



June 1, 2026

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-1851-P Medicare Program; FY 2027 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 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day, LeadingAge submits the following comments. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, 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, skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. LeadingAge is pleased to offer the following comments in response to the FY2027 Hospice Wage Index and Payment Rule.

Executive Summary

LeadingAge is concerned that the proposed 2.4% payment update fails to keep pace with the true cost of care. Our analysis shows a cumulative market basket forecasting error of -4.7% over the past five years, creating compounding financial strain on nonprofit providers. We also raise concerns about the hospice aggregate cap, specifically in Los Angeles County, and the potential for barriers to care for beneficiaries who were or may have been fraudulently enrolled in hospice by bad actors.

LeadingAge understands the Centers for Medicare and Medicaid Services' (CMS) concerns with the continuing increases to non-hospice spending. However, we are gravely concerned that the proposals in this rule will not address the root problems of non-hospice spending and instead will add additional burden to hospices and have a chilling impact on access to services. Hospices cannot prevent other providers from billing Medicare, and the proposals—particularly the mandatory election statement addendum and the Service and Spending Variation Index as currently constructed—will add regulatory burden without addressing root causes—our comments attempt to alleviate some of these concerns, but LeadingAge does not believe non-hospice spending should be part of the SSVI at this time. LeadingAge firmly supports CMS's proposal to add an icon to Care Compare for hospices who fail to comply with the hospice quality reporting requirements.

LeadingAge supports the proposed clarifying regulations but offers additional questions which require additional subregulatory guidance for hospice agencies including more guidance on the utilization of the face-to-face encounter via telehealth during the current moratorium. LeadingAge offers additional

feedback on the multiple requests for information for enhancing palliative care outside of hospice as well as the development of a hospice specific wage index.

LeadingAge appreciates the opportunity to comment on the proposed and rule and stands ready to serve as a resource to CMS as these programs and policies continue to evolve.

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Proposed FY2027 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. In fact, this increase is identical to last year's increase. This is the third consecutive year that the payment update has decreased. In the FY26 Final Rule, CMS staff reviewed the cost pressures for hospice and raised the final rate to 2.6%. We do not believe the cost pressures have changed in the time between the finalizing of the FY26 rule and the release of the FY27 proposed rule.

Many of our members' margins remain thin to non-existent. According to the Medicare Payment Advisory Commission (MedPAC), the aggregate margin for all nonprofit hospices was -1.3% in 2023 compared to 13.7% among for-profit hospices.¹ MedPAC also found that the number of nonprofit hospices continued to decline despite nonprofit providers being higher performers on quality measures. This raises deep concerns for our membership regarding the sustainability of nonprofit services, which often entail higher quality services including higher rates of inpatient services as well as more comprehensive volunteer and bereavement services.

Forecasting Error in the Market Basket

Given the growing costs of labor and supplies, which are necessary to support quality patient care, the accuracy of annual payment updates is essential to the continued sustainability of services from our nonprofit, mission driven hospice members. These annual payment updates are based on forecasts of the market basket increase for the upcoming payment year and are not measures of actual price growth, which are not available until much later.

Based on the available data from the CMS Office of the Actuary,² over the past five years, CMS' forecasts for the market basket have significantly underestimated the growth of costs. While CMS traditionally incorporates the most recent historical data into the final rule, this does not solve consistent under-estimation of the cost of services and leaves nonprofit, mission-driven providers in a financially strained environment. LeadingAge's analysis of the cumulative forecast error between 2021 and 2025 rulemaking reflects a -4.7% market basket adjustment. This creates a compounding effect on the stability of quality services.

MB Forecast Error Impact	2021	2022	2023	2024	2025	Cumulative
Projected Market Basket (Final Rules)	2.40%	2.70%	4.10%	3.30%	3.3%	12.5%
Actual Market Basket	3.40%	5.50%	4.50%	3.70%	3.4%	17.2%
Percent Point Difference	-1.00%	-2.80%	-0.40%	-0.40%	-0.10%	-4.7%

¹ Medicare Payment Advisory Commission. (2026, March). *Report to the Congress: Medicare payment policy (Chapter 10: Hospice services)*. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch10_MedPAC_Report_To_Congress_SEC.pdf

² Centers for Medicare & Medicaid Services. (n.d.). *Market basket data*. <https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data>

LeadingAge recommends CMS finalize a one-time forecast error recalculation to increase the base payment rate for hospice providers to account for the past five years of forecasting errors. While we understand that unlike the skilled nursing facility (SNF) prospective payment system (PPS), there is currently no mechanism to adjust for a market basket forecasting error, we do believe it is within CMS' authority to create a regulatory framework to address these discrepancies just as they do with the creation and rebasing of market baskets across different providers settings.

Complicating the compounding effect of underestimated market basket, unlike other part A services including home health, skilled nursing facilities, inpatient rehab facilities, and end-stage renal disease providers, hospice market basket is tied to the inpatient prospective payment system market basket and has no independent data associated with the actual cost of hospice care. Much like our response below to the request for information on creating a new wage index for hospice providers, we feel this association with the inpatient prospective payment system may be to the detriment of hospice services. For example, the IPPS market basket prioritizes weighting of expenses associated with blood and blood products and installation, maintenance, and repair services, which some hospices with in-patient units may incur but the majority of hospices will not. The weighting skews costs from other critical cost centers not prioritized in the IPPS market basket like transportation costs, which are more similar to the home health market basket than the IPPS. **LeadingAge recommends CMS investigate the development and modeling for a separate hospice market basket to better account for the true cost of hospice services just as they are doing for the development of a separate wage index.**

Hospice Cap Concerns

LeadingAge is grateful for this administration's decisive action against fraudulent actors in the hospice space, notably in California so far. We have been greatly concerned regarding the growth of fraud since 2022 and have made numerous recommendations to CMS and Congress to improve program integrity.³

With the growing number of enforcement actions across Los Angeles County, we have heard from members that there is a growing concern that many Medicare beneficiaries who were falsely enrolled in hospice may have trouble accessing hospice in the future due to the hospice aggregate cap policy.

The hospice cap policy was intended as a safeguard against hospice overutilization to control program costs and discourage long length of stays. These are valid policy rationales but a combination of current limitations of the cap policy and their intersection with geographies with high incidences of fraud have created a critical access issue for beneficiaries in Los Angeles and potentially other areas of the country as more fraud is identified.

Hospice payment rates are geographically wage adjusted, meaning that a high-cost state like California has a higher payment rate than other areas of the country. The aggregate cap is not wage adjusted. In a high-cost state like California, hospices are going to approach the aggregate cap more quickly than in areas with lower wage adjusted payment rates.

For beneficiaries who were inappropriately or fraudulently enrolled in hospice, this could mean their cost of care already far exceeds the yearly cap amount set by Medicare. When it comes time to truly enroll for hospice services, these beneficiaries may experience access issues when a hospice looks at

³ Palmetto GBA. (n.d.). *Hospice audit and reimbursement information*.
<https://palmettogba.com/jmh/hh/did/4dk9qtzqyo?cat=jmh/hh-audit-and-reimbursement>

their enrollment history and realizes they have already exceeded their cap leaving little space to appropriately pay for the cost of a beneficiary’s necessary care. With patients who were targets of fraudulent agencies, there will inevitably be inflated lifetime hospice day counts in the denominator of the proportional patient count formula used to determine the aggregate cap.

Some beneficiaries have experienced up to 20 or 30 prior fraudulent benefit periods. Based on this, legitimate providers have a relatively small number of legitimate care days. These providers’ proportional count for victims of fraud is significantly smaller making their total cap allowance artificially lower than it should be relative to the reimbursement that was legitimately earned. This will inevitably push some providers, especially in areas that saw significant volumes of fraudulent enrollments, towards and even over their cap through no fault of the legitimate provider.

In high wage index markets like Los Angeles County, this effect is even more punishing due to the area per diem reimbursement already being evaluated relative to the national cap amount. Our nonprofit, mission-driven providers want to support their communities to access quality hospice services. But the financial impact of this fraud is far reaching and many legitimate providers may make the decision to turn away victims of previous fraud to avoid the financial penalty of the cap.

The table below illustrates the impact of prior fraudulent hospice days on the aggregate cap for ethical providers based on CMS cap methodology.⁴

Patient	Hospice A Medicare Days FY2025	Prior Hospice Days	Later Hospice Days	Total Days ALL Hospices ALL Years	Hospice A FY2025 Beneficiary Allocation	Allowable Cap FY2025
1: Normal Beneficiary	90	0	0	90	1.000	\$34,465.34
2: Victim of Fraud	90	1,260	0	1,350	0.066	\$2,274.71
3: Victim of Fraud	90	1,260	90	1,350	0.062	\$2,136.85
		Revised: 2025 Beneficiary Count			1.128	\$38,876.90

One widely reported case⁵ of a healthy 69-year-old who had been on hospice for two years exemplifies this point. Hopefully, she will not need access to hospice services for many years, but when she does it is not fair to either this beneficiary or to a hospice that wants to provide her with quality hospice care that taking her on service would potentially result in a financial penalty. There may be hundreds of beneficiaries like this and there needs to be a solution that will allow quality programs to take on these beneficiaries without risking going over the cap.

