DECISION ASSIST LLC

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April 13, 2026

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS–1851–P

P.O. Box 8010

Baltimore, MD 21244–1850

Re: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements (CMS–1851–P)

Submitted Electronically via: *https://www.regulations.gov/docket/CMS-2026-1156*

To Whom It May Concern:

Decision Assist LLC respectfully submits the following comments in response to the above-referenced proposed rule published in the Federal Register on April 6, 2026 (91 FR 17338). These comments are submitted by Harry Feliciano, MD, MPH, Principal and Medical Director of Decision Assist LLC, a healthcare reimbursement and coverage strategy consulting firm. Dr. Feliciano served for 25 years as Contractor/Senior Medical Director at a major Medicare Administrative Contractor (MAC), during which time he led medical review operations, authored Local Coverage Determinations (LCDs) for the hospice benefit, and oversaw claims processing operations across a 16-state jurisdiction. That operational background informs the analytical perspective offered in these comments.

These comments focus exclusively on Section III.B of the proposed rule, specifically the analysis of Medicare non-hospice spending during a hospice election, the proposed Service and Spending Variation Index (SSVI), and the proposed mandatory hospice election statement addendum. While the Centers for Medicare & Medicaid Services (CMS) is to be commended for the rigor and transparency of its non-hospice spending analysis and for the programmatic intent behind both proposals, Decision Assist LLC respectfully submits that neither intervention, individually or in combination, addresses the root cause of the documented misclassification errors that are driving the growth in non-hospice spending. This comment proposes a complementary programmatic framework that, in the submitter's assessment, would provide CMS with a sustainable, scalable, and prospective mechanism for reducing that variation at the claims processing level.

I. AFFIRMING THE CMS EVIDENCE BASE AND DIAGNOSIS-GROUP CONCENTRATION

CMS has documented a pattern of non-hospice Medicare spending during hospice elections that is both substantial and diagnostically concentrated. The proposed rule reports that Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries increased from nearly $790 million in FY 2020 to over $2 billion in FY 2024, representing a 160 percent increase over four years. Non-hospice Part D spending increased from $552.9 million to $813.1 million over the same period, for a combined non-hospice spending total exceeding $2.8 billion in FY 2024.

Tables 7 and 8 of the proposed rule are particularly instructive. Two diagnostic coding groups — Neurological/Degenerative (ICD-10 codes G30, G31, G20) and Heart/Cerebrovascular (ICD-10 codes I11, I25, I50, I63, I67, I69, I13) — account for $575.6 million and $590.0 million respectively in DME and carrier claims (Table 7), and $205.1 million and $276.3 million respectively in Part D payments (Table 8). When respiratory disease claims (ICD-10 codes J44, J96) are added, these three diagnostic clusters collectively represent approximately 75 percent of the total documented non-hospice spending exposure. This concentration is consistent with a Pareto distribution and has direct implications for any proposed corrective mechanism. A pilot program scoped to these three diagnostic clusters would address the substantial majority of the documented problem, while limiting the operational complexity of initial implementation.

CMS's long-standing regulatory position further contextualizes the magnitude of this problem. Since the original implementation of the Medicare hospice benefit in 1983, CMS has maintained — and repeatedly reaffirmed across multiple Federal Register rulemakings (48 FR 56010; 84 FR 38509; 85 FR 47091; 86 FR 19713; 88 FR 20032; 89 FR 64202) — that services unrelated to the terminal illness and related conditions should be exceptional, unusual, and rare given the comprehensive nature of the services covered under the hospice benefit. The current data are inconsistent with that regulatory expectation, and the discrepancy warrants a structural rather than an administrative response.

II. THE ROOT CAUSE: A CLAIMS SYSTEM PROCESS GATE, NOT A DISCLOSURE GAP

CMS has identified four potential sources of the documented non-hospice spending growth: hospices misclassifying conditions, referring patients to non-hospice providers, failing to coordinate care, or deliberately avoiding costs. These are substantively different failure modes with different corrective requirements, but they share a common enabling architecture: the Medicare claims processing system's current handling of the Condition Code 07 (CC07) bypass mechanism for institutional claims and the GW modifier bypass mechanism for professional and supplier claims.

