Hospice: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192) – Request for Information

June 2025

On January 31, 2025, President Trump issued Executive Order 14192 "Unleashing Prosperity Through Deregulation" that stated in part that for each new regulation introduced, federal agencies must identify at least 10 prior regulations to be eliminated. In response, the Centers for Medicare & Medicaid Services (CMS) issued a Request for Information on April 11 to assist in identifying regulations that could be considered for elimination from the Medicare Program.

LeadingAge submitted deregulation recommendations covering regulations for home health and hospice, Medicare Advantage, nursing homes, and Programs of All-Inclusive Care for the Elderly (PACE). What follows below are the LeadingAge recommendations for nursing home deregulation.

Streamline Regulatory Requirements

Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

Payment for Physicians, and Nurse Practitioner and Physician Assistant Services. LeadingAge recommends the Administration revise section §418.304 allow nurse practitioners to bill for services not described in paragraph (a) of such section in the same manner as physicians may bill for such services in accordance with paragraph (b) of such section. Such revision should provide that such services furnished by a nurse practitioner shall be payable at the percent of the physician fee schedule specified in section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395l(a)(1)(O)).

Currently, hospices are not allowed to bill employed or contracted nurse practitioner (NP) or physician assistant (PA) services for Part A unless they are the attending physician for that specific patient. Hospices are currently permitted to bill and receive payment for physicians who are providing this care either as hospice employees or under arrangement with the hospice. Hospices, on behalf of all physicians regardless of their employment with the hospice or attending status with a patient, can bill Medicare Part A when physicians provide services above and beyond what is covered in the hospice benefit. Our research has not identified any

statutory text that requires NPs or PAs to be the attending physician in order for the hospices they are employed by or contracted with to bill Part A on behalf of NPs or PAs, with the acknowledgement that any billing for those professionals would be at the Medicare allowable rate.

This unnecessary, and statutorily incorrect exclusion in the hospice regulations creates significant burdens on providers and limits their ability to be nimble and innovative in the way they staff and contract for services. For example, inpatient hospice units which serve the most critical hospice patients utilize NPs and PAs to support patient care. They are often rounding on patients when emergencies arise and, while they provide care above and beyond what is covered in the hospice benefit at § 418.304(a), the hospice is unable to bill Medicare Part A for the work of the NP or PA because they are rarely the patient's attending in the inpatient setting. The role of attending physician in hospice is meant to promote continuity of care that connects a patient's pre-hospice care into hospice. For example, attendings are often the patient's primary care physician who seeks to stay involved in the patient's care through the end of life.

LeadingAge requests revision of this regulation as it is inconsistent with statutory text and generally is a burden to hospices by not allowing them to utilize nurse practitioners (NPs) and physician assistants (PAs) to the full scope of their professional abilities.

Waiver of Core Services Dietary Counseling. Dietitians and nutritionists are a highly specialized service as evidenced by the training required and professional licensure/certification requirements. It is difficult for hospices to attract and retain dietitians/nutritionists as full time employees as they are often working infrequently since not every patient will require extensive nutritional support. This reality makes it difficult to comply with the requirement for an employed or contracted dietitian/nutritionist. Furthermore, CMS' interpretation of this condition of participation is not consistently upheld and enforced by survey entities.

The requirement to employ dietitians or nutritionists imposes unnecessary operational and financial burdens on hospice providers, particularly on small hospices and those operating in rural regions, and is inconsistent with existing statutory flexibilities afforded hospices. Specifically, Section 1861(dd)(5)(c) of the Social Security Act provides hospices a waiver of dietary counseling services if the organization is "located in an area which is not an urbanized area (as defined by the Bureau of Census), and (ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel." Despite this statutory waiver and unlike the waiver for nursing services, there is no condition of participation which outlines how a hospice can apply for a waiver of dietary/nutrition services. This Congressionally required flexibility must be added to the existing conditions of participation to elevate the burden placed on hospice to retain this staff.

LeadingAge recommends that CMS create a waiver for the requirement that a registered dietitian or nutritionist be employed by the hospice.

Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Hospice Transfer Billing Policy. Currently, under Medicare billing policy on hospice patients transferring between hospices requires the receiving hospice to wait for the transferring hospice to submit their final claim before billing their first claim. This is an unnecessary burden on the receiving hospices who must float the cost of patient care while the transferring hospice submits their billing. Issues with the first hospices billing could lead to a denial in the entire stay for a transferred patient but that would be unknown to the receiving hospice until it was too late. Eliminating this process would allow hospice providers to bill confidently for the services they are providing to patients and not risk their financial wellbeing while another entity outside their control works to finalize their payments. Delaying payments to the receiving hospice does not protect the health and safety of the patient, instead it could compromise their safety by reducing the funding available to support that individual.

LeadingAge recommends CMS amend the transfer billing policy for hospices which is a significant process burden for hospices and delays payment for critical care of patients.

Continuous Home Care Billing Policy. Medicare subregulatory guidance currently states that in order to bill for Continuous Home Care (CHC), hospices provide a minimum of 8 hours of care during a 24-hour day which begins and ends at midnight. This midnight to midnight definition is an arbitrary and burdensome standard for hospices to maintain. A continuous home care day as defined by 42 CFR 418.302(b)(2) is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in § 418.204(a) and only as necessary to maintain the terminally ill patient at home. It does not define the day as a 24 hour period starting at midnight. This arbitrary distinction means that if a patient's symptoms indicate the need for CHC beginning at 8 p.m. and the hospice provides continuous in-home care until 4 a.m., the care is not billable as CHC because the full eight hours were not within the midnight-to-midnight window since four of those hours took place before midnight. There is no discernable health or safety implications to eliminating this requirement of midnight to midnight. Research published in the Journal of Pain and Symptom Management in 2016 suggested that continuous home care access is protective against hospice disenrollment and hospitalization after hospice enrollment. Eliminating barriers to this level of care is crucial to supporting patients.

LeadingAge recommends eliminate the arbitrary requirement for Continuous Home Care to start at midnight which significantly impacts providers ability to be appropriately paid to staff this critical piece of the hospice benefit.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

Timeline for Exceptional Circumstances in Delayed Hospice Face-to-Face. The face-to-face encounter is required by statute for Medicare hospice patients 30 days prior to the beginning of the patient's third benefit period and each subsequent recertification to confirm that the individual remains eligible for hospice services with a life expectancy of 6 months or less. Current CMS policy documentation states that in exceptional circumstances for a new hospice admission in the third or later benefit period, the face-to-face encounter can be considered timely if it is performed within two business days. However, LeadingAge believes this short timeframe does not account for the difficulties in transfers for hospice patients including receiving the correct documentation from the transferring hospice in order to meet regulatory requirements. Additional time is necessary to confirm eligibility and the need for a face-to-face encounter. Many times, these events occur over the weekend with emergency admissions, and while an additional two days allows staff to return to the office for normal work hours, if there are any issues scheduling a clinician visit the consequences of a missed face-to-face can be devastating to patients who will become ineligible for hospices services and lose access to care. Especially in rural areas the two day time period is difficult to accommodate due to limited staff and further distances to travel. Allowing additional time to schedule and organize the necessary details for the face-to-face would reduce burdens on hospices tremendously.

LeadingAge recommends extending the timeline for accepting delayed hospice face-to-face from two days to seven days.

Streamlining Transfer Forms. Hospice transfers are incredibly time consuming and cause burden for the hospice as well as the beneficiary receiving care. CMS has a responsibility to improve the transfer process between hospices to ensure beneficiaries receive seamless care. Currently, the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual site only three items that must be included in a signed statement from the individual. However, there is critical information necessary to discharge the patient and for the receiving hospice to create a new Notice of Election. Since there is no guidance from CMS on how this statement should look, unlike the sample Notice of Election statement that CMS maintains, each hospice creates a different version of this statement with varying information which causes administrative burdens for the receiving hospice. This has forced some states, like Mississippi,

to take matters into their own hands and create state specific Transfer of Hospice Provider forms for their Medicaid programs.

LeadingAge recommends CMS streamline forms for transfer to ensure all necessary information is available to the receiving hospice to prevent delays in care.

Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

Delaying Implementation of the Hospice Outcomes and Patient Evaluation Tool. LeadingAge asks that CMS waive the HOPE timeliness submission requirement for two calendar quarters post-implementation of the new Hospice Outcomes and Patient Evaluation, or HOPE Tool. We further respectfully request that CMS delay the HOPE implementation date until at least six months after CMS education, training, and final validation specifications are available and the application for iQIES access has been opened for hospices.

The transition from the current quality reporting tool, the Hospice Item Set (HIS), to the HOPE tool is technically complex and represents a distinct change in the timing and content of the documentation of the care delivered to hospice patients; moreover, it carries significant financial risk for hospice providers. The Hospice Quality Reporting Program (HQRP) is a "pay-for-reporting" program, which requires hospices to submit a high percentage (90%) of data records within a specified timeframe or receive an annual payment update penalty of four percent. This penalty is twice that of other providers and a significant impact for hospice providers as many are small, independent businesses a great deal of which are not-for-profit. Our associations remain fully committed to the HQRP, including the payment penalties for non-compliance, and recognize the critical importance of accurate, timely data submission to inform the delivery of high-quality hospice care. However, we have serious concerns about the potential for successful implementation of the HOPE tool. Providers and technology vendors have shared that there is a lack of information and clarity necessary to have a smooth, successful transition to the HOPE tool and to the new platform, iQIES, required for submission of HOPE records.

Identification of Duplicative Requirements

How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

Hospice Audit Burden. LeadingAge recommends CMS reevaluate the current audit processes which add significant costs to individual agencies that are not outweighed by public benefits and imposes undue burdens on small providers. CMS must first eliminate the ability of multiple auditors to conduct audits on the same hospice provider at the same time and second, implement an informal mechanism to enable Medicare Administrative Contractors (MACs) and

hospice providers to resolve technical claims denials prior to engaging in the formal appeal process which is costly and time consuming for both federal contractors and private entities.

Finally, LeadingAge strongly encourages CMS to conduct a thorough review of contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, top denial reasons and compliance with required timeframes for notification and review. The number of auditors that overlap in the hospice payment review alone on the same auditing areas raises significant flags of inefficiency.

Hospice providers report a substantial increase in the number and scope of government audits. LeadingAge, the National Association for Home Care & Hospice (NAHC), the National Hospice and Palliative Care Organization (NHPCO), and the National Partnership for Healthcare and Hospice Innovation (NPHI), in late 2023 surveyed their hospice provider members to gather insights into the auditing and adjudication processes of Medicare hospice benefit claims. The National Hospice Audit 2023 Survey Findings: Report found the majority of respondents were under two audits at once from at least two separate auditing entities. When hospice providers are under multiple audits including Target Probe and Educate audits initiated by MACs going funds can be tied up (for pre-pay) or be taken back (for post-pay) which imposes significant financial burdens on the private entities that is simply not outweighed by the public benefit. There are also significant an administrative cost in pulling together charts for additional documentation requests that impose undue burdens on small providers and impede their ability to be nimble and innovative in how they care for seriously ill patients. Furthermore, many survey respondents indicated that MACs provided varied and inconsistent information on how to resolve a technical billing issue, such as how to process a correction to missing information on an election statement or election addendum. For example, respondents indicated that one MAC might say that the provider could use a non-billable code for days not covered and obtain a corrected election statement, while another would say that the patient must be “administratively discharged” but with no instruction on which discharge reason code to use. This inconsistency in addressing simple technical audits causes undue burden to providers and holds up payment over minor technical issues that could be fixed through simple methods.

LeadingAge worked with the NPHI to propose audit targeting criteria for CMS to use which reveal, through claims-based measures, actions that are suggestive of profiteering behavior and malfeasance as opposed to the current focus on recouping payment for inadvertent billing and technical errors. These recommendations were sent to staff at the CMS Center for Program integrity on January 8, 2025.

It is important to note that no single indicator should be considered in isolation when identifying which hospices are appropriate for auditing. A variety of factors, including demographics and geographic considerations, can impact the case mix and care provision of

any single provider. Moreover, the existence of indicators should be assessed over a period of time to determine whether they demonstrate a pattern of intentionally wasteful or abusive practices. Note that some hospices with small censuses may appear as outliers on one or more measures as the result of a small number of instances among a small number of patients. However, due to the large number of small providers, CMS should consider:

1. Creating a small provider data set
2. Removing all exceptions/exclusions related to size for quality and data collection
3. Reviewing a small hospice's performance on a variety of measures in selecting them as an outlier hospice for further review or audit.