⁴ [NOTE: "Ibid." here incorrectly refers to the Palmetto GBA audit page (fn. 3). Please replace with the correct citation for the CMS aggregate cap methodology.]

⁵ CBS News. (n.d.). *She was an active 69-year-old, but records said she was dying in hospice* [Video]. <https://www.cbsnews.com/video/she-was-an-active-69-year-old-but-records-said-she-was-dying-in-hospice/>

LeadingAge urges CMS to enact regulatory relief that holds harmless beneficiaries who were fraudulently enrolled in hospice to prevent future barriers to legitimate hospice access because of aggregate-cap consequences tied to that fraudulent utilization.

One way we recommend providing immediate relief is to evaluate all providers who have been identified as fraudulent, revoked, or referred for fraud investigation and exclude the hospice days attributed to those providers from the lifetime hospice day count used for the proportional cap patient calculation. This corrects the denominator for the cap calculation, allowing legitimate hospices care to reflect the reality of their patient census. CMS already identifies providers revoked or suspended billing privileges and claims paid under these numbers are recoverable. This same logic should be extended to nullify the days associated with recoverable claims in the hospice cap calculation for all legitimate providers.

CMS should also allow hospices that can demonstrate cap liability attributable to patients with prior enrollments with hospices under investigation the opportunity for retroactive relief on cap determinations. Hospices cannot immediately identify if another provider's billing privileges were revoked or suspended but they can identify patients with excessively high prior hospice days, which would flag to any legitimate provider that they may not have been appropriately enrolled. CMS would need to provide instructions to Medicare Administrative Contractors (MACs) and hospices on how to submit evidence and documentation for requesting a cap recalculation.

Non-Hospice Spending During a Hospice Election

LeadingAge does not believe that the proposals offered in the FY2027 Hospice Wage Index proposed rule will lead to decreases in nonhospice spending as we will outline below. While we share CMS' concern with the growing spending outside the hospice benefit, we are gravely concerned that hospice organizations are the only entities being held accountable in what should be a coordinated system of care.

Nonhospice spending is billed to CMS by other Medicare providers and suppliers; CMS should be reviewing the spending at the time of the claim and denying inappropriate billing from these providers. Individual hospice agencies do not have this authority.

Additionally, CMS has never stated that no spending outside the hospice benefit is allowed but rather "virtually all" care deemed "reasonable and necessary" should be covered by the hospice. To date, and despite repeated requests for clarification from the hospices, CMS has declined to provide clearer guidance to hospices on what is considered "related to the terminal illness" and "reasonable and necessary" for the palliation.

LeadingAge believes CMS already has at its disposal solutions to de-escalate spending without adding additional regulatory burdens on hospice providers alone. What follows is our evaluation of the proposals with suggestions for improvement and an alternative solution to a universal addendum.

Service and Spending Variation Index (SSVI)

LeadingAge appreciates the opportunity for transparency CMS is offering in the development of the SSVI and we urge you to adopt our recommendations to improve this effort. We have previously advocated for clearer targeting of auditing criteria to hospices with aberrant patterns of utilization. In January 2024, LeadingAge and the National Partnership for Healthcare and Hospice Innovation (NPHI) partnered on a memo to CMS regarding improving CMS' targeting of hospice audits.⁶ This was targeted to program integrity efforts around waste and abuse in the hospice benefit, not necessarily outright fraud, including the fraudulent enrollment of beneficiaries into hospices with little to no services provided. The sector has clearly indicated in the past the immense audit pressure felt by providers and this was intended to focus audit activities and funding responsibly on aberrant providers.⁷

Hospice providers have no control over, and are frequently unaware of, care unrelated to the terminal condition that is billed to Medicare Part B or D for beneficiaries in hospice care. Additionally, it would not be appropriate for CMS to audit hospice providers for care because they are unaware of being billed by other providers. CMS should audit Part B and D billers to determine if their billing practices were appropriate.

LeadingAge is deeply concerned that the SSVI includes nonhospice spending with no transparency to individual providers on what types of claims drive their costs or what providers have been billing without the knowledge of the hospice. Hospices should be accountable to utilization patterns that drive up the cost of care across the benefit. But it is unfair and unrealistic to expect hospice providers to bear the entire burden for nonhospice spending when Part B and D billers must follow the same exact rules as hospice providers.

We do not believe that the proposals offered in the FY2027 Hospice Wage Index proposed rule will lead to decreases in nonhospice spending. We are equally concerned with the lack of transparency on CMS' intended use of the SSVI for program integrity. CMS states in the rule, "a high SSVI score indicates to CMS that a hospice might have more than one area of concern and may require additional targeted education or oversight, such as medical review, education, and investigations that could result in payment suspension, and revocation, if there is identified fraud, waste, or abuse." The rule fails to define what CMS believes is a "high" SSVI score. One program integrity contractor may see a hospice SSVI score of 3 and consider that high while another considers a 10 SSVI score high. Some may prioritize the nonhospice spending measure vs. the utilization measures. Furthermore, as our previous audit survey found, many contractors contradict each other's determinations, with some approving claims that others will later deny based on the same exact information. This is an unsustainable system that needs clarity and revision, not another tool to identify targets of oversight scrutiny.

There is already a clear example of how these types of indicators can be selectively used by contractors with significant consequences for the providers suspected of fraudulent activity based on a single metric. The Unified Program Integrity Contractor Western Jurisdiction (UPICW) has sent numerous

⁶ LeadingAge. (2025). *Retargeting hospice audits memo*. https://leadingage.org/wp-content/uploads/2025/05/Retargeting-Hospice-Audits-Memo_1.8.25.pdf

⁷ LeadingAge. (2024). *2023 hospice audit survey report*. <https://leadingage.org/wp-content/uploads/2024/01/2023-Hospice-Audit-Survey-Report-Final.pdf>

hospices letters of Medicare payment suspension based on a single metric: live discharges.⁸ This is a direct contradiction of CMS' goal with the SSVI.

It is important to note that falling into this quartile on a single measure does not necessarily indicate poor performance or improper practices. There are often legitimate operational reasons for a hospice to be an outlier in an isolated area. Instead, this 25 percent threshold acts as a preliminary filter. The objective of the SSVI is not to evaluate hospices based on a single metric, but to identify hospices that are outliers across multiple independent metrics.

The vagueness of CMS's intended use of SSVI for oversight purposes across contractors and the already apparent misattribution of fraudulent characteristics based on a single metric is deeply concerning. Without parameters for the SSVI's use and clear definitions of when intervention and further review is appropriate, the SSVI loses all meaning and negates any proactive changes from hospice providers.

SSVI Utilization Measures

Several of the outcome measures need modifications to ensure they are looking at the correct populations, and more clearly report not only on percentiles but also proportions/effect sizes. Below we have outlined our recommendations for changes to the outcome-based measures in the SSVI.

- *Sum of Hospice has no days of Continuous Home Care (CHC) and no days of General Inpatient Care (GIP).* We support CMS looking at this measure as part of utilization patterns. However, we do note that this measure is easily gameable as it only requires hospices to have a single day per year, regardless of their size, of GIP or CHC level of care. Additionally, for smaller and more rural hospices the reality of providing and billing for these complex services is extremely difficult. CMS should reconsider the threshold for this measure. We also question if CMS should add inpatient respite care to the count as it is also underutilized but a required level of care. Finally, we would like to reiterate our deregulation recommendation in response to Executive Order 14192 "Unleashing Prosperity Through Deregulation," where we request CMS "eliminate the arbitrary requirement for CHC to start at midnight which significantly impacts providers ability to be appropriately paid to staff this critical piece of the hospice benefit."⁹ We believe this would lead to an appropriate increase in the utilization of CHC services.
- *Sum of Hospice has 40% or more of RHC days provided in a nursing home or skilled nursing facility.* LeadingAge has previously supported the inclusion of nursing facility and skilled nursing facility utilization measures as a program integrity tool, and we continue to believe that monitoring site-of-service patterns is a legitimate component of hospice oversight. However, we are concerned that the current 40% threshold for this metric is inconsistent with the 75th or 25th percentile methodology CMS applied to other SSVI measures, and that this inconsistency disproportionately flags providers whose NF/SNF utilization reflects mission-driven integrated care rather than the enrollment manipulation or cost-shifting the SSVI is designed to detect.

⁸ Inside Hospice. (n.d.). *CMS launches hospice inquisition*. Inside Hospice. <https://www.insidehospice.com/p/cms-launches-hospice-inquisition>

⁹ LeadingAge. (2025, June 11). LeadingAge EO response requests deregulation across multiple programs. <https://leadingage.org/leadingage-eo-response-requests-deregulation-across-multiple-programs/>

Many LeadingAge hospice members are part of Life Plan Communities — organizations that operate both hospice programs and associated nursing homes or skilled nursing facilities as part of a unified continuum of care. These providers did not develop hospice programs primarily as a growth strategy; they did so to meet a genuine community need for integrated end-of-life care within settings their residents already call home. For these providers, high NF/SNF utilization reflects care coordination and continuity, not financial self-dealing.

