June 10, 2025

Mehmet Oz, MD
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: CMS-1831-P Medicare Program; FY 2026 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

Submitted electronically via https://www.regulations.gov

Dear Administrator Oz,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services, including home health and hospice, and our 36 state partners in 41 states, LeadingAge is pleased to offer the following comments in response to the FY2026 Hospice Wage Index and Payment Rule.

Proposed FY2026 Hospice Payment Rates

While we appreciate the positive proposed 2.4% increase in the wage index and rate update, we want to emphasize that this proposed increase is not sufficient to cover the current needs of hospice providers. This is the third consecutive year that the payment update has decreased. In the FY2025 Final Rule, CMS staff reviewed the cost pressures for hospice and raised the final rate to 2.9%. We do not believe the cost pressures have changed in the time between the finalizing of the FY2025 rule and the release of the FY2026 proposed rule.

Many of our members' margins remain thin; increased payment this year and into the future will continue to be essential. According to the Medicare Payment Advisory Commission (MedPAC), the aggregate margin for all nonprofit hospices was 0.3% in 2022 compared to 16.1% in for-profit hospices.[1] MedPAC also found that the number of nonprofit hospices is declining despite nonprofit providers being higher performers on CAHPS ratings.

We have repeatedly shared concerns with CMS on the quality of cost report data, especially with regards to capturing actual labor costs, which for hospice are the largest portion of costs. Cost reports should be audited, improved, and optimized before they are used for payment purposes. Specifically:

- We recommend that the cost reports be amended to allow for a greater breakdown of costs for contracted vs. hospice-administered inpatient services to apportion the labor share appropriately.
- We request that CMS clarify how frequently they intend to update the labor shares component moving forward and clarify the development and methodology around the "standardization factor." This includes clarification as to how CMS will adjust the labor share if certain types of hospices are found to provide more services and thus, likely have a larger labor share, but contribute fewer cost reports.

[1] The Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2025 Mar . Chapter 9, Hospice services; Available from: https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch9_MedPAC_Report_To_Congress_SEC.pdf

- If the labor shares are going to have a greater weight on Continuing Home Care (CHC), let hospices utilize it effectively. We recommend that the definition of a day be any 24-hour period or that CMS create a modifier to allow hospices to bill into a second day up to a 24-hour limit.
- Other changes as indicated from the results of the audit with notice and comment opportunity.

LeadingAge therefore strongly recommends CMS increase the proposed payment rate of 2.4% to at least 3%.

Wage Index

The current workforce crisis has created access issues across the country for individuals seeking hospice services and rural communities, which have larger portions of the aging population, have been hit hardest.[2] **We reiterate our long standing ask that CMS reinstitute its prior policy that no hospice be paid below the rural floor for their state and consider working with the Congress on policies to reform the wage index, such as looking at how MedPAC's 2022 wage index proposal[3] would impact hospice and working with stakeholders, including Congress, on how to implement a fairer system that also takes into account increased labor costs.**

Adequately Capturing Telehealth in Claims and Cost Data

In May 2025, CMS asked for information from stakeholders to modernize the nation's digital health ecosystem with a focus on empowering Medicare beneficiaries through greater access to innovative health technologies.[4] LeadingAge would like to reiterate our multi-year recommendation to CMS to capture telehealth information in claims and cost reports for hospice providers. The continuation of pandemic era flexibilities around telehealth for face-to-face visits, as well as the potential for use in the Hospice Outcomes and Patient Evaluation (HOPE) data collection tool, is an unprecedented opportunity for hospices to capture data to evaluate the use of telehealth to serve beneficiaries more effectively. Unfortunately, due to the current limitations of claims and cost reports, hospice use of these flexibilities is not adequately captured. Without data tracked nationwide, patients and caregivers, app developers and other technical vendors have no access for appropriate and valuable use.

