HOSPICE CARE ACCOUNTABILITY, REFORM, AND ENFORCEMENT (HOSPICE CARE) ACT

SECTION-BY-SECTION BILL SUMMARY

SECTION 1. SHORT TITLE

This Act may be cited as the "**Hospice Care Accountability, Reform, and Enforcement Act of 2026**" or the "**Hospice CARE Act of 2026**".

SECTION 2. MANDATORY TEMPORARY MORATORIUM ON ENROLLMENT

Paragraph (1): This paragraph requires the Secretary of the Department of Health and Human Services (the Secretary) to impose a temporary, nationwide moratorium on the enrollment of new hospice programs for a five-year period beginning on the date of enactment. The Secretary may exempt a new hospice from the moratorium if the hospice furnishes care in an area with insufficient access to hospice care, determined by taking into consideration the current availability of hospice care, evidence of any unmet need, and the hospice's plan to address any gaps in access to hospice care. Additionally, the Secretary is permitted to shorten the moratorium period in a particular state (or a particular geographic area within a state) before the end of the five-year period. If the Secretary shortens the mortarium period, new hospices in the state (or a particular geographic area within a state) are subject to a provisional period of enhanced oversight in accordance with subsection (b), below. Given past experiences with previous enrollment moratoria (e.g., home health), often bad actors will move to other areas and states to evade an enrollment moratorium. A nationwide enrollment moratorium is needed to prevent the spread of fraud, waste, and abuse to other states.

During the five-year moratorium period, this subsection also requires the Secretary to conduct prepayment medical review of routine home care claims submitted after the first 90-day benefit period by hospices with aberrant billing patterns (e.g. outlier with respect to live discharges). If a hospice has a low rate of denial, the Secretary may terminate the application of prepayment medical review. The Secretary may revoke the termination of prepayment medical review for an individual hospice in the future, if appropriate.

Within six months of the date of enactment, this subsection requires the Secretary to revalidate the enrollment information of each hospice program enrolled in Medicare and, no later than one year after the date of enactment, publish the updated ownership interest and managing control information collected via revalidation. No later than January 1, 2028, the Secretary is required to submit a Report to Congress on hospice ownership and control.

Paragraph (2): Outside of hospice-specific moratorium outlined in paragraph (1), this paragraph provides general authority to the Secretary to exempt a provider or supplier otherwise subject to a moratorium, if determined appropriate by the Secretary.

SUBSECTION (B). EXTENSION OF OVERSIGHT OF NEWLY-ENROLLED HOSPICE PROGRAMS

This subsection extends to the ability of the Secretary to establish provisional periods of enhanced oversight to two years in the case of hospice programs (rather than one year under the existing statute). During a provisional period of enhanced oversight, providers or supplies are subject to enhanced oversight, such as prepayment review and payment caps. If the Secretary exempts a new hospice from the moratorium or shortens the moratorium period in a particular state (or geographic area within a state), the new hospice program (either exempted or in an area where the moratorium period was shortened) will be subject to a provisional period of enhanced oversight.

SUBSECTION (C). INCREASE IN SURVEY FREQUENCY FOR CERTAIN HOSPICE PROGRAMS

This subsection requires the Secretary to create a list of hospices subject to more frequent surveys – every 18 months rather than every 36 months under current law. The Secretary's list must include hospice programs that first submitted claims to Medicare within five years prior to the date of enactment or that first submitted claims to Medicare on or after the date of enactment. The Secretary may also include on the list hospices that may not be providing the full scope of services covered under the Medicare hospice benefit, hospices that are outliers with respect to their live discharge rates, or for other reasons as determined appropriate by the Secretary. A hospice program is removed from the list (reverting to being surveyed every 36 months) if the hospice program has been surveyed at least twice and was not subject to an enforcement action for being non-compliant with the hospice Conditions of Participation related to providing substandard quality of care. A hospice is also removed from the list if the hospice is part of the hospice Special Focus Program, as such hospices would already be subject to increased surveys as part of their participation in that program.

Additional funding is allocated to the Secretary for general hospice survey activities.

SUBSECTION (D). PROHIBITION ON PAYMENT FOR FAILURE TO MEET QUALITY DATA REPORTING REQUIREMENTS

This subsection prohibits payment to hospice programs that do not submit required quality data to the Secretary, starting in fiscal year 2028. Currently, about 20 percent

of hospice programs do not submit quality data even though they are subject to a four percent payment penalty. The current exemptions and extensions policy in the regulations would apply.