Our analysis of member SSVI scores confirmed that this measure flagged a significant number of our members as outliers. However, when we examined the broader universe of hospices that triggered this measure, we found that the average NF/SNF utilization rate among flagged hospices was 58.2%. This suggests the current threshold is not functioning as a 75th percentile cut within the relevant population of NF/SNF-serving hospices, but rather as a much lower percentile filter that captures providers whose utilization is typical for their care setting. A well-calibrated outlier measure should identify genuinely unusual behavior, not flag the majority of providers operating in a given care model.

We also note that size compounds this problem. Among hospices with 0–49 beneficiaries that triggered this measure, the average NF/SNF utilization rate was 63%. Small hospices serving Life Plan Communities or rural nursing facilities may serve the majority of their patients in those settings by design, and a single-threshold approach applied uniformly across hospices of all sizes will consistently misclassify these providers.

We urge CMS to: (1) recalibrate the NF/SNF utilization threshold to align with the true 75th percentile of the full hospice distribution, which our analysis suggests is substantially higher than 40% and (2) apply a size-adjusted threshold or confidence interval approach for smaller hospices.

We want to stress the importance of this threshold change as it could lead to a chilling effect on access to hospice services in SNF/NF. According to MedPAC, about 1.2 million people live in nursing facilities and about 27% of residents died in the nursing home.¹⁰ Yet only about 14% of hospice claims have nursing home as the service location.¹¹ The national rate of hospice deaths regardless of setting is 52.9%. Based on these data we can see there may already be hospice access issues for residents of nursing homes. This may be due to a multitude of factors from difficulty coordinating services to complex reimbursement issues with the Medicaid passthrough. Additionally, while not all residents are eligible for the services or would choose to enroll in services, a significant number could benefit from the supportive services that come with hospice. However, if hospices see their SSVI increase, and potentially their risk of further program integrity scrutiny, due to serving this population, there could be a reactionary decrease in the number of hospices serving nursing home residents. There is precedent for the effects of

¹⁰ Medicare Payment Advisory Commission. (2025, June). *Report to the Congress: Medicare and the health care delivery system (Chapter 5)*. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch5_MedPAC_Report_To_Congress_SEC.pdf

¹¹ Research Institute for Home Care. (2025). *Hospice care chartbook*. <https://researchinstituteforhomecare.org/wp-content/uploads/2025-RIHC-Hospice-Care-Chartbook-12182025-1.pdf>

targeted setting audits on reduced services, particularly in GIP.¹² In the previously mentioned hospice association audit survey, 81% of respondents indicated audits were targeted to general inpatient level of care claims.¹³ We urge CMS to proceed with caution on this measure and to continue to monitor access to hospice services for NF/SNF residents.

- *Sum of Hospice's rate of providing visits during the last two RHC days of life that is less than or equal to the 25th Percentile (87.5%):* **We do not believe this measure appropriately distinguishes poor performing hospices and urge CMS to consider replacing this measure with the HVLDL.** We request clarification on CMS's selection of this measure over the Hospice Visits in the Last Days of Life (HVLDL), which is formally endorsed by the Consensus Building Entity. We understand that the selected measure is part of the Hospice Care Index (HCI), but that is not an endorsed measure, and CMS is seeking to redefine that measure to seek endorsement. When we analyzed our members' SSVI score, we cross referenced those who received a point for this measure with the members' outcomes on the HVLDL and found our members generally met or exceeded national averages on HVLDL.
- *Sum of Hospice's percentage of discharges that are live is greater than or equal to the 75th Percentile (46.7%):* **We believe this is an incredibly valuable measure to understand hospice care. However, we would like to make several recommendations to the exclusions for this measure and how the measure is reported out in the SSVI resources for agencies.** First, it would be very beneficial for hospices to understand how their live discharge rate broke down across reasons, similar to what was published in the April 2026 Hospice Monitoring report. There are different ways hospices can manage these live discharge reasons and effectuate change and improvement.¹⁴ Second, we would ask that live discharges with the condition code H2 or discharge for cause be excluded from the measure calculation. These are often difficult decisions for hospices to make and they should not be penalized for protecting the safety of staff and patients. Third, for condition code 52, the manual states "Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice." We are concerned this encompasses too broad a range of circumstances for hospice live discharges to truly determine what is an inappropriate live discharge. It would be best if these two reasons (moved outside/temporarily the service area vs. admitted to uncontracted facility) were separated or if the descriptor for the code were changed to encompass what is truly intended - the hospice is not able to carry out the plan of care. Finally, CMS should add a discharge condition code for valid and required administrative discharges such late face-to-face, payor changes, or changeover to new electronic medical record (EMR).

¹² Hospice News. (2021, August 13). *Hospices feel strain of GIP audits as inpatient care days dwindle.*

<https://hospicenews.com/2021/08/13/hospices-feel-strain-of-gip-audits-as-inpatient-care-days-dwindle/>

¹³ LeadingAge. (2024). *2023 hospice audit survey report.* <https://leadingage.org/wp-content/uploads/2024/01/2023-Hospice-Audit-Survey-Report-Final.pdf>

¹⁴ Centers for Medicare & Medicaid Services. (2026, April). *Hospice monitoring report* [Report]. <https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf>

SSVI Nonhospice Spending Measure

LeadingAge does not believe CMS should include the nonhospice spending measure of the SSVI. As currently constructed, the nonhospice spending measure lacks individual provider transparency, disregards the influences of size and scale on spending, includes questionable data points, and is completely inactionable on the part of hospices as they cannot prevent the billing of outside providers. While we do not believe this measure is appropriate at this time for inclusion in the SSVI, we do understand the importance of monitoring nonhospice spending. Therefore, LeadingAge offers the following recommendations for amending the current calculation of nonhospice spending measure for hospice agencies.

- *Scoring of Nonhospice Spending:* LeadingAge believes the scoring system artificially inflates the importance of nonhospice spending. As we stated earlier, much of this spending is beyond the control of hospice agencies. There is no clear logic to creating 8 separate spending levels other than to neatly line up with the 8 utilization-based measures. The current structure does not have a clear policy intent and should be revised to be based on a distribution curve marking true outliers from average or median hospice spending with a consistent formula that is replicable by outside stakeholders.
- *Proportions/Effect Sizes:* The nonhospice spending component of the SSVI raises significant methodological concerns about how spending thresholds are defined and how size affects scoring. According to our analysis of CMS's SSVI data, two-thirds of hospices have less than \$10 per day in nonhospice spending per beneficiary — yet CMS has not defined what level of nonhospice spending actually constitutes a problem warranting scrutiny. Without a clearly articulated threshold, the scoring tiers risk functioning as arbitrary cutoffs rather than meaningful indicators of aberrant behavior.

This concern is compounded by the metric's sensitivity to hospice size. As MedPAC noted in its comment on the FY 2027 proposed rule: "measuring a hospice provider's nonhospice spending in aggregate may miss smaller hospice providers that have high nonhospice spending on a per patient basis but low aggregate spending because they serve smaller patient populations. Structuring the measure to adjust for size of patient population in some way might better ensure providers of all sizes with aberrant patterns could be identified and help avoid creating incentives for providers to remain small to avoid scrutiny."¹⁵ LeadingAge strongly agrees with this assessment. Our own membership data illustrates this problem concretely. Over 90 percent of LeadingAge hospice members serve more than 50 beneficiaries annually, meaning they are among the larger providers in the industry. When we analyzed their SSVI scores, we found that members scored substantially higher on the nonhospice spending component than on utilization measures — an average of 5 points on spending versus 1 point on utilization.

Furthermore, when we examined actual nonhospice spending on a per-beneficiary basis, LeadingAge members — regardless of size — spent between \$9 and \$10 per beneficiary. By

¹⁵ Medicare Payment Advisory Commission. (2026, April 30). *Comment on FY 2027 hospice wage index proposed rule*. https://www.medpac.gov/wp-content/uploads/2026/04/04302026_MedPAC_FY27_hospice_comment_V2_SEC.pdf

contrast, the industry-wide average was \$12 per beneficiary. In other words, our members score higher on the SSVI spending component despite spending less per patient than the average hospice. This is a direct indication that the current aggregate spending methodology is not accurately distinguishing between high-volume providers and high-spending providers.

LeadingAge urges CMS to restructure the nonhospice spending component to incorporate both aggregate spending and average daily spending at the individual patient level — calculated specifically among patients who actually have nonhospice spending, rather than averaged across all patients. Focusing on patients with nonhospice spending isolates the population where aberrant behavior is most likely to appear and avoids diluting the signal by including patients with no nonhospice spending at all. This dual approach would more accurately identify hospices that are genuinely avoiding costs to increase revenue, while reducing false positives among larger mission-driven providers whose aggregate spending reflects patient volume rather than problematic patterns.

