

## MEMORANDUM

A.10310-B (Paulin)/S.9620-A (Scarcella-Spanton)

***AN ACT to amend the public health law, in relation to requiring residential health care facilities to maintain hospice agreements to ensure access to hospice services for eligible residents***

This bill would require all nursing homes to enter into a contract with at least one hospice program to deliver hospice services to nursing home residents who elect hospice. LeadingAge New York recognizes the importance of access to hospice services for all New York State residents, including nursing home residents. We share the sponsors' concerns regarding low hospice utilization overall in New York State. However, this legislation attempts to address a multi-dimensional problem through a one-sided, potentially punitive mandate on nursing homes that does not target the root causes of the problem and will have little real-world impact on hospice access or utilization.

Data published by the Centers for Medicare and Medicaid Services indicate that hospice utilization among New York's nursing home residents mirrors the state's overall low utilization rate, pointing to causes that exist beyond the nursing home setting. In fact, although hospice utilization overall in New York State is among the lowest nationwide, nursing home residents' share of total hospice days of care in New York is at or above national levels.<sup>1</sup> Further, research studies of hospice utilization suggest that strategies such as physician and consumer education, stronger coordination among medical professionals at the end of life, and workforce development are needed improve hospice access and utilization.<sup>2</sup> Rather than addressing these important issues, this bill would require nursing homes to contract with a hospice program, even if the only hospice program in the county is unable to fulfill contract requirements, unwilling to enter into a contract, or unable to provide high quality care.

The bill's contracting requirement overlaps with, and goes beyond, existing federal regulations governing the delivery of hospice services to nursing home residents. Federal regulations and guidance provide that if a nursing home resident meets the eligibility criteria and elects hospice, the nursing home *may* arrange for hospice services through agreement with a Medicare-certified hospice *or* assist the resident to transfer to another facility that will arrange for hospice (42 CFR § 483.70(n)). Nursing homes that opt to arrange for hospice services on-site must have an agreement with the hospice that, at a minimum, describes their respective responsibilities, their communication process, the required notifications about changes in condition, and the collaboration process for developing a coordinated plan of care that clearly assigns responsibility for each service. The nursing home is also obligated to

<sup>1</sup> CMS Hospice Compare, Location of Care, Feb. 2026.

<sup>2</sup> Dhingra, L., Braveman, C., Kassner, C., Schechter, C., DiFiglia, S, PhD, Portenoy, R. Low Hospice Utilization in New York State: Comparisons Using National Data, *J Pain and Symptom Manage*, Apr. 2022. See also Dhingra L., Braveman, C., Roberts, K., DiFiglia, S., Kassner, C., Portenoy, R. Low Hospice Utilization in New York State: Framework for Compiling and Ranking Barriers, *J Palliat Med*, Oct. 2022.

monitor the hospice to ensure that services meet professional standards and the residents' needs in a timely manner.

Mandating nursing home contracts with hospice programs will not address the most significant factors that impede hospice access and discourage utilization. A major barrier to hospice care for nursing home residents who are not on Medicaid is the lack of a payment source for the room and board component of care if they elect hospice. Medicare will cover the hospice services for nursing home residents, but will not cover their room and board except in very limited circumstances. By contrast, Medicare covers room and board, as well as health care services, for residents receiving non-hospice, post-acute care in nursing homes. Thus, a nursing home resident who is on Medicare, but not Medicaid, and elects hospice, will have to pay the nursing home out-of-pocket for room and board. Requiring nursing homes to contract with hospice programs will not alleviate the significant financial burden associated with electing hospice for certain residents.

In addition to the potential financial burden that hospice election may create for residents, research studies examining hospice utilization have identified a diverse array of health system, social, demographic, and education-related factors that are associated with low utilization rates. Several studies have found that race, male gender, being unmarried, low socio-economic status, and rural residence are associated with low palliative/hospice care utilization.<sup>3</sup> In addition to social and demographic factors, other barriers cited include negative stereotypes from patient and families, lack of knowledge about hospice care, and physician hesitancy due to uncertainty of prognosis. Factors identified in a New York State-focused study include, among others, the relatively higher socioeconomic status of the New York State population and the higher number of physicians seen in the last two years of life.<sup>4</sup> It also noted, based on a related study, gaps in clinician and consumer knowledge about palliative care and hospice services; negative patient/family attitudes or beliefs about hospice; limitations in families' financial or supportive care resources; and barriers related to the operation of hospitals, hospital-based palliative care services, and nursing homes.<sup>5</sup> Among other factors, it suggested that nursing facilities' emphasis on skilled nursing and rehabilitation may distract from promoting access to hospice for end-of-life care. A contracting mandate will not address any of these problems.

These findings suggest alternative strategies to address access and utilization:

<sup>3</sup> Parajuli J, Tark A, Jao Y, Hupcey J. Barriers To Palliative and Hospice Care Utilization in Older Adults with Cancer: A Systematic Review. *Journal of Geriatric Oncology* 2020. See also O'Mahony S, McHenry J., Snow D. *et al.* A Review of Barriers to Utilization of the Medicare Hospice Benefits in Urban Populations and Strategies for Enhanced Access. *J Urban Health* (2008)

<sup>4</sup> Dhingra, L., Braveman, C., Kassner, C., Schechter, C, DiFiglia, S, PhD, Portenoy, R. Low Hospice Utilization in New York State: Comparisons Using National Data, *J Pain and Symptom Manage*, Apr. 2022.

<sup>5</sup> Dhingra L., Braveman, C., Roberts, K., DiFiglia, S., Kassner, C., Portenoy, R. Low Hospice Utilization in New York State: Framework for Compiling and Ranking Barriers, *J Palliat Med*, Oct. 2022.

- Improving clinical training in serious-illness conversations across medical education and continuing education;
- Enhancing clinician, patient, and public understanding of hospice eligibility and benefits;
- Introducing hospice earlier in the disease trajectory as part of a continuum of care;
- Expanding hospice workforce capacity and hospice residence availability; and
- Revisiting Medicare payment and coverage policies that favor skilled rehabilitation over hospice care and generally exclude room and board payment for hospice patients in nursing homes.

Mandating nursing home-hospice contracts is a blunt policy tool that risks imposing administrative burdens and monetary penalties without addressing the most salient drivers of low hospice utilization or improving real-world access to hospice care. Moreover, a one-sided contracting mandate may force nursing homes to enter into contracts that do not meet the needs of residents nor ensure high-quality care.

More effective strategies to expand hospice utilization and access include education of medical professionals and consumers, closer coordination of health care services at the end of life, workforce development, and reimbursement increases. Such approaches are more likely to improve both utilization and the quality of end-of-life care for nursing home residents in New York State. LeadingAge New York looks forward to joining in efforts to promote these and similar strategies.

**For these reasons, we urge the Legislature to oppose A.10310-A (Paulin)/S.9620 (Scarcella-Spanton).**

*LeadingAge New York represents approximately 350 not-for-profit and public long term care providers, including nursing homes, home care agencies, senior housing, retirement communities, assisted living, adult care facilities, adult day health care and managed long term care.*

Contact: Sarah Daly, [sdaly@leadingageny.org](mailto:sdaly@leadingageny.org)