Hospice and Palliative Care

Expand Services to Ensure Access & Caregiver Support

Hospice policy has not significantly changed since its inclusion in the Medicare program in 1982. Reforms will ensure greater access and better support for beneficiaries and their families.

LeadingAge supports policies that expand access to care, reduce bad actors, promote sustainable reimbursement, and ensure the viability of high-quality providers into the future.

A number of policies that support these goals are included in the *Hospice Care, Accountability, Reform, and Enforcement (CARE) Act of 2026* (HR 7966 / S 4118). LeadingAge is deeply engaged with the bills' sponsors and remains committed to working with these offices to maintain the components of the bill that we support and amend the provisions that our members feel are not operationally feasible.

Ensure Access to Care and Support for Beneficiaries and Families

- Increase payment to hospice organizations for appropriate palliative therapies (e.g., palliative radiation, palliative dialysis) sustainably and consistently, which would increase timely enrollment in hospice.
- Expand access to inpatient hospice care by creating a residential level of hospice care in the Medicare program, allowing patients to "step down" from more intensive services without a disruptive move and for those who prefer to die outside their home to do so with more supports.
- Expand hospice to include a home-based respite level of care so caregivers can access respite even if they do not want to move their loved one to an inpatient respite bed.
- Amend the Social Security Act to allow for a clean two-year extension of the ability of hospices to perform the face-to-face recertification via telehealth.
- Reject proposals that add hospice into the Medicare Advantage program (i.e., reject the "hospice carve-in"). We oppose HR 3467, the *Medicare Advantage Reform Act*, which would include the hospice benefit under MA, which was previously tested and ended early because it was unsuccessful.
- Enact legislation instructing CMS to assign sustainable payment under Medicare Part B for outpatient and at-home palliative care services as well as defining a standard set of palliative care services for Part B. These payments and services should allow for a full, team-based approach to palliative care at a sustainable rate and be billable by the wide range of providers that engage in palliative care.

Disrupt Fraud and Protect Beneficiaries

- Congress should authorize and fund CMS to target new and outlier hospice agencies with additional surveys, and fund enhanced site visits to better target fraudulent and bad actors.
- Congress should require CMS audit contractors to be transparent in their process and better target oversight resources.
- Congress should prohibit payment to hospices that do not submit required quality data to the Secretary, with existing exemptions remaining in place.

Fortify and Expand the Hospice and Palliative Care Workforce

- Enact the *CONNECT for Health Act* (S 1261 / HR 4206) to permanently allow the home to be the originating site for telehealth services, remove telehealth geographic restrictions, allow a wider range of providers to bill for telehealth services, and allow the hospice face-to-face recertification to occur via telehealth.
- Enact the *Improving Care and Access to Nurses (I CAN) Act* (S 575 / HR 1317). This bill expands the scope of practice for advanced practice registered nurses (APRNs), allowing them to certify terminal illness in hospice and to bill for physician services under the hospice benefit even when they are not the attending physician. The Hospice CARE Act also would permit APRNs and physician assistants who are acting as the patient's attending physician to certify the terminal illness.
- Enact the *Palliative Care and Hospice Education and Training Act* (PCHETA) (S 2287 / HR 4425). The bill would support the training of interdisciplinary health professionals in hospice and palliative care and authorize grants to develop programs to train individuals to provide palliative care in hospital, hospice, home, or long-term care settings.