These bypass mechanisms were deliberately designed as a provider trust architecture, consistent with CMS's longstanding deference to physician and provider clinical judgment. The underlying premise — that hospice providers would responsibly distinguish related from unrelated services because such determinations would be rare and exceptional — was reasonable at the time the hospice benefit was designed, when cancer accounted for the majority of hospice cases and the clinical profile of hospice patients was relatively uniform. That premise is no longer operationally sustainable.

The current claims processing workflow in the Fiscal Intermediary Shared System (FISS), the Multi-Carrier System (MCS), and the ViPS Medicare System (VMS) functions as a swinging door rather than a bona fide process gate. When a non-hospice provider appends CC07 or the GW modifier to a claim for a Medicare beneficiary with an active hospice election, the claims system processes that attestation without semantic interrogation. It does not evaluate whether the service claimed is clinically distinguishable from the palliation and management responsibilities the hospice assumed at the time of

election. It does not cross-reference the service against the hospice's documentation of the patient's terminal diagnosis, comorbidity profile, or functional status. It processes the bypass attestation as a binary instruction and pays accordingly.

This architecture means that the root cause of misclassification-driven improper payments does not reside in a failure of beneficiary disclosure, a failure of provider education, or a failure of post-payment auditing capacity. It resides in the absence of a semantic validation function at the claims submission level — a function that would evaluate whether a given service, item, or drug claimed as unrelated to the terminal illness and related conditions is, in fact, clinically distinguishable from the scope of care the hospice per diem is designed to cover.

III. ASSESSMENT OF THE PROPOSED INTERVENTIONS

A. The Mandatory Hospice Election Statement Addendum

The proposal to require hospices to provide the election statement addendum to all Medicare beneficiaries at the time of hospice election, effective October 1, 2026, is an appropriate and overdue transparency measure. The regulatory requirement that hospices document which conditions, items, services, and drugs they have determined to be unrelated to the terminal illness and related conditions — with supporting clinical explanation and reference to relevant clinical practice guidelines — creates a structured, provider-authored document that did not previously exist as a universal admission-time record.

However, the mandatory addendum is a disclosure instrument, not a validation instrument. It formalizes and standardizes the communication of existing hospice determinations but does not evaluate whether those determinations are clinically defensible. A hospice that systematically misclassifies conditions as unrelated — whether through clinical error, inadequate documentation processes, or deliberate cost avoidance — will produce a mandatory addendum that reflects and perpetuates those misclassifications. The addendum requirement does not contain a mechanism for detecting that failure at the point of documentation.

The significance of the mandatory addendum lies not primarily in its disclosure function but in the documentary substrate it creates for a downstream semantic validation process. Beginning October 1, 2026, every eligible hospice election will generate a structured, standardized document listing the specific conditions, items, services, and drugs the hospice has determined to be unrelated. That document, if made available to the processing MAC at the time a non-hospice claim with CC07 or GW modifier is received, would provide the semantic input necessary for a claims-level validation process of the kind described in Section IV of these comments. The mandatory addendum is, in this sense, a necessary but not sufficient precondition for the corrective architecture that would actually prevent the improper payments CMS has documented.

B. The Service and Spending Variation Index (SSVI)

The SSVI represents a meaningful advance in CMS's capacity to identify hospice-level outliers across multiple utilization and spending dimensions. The nine-metric scoring architecture, with particular weight given to total non-hospice spending through an eight-tier point allocation, will allow CMS and its contractors to rank hospices by composite risk profile and focus program integrity resources — medical reviews, targeted education, and investigations — on the highest-concern providers.

Notwithstanding this advance, the SSVI is, by design, a lagging aggregate outcome measure. It is calculated from prior fiscal year claims data, published retrospectively, and applied to focus downstream review activity on already-paid claims. As an analytical tool in a Define-Measure-Analyze-Improve-Control (DMAIC) quality framework, the SSVI operationalizes the Measure phase: it quantifies and ranks the output variance that has already occurred. It does not address the Improve or Control phases, which require intervening in the process that generates the variance before payment is made.

