Discussion Draft:
Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act
Representative Blumenauer (D-OR)
Section-by-Section Summary

Section 1. Short Title

Section 2. Ensuring the Integrity of Hospice Care Furnished Under the Medicare Program

Subsection (a). Mandatory Temporary Moratorium on Enrollment

This subsection requires the Secretary to impose a nationwide temporary 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. Hospice care is primarily provided in an individual's place of residence; thus, a hospice does not need to be located in the same area as the patients it serves. 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 [5-year] moratorium, this subsection 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., high rates of 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 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, 2027], the Secretary is required to submit a Report to Congress on hospice ownership and control trends and the role of private equity in the hospice industry.

The Secretary is to implement these provisions through program instruction or other forms of sub-regulatory guidance.

Paragraph (2): Outside of the 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). Authority to Extend Oversight of Newly-Enrolled Hospice Programs

This subsection extends 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.

Subsection (c). Increase in Survey Frequency for Certain Hospice Programs

This subsection requires the Secretary to survey new hospices more frequently, every [15-18] months, rather than every 36 months. The Secretary is required to create a list of 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. A hospice program is removed from the list (reverting back to being surveyed every 36 months) if the hospice program has been on the list for a continuous five-year period and during such period 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 its participation in the special focus program.

Additional funding would be allocated to the Secretary to conduct these increased surveys.

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 2027. 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). Independence of Attending Physician

This subsection prohibits a hospice-employed physician or a physician with an ownership, financial, or contractual relationship with the hospice program to certify terminal illness for the initial 90-day election period through the role of the individual's attending physician. 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 Nurse Practitioners to Certify Terminal Illness

This subsection allows nurse practitioners 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. 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's attending physician is certifying that 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) should serve as the basis for the initial certification of terminal illness, with supporting information from the hospice program involved.

Subsection (h). Inclusion of Hospice Care as a Designated Health Service

This subsection adds hospice care as a designated health service for purposes of the physician self-referral ("Stark") law. The physician self-referral law prohibits a referral by a physician of a Medicare or Medicaid patient to an entity for the provision of designated health services if the physician or immediate family member has a financial relationship with that entity.

Subsection (i). 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. 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 (j). Medical Review of Hospice Outliers and Care Unrelated to Terminal Condition

Paragraph (1): Amends 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, this language would require the Secretary to conduct prepayment medical review for individuals that have stays longer than 90 days in instances where a hospice program has a certain percentage of patients with long stays or has a certain percentage of patients that were discharged alive (e.g., the hospice discharged the patient or the patient revoked his/her election), as determined by the Secretary.

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. 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 to providers and suppliers 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 (k). 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 (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 any mistakes or fraud in such an election and report such instances to the hospice, 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 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 (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 specialized training in medical prognostication for reviews conducted on or after [January 1, 2027].

Paragraph (2): Requires the Secretary to submit a Report to Congress no later than [January 1, 2027] on all hospice medical review activities performed between January 1, 2019 and December 31, 2024 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 require a face-to-face encounter to occur before each recertification of terminal illness; such encounter cannot be conducted via telehealth. 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 requirement 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 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 in-person, with sensitivity toward the patient and family.

Subsection (o). Ensuring Medical Director and Physician Availability

This subsection limits a physician from serving as the medical director for more than two hospice programs and 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 provided in an individual's home. These provisions would be effective beginning on [January 1, 2028].

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 are to be adjusted by percentages specified by the Secretary for specified fiscal years. The specified fiscal years are 2027 and every fifth year thereafter. In the case of routine home care, such payment adjustments begin in fiscal year 2032 and occur every fifth year thereafter.

In fiscal year 2027, the Secretary is to establish a new 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 and establish new per-visit payment amounts for visits that can vary based on the type and duration of visit.

In fiscal year 2028 and subsequent years, the rates in effect for the previous fiscal year are to be adjusted by, in the case of a specified fiscal year, 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, 2026, and ending in September 30, [2031], in lieu of the routine home care rate, the Secretary shall pay hospice programs [200 percent] of the fiscal year 2026 routine home care rate updated each fiscal year by the market basket reduced by a productivity adjustment for each day during which palliative chemotherapy, radiation, blood transfusions, or dialysis are provided to an individual (or such other amount determined appropriate by the

Secretary, which may vary based on the type of item or service). In the case of palliative dialysis, payment is only made at [200 percent] of the routine home care rate if the individual was receiving dialysis before electing hospice, and payment is limited to 10 sessions of dialysis, unless any sessions over 10 are prior authorized.

Paragraph (2): 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 (3): 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).

Paragraph (4): Starting on October 1, [2031], the Secretary may provide an additional payment 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 (5): Adjusts the cap amount 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.

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 to hospice payments in any given year.

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 thereafter) 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 includes "specified hospice care" days (i.e., palliative chemotherapy, palliative radiation therapy, palliative blood transfusions, and palliative dialysis) when counting days for purposes of the inpatient cap (currently general inpatient care and inpatient respite care days), reduces the 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.

Subsection (d). Hospital Discharge Planning Requirements

This subsection requires hospitals, starting on [January 1, 2028], to include in a patient's discharge planning evaluation the availability of hospice respite care, including a 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): Creates a short-term home respite level of care for 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) for at least eight hours during a 24-hour period for no more than five days during an election period, effective on or after October 1, 2026. Home respite care days would also count toward the hospice's cap, in addition to the number of "specified hospice care" and inpatient care (general inpatient and inpatient respite) days.

Paragraph (2): Requires the Secretary to establish an hourly rate for short-term home respite care starting in fiscal year 2027. 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.