compensation arrangements for marketers and any other incentive compensation arrangements.

Hospices must include a list of mandatory items in their marketing materials, including in an explanation of the hospice election statement:

- Clear explanation of waiver of curative care including differentiating specified hospice care from curative care

- Clear explanation of requirement for 6-month prognosis

- Clear explanation that hospice services are of palliative and not considered curative.

CMS should include interpretive guidance of these new CoPs as part of the State Operations Manual Appendix M.

Technical Expert Panel on Nursing Home and Hospice Intersection

Congress should instruct CMS to employ a technical expert panel on hospice and nursing home stakeholders to ensure that hospice CoPs and nursing home RoPs are aligned on key issues as well as giving representatives from both communities the opportunity to talk through clinical coordination issues and how the partnerships between these provider types could be strengthened.

Hospice Carved into Medicare Drug Pricing Negotiated Rates

As Medicare moves forward with implementation of the Inflation Reduction Act's authorities around negotiating high drug prices, we ask that hospice be included so that if we have a patient who is taking one of those drugs, hospices can access the negotiated rate.

Thank you again for your hard work on this draft and we look forward to continuing collaborations on this important, groundbreaking legislation. If you have questions or wish to discuss these recommendations further, please contact Mollie Gurian, Vice President, Policy and Government Affairs, at mgurian@leadingage.org

Cc Asha Samuel, Rachel Dolin, Hillary Loeffler