- ***Skin Substitute Spending: LeadingAge urges CMS to remove claims regarding these products be removed as part of the nonhospice spending metric given the significant investigations by the Department of Health and Human Services as well as the Department of Justice (DOJ) into the skin substitute industry. To retain these claims as part of the nonhospice spending calculation further legitimizes the use of these low value products and potentially fraudulent providers.***

In 2025, the HHS Office of Inspector General (OIG) released a report reviewing the astronomical growth in skin substitute expenditures and highlighting that home care enrollees accounted for more than half the Part B spending on skin substitute expenditures.¹⁶ In 2025, the DOJ convicted owners of a wound care company in Arizona which was an egregious and heartbreaking example of beneficiary harm.¹⁷ According to the DOJ press release, the wound company owners “...instructed the nurse practitioners to suspend their medical judgment and apply whatever quantities and sizes of grafts were ordered by the medically untrained sales representatives, regardless of medical necessity.”

Other cases identified by Accountable for Care, a nonpartisan national advocacy and policy analysis organization accelerating the adoption of effective accountable care, found through its Accountable Care Organization membership instances of hospice patients inappropriately targeted by these wound care agencies. From their unique position of monitoring spending across their patient populations, ACOs have the ability to identify Significant, Anomalous, and Highly Suspect (SAHS) billing activity and have tracked skin substitute abnormalities for the past several years. One story in particular from Accountable for Care was of a hospice patient who routinely had these skin substitutes applied without consulting the hospice care team and the patient died due to complications from the application of these substitutes and not the terminal

¹⁶ Office of Inspector General. (2025). *Medicare payments for skin substitutes (OEI-BL-24-00420)*. <https://oig.hhs.gov/documents/evaluation/10939/OEI-BL-24-00420.pdf>

¹⁷ U.S. Department of Justice. (n.d.). *Wound graft company owners sentenced for health care fraud*. <https://www.justice.gov/opa/pr/wound-graft-company-owners-sentenced-12b-health-care-fraud-and-agree-pay-309m-resolve-civil>

condition for which she enrolled in hospice.¹⁸ There is significant concern these instances of beneficiary harm could be more widespread. Similar accounts have been shared with LeadingAge from our hospice members regarding wound care companies which are no longer acting in good faith and refuse to stop treating hospice enrolled patients when the hospice deems wound care related to the individual's terminal condition or related conditions. In our review of the Expanded Parts B/D Non-Hospice Spending files provided by CMS for this rule, we found that the seven significant expenditures across all HCPCS codes in the DME & Carrier Claims were for skin allograft DME. These claims accounted for 50% of all spending in the DME & Carrier Claims. Each of these HCPCS codes is included in the Wasteful and Inappropriate Service Reduction (WISeR) Model as a wasteful, low-value service which requires prior authorization for approval.¹⁹

Despite this clear evidence of widespread fraud in skin substitutes, CMS stated in the proposed rule, "Additionally, it is not unusual for terminally ill patients to have skin breakdown as a result of their deconditioned state and where wound care would be appropriate for comfort. As such, we question why hospices would not be providing needed wound care for pressure ulcers (which could potentially require a skin substitute in certain circumstances) given that pressure ulcers generally develop from unrelieved pressure as a result of limited mobility and in terminally ill individuals who are chairbound or bedbound."

CMS made changes in the CY2026 Physician Fee Schedule reimbursement for skin substitutes beginning in 2026 to significantly reduce the Medicare spending on these projects. In a March 2026 letter to ACO REACH model participants stating that due to the disproportionate impact of skin substitute spending on their populations, "CMS will remove 90% of skin substitute expenditures for 254 HCPCS codes related to skin substitutes for PY 2025 and likewise recalculate the stop-loss and the RTA and exclude 90% of skin substitute billing activity from historical benchmark years for PY 2025. CMS will also calculate shared savings to hold REACH ACOs harmless to any downside impacts from the removal of skin substitutes for PY 2025."²⁰ ACO REACH model participants serving equally vulnerable populations received a reprieve from CMS regarding fraudulent skin substitute billing – hospices should too. **LeadingAge asks CMS to be consistent in their application of this policy against fraudulent providers of skin substitutes and remove 90% of the skin substitute expenditures associated with nonhospice spending and recalculate total expenditures for 2025 and 2024.**

¹⁸ Accountable for Care. (n.d.). *Medicare's skin substitute crisis*. <https://accountableforhealth.org/medicares-skin-substitute-crisis/>

¹⁹ Centers for Medicare & Medicaid Services. (n.d.). *WISeR model*. <https://www.cms.gov/priorities/innovation/innovation-models/wiser>

²⁰ The Centers for Medicare and Medicaid Services. *The ACO REACH Model. 2025 Significant, Anomalous, and Highly Suspect (SAHS) billing and Skin Substitute billing in the ACO REACH Model and the Medicare Shared Savings Program*. March 31, 2026.

- *Spending Categories Conflict with CMS Regulations:* LeadingAge members include both nonprofit hospice providers and the skilled nursing facilities and nursing homes in which many hospice patients reside. This dual perspective gives us direct insight into a billing pattern that may be causing CMS to overstate nonhospice spending attributable to hospice elections: the routine physician visits required by federal Long-Term Care Requirements of Participation (RoPs) for nursing facility residents. Under consolidated billing rules, physician services furnished to Medicare beneficiaries during a Part A skilled nursing facility stay are bundled into the SNF payment and would not appear as separate Part B claims. For long-stay residents, including those who exhaust their Part A SNF benefit, physician services may be billed separately under Part B — and when such a resident also elects the hospice benefit, those Part B physician claims may be captured in CMS's nonhospice spending data even though they are both regulatorily required and clinically appropriate. Federal Long-Term Care RoPs require that a physician visit residents at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.²¹ These visits are a requirement of participation — not discretionary services — and the associated billing is entirely consistent with applicable regulations. Based on our review of the Expanded Parts B/D Non-Hospice Spending files provided by CMS for this rule, we are concerned that evaluation and management (E&M) claims for these required physician visits may be included in the nonhospice spending figures used to calculate SSVI scores.

The appropriate treatment of these claims depends on who is conducting the visits and in what capacity. A visit conducted by the nursing facility's medical director in fulfillment of RoP requirements is categorically different from a visit conducted by an outside provider with no existing relationship to the resident. A visit by the resident's chosen attending physician — who may also serve as the attending physician of record under the hospice benefit — may raise different questions entirely. CMS's current data does not make these distinctions visible, and without that clarity it is not possible to assess whether the E&M spending appearing in nonhospice claims represents a coverage gap, a compliance issue, or simply the ordinary operation of two overlapping regulatory frameworks.

Because physician visits to nursing facility residents represent one of the more significant cost categories in the nonhospice spending data, **LeadingAge requests that CMS: (1) analyze the E&M claims appearing in the nonhospice spending files to determine whether they reflect visits conducted by the medical director in fulfillment of RoP requirements, by the resident's attending physician, or by unrelated outside providers; (2) provide transparency to stakeholders about how these claims are currently being categorized; and (3) remove from the nonhospice spending measure any E&M claims that CMS determines were billed in compliance with applicable Long-Term Care RoP requirements. Counting regulatory-required physician visits as evidence of inappropriate nonhospice spending would penalize nursing facilities and their associated hospice programs for complying with federal law.**

²¹ U.S. Government Publishing Office. (n.d.). *42 CFR § 483.30(c)(1)*. [https://www.ecfr.gov/current/title-42/part-483/subpart-B#p-483.30\(c\)\(1\)](https://www.ecfr.gov/current/title-42/part-483/subpart-B#p-483.30(c)(1))

- National Council for Prescription Drug Programs Hospice Workgroup:* LeadingAge strongly supports the efforts of the National Council for Prescription Drug Program’s (NCPDP) work to align Part D and hospice billing and prior authorization requirements.²² In August 2022, NCPDP launched a pilot to design a hospice election notification system. In June 2024 CMS virtual data center information was added to help pilot participants transmit and receive Notice of Election (NOE) statements in a reduced time frame. The electronic notification, called the Hospice N, reduces the notification timeframe by 20 to 30 days. With the median length of stay in hospice being 19 days in 2024, this could mean a significant reduction in nonhospice Part D spending if CMS allows time for hospices and Part D plans to adopt the alternative method. It was only in August 2025, that CMS announced this alternative, faster method for transfer of NOEs to Part D plan sponsors and hospices. CMS strongly encourages Part D plans placing beneficiary-level prior authorizations on four categories of traditionally palliative care focused drugs: analgesics, antianxiety drugs, anti-nauseants, and laxatives.²³ While these four categories do not rise to the top of the Part D therapeutics spending, CMS could reevaluate and expand the 2016 guidance for Part D prior authorization for hospice beneficiaries. **Regardless, LeadingAge requests CMS reevaluate the use of the hospice Part D spending amounts in the calculation of the SSVI spending measures in 2025 to allow more time for hospices and Part D sponsors to engage in the NCPDP pilot.** CMS should also support the expansion of participation in the pilot through training for Part D and hospice providers. LeadingAge would welcome the opportunity to partner with CMS and engage our membership in the pilot project.

Data Transparency: For the nonhospice spending measure to be an effective tool not only for program integrity but also individual hospice quality improvement, individual hospice level nonhospice spending data is necessary. And this data must include names of the providers billing for services during hospice. Individual providers cannot begin to understand their scores without this. Though we caution that, again, hospices have no control to prevent the billing of other providers and CMS should not consider hospices responsible for nonhospice spending unless they are prepared to give hospices the authority to reject claims from other providers which do not meet CMS’s expectations of “virtually all” care “related to the terminal illness” and “reasonable and necessary.”