SUBSECTION (E). ENSURING INDEPENDENCE OF CERTIFICATIONS OF TERMINAL ILLNESS

If an individual does not designate an attending physician or the designated attending physician is employed by the hospice program (or otherwise has an ownership or financial relationship to the hospice program), this subsection requires a physician nurse practitioner, or physician assistant that does not have such a relationship (employment, ownership, or financial) with the hospice to certify terminal illness for the initial 90-day benefit period. The Department of Health and Human Services Office of Inspector General (OIG) has uncovered frequent fraud schemes involving hospice physicians inappropriately certifying patients as terminally ill. Currently, there is generally no prohibition on arrangements, financial or otherwise, between hospices and physicians that certify that a patient is eligible for hospice care (i.e., terminally ill with a life expectancy of six months or less). Such arrangements can result in financial incentives for physicians to falsely certify patients as eligible for hospice care.

SUBSECTION (F). ALLOWING ADDITIONAL PROVIDERS TO CERTIFY TERMINAL ILLNESS

This subsection allows nurse practitioners and physician assistants acting as the patient's designated attending physician to certify terminal illness.

SUBSECTION (G). ALLOWABLE USE OF SUPPORTING MATERIAL IN MEDICAL REVIEW OF HOSPICE CARE

This subsection requires the Secretary, when conducting medical review of hospice care for the initial 90-day election period, to use documentation in the medical record of the individual's attending physician that certified the patient as terminally ill or the physician, nurse practitioner, or physician assistant that so certified as the basis for determining whether the individual meets the hospice benefit eligibility criteria at the time of election. The Secretary may use documentation from the hospice program furnishing hospice care as supporting material, as determined appropriate by the secretary. When an individual first elects to receive hospice care, there should be medical record documentation that demonstrates why the individual was referred to hospice care and why the individual has a prognosis of six months or less (if the illness runs its normal course). Such documentation (i.e. longitudinal information about the patient's condition from before electing to receive hospice care) should serve as the basis for the initial certification of terminal illness, with supporting information from the hospice program involved.

SUBSECTION (H). PROHIBITION ON CERTAIN CHANGES IN MAJORITY OWNERSHIP

This subsection prohibits the hospice provider agreement and billing privileges to convey to a new owner within 60 months of initial certification (or the last majority change in ownership), rather than 36 months. This provision would sunset after the five-year period starting on the date of enactment and revert to the 36-month timeframe in current regulations. Recent fraud schemes have included "churn and burn" schemes, where a new hospice opens and starts billing, but once that hospice is audited or reaches its statutory yearly payment limit, it shuts down, keeps the money, buys a new Medicare billing number, transfers its patients over to the new Medicare billing number, and starts billing again.

SUBSECTION (I). ADVANCED NOTICE OF CHANGES IN OWNERSHIP OR CONTROL

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SUBSECTION (J). REQUIRED PROVISION OF ADDENDUM OF NON-COVERED SERVICES

This subsection requires hospices to automatically provide to the patient the election statement addendum that explains whether the hospice has determined that any necessary items or services are unrelated to the patient's terminal condition and thus not the responsibility of the hospice (other Medicare benefits would be available to cover the needed items and services). Currently, hospices only provide the addendum upon request.

SUBSECTION (K). MEDICAL REVIEW OF HOSPICE OUTLIERS AND CARE UNRELATED TO TERMINAL CONDITION

Paragraph (1): Sunsets the current requirement for the Secretary to conduct medical review for hospice care provided to an individual for more than 180 days when the hospice program has a certain percentage of patients that have stays that exceed 180 days. Instead, new language would require the Secretary to conduct prepayment medical review after the end of the five-year moratorium period for individuals that have hospice stays longer than 90 days in instances where a hospice program has aberrant billing patterns, as determined by the Secretary. Prior to

implementing these new prepayment reviews, the Secretary is required to convene a technical expert panel to prioritize recommendations for what should be considered "aberrant" billing, taking into consideration the prepayment review activities conducted by the Secretary under the moratorium period.

Paragraph (2): Requires the Secretary to conduct prepayment reviews for any claims submitted by providers and suppliers (not the hospice) that indicate that such claim is for an item or service unrelated to the terminal condition with respect to which a diagnosis of terminal illness has been made. Such reviews are to include a review of the information on the hospice election statement addendum furnished to the provider or supplier that submitted the "unrelated" claim. Hospice is a holistic, comprehensive benefit and it should be rare for an item or service to be unrelated to the patient's terminal condition. However, in fiscal year 2023, over $1.2 billion was paid for items and services provided during a patient's hospice election that were identified as unrelated.