The SSVI will meaningfully improve the targeting efficiency of the Supplemental Medical Review Contractor (SMRC) by concentrating retrospective review resources on higher-scoring hospices. However, SMRC review is a statistically sampled, retrospective, record-review process. It recovers a fraction of already-made improper payments and generates corrective feedback that may influence future provider behavior. It cannot prevent a CC07 or GW modifier bypass claim from being paid tomorrow, next week, or next year. The SSVI, even fully implemented and accompanied by the mandatory addendum, does not close the process gate that is currently enabling the scale of non-hospice spending CMS has documented.

Decision Assist LLC respectfully suggests that future iterations of the SSVI would benefit from disaggregating the non-hospice spending component by the principal hospice diagnosis coding groups identified in Tables 7 and 8 of the proposed rule. A diagnosis-group-level SSVI metric would allow CMS and its contractors to distinguish between hospices whose non-hospice spending is concentrated in the highest-prevalence diagnostic clusters — Neurological/Degenerative, Heart/Cerebrovascular, and Respiratory — and hospices whose spending patterns reflect a different profile. This refinement would improve the SSVI's utility as a Control-phase feedback mechanism and would align the measure with the Pareto-based pilot scope described below.

IV. A DMAIC-STRUCTURED PILOT: THE INTEGRATED MULTI-SYSTEM MAC ARCHITECTURE

The following proposal describes an operational framework that would use the documentary infrastructure created by the mandatory addendum to implement a prospective, claims-level semantic validation process for CC07 and GW modifier bypass claims. The framework is grounded in existing MAC infrastructure and does not require new statutory authority, new claims system development at the national level, or new data sharing arrangements between otherwise independent contractor entities.

A. The Integrated Multi-System MAC Architecture

The six non-hospice claim types documented in Table 5 of the proposed rule are processed across three distinct Medicare claims processing systems, each with different contractor access rights. FISS processes all Part A and institutional Part B claims — inpatient, outpatient, home health, and skilled nursing facility — making such claims accessible to any A/B MAC holding concurrent HHH jurisdiction. MCS processes professional and carrier claims and is similarly accessible to any A/B MAC. VMS — the ViPS Medicare System — processes DME supplier claims and is accessible exclusively to DME MACs; A/B MACs do not have VMS access regardless of their HHH scope. This three-system reality means that no single contractor can access all six claim type channels unless it holds concurrent A/B MAC HHH and DME MAC jurisdiction over the same beneficiary geography. That describes a unique position in the Medicare contractor landscape, and it is what makes a collaborative pilot under a shared corporate parent

uniquely feasible without requiring inter-contractor data sharing agreements between independent organizations.

Decision Assist LLC proposes a bifurcated pilot architecture organized along claims system access lines, with two forks operating collaboratively under a shared corporate parent:

Fork 1 — HHH/A/B MAC Scope (FISS and MCS): Covers five of the six Table 5 claim types — inpatient CC07 ($193.3 million), SNF CC07 ($17.7 million), home health CC07 ($20.6 million), outpatient CC07/GW ($202.9 million), and professional/carrier GW ($1.563 billion) — representing approximately $1.997 billion of the $2.066 billion Table 5 total, or approximately 97 percent of the documented non-hospice spending problem. Fork 1 is executable by any A/B MAC that also holds HHH jurisdiction. The four FISS-processed claim types benefit from single-system trigger architecture: both the hospice election record and the triggering CC07 claim reside in FISS, requiring no cross-system coordination. Professional and carrier GW modifier claims require a straightforward FISS-to-MCS cross-reference within the same A/B MAC HHH operational environment.

Fork 2 — Full-Spectrum Scope (FISS, MCS, and VMS): Extends Fork 1 by adding the DME supplier GW modifier channel ($68.3 million in FY 2024), processed through VMS, to achieve complete coverage of all six Table 5 claim types. Fork 2 requires concurrent A/B MAC HHH and DME MAC jurisdiction over the same beneficiary geography — a configuration that exists for only one Medicare contractor — and can therefore only be executed by that contractor or through a collaborative arrangement between an A/B MAC HHH contractor and a DME MAC contractor operating under a shared corporate parent within the same geographic footprint.