Proposed Mandatory Hospice Election Statement Addendum for All Elections

LeadingAge opposes CMS’s proposal to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election. LeadingAge has been clear on this position before in response to the Hospice Care Accountability, Reform and Enforcement (CARE) Act of 2024.²⁴

²² Alliance for Care at Home. (2022). Hospice NOE pilot. https://allianceforcareathome.org/wp-content/uploads/HospiceNOEpilot_1755439270.pdf

²³ Centers for Medicare & Medicaid Services. (n.d.). *Medicare Prescription Drug Benefit Manual: Chapter 6*. <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf>

²⁴ LeadingAge. (2024). Hospice CARE Act comments. <https://leadingage.org/wp-content/uploads/2024/07/LeadingAgeHospiceCAREActCommentsFINAL.pdf>

CMS did not propose any changes to the hospice election statement addendum process or content, which makes this proposal even more infeasible. If CMS were to move forward with a universal addendum, the following changes would be helpful but do not outweigh clear member feedback in opposition to the proposal.

- Delay the implementation timeframe of October 1, 2026, by at least six months to allow hospice providers and their EMR partners to appropriately prepare for the additional regulatory burdens associated with a universal election statement.
- Extend the timeframe for submission of the addendum until after the first interdisciplinary group (IDG) meeting has occurred – at least two weeks.
- 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. This requirement becomes additionally burdensome if the beneficiary is unable to sign for themselves and the hospice needs to track down the individual's representatives who do not live in the area (those that do not want it delivered electronically, incorrect emails, cannot otherwise reach the representative, signatures, etc).
- CMS would need to provide technical specifications and support to make the addendum electronic which would incur additional costs for hospices as EMR systems would need to be updated.
- The addendum does not address all non-covered items, services, and drugs. However, Medicare does not cover items, services, and drugs unless they are “medically reasonable and necessary”. Currently, addendum is for “unrelated” only which is distinct from medical necessity determinations. We believe some of the nonhospice spend, while coded as unrelated, is actually not reasonable and necessary. CMS would need to amend to form to clarify how to address these situations.

There are two core concerns with our members raised during discussions about this proposal. First, LeadingAge members felt this put an unjustified burden on families to adjudicate appropriate care. We understand CMS intended the addendum to help families understand what they were electing when enrolling in hospice. And for those families prepared to request the addendum, it can be helpful. However, for many families who spend little more than two weeks with hospices, this is yet another piece of paperwork during an already emotionally difficult time where often the family is both grieving but also providing care. The expectation that a family should be able to review the addendum when another provider offers support for their loved one and turn them away is simply unrealistic and not the responsibility of a grieving family.

Secondly, members strongly believe that the provision of the addendum to every patient will not solve the problem of unrelated spending. Nearly all of this spending is completely out of the hospice's control and necessitates interventions in the Part A, B and D billing systems. CMS asserts that providers have approached them regarding hospices being unresponsive but does not discuss the alternative position when a hospice asks a provider to cease billing for items and services that should be under the purview of the hospice and the provider refuses. There is currently no recourse for hospices in this situation as they have no authority to reject billing of other providers.

Alternative Proposal for Reducing Nonhospice Spending

LeadingAge proposes CMS to hold nonhospice providers accountable for billing nonhospice services. CMS indicated that in Expanded Parts B/D Non-Hospice Spending files that claims included “Part B paid amounts are the total reported on the claim, without regard to the presence of modifiers (GV/GW or condition codes (07)).” However, in the burden reduction estimate for the mandatory statement, CMS calculates the estimated reduction based on the use of the GW professional claims modifier and 07 institutional modifier claiming that it would reduce the time a nurse from a nonhospice providers takes to get the relevant information from a hospice provider 5 minutes rather than 15 minutes. But this is contrary to the existing FAQs of the addendum²⁵:

FY 2020 Hospice final Rule (84 FR 38508): Likewise, the hospice beneficiary (or representative) would not have to separately consent to the release of this information to non-hospice providers furnishing services for unrelated conditions as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient’s express authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient (45 CFR 164.506). Therefore, the patient does not have to authorize release of this information to provide the addendum to non-hospice providers.

If the purpose of the addendum is simply to save time and reduce cost burdens to nonhospice providers, there is already a mechanism in place with the current addendum requirements. Nonhospice providers can request this information today and are not.

We believe this is due to existing modifier loophole in the billing for services outside of the hospice benefit. In 2025, CMS took action to curb the overuse of the 07 modifier through a claims edit.²⁶ The 07 institutional claim modifier edit rejects any claims where the primary diagnosis code on the institutional claim matches the hospice claim. LeadingAge argues that, given the extensive billing in the Part B systems, the GW and GV modifiers need a similar code edit to prevent further abuses. We recommend the following actions:

- CMS must create an edit through the Common Working File (CWF) system where the presence of a timely Hospice Notice of Enrollment (NOE) stops any other payment for services on those dates (excluding admission and live discharge days) unless the provider billing non-related items uses the GW or GV modifier.
- If the GW or GV modifier is present on the claim, the provider of that service should be required to furnish the addendum requested from the hospice, which should not require the patient signature, which states the services they are providing are unrelated to the terminal condition.

²⁵ Palmetto GBA. (n.d.). *Hospice beneficiary election statement addendum FAQs*.

[https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/multi_mac_hospice_beneficiary_election_statement_addendum_faqs.pdf/\\$file/multi_mac_hospice_beneficiary_election_statement_addendum_faqs.pdf](https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/multi_mac_hospice_beneficiary_election_statement_addendum_faqs.pdf/$file/multi_mac_hospice_beneficiary_election_statement_addendum_faqs.pdf)

²⁶ Centers for Medicare & Medicaid Services. (2025). *Outpatient services hospice patients: New edit (MLN Matters)*. <https://www.cms.gov/files/document/mm14219-outpatient-services-hospice-patients-new-edit.pdf>

- As with the efforts undertaken by NCPDP pilot, CMS should assess the feasibility of making the addendum an electronically submitted form which can quickly move between providers to eliminate any delays to necessary care that is deemed unrelated to the terminal condition.
- The review should be only ONE time. If a hospice puts a service, item, or 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 support for issues unrelated to their terminal condition.
- CMS should 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.

LeadingAge acknowledges that some members are concerned that this will increase the burden of review requests from nonhospice providers. However, members also acknowledge that to address the nonhospice spending issues, they must take on more responsibility to protect beneficiaries and the hospice benefit.

Proposed Clarifying Regulations Text Changes

Discharge From Hospice Care

LeadingAge supports CMS' clarifications at §418.26 with the addition of the physician designee and physician member of the interdisciplinary group language and believes that it will add clarity to the physician's role in discharge process. We appreciate CMS' continued review of regulatory text and appreciate their willingness to make changes that improve the program overall.

Face-to-Face Encounter

LeadingAge supports CMS' obligation to codify components of the Consolidated Appropriations Act of 2026 (CAA, 2026) regarding the use of telehealth to conduct a face-to-face encounter into hospice regulations. However, CMS should issue more guidance regarding utilization of telehealth during the hospice enrollment moratorium.

CMS put out frequently asked questions (FAQ) on the national moratoria for home health and hospice that went into place on May 13, 2026.²⁷ This FAQ noted that hospices could continue to use telehealth to perform the face-to-face encounter during the hospice moratorium but provided no further guidance. We are receiving questions from members and legal experts about the nature of this interpretation, the guidance that will be issued to the Medicare Administrative Contractors (MACs), and whether this FAQ will be relied on by Administrative Law Judges (ALJs). **CMS should put out additional guidance so that hospices can feel confident in continuing to use telehealth during this moratorium consistent with CMS' intent.**

Regarding the implementation of a new G-code identifying face-to-face encounters furnished via telehealth, LeadingAge would like to point out some key barriers and potential solutions to implementation of this statute.

²⁷ Centers for Medicare & Medicaid Services. (2026, May). *Home health and hospice nationwide moratorium FAQs*. <https://www.cms.gov/files/document/hh-hospice-moratorium-faqs.pdf>

Non-Billable Claim: The hospice face-to-face is currently not collected on the claim because it is an administrative requirement and non-billable. CMS will need to establish expectations and parameters for these non-billable codes.

Face-to-Face Clinicians: The clinician completing the face-to-face is not necessarily listed on the claim (especially if it is a nurse practitioner), as the clinician does not necessarily need to be the original certifying physician or the attending physician. CMS will need to establish a place on the claims for reporting the clinician who conducted the face-to-face and their associated NPI number to establish a claims edit like the one implemented for certifying physicians in 2024. Hospices will need extra time to ensure compliance with this requirement as well.

Date of Face-to-Face: Currently, claims list the date of the recertification but not the date of the face-to-face encounter. These dates may differ as we previously mentioned the clinician conducting the face-to-face may not be the one who originally certified or who will recertify. In the case of nurse practitioners, they may conduct the face-to-face but they cannot certify or recertify a patient for hospice. In order to operationalize the statute, CMS will need to add a date for the face-to-face encounter on claims.