In 2022, MedPAC called on the Department of Health and Human Services to require that hospices report telehealth services on Medicare claims.[5] Additionally, we believe CMS has the ability quickly develop modifiers based on the G-Codes required of home health providers in July 2023.[6] **We strongly recommend that CMS implement G-Codes in line with home health billing codes and create a field on the hospice claim for telehealth visits from any discipline to more accurately represent the full range of visits that hospices provide.**

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[2] Hospice News. "Obstacles Persist for Rural Patients to Access Hospice." Sept. 2021. Available from: https://hospicenews.com/2021/09/28/obstacles-persist-for-rural-patients-to-access-hospice/

[3]The Medicare Payment Advisory Commission. "Wage Index March 2023 SEC. https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf

[4] The Centers for Medicare and Medicaid Services. "CMS Seeks Public Input on Improving Technology to Empower Medicare Beneficiaries." May 13, 2025. Available from: https://www.cms.gov/newsroom/press-releases/cms-seeks-public-input-improving-technology-empower-medicare-beneficiaries

[5] The Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2022 Mar . Chapter 11, Hospice services; p. 299 – 320. Available from: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf

[6] MLN Matters. "Telehealth Home Health Service: New G-Codes." July 21, 2022. https://www.cms.gov/files/document/mm12805-telehealth-home-health-services-new-g-codes.pdf

Furthermore, while hospices can report the total cost of telehealth services on cost reports, the expenses are covered in the non-reimbursable cost centers. In the CY2021 Home Health final rule, CMS gave home health agencies the ability to capture the costs of these services as allowable on cost reports. **We urge CMS to allow hospices broader use of telecommunications technology during routine home care visits and that these costs be considered an allowable administrative cost on the hospice agency cost report.**

Proposed Clarifying Regulation Text Changes

Certification of Terminal Illness and Admission to Hospice Care

LeadingAge supports CMS' clarifications at §418.25 with the addition of the physician member of the interdisciplinary group language and believes that it will add clarity to the physician's role in certification in each section of regulatory text. We appreciate CMS' openness to suggestions made by LeadingAge and other advocates in response to the FY2025 Proposed Rule.

Face-to-Face Attestation

We appreciate CMS' reflection on discrepancies in the face-to-face attestation requirements which have led to confusion about expectations from Medicare Administrative Contractors (MAC) and other audit entities. However, we do not agree with CMS that the lack of clarity around elements to be included in the attestation undermines the intent of the original statute and rule or that this additional regulatory language will lead to less burden for hospices.

We wish to point out that the statutory language for the hospice face-to-face requirement does not explicitly call for a signature and date:

> '(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary);[7]

While the language does provide for the Secretary to establish procedures, we would argue that these procedures are already established in regulatory requirements for the maintenance and authentication of clinical records which already exist for hospices:

> § 418.104 Condition of participation: Clinical records. (b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.[8]

Finally, CMS has extensive subregulatory guidance for clinicians on complying with Medicare signature requirements, including detailed requirements in the Medicare Program Integrity Manual Section 3.3.2.4 – Signature Requirements,[9] along with a plain language MLN factsheet.[10]

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[7]Patient Protection and Affordable Care Act, H.R. 3590, 11th Cong. (2010). https://www.congress.gov/bill/111th-congress/house-bill/3590/text

[8] Conditions of Participation: Clinical records, 42 C.F.R. § 418.104(b). https://www.ecfr.gov/current/title-42/part-418#p-418.104(b)

[9] The Centers for Medicare and Medicaid Services. "Medicare Program Integrity Manual: 3.3.2.4 – Signature Requirements." (2025). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf#page=43

[10] MLN Matters. "Complying with Medicare Signature Requirements." April 2024. https://www.cms.gov/files/document/mln905364-complying-medicare-signature-requirements.pdf

Taking the existing legislative, regulatory and subregulatory guidance into consideration, we believe CMS' proposed language will only lead to further technical denials. Specifically, we believe the proposal to add the following language will create more confusion:

> *The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.*

Based on the individual preferences of each MAC review, a denial could be made on an agency submitting the required documentation in either a "section" or "addendum." This could result in additional technical denials which are a waste of resources for both auditors and hospice providers especially while true malicious subversion of the hospice benefit continues unchecked. While we agree with CMS' concern that the lack of clarity has led to documentation issues with Medicare Administrative Contractors, this clarification is unduly burdensome for providers.