A collaborative pilot under a shared corporate parent — one subsidiary executing Fork 1 across its HHH jurisdiction using FISS and MCS, the other executing Fork 2 within its overlapping HHH and DME MAC jurisdiction using FISS, MCS, and VMS — would achieve comprehensive coverage of all six Table 5 claim types across a contiguous beneficiary geography without requiring any inter-contractor data sharing agreement between independent entities.

In both forks, the trigger logic is operationally consistent: when a non-hospice claim is received bearing Condition Code 07 or a GW modifier for a beneficiary with an active hospice election on file within the designated geographic footprint, the receiving contractor triggers an automated ADR to the hospice of record for the election statement addendum. The mandatory addendum, once effective October 1, 2026, will be on file at the hospice within five days of election and updated within three days of any plan of care change affecting its content. It is therefore available as a contemporaneous clinical document at the time most non-hospice claims would be received. The ADR-triggered retrieval of this document creates the semantic input that a structured clinical validation

methodology can then interrogate: does the condition, item, or drug on the non-hospice claim appear on the addendum as unrelated? If yes, is the hospice's clinical explanation for that unrelated determination defensible against the diagnostic and functional profile of the patient's terminal illness and related conditions? If no, the claim warrants either denial or escalation to a human medical reviewer.

B. The DMAIC Framework Applied to the Pilot

The pilot architecture maps directly onto the DMAIC quality improvement methodology:

1. Define: The problem is defined by CMS's own data in Sections III.B.1 and III.B.2 of the proposed rule — $2.8 billion in annual non-hospice spending during hospice elections, concentrated in three diagnostic clusters, driven in part by misclassification errors enabled by a systematic bypass architecture.
2. Measure: The SSVI, once implemented, operationalizes this phase by quantifying and ranking hospice-level non-hospice spending. Diagnosis-group disaggregation, as recommended above, would further refine the measurement instrument.
3. Analyze: SSVI-driven outlier reports enable the SMRC and MACs to identify which hospices and which diagnostic categories warrant targeted review. The mandatory addendum creates a new analytical input by providing a structured record of hospice-level unrelated determinations that can be compared against the non-hospice claims data for the same beneficiary population.
4. Improve: An ADR-triggered, addendum-based semantic validation process at the integrated multi-system MAC level, scoped to the three highest-volume diagnostic clusters, implements a prospective process intervention at the claims submission level. This is the phase the proposed rule’s current interventions do not reach.
5. Control: SSVI trend data, disaggregated by diagnosis group, provides the longitudinal feedback mechanism to evaluate whether the semantic validation process is reducing unwarranted CC07 and GW modifier bypass claim volume in the targeted diagnostic clusters over time, and to identify any shift in the problem to other diagnostic categories.

A further advantage of the proposed geographic scoping is that it creates a natural quasi-experimental design for evaluating pilot effectiveness. Because the integrated multi-system MAC architecture would be implemented within a defined contractor geographic footprint, Medicare beneficiaries enrolled in hospice in states outside that footprint would

constitute a natural control population. Their SSVI scores and non-hospice spending patterns — driven by the same administrative interventions (mandatory addendum and SSVI publication) but without the benefit of the claims-level semantic validation process gate — would provide a contemporaneous comparator against which CMS could measure the incremental effectiveness of the structural intervention. This quasi-experimental framework would allow CMS to isolate the marginal impact of the process gate from the background effect of the administrative interventions, producing rigorous, publishable evidence on whether a claims-level semantic validation methodology meaningfully reduces unwarranted CC07 and GW modifier bypass volume beyond what the mandatory addendum and SSVI achieve alone. Decision Assist LLC respectfully submits that this natural control structure should be explicitly incorporated into the pilot evaluation design from the outset, and that CMS should commit to publishing the comparative results in conjunction with the SSVI annual publication for the first two fiscal years following pilot implementation.