In other words, hospices should be selected for potential Medicare audits based on multiple criteria, that when taken together, suggest an increased likelihood that the hospice is purposefully engaging in actual waste or abuse. This approach necessitates an exercise in weighting of different metrics which is not fully discussed in this document. The hospice community stands ready, however, to engage collaboratively with CMS to determine both the appropriate mix of criteria and how those individual metrics are compared to each other.

Adopting such a matrix-style targeting approach could more accurately identify fraudulent, wasteful, and abusive providers, and result in a more tailored and efficient auditing program that better protects the integrity of the hospice benefit while minimizing burdens for providers by reducing claim denial appeals and reversals. Ultimately, CMS has limited resources to ensure proper payment for hospices services and the hospice provider community seeks to ensure those resources are appropriately targeted at bad actors seeking to subvert the intent of the benefit or committing outright fraud.

How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Hospice Ownership Transparency. LeadingAge is committed to provider ownership transparency as we have stated on multiple occasions in letter and comment. We believe eliminating the "other" ownership category from publicly available hospice data would improve transparency for hospices. No other Medicare provider types include the ownership category "other" in their publicly available information. We believe this data comes from the form CMS-417 which lists "other" as an option under the core Type of Control's for non-profit, proprietary, or government and is not in itself a stand-alone option for the type of control. There is not a category for "Other" in the 855A form that hospice providers need to complete to enroll in Medicare. We are unaware of any Internal Revenue Service business designations which would fall into the categorization of "Other" rather than proprietary, non-profit, or government. Additionally, the hospice data dictionary available on CMS' data website does not define

"Other" despite over 400 hospices identified by that ownership type. This is simply a misleading designation that no other CMS regulated provider has and the inclusion of this data makes it extremely difficult for public to understand the governing nature of the hospice they are considering. We ask CMS to make this minor but meaningful change to help the public better understand the agencies which are providing hospice services. LeadingAge requests CMS eliminate the ownership type "Other" from the hospice data dictionary.

Additional Recommendations

We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Special Registrations for Telemedicine and Limited State Telemedicine Registrations. LeadingAge also strongly encourages CMS to request DEA to revise these rules, in consultation with stakeholders, to further account for providers who serve equally vulnerable individuals outside of nursing homes and hospices, including providers serving palliative care patients and home health patients.

LeadingAge understands the difficult situation the DEA finds itself in regarding protecting against the abuse of controlled substances while also ensuring Americans can access needed medicine and use telemedicine consultations as a method of access. LeadingAge also agrees that guardrails are needed around telehealth utilization broadly and most especially when there is a high-risk situation such as overprescribing of controlled medications. However, LeadingAge is gravely concerned that the proposed rule laid out by DEA will only further limit access to critical drugs for the vulnerable older adults LeadingAge members serve.

As we outlined in great detail in our March 18, 2025, comment letter responding to the proposed rule for e-prescribing of controlled substances, we do not believe prescribing controlled medications using telehealth for hospice patients or residents in long-term care is a high-risk situation that requires the guardrails outlined in DEA's proposed rule. Furthermore, the consequences of adding additional oversight to hospice and skilled nursing clinical practitioners, especially with requirements for prescribing schedule II-controlled substances which are critically needed in these settings, would not only be burdensome but would also create catastrophic access issues for the older adults these settings serve. We are most concerned regarding the unduly restrictive nature of the guardrails for schedule II-controlled substances which are commonly found in these care settings.

LeadingAge requests CMS support the rescission of the Drug Enforcement Agency's (DEA) proposed rule on Special Registrations for Telemedicine and Limited State Telemedicine Registrations based on its burdensome nature and the costs imposed on small entities. We ask that for the DEA Administrator and the Secretary of Health and Human Services use existing authority, provided them by the Ryan Haight Online Pharmacy Consumer Protection Act of

2008, to jointly provide exemptions to hospice and skilled nursing providers from any future similar rules.