This proposal is also in complete opposition to Executive Order 14192 and subsequent CMS request for information on regulatory relief. **With CMS' stated goal of reducing the costly private healthcare expenditures required to comply with Federal regulations, we believe this change in the regulations will result in more regulatory burden and not a reduction in documentation expectations for providers and should not be implemented.**

Furthermore, we recommend CMS educate audit contractors on already established program integrity requirements regarding signatures and dating of attestations. In January 2024, LeadingAge along with three other national hospice associations, conducted a survey to assess the burden of audits across our memberships and to gather data to share with CMS. We sent the comprehensive survey findings in a report to CMS on January 5.[11] The key findings from the survey include:

- a misapplication of regulatory requirements or the relevant legal standard
- audit contractors not following proper policies and procedures
- frequent substitution of the audit reviewer's clinical judgement in place of the physician responsible for the patient
- hospice providers being subjected to concurrent audits or audits being conducted in close proximity
- physician service denials, the lack of effective TPE education with inadequate or inconsistent guidance
- high claim denial overturn rates on appeal which emphasizes a need to not only look at initial error rates but also the final error rate following the appeal process

The survey results underscored themes LeadingAge has continually heard from members regarding the lack of auditor education and knowledge of hospice, the burdensome nature of the process, and questions about why CMS is focusing on certain areas for scrutiny. The recommendations included in the report highlight the issues inherent in the auditor's education and lack of training on basic Medicare rules. This must be the focus of CMS moving forward.

[11] LeadingAge. "National Hospice Audit 2023 Survey Findings." 2023. https://leadingage.org/wp-content/uploads/2024/01/2023-Hospice-Audit-Survey-Report-Final.pdf

Hospice Quality Reporting Program

Hospice Outcomes and Patient Evaluation (HOPE) Tool Implementation Timeline

We appreciate CMS' update on the implementation of the HOPE tool. As we stated in our FY2025 Hospice Wage Index Rule comment letter, this is an incredibly quick timeline. Electronic Medical Record (EMR) companies, critical partners in the implementation of this tool, need more time with the final HOPE technical specifications before they are able to develop and implement the tool.

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 4%. 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 nonprofit.

LeadingAge remains fully committed to the HQRP, including the payment penalties for non-compliance, and recognizes 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.

In this proposed rule, CMS reiterates their commitment to migrating systems for submitting and processing assessment data. However, this was initially finalized in the FY2020 Hospice Wage Index final rule for implementation as soon as 2020. Five years later, the transition has still not occurred. Additionally concerning is CMS continued delay of other settings transition to iQIES, specifically nursing home, meaning there is less bandwidth at the agency to support hospices transitioning.[12]

LeadingAge would like to reiterate the ask made by the three national hospice associations in a May 19 letter.[13] **CMS should 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.**

Hospice Visits in the Last Days of Life (HVLDL)

We would like to take this opportunity to reiterate long-standing concerns with the HVLDL claims-based measure. We do not reject the premise of the measure and indeed believe strongly that quality hospice care includes visits at the end of life. However, the measure only captures visits from two members of the hospice interdisciplinary team, which is inconsistent with the core philosophy of hospice that the whole person must be treated. Additionally, there are no exclusions for patients which refuse visits, which is again, inconsistent

[12] The Centers for Medicare and Medicaid Services. "Revised: Training Plan for iQIES Launch in Long-Term Care." March 7, 2025. https://www.cms.gov/files/document/admin-info-25-07-nh.pdf

[13] LeadingAge. LeadingAge, Hospice Associations Seek Delay In HOPE Implementation. May 28, 2025. https://leadingage.org/leadingage-hospice-associations-seek-delay-in-hope-implementation/

with the person-centered nature of the benefit and also inconsistent with the two new measures being implemented for the HOPE assessment which allows a patient to refuse a visit.

We strongly agree with the Partnership for Quality Measurement's Evaluation and Maintenance Committee's endorsement rationale/justifications which state that the developer should:[14]

1. Explore the feasibility and utility of adding additional disciplines and patient preferences to the measure;
2. Conduct updated correlation analyses exploring included disciplines with patient/family satisfaction; and
3. Explore, with the developer's technical expert panel (TEP), the timing and unpredictability of end-of-life events.

As the measure's steward, we urge CMS to begin the reevaluation of this measure immediately to allow providers ample time to participate in the TEP and provide feedback, as well as allow the measure developer time to evaluate correlation with disciplines and the new CAHPS satisfaction surveys which went into effect April 2025.