While CMS solicited additional comments on the use of a new G-code to identify when face-to-face was conducted using telehealth, CMS did not mention the requirement of clinicians who are not physicians, specifically nurse practitioners, to be enrolled in Medicare when completing the face-to-face requirement. We believe that most nurse practitioners employed by hospices are enrolled in Medicare, however, additional information on enrollment or opt-ed out status has not been shared publicly and it is not clear how CMS intends to operationalize this additional provision of the CAA, 2026. We request CMS provide additional information and establish timelines for ensuring all providers who are eligible to conduct the face-to-face understand their responsibilities to properly enroll or opt-out of the system.

We are also concerned with expectations of § 418.22(a)(4)(ii)(b). It is not entirely clear how a hospice will be determined to be under a Provisional Period of Enhanced Enrollment, particularly as it relates to new G-Codes establishing the face-to-face via telehealth. Our understanding is that when a PPEO is established, a newly enrolling provider can anticipate being under enhanced oversight lasting from 30 days to 1 year.²⁸ However, being under this enhanced oversight does not automatically mean that a provider's claims will be rejected or subject to an edit. The experience of many hospice providers is an initial 1 or 2 rounds of limited claims review. However, there is no clear indication of if a provider has "passed" the initial review and is "graduated" from the PPEO. Are providers to assume they are formally under PPEO for a full year, or are they cleared under PPEO after the designated MAC clears their potentially multiple rounds of claims?

There are additional issues with the current process of PPEO communications as some providers receive notices of revocation of billing privileges or 100% prepayment reviews while others receive no additional information on their performance. Without a clear subregulatory guidance on what providers can expect in the PPEO process, it will be difficult to know if a provider is, for the purposes of this new statute "under PPEO" or if they have officially passed their PPEO. LeadingAge requests CMS establish clear guidelines for whether a provider is under PPEO and a clear, standardized process for "graduating"

²⁸ Centers for Medicare & Medicaid Services. (n.d.). *Period of enhanced oversight for new hospices*. <https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas-georgia-ohio.pdf>

from the PPEO. We also request that CMS establish accountability for the MACs charged with enforcing the PPEO and clear standards for transparency and communications that makes the PPEO process consistent across MACs.

Finally, we would like to take this opportunity to reiterate our multi-year recommendation to CMS to capture telehealth information in claims and cost reports for hospice providers, beyond the use of telehealth for face-to-face encounters. 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, especially in rural areas of the country. 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.²⁹ Additionally, we believe CMS has the ability quickly develop modifiers based on the G-Codes required of home health providers in July 2023.³⁰ **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.**

Hospice Provider Enrollment Moratorium

LeadingAge supported a short-term pause on new hospice provider enrollments as announced by CMS on May 13, 2026. While we are supportive, we have already been alerted by our membership of potential unintended consequences for access to care. We reiterate the need to swiftly implement focused approaches to oversight including enhanced site visits, as well as stronger enrollment controls so that, when the freeze is lifted, newly enrolled providers are screened more appropriately for participation in the Medicare program and existing bad actors are caught. **Finally, we request CMS provide additional transparency on the planned actions for additional oversight on enrollment and clear criteria CMS will use to determine when the moratoria will end.**

Request for Information: Enhance the Provision of Palliative Care Outside of Hospice Care

As outlined in LeadingAge Hospice Benefit Reform Ideas from January 2023, we strongly believe a patient who wants to continue to pursue treatment aimed at “curing” their underlying illness deserves wraparound supportive services and palliative care programs have a significant role to play in supporting these patients.³¹

²⁹ Medicare Payment Advisory Commission. (2022, March). *Report to the Congress: Medicare payment policy (Chapter 11)*. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf

³⁰ Centers for Medicare & Medicaid Services. (2022, July 21). *Telehealth home health services: New G-codes (MLN Matters)*. <https://www.cms.gov/files/document/mm12805-telehealth-home-health-services-new-g-codes.pdf>

³¹ Centers for Medicare & Medicaid Services. (2015, June). *Palliative care infographic* [Infographic]. <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/infograph-palliativecare-%5Bjune-2015%5D.pdf>

Many hospices offer palliative care because of the overlapping skillset which focus on the holistic treatment of a patient's medical, emotional and psychosocial needs. Through LeadingAge's diverse membership from congregate settings to community-based providers, we believe palliative care services should be able to be offered by hospices and other providers in inpatient, outpatient, or at home. An individual's need for palliative care can fluctuate over the course of several years and should be considered as a distinct service from hospice. A newly enrolled Medicare beneficiary may face a sudden serious illness such as a cancer diagnosis and require additional support during the treatment process before they go into remission and live another decade or more before needing hospice services. This is the perfect situation for palliative involvement.

Understanding Billing Practices and Delivering Palliative Care

Do the E/M codes, care management codes, and ACP codes represent the majority of the billing codes providers use to capture community palliative care services?

As CMS acknowledges in this RFI, most palliative care programs utilize Part B billing for palliative care programs. Members shared that they use a mix of E&M codes including but not limited to the Advanced Care Planning codes and care management codes including the Principal Illness Navigation (PIN) codes. One member shared nearly 50 different codes their billing team uses to bill for palliative services. Members are also incorporating other E&M codes including smoking cessation and PHQ9 to support more lifestyle and psychosocial challenges for beneficiaries with serious illness.

While LeadingAge strongly supports the work of CMS to provide billing codes that encourage advanced care planning/goals of care conversations, challenges with these codes remain. The conversations themselves can be time intensive but not adequately reimbursed for the time taken. Additionally, many of our members found this discussion most well suited for social workers or nurses who are part of a typical palliative program's interdisciplinary team, but at this time social workers and nurses cannot independently bill for these codes. Unfortunately, for many members they could not afford to hire a full-time social worker specifically for palliative care, it is not financially viable given the low pay and time-consuming work required of the codes.

What services are typically provided when Z51.5 is billed?

When we spoke with members, many included the Z51.5 as a code in their billing, often the last code. In speaking with other partners in the palliative care community, it is generally felt that this ICD-10 code is over utilized. There is no clear guidance from CMS when this code is appropriate or who should use this code in terms of provider setting. As such, LeadingAge does not believe it is useful for the purposes of improving the provision of community-based palliative care.

Are there challenges in meeting documentation requirements or integrating non-billable team members, such as social workers, chaplains, or nurses who are crucial to palliative care delivery?

Members did not feel there were any significant issues in meeting the documentation required to demonstrate a need for palliative care. Especially for hospice and home health-based palliative care providers who have detailed local coverage and national coverage determinations, appropriate documentation is essential to these providers in other payment settings. Arguably the most significant

challenge of community-based palliative care providers is sustaining the interdisciplinary model with the limited Part B codes available. According to CMS's definition of palliative care, it is a multi-disciplinary approach.³² However, several core members of the team are not allowable billers including nurses, social workers, and chaplains. Many of our members expressed the deep desire to be able to offer more services, including chaplains, to support the spiritual well-being of patients faced with serious illness. Yet again, the limiting factor is the inability to sustain the full team on the limited coding available for palliative care services.

What non-medical services, such as caregiver training or spiritual care, would most benefit patients if reimbursed? And what enhancements to existing benefits (not requiring legislation) could strengthen palliative care? These might include expanding social worker billing privileges or creating standardized codes or definitions for serious-illness care.

Based on discussions with our members, spiritual care support is most beneficial for patients in need of palliative care support but the least likely to be offered due to the lack of reimbursement. As LeadingAge has mentioned in previous comments throughout the years, chaplain services are an essential part of the hospice process and that extends to palliative care as well. Currently, codes used for Primary Illness Navigation and Community Health Integration offer opportunities to use auxiliary personnel under the supervision of the billing practitioner with the expectation that these staff have the appropriate credentials to provide competent care. LeadingAge believes CMS can utilize this standard to more fully incorporate chaplain services into the interdisciplinary team.

Understanding Program and Beneficiary Needs

What aspects of palliative care are financially unsustainable for providers?

Unfortunately, few palliative care programs can fully cover their costs; the majority of our member community-based palliative care programs rely on organizational subsidies to sustain their services. This unsustainability has made community-based palliative care programs a loss leader for hospice services. Our members were clear; converting patients to hospice exclusively should not be the goal of palliative care. Our members also share that there is a general lack of consistency across palliative care programs with some using only an advanced practice provider while others have two to three other members of an interdisciplinary team.

What documentation requirements do providers typically use, or suggest using, to identify the provision of palliative care?

LeadingAge recommends working to improve access to Part B palliative care through assigning adequate payment to an existing CMS comprehensive management and care coordination methodology. Specifically, both Hawaii and New Jersey have developed palliative care programs which rely on three main codes: S0280, S0311 and S0281. The first and third codes are essential to the developing a comprehensive framework under existing authorities for palliative care as they relate to the assessment of the patient and reassessment to ensure ongoing eligibility for care. For hospice and home health

³² Centers for Medicare & Medicaid Services. (2015, June). *Palliative care infographic* [Infographic]. <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/infograph-palliativecare-%5Bjune-2015%5D.pdf>

providers who have traditionally served these patients, ongoing assessment is essential for clearly defining and meeting goals of care. Requiring assessments will also support the development of clearer definitions and populations for palliative support in the future. S0311 allows for a monthly bundled payment which, if activated in Medicare, would allow for essential members of the interdisciplinary team who cannot bill Medicare directly to be incorporated into palliative care clinical models without practices or agencies losing money. CMS should look at operationalizing these codes within the Medicare program.