Paragraph (3): Additional funding would be provided to the Secretary to conduct these reviews.

SUBSECTION (L). PROVISION OF EXPLANATION OF BENEFITS UPON HOSPICE ELECTION

Paragraph (1): Requires the Secretary, within 15 days of an individual's hospice election, to provide notice of such election so that beneficiaries can identify potentially fraudulent activity and report such instances to the Centers for Medicare & Medicaid Services (CMS) or the OIG. Since electing the Medicare Hospice Benefit means that individuals forgo their right to have Medicare payment made on their behalf for any items and services not provided by the hospice, appropriate safeguards must be put in place so that individuals are not fraudulently enrolled in hospice and encounter difficulties accessing needed care.

Paragraph (2): Provides additional funding to the Secretary for sending these notices to beneficiaries.

Paragraph (3): Requires the Secretary to begin sending these notices to individuals electing hospice one year after the date of enactment.

SUBSECTION (L). PROVISION OF EXPLANATION OF BENEFITS UPON HOSPICE ELECTION

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place so that individuals are not fraudulently enrolled in hospice and encounter difficulties accessing needed care.

Paragraph (2): Provides additional funding to the Secretary for sending these notices to beneficiaries.

Paragraph (3): Requires the Secretary to begin sending these notices to individuals electing hospice one year after the date of enactment.

SUBSECTION (M). MEDICAL REVIEW OF HOSPICE CARE CONTRACTOR REQUIREMENTS

Paragraph (1): Requires contractor staff performing medical reviews of hospice care to receive specialized instruction on the philosophy behind hospice care and medical prognostication for reviews conducted on or after January 1, 2028. The Secretary is required to consult with hospice programs on the content and development of the specialized instruction and any training programs developed must be publicly available through the CMS website.

Paragraph (2): Requires the Secretary to submit a Report to Congress no later than October 1, 2028, on all hospice medical review activities performed between January 1, 2020, and December 31, 2025, and provide information on the total number of claims reviewed, the percentage of claims denied that were appealed, the percentage of appealed claims overturned on appeal by level of appeal, a list of hospice medical review projects undertaken by contractors, and steps that the Secretary will take to reduce the audit burden on hospices and to minimize the number of denials of claims for hospice services that are overturned on appeal.

SUBSECTION (N). REQUIRING FACE-TO-FACE ENCOUNTERS BEFORE RECERTIFICATIONS OF TERMINAL ILLNESS

This subsection would permit physician assistants to perform hospice face-to-face encounters (in addition to physicians and nurse practitioners). A face-to-face encounter would be required to occur within 30 days prior to each recertification of terminal illness. The first recertification period face-to-face encounter must be performed in-person. However, all subsequent face-to-face encounters may be performed via telehealth if a hospice nurse or aide is present in person with the patient to facilitate the telehealth encounter with the hospice physician/nurse practitioner/physician assistant.

The purpose of the face-to-face encounter is primarily to gather clinical findings to determine whether a patient continues to be eligible for hospice care (i.e., continues to have a prognosis of a life expectancy of six months or less if the illness runs its normal course). Current law requires such an encounter to be performed before the second and later recertifications. This visit is the only time that a physician or nurse

practitioner is required to directly assess the patient. Active participation of a physician or nurse practitioner (and through this legislation, a physician assistant) is critical from a quality-of-care standpoint, given that hospice patients are the sickest patients in the health care system. Additionally, performing a physical exam on dying patients to gather clinical findings related to prognosticating their life expectancy should be done with hospice staff present in-person, with sensitivity toward the patient and family.

SUBSECTION (O). ENSURING MEDICAL DIRECTOR AND PHYSICIAN AVAILABILITY

This subsection requires hospice medical directors to have an active medical license to practice medicine in the state where the physician practices and limits a physician from serving as the medical director for more than two hospice programs. The Secretary may permit a physician to serve as a medical director for more than two hospices on a case-by-case basis, as determined appropriate by the Secretary, taking into account the average daily census for each of the hospices, the geographic areas served by the hospices, and any other information determined appropriate.

This subsection also requires the medical director or physician member of the interdisciplinary group be available for immediate consultation (which may be through telehealth) when hospice care is being provided in an individual's home. This will help to ensure that hospice staff caring for patients in their places of residence have access to a physician in real-time for consultation in instances where, for example, the patient may need adjustments to medications or other interventions for immediate symptom control and management.

These provisions would be effective beginning on January 1, 2029.