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

LeadingAge appreciates the opportunity to comment on the adoption of health IT in the hospice space. However, we write to express our concerns regarding the feasibility of implementing health IT with the specifications outlined in the RFI and the impact it would have on hospice providers, including significant burdens on staff and budgets.

To our knowledge, all LeadingAge hospice members utilize health IT systems to maintain patient records and specifically utilize electronic records. However, part of the longstanding work of the LeadingAge Center for Aging Services Technology, or CAST, has been to annually review how sophisticated our provider members are in using their electronic health records (EHR).[15] CAST reaches out to EHR vendors each year to assess how the vendors' clients are using EHRs, as well as the percentage of their clients along the scale of EHR adoption. The 2024 results are almost identical to 2023. They show little to no advancement in the use of higher interoperable functionalities of EHRs. In 2024, the most providers (25%) are in Stage 5 of the scale, using a basic integration between the EHR and other external and ancillary systems. Nearly 20% of providers are in Stage 6, which enables providers to engage different members of the care team, including the physician and possibly the patient/resident/client, and offers basic information exchange capabilities. Yet only 8% fall into Stage 7, which represents the ideal full interoperability stage.

Additional research by the Assistant Secretary of Evaluation and Planning published in 2023 confirms LeadingAge's findings that overtime the adoption of EHR technology has increased in the post-acute care sector, however the interoperability of that technology remains limited.[16] This research alone leads us to believe that CMS is starting from the wrong place in asking these questions of hospice providers.

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[14] Partnership for Quality Measurement. "Hospice visits in the Last Dyas of Life." https://p4qm.org/measures/3645
[15] LeadingAge. "Adoption of Advanced EHRs Stalls in the Aging Sector." June 10, 2024. https://leadingage.org/adoption-of-advanced-ehrs-stalls-in-the-aging-sector/
[16] Assistant Secretary for Planning and Evaluation, the Department of Health and Human Services. "Health Information Technology Adoption and Utilization in Long-Term and Post-Acute Care Settings." December 2023. https://aspe.hhs.gov/sites/default/files/documents/cf9c988536e481d688f224b7653704f9/hit-adoption-utilization-ltpac-settings.pdf

The HITECH Act of 2009, which established federal program or requirement for incremental progress toward interoperability for have care providers, excluded long-term care and post-acute care (LTPAC) providers like hospices. Unlike with the Meaningful Use/Promoting Interoperability program in this original legislation, there are no levers or drivers requiring LTPAC providers to share information with hospitals and office-based settings, making the likelihood of adoption small.

In response to the January 6, 2025, HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information, LeadingAge submitted extensive comments on the realities of complying with the proposals.[17] While supporting the rule's goal of better protecting the confidentiality, integrity, and availability of electronic Personal Health Information (ePHI), our letter voiced concerns regarding the feasibility, cost, and administrative burden of the proposed requirements for aging services providers.

LeadingAge emphasized flaws with the one-size-fits-all nature of the proposed rule. The Office of Civil Rights (OCR) proposal would treat all HIPAA-covered entities the same, despite differences in size, resources, and risk levels. Aging services providers, for example, were excluded from federal HITECH incentives for health information technology (IT) adoption and have less mature digital infrastructure in place, as well as fewer resources generally, compared to hospitals and larger health systems. Further, OCR acknowledges that smaller and rural providers face unique challenges, but the agency assumes that all providers equally should and can comply.

Our letter also argued that OCR has significantly underestimated the costs of compliance. The proposal's required Regulatory Impact Analysis estimates implementation costs at $183 million annually, but LeadingAge believes that actual costs would be much higher. We cited several examples where agency calculations of the time and cost that would be needed to complete certain actions are much lower than is realistic.

In addition to the complexity of the proposed requirements, a major issue is that the proposed timeline for implementation is unrealistic. The proposed rule would require full compliance within 240 days (8 months) after publication of a final rule, which is impractical for most organizations. LeadingAge called for a longer, phased approach if OCR issues a final rule, so that regulated entities would have sufficient time to establish and implement policies, procedures, and practices to achieve compliance with new or modified standards.

We reiterate similar recommendations from that letter here:

CMS should conduct further engagement with hospices beyond this RFI in the proposed rule, to build deeper understanding of feasibility and consider flexibilities for organizations with fewer resources and less mature systems.