Do providers commonly refer patients for home health services when a patient needs palliative care concurrently with curative or life-sustaining care?

In addition to ensuring adequate, flexible payment in Part B, palliative care should be made more readily available through the home health benefit. Home health agencies are uniquely positioned to support palliative care needs of Medicare beneficiaries if the current structure of their payment and quality incentives is changed. A significant portion of Medicare beneficiaries dealing with serious illness meet the homebound and skilled need requirements of home health eligibility. However, most agencies struggle to serve or purposefully avoid these individuals due to the mismatched incentives in the current home health payment and quality structure.

Payments to home health agencies have decreased over the last five years since the implementation of the Patient Driven Groupings Model. This has led to the shortening of home health stays and decreases in the number of visits overall. It is difficult to adequately address all the issues associated with the interdisciplinary needs of a palliative care patient with this limited reimbursement. There are also issues with the HCPCS codes available in home health to bill in the bundle for telephonic services of social workers (such as the HCPCS G0155, REV 0569 in hospice). Additionally, there is a lack of coding for the delivery of a nurse focused maintenance program. Currently, there are HCPCS codes for therapy-based maintenance programs (G0159, G0160, G0161) but, as was required by the *Jimmo v. Sebelius* settlement, maintenance extends to not only therapy but nursing supports.

Quality reporting creates even more disincentives to support palliative care patients due to the exclusive focus on improvement in function. Despite the *Jimmo* settlement, the focus of nearly all home health quality measures on the improvement of function for patients diminishes the real ability of home health agencies to support maintenance of function. For many palliative care patients at the beginning of their illness trajectory, this maintenance is far more important than improvement and is a truer metric of the quality of care they receive.

To address these issues and encourage more palliative care services in home health, LeadingAge makes the following recommendations:

- Create a distinction for patients in home health who receive rehabilitative services vs. maintenance/palliative services. This distinction would be established by the certifying clinician on their orders for home health. CMS would need to add an item to the OASIS indicating which type of home health service was to be delivered based on the certifying clinician's orders and that would adjust which items need to be responded to and how quality measures would be

calculated from the responses. While not endorsed by the Consensus Building Entity, CMS already has measure specifications for stabilization built into OASIS.³³

- Enhance the payment structure for palliative care patients to incentivize greater coordination between the certifying clinicians as well as incentivize use of more disciplines from the home health benefit. Currently, due to the restrictive payments, social work and aide services are deeply underutilized despite the benefits to this population. Nursing services are most common which can support the physical needs of palliative care patients such as medication adherence and evaluation. More clearly established coding for nursing-based maintenance programs and coding for social work education of families and social work telephonic based outreach are also needed.

What services do providers typically offer patients who are not eligible or ready to elect hospice care but require palliative services?

LeadingAge would like to reiterate that the goal of palliative care should not be to exclusively bridge the gap between curative treatment and hospice services. As discussed at the start of our response to this RFI, many Medicare beneficiaries will find themselves in need of palliative care for a short period of time before a remission or subsiding of symptoms of serious illness. This trajectory does not always lead to hospice and for many individuals there are cultural reasons they choose not to elect hospice services. CMS should not tie the improvement of palliative care access through Part B or home health to transitioning the patient into hospice care.

Additional Targeted Enhancements

We would also encourage CMS to consider how these palliative care service structures could be used in response to live discharge from hospice, with hospice teams focused on providing continuity of care for people with conditions that cause them to intermittently graduate from and return to hospice eligibility. Treatments aimed at “curing” an illness would still be offered in the same way they are now, but the ability to receive some level of supportive services would be more accessible.

It is essential for CMS to develop detailed and clear coding expectations for these programs as they move forward. The universe of possible codes to support the diverse population who could benefit from palliative care support is overwhelming for programs and needs clear boundaries and documentation expectation. Members shared that support from CMS on one set of codes which appropriately pays providers for palliative care. If CMS leads on this standardization in traditional Medicare, it is more likely that other payers will follow, especially if it builds on the work that is being done in state Medicaid programs.

Request for Information: Construction of a Hospice Specific Wage Index

LeadingAge conceptually supports the development of an independent hospice wage index. However, LeadingAge does have concerns about specific aspects of the potential methodology outlined in this

³³ Centers for Medicare & Medicaid Services. (n.d.). *Home health outcome measures table: OASIS-E 2025* [Data table]. <https://www.cms.gov/files/document/home-health-outcome-measures-table-oasis-e2025.pdf>

request for information as well as the Technical Expert Panel report published in March 2026.³⁴ We appreciate CMS' willingness to seek additional feedback from stakeholders and we hope that CMS continues to publish additional information and seek feedback in the coming comment cycles before any implementation of a new hospice specific wage index.

What data sources and changes should be considered to develop a wage index specific for hospices? What are the advantages of the suggested approach to constructing wage indexes, relative to the current system?

LeadingAge supports the concept of a new wage index based on the Bureau of Labor Statistics (BLS), however, there remain several issues to address before CMS moves forward with this data.

Incorporating a hospice-specific labor mix offers a more accurate representation of the occupational categories actually found in hospice settings, improving the relevance of the data in comparison to the current wage index which is based on hospital occupational mix. This data also has the potential to be more recent wage data, allowing for wage index calculations to better reflect the current labor market instead of the two-year lag time with hospital-based cost reports. The cross-industry data available through the BLS dataset is also much larger than only hospital data.

What are the main limitations of the suggested approach?

There are several significant concerns with the alternative BLS-based hospice wage index methodology that require resolution.

First, issues related to data representativeness and completeness raise questions about the accuracy of the alternative BLS-based wage index approach presented. Based on feedback from our members, there is a significant portion of hospice wages that are excluded from the calculation due to the omission of key occupational categories such as spiritual counseling, dietary counseling, medical records, volunteer coordination, and pharmacy services. Additionally, the technical report categorization of hospice physicians under the broad "Physicians, All Other" label is problematic, as anecdotally hospice physicians are typically evenly split between Family Medicine and General Internal Medicine. Furthermore, "Physicians, All Other" wage data is missing for 16 percent of counties, requiring substantial imputation and reducing data reliability. We also note that using hourly wage rates for home health aides from the BLS "Home Health and Personal Care Aides" category (31-1120) should be revisited as home health aides have specialized training for health-related tasks (e.g., monitoring vitals, assisting with the administration of medication, simple wound dressing changes, etc.) under the direction and supervision of a nurse that personal care aides are not qualified to perform. Additionally, hospices often compete with other occupations, like food service and retail, for entry-level home health aides, and these categories of wages should be considered in constructing a wage index.³⁵

Second, there are concerns with the labor mix methodology. The use of unaudited cost report data introduces the risk of inaccurate allocations and potential data manipulation. In addition, the reliance on

³⁴ Centers for Medicare & Medicaid Services. (2025, September). *Hospice wage index technical expert panel report*. <https://www.cms.gov/files/document/hospice-wage-index-technical-expert-panel-meeting-technical-report-september-2025.pdf>

³⁵ U.S. Government Accountability Office. (2021). *Health care workforce: GAO-21-72*. <https://www.gao.gov/assets/gao-21-72.pdf>

claims-based minutes for certain occupations does not accurately capture total paid hours or actual labor cost shares. Combining cost report data with claims data further complicates the methodology due to inconsistencies in data sources, claims for some occupations and cost reports for others. This inconsistency in measurement units, as the Medicare Payment Advisory Commission (MedPAC) points out in their comment letter on the FY2027 Hospice Wage Index Proposed Rule, “can distort occupational shares because costs reflect both wages and time, while visit minutes reflect time only.”³⁶ If CMS pursues a new wage index, they must regularly audit the cost reports.

Third, the approach to weighting for purposes of imputing missing values and calculating national average wage rates needs further study and potential refinement. The current census population-based weighting approach likely does not align with how hospice services are distributed, and there is a mismatch between where hospices pay for labor (provider location) and where services are delivered (beneficiary location). Lastly, the exclusion of contract labor costs from BLS data fails to account for a significant portion of hospice labor expenses, undermining the completeness and accuracy of the wage index.

Can any limitations be addressed through changes to the data sources mentioned, such as cost reports and claims?

LeadingAge recommends several improvements to the alternative BLS-based hospice wage index methodology through revisions to the proposed data sources.

First, hospice cost reports should be revised to include full-time equivalent (FTE) and reporting by contract versus non-contract staff, consistent with existing requirements for hospitals, dialysis facilities, skilled nursing facilities, and home health agencies. Second, claims data could be enhanced by requiring county code reporting using Value Code 85 with FIPS codes, allowing for more precise weighting based on where services are delivered. Finally, CMS needs ensure all relevant occupations are included on the claims to address the missing data highlighted in the proposed rule around physician services and nurse practitioners. Equally important to the adequate representation of hospice costs is the need to adopt codes to capture chaplain visits on the claims. LeadingAge has repeatedly made the recommendation to CMS to adopt codes previously updated for use in 2022³⁷:

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

What occupations should be included in the occupational mix to estimate geographic differences in expected prices to employ healthcare staff in hospices?