SUBSECTION (P). GAO REPORT ON HOSPICE ACCREDITING ORGANIZATIONS

This section requires a Government Accountability Office (GAO) Report to Congress on the Secretary's oversight of hospice accreditation organizations (AOs), including information on differences in survey findings between accreditation organizations and state survey agencies, AO conflicts of interest, and overall performance of AOs specific to hospice.

SECTION 3. PAYMENT REFORMS FOR HOSPICE CARE FURNISHED UNDER THE MEDICARE PROGRAM

SUBSECTION (A). ADJUSTING PAYMENTS FOR HOSPICE CARE

Paragraph (1): Requires the Secretary to calculate the percentage difference between the hospice payment rates and the average costs of providing such care, which may

vary based on the setting in which such care is furnished and taking into account any additional factors as determined appropriate by the Secretary. The payment rates for hospice care are to be adjusted by percentages specified by the Secretary for specified fiscal years (except for routine home care in fiscal year 2030, which will be split into a per-diem payment and separate per-visit payments).

In fiscal year 2030, the Secretary is to establish a per-diem payment amount for routine home care that reflects the components of such rates attributable to hospice care not consisting of direct patient care costs, which may be adjusted for case-mix. In addition, the Secretary is to establish per-visit payment amounts for visits that can vary based on the type and duration of visit, subject to frequency limits as may be specified by the Secretary.

In fiscal year 2031 and subsequent years, the rates in effect for the previous fiscal year are to be adjusted by, in the case of specified fiscal years, the percentages specified by the Secretary, and the market basket percentage increase reduced by a productivity adjustment.

The term "visit" is defined as in-person contact with an individual receiving hospice care, not including contact conducted via telehealth or any other form of telecommunications technology. Starting on October 1, 2027, and ending on September 30, 2032, in lieu of the routine home care rate, the Secretary shall pay hospice programs 400 percent of the routine home care rate (which may vary based on the type of item or service) for each day during which palliative chemotherapy, radiation, blood transfusions, or dialysis are provided to an individual. In lieu of 400 percent of the routine home care rate, the Secretary may establish alternate payment amounts for specified hospice services, as determined appropriate by the Secretary (such as payment based on the Physician Fee Schedule amounts). In the case of palliative dialysis, the individual must have been receiving dialysis before electing hospice, and payment is limited to 10 sessions of dialysis, unless any sessions over 10 are prior-authorized. In the case of palliative blood transfusions, such transfusions are subject to frequency limits as may be specified by the Secretary.

Prior to the payment changes and adjustments for the specified fiscal years (i.e., 2031, 2036, 2041), the Secretary is required to audit a representative sample of hospice cost reports for cost reporting periods beginning in fiscal year 2026 and then again in fiscal year 2031 and fiscal year 2036. After such audits are conducted, the Secretary is required to convene a technical expert panel to discuss the methodology and audit results. The results of such audits may be considered by the Secretary when implementing the required changes and adjustments to the hospice payment rates. Funding will be provided to the Secretary for conducting these audits.

Paragraph (2): After the increase in routine home care payments for specified hospice care (i.e., palliative chemotherapy, radiation, dialysis, and transfusions) sunsets on September 30, 2032, starting on October 1, 2032, the Secretary may provide an additional payment for specified hospice care and other such specified

hospice care and other such specified care to account for unusual variations in the type or amount of routine home care provided under the hospice benefit (i.e., outlier payments). Total outlier payments estimated to be made in a fiscal year may not exceed five percent of total Medicare hospice payments and total outlier payments to a hospice program in a fiscal year may not exceed 10 percent of total payments to that hospice. The Secretary shall reduce the per-diem payments for routine home care by five percent if an outlier policy is implemented in such year.

Paragraph (3): If the patient's plan of care includes palliative chemotherapy, radiation therapy, blood transfusions, or dialysis, the plan of care must be reviewed by an oncologist (in the case of chemotherapy, radiation therapy, and blood transfusions) or nephrologist (in the case of dialysis) that does not have a significant ownership interest in or significant financial relationship with the hospice program.

Paragraph (4): Removes coverage of home health aide services from the hospice benefit for individuals residing in a skilled nursing facility or nursing facility. In its June 2013 Report to Congress, the Medicare Payment Advisory Commission noted that the provision of aide visits in nursing facilities raises issues of duplicate payment given that the nursing home room and board fees—paid largely from Medicaid funds or by patients and families—explicitly cover aide services provided by nursing facility staff to assist residents with their personal care needs (e.g., activities of daily living). Hospices would still be able to provide homemaker services, but only on a volunteer basis, for individuals residing in nursing homes. Such volunteer services could include companionship and social interaction with the hospice patient.