C. Recommended Pilot Scope

Consistent with the Pareto concentration documented in Tables 7 and 8 of the proposed rule, Decision Assist LLC recommends that the pilot be scoped to the three diagnostic clusters identified below. The dollar figures cited reflect DME/carrier (Part B) and Part D non-hospice spending as reported by diagnostic cluster in Tables 7 and 8 — the only tables in the proposed rule that disaggregate non-hospice spending by diagnosis group. The pilot scope encompasses all six Table 5 claim types for each cluster, including inpatient, outpatient, home health, SNF, professional/carrier, and DME claims, consistent with the Fork 1 and Fork 2 architecture described above. The three clusters collectively represent approximately 75 percent of the documented non-hospice spending problem:

- Neurological and Degenerative Diseases (ICD-10-CM codes G30, G31, G20): approximately $780 million in combined DME/carrier (Part B) and Part D non-hospice spending in FY 2024 per Tables 7 and 8 of the proposed rule. Additional non-hospice spending attributable to this cluster from inpatient, outpatient, home health, and SNF claim types (documented in aggregate in Table 5 but not disaggregated by diagnostic cluster in the proposed rule) increases the total exposure for this cluster beyond the figure cited.
- Circulatory and Cerebrovascular Diseases (ICD-10-CM codes I11, I25, I50, I63, I67, I69, I13): approximately $866 million in combined DME/carrier (Part B) and Part D non-hospice spending in FY 2024 per Tables 7 and 8. As with the

Neurological/Degenerative cluster, the full cross-claim-type exposure including inpatient, outpatient, home health, and SNF claims exceeds this figure.

- Respiratory Diseases (ICD-10-CM codes J44, J96): approximately $195 million in combined DME/carrier (Part B) and Part D non-hospice spending in FY 2024 per Tables 7 and 8. As with the other two clusters, the full cross-claim-type exposure including inpatient, outpatient, home health, and SNF claims exceeds this figure.

These three clusters are not selected arbitrarily. They represent the diagnostic categories in which the clinical boundary between palliation and management of the terminal condition and care of an unrelated condition is most frequently questioned in medical review, most susceptible to misclassification through inattentive documentation, and most directly addressed by existing LCD guidance. A pilot constrained to these clusters is operationally bounded, evidence-anchored, and clinically coherent. It is also consistent with CMS's deregulatory posture, as it concentrates pilot resources on the highest-return opportunity rather than attempting a program-wide implementation before the underlying methodology has been validated.

V. THE ROLE OF STRUCTURED CLINICAL DOCUMENTATION METHODOLOGY

The semantic validation function described above requires a clinical reference framework that can evaluate whether a given service, item, or drug is distinguishable from the palliation and management responsibilities associated with a specific terminal illness, related conditions, and comorbidity profile. In Decision Assist LLC's assessment, the World Health Organization's International Classification of Functioning, Disability and Health (ICF) provides the most appropriate structural foundation for this function.

The ICF framework characterizes the relationship between a health condition and its functional consequences across body functions and structures, activities, and participation, in the context of the individual's environmental and personal factors. Applied to the hospice related/unrelated determination, the ICF framework enables a clinically grounded distinction between: (a) services that address the functional consequences of the terminal illness and related conditions, which are the hospice's coverage responsibility; and (b) services that address conditions whose functional profile is genuinely independent of the terminal illness and related conditions, which may appropriately be classified as unrelated.

This distinction is precisely what the current CC07 and GW modifier bypass architecture cannot make and what the mandatory addendum alone cannot validate. It requires a structured clinical documentation methodology that maps the beneficiary's principal diagnosis, comorbidity profile, and functional status onto an explicit framework for evaluating the clinical relationship between conditions — and that produces a documented, auditable basis for the hospice's related/unrelated determination.

The ICF framework's particular suitability for this application is reinforced by its established presence in Medicare Hospice LCD guidance. HHH MAC-issued LCDs for coverage of Hospice Alzheimer's Disease and Related Disorders, Hospice Neurological Conditions and Hospice Cardiopulmonary Conditions have incorporated ICF-based conceptual frameworks for evaluating the functional trajectory of terminally ill Medicare beneficiaries. The application of ICF-grounded documentation methodology to the related/unrelated determination is therefore not a departure from existing Medicare coverage policy; it is a natural extension of an analytical approach already embedded in the coverage landscape.