The occupational categories used in the alternative wage index calculations should be expanded to include all relevant hospice positions, particularly those involved in direct patient care (e.g., chaplains).

³⁶ Medicare Payment Advisory Commission. (2026, April 30). *Comment on FY 2027 hospice wage index proposed rule*. https://www.medpac.gov/wp-content/uploads/2026/04/04302026_MedPAC_FY27_hospice_comment_V2_SEC.pdf

³⁷ 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>

Physician categorization should be revised to reflect the typical hospice blend, anecdotally Family Medicine and General Internal Medicine, rather than using the overly broad "All Other" category which is also missing 16 percent of the time. Additionally, Abt Global should closely evaluate whether population-based weighting versus hospice days weighting using beneficiary location data derived from claims, more accurately reflects service distribution. Also, in calculating the national average wage rates, we believe the BLS has national wage rate data, so CMS should evaluate whether calculating weighted averages is even necessary. To improve data reliability, stronger integrity measures should be applied to hospice cost reports, including robust trimming and validity checks. This should occur prior to any formal introduction of them into the wage index methodology.

What additional labor categories, if any, should be added to cost reports to support the revision of the hospice wage index? Are any other changes to the cost reports required for this purpose?

CMS should be consistent in the occupational mix and the requirements of participation for hospices. Counseling services per 42 CFR 418.64(d) including bereavement counseling, dietary counseling, and spiritual counseling are missing from the current occupation list. These are considered core services of hospice conditions of participations meaning all hospices are required to “routinely provide substantially all core services directly by hospice employees.” These are patient-facing roles and should be included on claims to appropriately capture their use in the mix of services. Hospices are also regulatorily required to have volunteer services (42 CFR 418.78) which require staff to organize and therefore should be included in cost reports as they are not patient facing in the performance of their duties much like the “Nursing Administration” or corresponding BLS title “Medical and Health Services Managers” who are essential staff to ensure quality, compliance, and support appropriate billing. CMS should also create consistency between the ESRD wage index and this proposal and include similar occupations which are necessary to both providers. As noted below, a crosswalk from the original ESRD wage index proposal includes the administrative staff as well as management staff necessary to run an effective health care organization.³⁸ Those occupations should be included for hospice as well.

Table 1: Crosswalk of Occupation Codes on ESRD Cost Reports and BLS Data

ESRD PPS Colloquial Name	BLS Occupation Title	Occupation Code
Registered Nurses (RN)	Registered Nurses	29-1141
Licensed Practical Nurses (LPN)	Licensed Practical and Licensed Vocational Nurses	29-2061
Nurse Aides	Nursing Assistants	31-1131
Technicians	Health Technologists and Technicians, All Other	29-2099
Social Workers	Healthcare Social Workers	21-1022
Dieticians	Dieticians and Nutritionists	29-1031
Administrative Staff	Medical Secretaries and Administrative Assistants	43-6013
Management	Medical and Health Services Managers	11-9111

³⁸ Centers for Medicare & Medicaid Services. (n.d.). *Addendum C: ESRD PPS proposed wage index methodology*. <https://www.cms.gov/files/document/addendum-c-cms-1805-p-esrd-pps-proposed-wage-index-construction-methodology.pdf>

How should CMS appropriately compare wages between geographic areas that match the way hospice services are delivered? Should CMS maintain the use of CBSA, or consider other geographic delineation, such as county, census area, etc.?

To fully evaluate the alternative BLS-based wage index approach, additional data and analysis are needed. Specifically, it is necessary to examine the impact of a potential shift to hospice days-based weighting or using a BLS national wage rate on wage index values, and to compare labor cost shares derived from different data sources, such as from cost shares or eventual FTE counts following needed cost report changes. An analysis of missing data patterns and the effect of imputation is also critical to understanding the reliability of the alternative index. A thorough assessment of outlier impacts and changes in variance is required to ensure the new methodology produces fair and stable results across all hospice providers. LeadingAge also reiterates our long standing ask that CMS reinstitute its prior policy that no hospice be paid below the rural floor for their state.

How should CMS reduce large differences in wage index values for adjacent geographic areas?

CMS should evaluate how hospital reclassification policies impact the ability of other providers, such as hospices, to compete for qualified staff and consider policy approaches to help hospices and other providers compete more effectively with hospitals for staff in these higher wage areas. Finally, CMS should evaluate whether the hospice wage index floor policy should be modified given the policy goal of providing additional support for providers operating in low-wage regions, helping to ensure continued access to care.

How should CMS consider policy to support the transition between the current hospice wage index approach to a new one?

Implementation of any changes to the hospice wage index should be approached with careful consideration to ensure stability and transparency, including publicly publishing the methodology and resulting wage index values before notice and comment rulemaking to allow all providers to share feedback. This includes being transparent about the wage index values produced using the BLS-based approach before and after the application of the 5% cap on wage index decreases. During the transition period from using the hospital wage index to a BLS-based wage index for hospice, several protections should be put in place. These include implementing an aggregate cap hold-harmless provision to prevent significant reductions in overall payments if a hospice were to exceed their cap due to an increase in their wage index, which is beyond their control. Additionally, the impact analysis by census region presented during the TEP discussion shows that CMS should carefully address the disproportionate effects of the BLS-based approach, limiting decreases to no more than 0.5% per year in any region to avoid destabilizing hospice care in affected areas. It is also important to assess the potential impact on state Medicaid budgets, as states must statutorily base Medicaid payment rates on the Medicare rates. Additionally, the revised methodology must be transparent, replicable, and capable of being validated by hospice providers. Ample lead time before any changes to the hospice wage index are implemented is critical for hospices to effectively plan, adjust budgets, modify staffing strategies, and ensure continued access to quality care without disruption.

Request for Information: Medical Aid in Dying (MAID)

LeadingAge appreciates CMS's inquiry on the impact of Medical Aid in Dying (MAID) on hospice providers. As CMS notes, many states have adopted state laws with strict criteria, and more states have pending legislation which would allow this practice. We look forward to CMS's discussion and analysis of the comments submitted in response to this request for information in the FY2027 Hospice Wage Index final rule. We ask that CMS use this opportunity to provide specific guidance based on this feedback and to define more clearly what actions would be permitted and prohibited to ensure that hospice providers comply with the prohibition on Medicare funds being used to facilitate MAID.

Updates for Hospice Quality Reporting Program (HQRP)

HOPE Timeliness Reporting Waiver

LeadingAge would like to take this opportunity to thank the staff at CMS for making the decision to consider all new Hospice Outcomes and Patient Evaluation assessments submitted in the first quarter of implementation timely. LeadingAge requested CMS waive the 90% threshold for the first quarter of reporting for over two years. This is an enormous weight off providers' shoulders and we are grateful for CMS' support.

Icon for Hospices on Care Compare to Indicate Failure to Meet Reporting Requirements

LeadingAge supports CMS' proposal to include an Icon on Care Compare starting in the first quarter of FY2028 which would indicate if a provider is non-compliant with HQRP. As mentioned in the proposed rule, despite the increase in the Annual Payment Update (APU) penalty from 2% to 4% in FY 2024, there has not been a significant improvement in the number of hospices meeting the HQRP reporting requirements. LeadingAge has flagged this concern for both CMS and Congressional leadership for the past several years. Equally of concern, many programs found to be out of compliance with reporting requirements are in areas of aberrant billing which are now under the Provisional Period of Enhanced Oversight, such as Arizona, California, Nevada and Texas.

Additionally, CMS has put into place several processes to allow extensions, exemptions, and reconsideration requests for providers who may be in danger of not meeting the 90% threshold within the required 30-day time frame. To that end, we ask that CMS consider any submission of one of these requests, as long as it complies with the regulatory requirements for submission (42 CFR 418.312(h) and 42 CFR 418.312(i)), as a good faith effort to comply with HQRP and not apply an icon to their yearly Care Compare update. From speaking with staff at CMS, these tools are rarely used by providers, however when they are it is an indication of good faith effort to comply with reporting requirements in the face of operational issues which are often out of a provider's hands such as disruptive technology transitions and disasters. We also request a direct contact at CMS if there is a mistake with the icon. Currently, corrections to some Care Compare data can take up to 6 months.

Finally, the text of the rule proposes focusing on the timely submission of at least 90% of HOPE assessment data however, the HQRP also includes the Hospice CAHPS survey. It is unclear in the annually posted hospice APU documentation if an agency failed to comply due to assessment submission or lack CAHPS participation. We request that in this new proposal, CMS clarify and ensure

non-participation in CAHPS reporting for qualifying hospices (50 or more survey-eligible decedents/caregivers) is included in the determination for applying the non-compliance icon. The Hospice CAHPS survey is an invaluable tool for understanding hospice quality for consumers. It is difficult to determine the quality of those hospices who do not conduct surveys despite their size.

Sincerely,

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About LeadingAge: *We represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, 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, hospice, Programs of All-Inclusive Care for the Elderly (PACE), 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. For more information, visit leadingage.org.*