Endorse legislation and work to provide positive supports to help hospices implement these changes, such as federal funding similar to "meaningful use" dollars that incentivized the use of industry IT standards in hospitals.

[17] LeadingAge. "HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information (RIN Number 0945-AA22)." March 7, 2025. https://leadingage.org/wp-content/uploads/2025/03/LeadingAge-Comments-on-HIPAA-Security-Rule-Revisions_03.07.2025.pdf

RFIs on Future Quality Measure Concepts for the Hospice QRP

We are grateful for the opportunity to provide feedback on new quality measure concepts for hospice. Because hospice is such an individualized benefit it can often be difficult to measure the quality of care someone receives against another person's experience. To date, the majority of measures used in this setting have focused on the processes related to hospice, whether it is assessment and reassessment of symptoms or making sure preferences were discussed. While there are two quality measures focused on outcomes in hospice, Hospice Visits in the Last Days of Life and the Hospice Care Index, as we stated earlier in this comment letter, issues remain with the measures design and implementation. We strongly encourage this administration to include hospice in future measure development efforts and make sure there is a place at the table for these critical person-centered discussions.

Interoperability

As our comments on the previous section's RFI indicate, we do not feel that at this time hospices are not at the appropriate level of technology adoption for interoperable data exchange, or measures that evaluate the ability of data systems to securely share information across the spectrum of care. We do not believe this measure would be meaningful to hospices with limited expertise, staff, and financial resources to implement such systems. **LeadingAge cannot support the adoption of measures for interoperability in hospice at this time.**

Well-Being

LeadingAge appreciates CMS' interest in assessing the well-being of patients at the end-of-life. We do believe this is a difficult task to undertake for a population which has made an arguably difficult choice to stop receiving medical interventions for their terminal condition. As we stated in our FY2025 Hospice Wage Index Proposed Rule comments, hospice is a unique benefit in the Medicare system, requiring a holistic view of the individual outside of their terminal illness, allowing them to chart their own course and decide what is most important for their final days. For some this could mean support from a chaplain, for others it could be preventing pain, still others it is prolonging life and comfort to make it to the birth of their grandchild. Measuring these disparate, individual goals could be impossible but it is core to the work of hospice and must be represented in any future use of the tool beyond the purpose of data collection.

Hospice is a unique benefit in that the interdisciplinary team overseeing the care of the patient is required to include social workers and chaplains to assess the psychosocial, emotional, and spiritual needs of patients and families. In the beta testing of the HOPE tool a social work and chaplain form were tested with mixed results. According to the beta test report:

> SWs and chaplains both conveyed that while the HOPE domains aligned with their current assessments, their HOPE forms did not support relationship building in the same way. SWs noted patients feeling overwhelmed with the SW Admission form. Chaplains noted challenges for patients who identify as neither religious nor spiritual. Both SWs and chaplains found their respective admission forms difficult to complete in a single visit, as patients may not be ready to answer the more personal questions involved in determining social work or spiritual care needs until a more solid rapport has been established.[18]

[18] Abt Associates. "Hospice Quality Reporting Program: Hospice Outcomes and Patient Evaluation (HOPE) Development and Testing. December 18, 2023. https://www.cms.gov/files/document/hqrp-hospice-outcomes-and-patient-evaluation-hope-development-and-testing-report.pdf

More work is necessary to ensure the development of meaningful measures that capture patients' well-being at the end of life. However, we do believe CMS can make immediate progress on this item by adopting codes to capture chaplain visits. On October 1, 2022, CMS updated three HCPCS Level II codes which had previously only been used in the Veterans Affairs Administration:[19]

- Q9001 Assessment by chaplain services
- Q9002 Counseling, individual, by chaplain services
- Q9003 Counseling, group, by chaplain services

Currently, CMS collects data on all other core disciplines in hospice via hospice claims – physician, registered nurse, medical social worker, in addition to home health aides and therapy services. The only service exception is chaplains (pastoral counselors). The claims data from other disciplines is used in quality measures in HQRP. However, it is not clear if or when CMS has not discussed further use of these codes in hospice services despite the benefit being the only service with a defined role for chaplains.