Decision Assist LLC is engaged in the development and validation of a structured clinical documentation platform grounded in the ICF framework, designed to support defensible, auditable related/unrelated determinations at the point of hospice admission and plan of care update. The platform is currently in proof-of-concept development. These comments are submitted in the interest of informing CMS's programmatic framework, not in promotion of any specific commercial product. Decision Assist LLC welcomes the opportunity to discuss the methodology underlying this platform with CMS and its contractors as the mandatory addendum implementation and SSVI pilot are operationalized.

VI. SUMMARY OF RECOMMENDATIONS

Decision Assist LLC respectfully offers the following recommendations for CMS's consideration in the FY 2027 Hospice Wage Index final rule and in subsequent programmatic guidance:

1. Affirm the mandatory addendum as a necessary precondition for claims-level semantic validation and, in final rule guidance, explicitly anticipate its role as a documentary input to MAC-level medical review processes triggered by CC07 and GW modifier claims.
2. Direct the SSVI's non-hospice spending component to be disaggregated by the principal hospice diagnosis coding groups represented in Tables 7 and 8 of the proposed rule in future SSVI publications, enabling diagnosis-group-specific benchmarking and Control-phase feedback.
3. Initiate a DMAIC-structured pilot implementing an Integrated Multi-System MAC Architecture, bifurcated into Fork 1 (FISS/MCS, executable by any A/B MAC with concurrent HHH jurisdiction, covering five of six Table 5 claim types representing approximately 97 percent of documented non-hospice spending) and Fork 2 (FISS/MCS/VMS, requiring concurrent HHH and DME MAC jurisdiction, closing the DME supplier channel to achieve complete coverage of all six claim types). The pilot should be scoped to the three diagnostic clusters — Neurological/Degenerative, Circulatory/Cerebrovascular, and Respiratory — representing approximately 75 percent of documented non-hospice spending, and should be implemented through a collaborative arrangement between contractors sharing a common corporate parent with the requisite overlapping HHH and DME MAC jurisdictions, thereby avoiding the need for inter-contractor data sharing agreements between independent entities.
4. Engage with stakeholders developing ICF-framework-grounded structured clinical documentation methodologies as potential inputs to the semantic validation function, consistent with CMS's stated interest in clinical practice guidelines and relevant research as the appropriate basis for related/unrelated determinations.
5. Publish proposed process metrics for the Improve and Control phases of the DMAIC framework — including pilot-period changes in CC07 and GW modifier claim volume by diagnosis group — in conjunction with the SSVI annual publication, to enable transparent assessment of pilot effectiveness.

VII. CONCLUSION

The FY 2027 proposed rule reflects a serious and data-driven effort by CMS to address a documented and growing program integrity vulnerability. The mandatory addendum and the SSVI are constructive steps that create, respectively, the documentary substrate and the measurement infrastructure that a more complete corrective architecture requires.

Decision Assist LLC respectfully submits that the next step — the claims-level process gate that would prevent rather than measure improper payments — is operationally feasible within existing MAC infrastructure, logically sequenced to follow the mandatory addendum's October 1, 2026 effective date, and proportionate in scope to the Pareto concentration of the documented problem.

CMS's own regulatory history on the related/unrelated determination provides the policy foundation. The 1983 declaration that virtually all care needed by terminally ill patients would be provided by the hospice was not aspirational; it was a structural description of the benefit's design. Restoring operational fidelity to that design requires addressing the process architecture that has allowed systematic deviation from it. Decision Assist LLC respectfully urges CMS to include the pilot framework described in these comments in its program integrity planning for the post-addendum implementation period.

Thank you for the opportunity to submit these comments. Decision Assist LLC welcomes further engagement with CMS, the Center for Program Integrity, and MAC contractors on the technical and operational aspects of the proposed framework.

Respectfully submitted,

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