Paragraph (5): Adjusts the cap amount in specified fiscal years to reflect the estimated percentage change in the total amount of payment made under this part for hospice care attributable to the amendments in paragraph one; also updates the cap amount from the previous fiscal year by the market basket percentage increase reduced by a productivity adjustment (rather than updating the amount by the Consumer Price Index for All Urban Consumers (CPI-U)).

SUBSECTION (B). WAGE ADJUSTING CAPS

This subsection multiplies the hospice cap amount for a year by a wage index ratio so that a hospice's aggregate cap reflects differences in area wage levels. The aggregate cap limits the total amount of payments that a hospice can receive in a given fiscal year. If a hospice goes over its aggregate cap amount, it must pay back the difference. Additionally, this paragraph adds a statutory requirement that the cap amount be reduced by sequestration if it is applied in any given year.

This subsection also requires the Secretary, no later than one year after the date of enactment, to provide a report to the authorizing committees on the hospice aggregate cap calculations under 1814(i)(2) for each of the past five accounting years as of the date of enactment. The report shall include the amount of payment made

1814(i)(2) for each of the past five accounting years as of the date of enactment. The report shall include the amount of payment made under this part for hospice care relative to the cap amount in the respective accounting year, the amount recouped by the Secretary for hospice programs that exceeded the cap amount, and the live discharge rates associated with each hospice program in the accounting year. The Secretary is required to post these reports publicly on a CMS website and update these public reports annually.

SUBSECTION (C). MODIFICATION OF REQUIREMENTS RELATING TO SHORT-TERM INPATIENT CARE

This subsection changes the current statutory language that limits inpatient respite care to no more than five consecutive days to no more than five days during an election period (i.e., five days in the first 90-day election period, another five days in the second 90-day period, and five days for each 60-day election period) and adds a transitional inpatient respite care period of an additional 15 days. Thus, individuals can receive up to 20 days of inpatient respite care during the first 90-day election period.

Transitional inpatient respite care is available for patients that first elect hospice from a hospital stay (which may include a stay for observation). Today, some patients who would otherwise elect to receive hospice care instead opt to receive care at a skilled nursing facility so that room and board is covered for a period of transition. Other beneficiaries have not been told that they are hospice eligible until a hospital stay, and the family needs time to figure out how to ensure the patient has sufficient caregiver support to be safely cared for at home. This legislation creates a transitional inpatient respite period of 15 days that can be used to help eligible patients transition into hospice care sooner from a hospital stay rather than choosing to first go to a skilled nursing facility.

This subsection also reduces the inpatient cap from 20 percent to 10 percent and instructs the Secretary to apply the cap on a real-time basis. Any inpatient care days that exceed the cap are paid the routine home care amounts rather than the inpatient respite or general inpatient care rates. The Secretary would be able to increase the cap from 10 percent up to 20 percent if the Secretary determines such an increase is necessary to ensure sufficient access to care.

Finally, this subsection permits hospices to contract with residential care facilities that are dedicated solely to caring for individuals enrolled in hospice to provide inpatient respite care (including transitional respite care) if they meet the appropriate health and safety standards determined by the Secretary, which may include consideration of the requirements that such facilities may already meet for purposes of state licensure.

SUBSECTION (D). HOSPITAL DISCHARGE PLANNING REQUIREMENTS

This subsection requires hospitals, starting on October 1, 2027, to include in a patient's discharge planning evaluation the availability of hospice respite care, including the new transitional respite period of an additional 15 days, in addition to assessing a patient's likely need for hospice and the availability of hospice care.

SUBSECTION (E). PAYMENT FOR RESPITE CARE FURNISHED IN THE HOME

Paragraph (1): Allows payment for short-term home respite care when respite care is provided to individuals in their homes (other than a skilled nursing facility, nursing facility, assisted living facility, or other facility as defined by the Secretary), effective on or after October 1, 2029. Home respite care is limited to 120 hours for the first two 90-day benefit periods and limited to 80 hours per benefit period for each subsequent 60-day benefit period.

Paragraph (2): Requires the Secretary to establish an hourly rate for short-term home respite care starting in fiscal year 2029. Payment for home respite care in a 24-hour period cannot exceed the payment amount for inpatient respite care. The hourly rate is in addition to the routine home care per diem amount. The hourly rate in subsequent years would be updated by the market basket percentage increase reduced by a productivity adjustment, as currently required in statute for hospice payment rate updates

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