Chaplain services would not be reimbursed separately due to the per diem payment mechanism of the benefit, but having these codes will help the CMS better understand chaplain visits at the end of life. This could lead to future updates in the new claims-based measure Hospice Visits in the Last Days of Life (HVLDL) to reflect the real value chaplains bring to end of life care including supporting the well-being, purpose, and fulfillment of patients. In many instances, the clinically appropriate, and person-centered interdisciplinary team member to visit in the final days of life is the chaplain. However, when the claims measure was being developed there was no coding available to capture those visits, therefore chaplains were excluded as part of the eligible clinicians for the new claims measure. **LeadingAge urges CMS to establish further guidance to define what is considered chaplain services and establish guidelines for tracking chaplain visits through claims-based data.**

Nutrition

LeadingAge does not feel that a measure regarding nutrition, as described in the request for information, is appropriate for hospice.

First and foremost, hospice's intent is not to prolong life but rather to emphasis the quality of life and symptom management when an individual has chosen to discontinue medical interventions to treat their terminal condition. With this in mind, the nutritional composition of a meal offered to a hospice patient should not be the focus of a hospice, but rather they should focus on the pleasure and therapeutic benefits of feeding and hydration.

Furthermore, the American Academy of Hospice and Palliative Medicine's (AAHPM) position statement on Artificial Nutrition and Hydration (ANH) states that ANH is unlikely to prolong life in hospice patients and can potentially lead to medical complications and increased suffering.[20] AAHPM advocates for respectful and informed discussion of ANH near the end of life before the dying process has begun. If nutrition was expected to be attempted at all stages of the dying process, without an informed discussion with the patient, at some point ANH would be the only course of action and could significantly impact on the quality of end-of-life.

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[19] The Centers for Medicare and Medicaid Services. "Centers for Medicare & Medicaid Services' (CMS') Healthcare Common Procedure Coding System (HCPCS) Level II Final Coding, Benefit Category and Payment Determinations." 2022. https://www.cms.gov/files/document/2022-hcpcs-application-summary-biannual-1-2022-non-drug-and-non-biological-items-and-services.pdf

[20] American Academy of Hospice and Palliative Medicine. "Artificial Nutrition and Hydration Near the End of Life." 2025. https://aahpm.org/advocacy/where-we-stand/anh/

We do believe the soon to be implemented HOPE tool does review nutrition and activity in an effective way for patients at the end-of-life. The F2100. Other Life-Sustaining Treatment Preferences item discusses the expectation that treatments beyond CPR and hospitalization be discussed with the patient including tube feeding and IV fluids. If it is the patient's choice to receive these interventions it would be appropriately documented in the medical recorded and noted as part of the item's discussion. CMS was also interested in aspects of health that support or mediate nutritional status, such as activity and sleep. The new item J2051. Symptom Impact in the HOPE tool is meant to address the impact of symptoms on activities including sleep and day-to-day activities which may contribute to an individual's unwillingness or disinterest in nutrition.[21]

Further testing around activity was included in the beta testing of the tool coinciding with the GG items from other post-acute care settings like home health and skilled nursing including GG0130. Self-Care which looks at the ability to eat. While overall the items had no validity or feasibility challenges, about 18% of patients in the beta test were completely dependent for support in eating. Furthermore, the GG items are meant to be indicators of improvement in ability and simply do not make sense for a population that is at the end of life, who will not improve and should not be forced to attempt improvement at the end of life.

Finally, we are concerned that any kind of measure regarding nutrition would inadvertently call into question a patient's eligibility for hospice. Local Coverage Determination – L34538 Hospice Determining Terminal Status explicitly discusses progressive inanition and dysphagia leading to inadequate oral intake.[22] As nutritional decline and activity decline are core indicators of hospice eligibility, we do not believe a measure of nutrition is appropriate for the hospice population.

LeadingAge appreciates the opportunity to provide comments on the proposed rule. LeadingAge along with our members stand ready to be a resource for CMS as the programs and payer support continue to evolve.

Sincerely,

Katy Barnett

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About LeadingAge: *We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.*

[21] The Centers for Medicare and Medicaid Services. "Hospice Outcomes and Patient Evaluation (HOPE) Guidance Manual v1.01."2025. https://www.cms.gov/files/document/hope-guidance-manualv101.pdf-0

[22] The Centers for Medicare and Medicaid Services. "Local Coverage Determination (LCD): Hospice Determining Terminal Status." June 27, 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538