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(HPCANYS)

Joint Legislative Budget Hearing on Health
State Fiscal Year 2026–27 Executive Budget

Presented Before:

Senator Liz Krueger, Chair, Senate Finance
Assemblymember J. Gary Pretlow, Chair, Ways and Means

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EXECUTIVE SUMMARY

Overview

The Hospice and Palliative Care Association of New York State (HPCANYS) is the only statewide association exclusively representing New York's hospice and palliative care providers and the interdisciplinary workforce delivering compassionate, community-based care to New Yorkers facing serious illness and the end of life.

Once again, the Executive Budget proposal fails to address the unique and escalating challenges facing New York's hospice system. Accordingly, the Legislature must include the HOSPICE CARE Initiative in both one-house budget bills and fully fund and enact it in the final State Fiscal Year (SFY) 2026–27 budget, while taking affirmative steps to preserve hospice integrity and ensure high-quality care for New Yorkers facing serious illness.

The HOSPICE CARE Initiative is a coordinated five-bill legislative package designed to modernize New York's hospice, palliative, and serious-illness care system while safeguarding hospice integrity. The Initiative strengthens the workforce, improves access and care coordination, expands advance care planning, enhances accountability, and removes statutory barriers that fragment care—without creating new Medicaid entitlements or expanding eligibility.

To achieve its intended impact, the Initiative must be implemented within a protected, modernized Certificate of Need (CON) framework and subject to clear statutory limits on the creation or expansion of for-profit hospice providers. Together, these measures ensure that public investment strengthens New York's existing community-based hospice infrastructure and supports high-quality, compassionate, and fiscally responsible end-of-life care.

Context and Need

New York State has one of the lowest hospice utilization rates in the nation despite a strong network of predominantly not-for-profit, community-based hospice providers. This gap is not due to a lack of need or provider capacity, but rather to systemic barriers within the current care-delivery and referral framework.

As New York's population ages and more residents live longer with serious and chronic illness, demand for hospice and palliative care continues to grow. The enactment of Medical Aid in Dying is expected to further increase appropriate hospice utilization, as observed in other states. However, enactment alone is insufficient. Without targeted investment, workforce stabilization, and strong system oversight, New York's hospice and palliative care infrastructure will not be positioned to meet this demand or to fully support patient choice and autonomy at the end of life.

Experience in other states demonstrates that increasing the number of hospice providers does not increase appropriate utilization. Unchecked growth—particularly among for-profit and private-equity-backed hospice providers—has been associated with fraud, diminished quality, workforce instability, and poorer patient and caregiver experiences, without improving access. These outcomes underscore the importance of protecting New York's existing hospice system from inappropriate market expansion.

I. The HOSPICE CARE Initiative: Five-Bill Legislative Package[1]

1. **Hospice Workforce Stabilization and Innovation Act**
Establishes a hospice-specific workforce and education initiative to stabilize and grow interdisciplinary teams statewide, including recruitment, retention, training, regional pipeline development, and public education.

2. ***Palliative and Hospice Care Access Act***
Strengthens hospital identification, referral, and care coordination requirements for patients with serious illness; clarifies the role of community-based palliative care; recognizes hospice as a palliative option; and advances hospital–hospice collaboration through structured demonstration projects.

3. ***Serious Illness Care Equity Act***
Operationalizes New York's Advance Care Planning authorization through a statewide, multilingual public education campaign and community-based outreach grants, with required outcome reporting to measure impact and equity.

4***. HEART Act***
Ensures that nursing home residents who are eligible for and elect hospice care can access services without unnecessary barriers, and reinforces Department of Health oversight through existing authority.

5***. Seamless Care Enrollment Act***
Removes statutory barriers that prevent hospice patients from enrolling in Managed Long-Term Care plans, ensuring continuity of home- and community-based services and improved care coordination.

II. System Integrity, Certificate of Need Protection

The effectiveness of the HOSPICE CARE Initiative depends on a strong and modernized Certificate of Need framework. New York's CON process has been essential to preserving hospice quality, preventing market fragmentation, and

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[1] THE HOSPICE CARE INITIATIVE: *Hospice Oversight and Support to Promote Integrity, Compassion, and Equity in Community Access and Responsive Engagement*

protecting patients and the workforce from the harms associated with unchecked for-profit expansion seen in other states.

Consistent with this framework, the Initiative must be implemented alongside explicit protections against inappropriate market entry. The Legislature should include language in the Assembly One-House budget banning the creation of new or the expansion of existing for-profit hospice providers, consistent with A.565 of 2025 and the Assembly sign-on letter led by Assembly Health Committee Chair Amy Paulin.

Preventing further for-profit hospice expansion is essential to ensuring that public investment strengthens care delivery rather than destabilizing the workforce, eroding quality, or diverting limited resources away from patient-centered, community-based providers.

Fiscal Framework

The HOSPICE CARE Initiative includes a targeted $31 million investment eligible for Health Care Reform Act (HCRA) funding. *The Initiative does not create new Medicaid benefits or expand eligibility and is expected to be cost-neutral to cost-saving through improved care coordination, reduced avoidable hospitalizations, and better alignment of care with patient goals.*

Conclusion

When implemented alongside a protected and modernized Certificate of Need framework—and with clear statutory limits on for-profit hospice expansion—the HOSPICE CARE Initiative offers a comprehensive, evidence-based approach to strengthening New York’s hospice and palliative care system at a pivotal moment. By addressing workforce capacity, access, equity, coordination, and system integrity, the Initiative ensures that New Yorkers with serious illness can receive compassionate, high-quality end-of-life care aligned with their values, goals, and needs.

HOSPICE CARE Initiative - FY 2026–27 Budget Summary

The HOSPICE CARE Initiative is a coordinated five-bill legislative package designed to modernize NYS's hospice, palliative, and serious-illness care system. The Initiative strengthens the workforce, improves access and care coordination, expands advance care planning, enhances accountability, and removes statutory barriers that fragment care without creating new Medicaid entitlements or expanding eligibility. Together, these bills support high-quality, compassionate, and fiscally responsible end-of-life care for New Yorkers.

Bill	**Purpose**	**Budget Request**	**Funding Source**
Hospice Workforce Stabilization and Innovation Act	Stabilizes and expands the hospice workforce through retention, training, pipeline development, and public education	$16,000,000	HCRA-eligible
Palliative and Hospice Care Access Act	Improves accountability for hospital-hospice collaboration, patient identification, education, referral, and coordination through demonstration projects	$5,000,000	HCRA-eligible
Serious Illness Care Equity Act	Funds statewide advance care planning, public education, and community-based outreach	$10,000,000	HCRA-eligible
HEART Act	Ensures nursing home residents can access hospice care when eligible and electing hospice	$0	No fiscal impact
Seamless Care Enrollment Act	Removes barriers to MLTC enrollment for hospice patients and improves care coordination	$0	No fiscal impact

Total Investment: $31,000,000

Testimony

Chair Krueger, Chair Pretlow, Chair Paulin, Chair Rivera, and distinguished members of the Committees, thank you for the opportunity to testify today.

My name is Jeanne Chirico, and I am President and CEO of the Hospice and Palliative Care Association of New York State. I appreciate the opportunity to speak with you regarding the State Fiscal Year 2026–27 Executive Budget.

HPCANYS is the only statewide association exclusively representing New York’s hospice and palliative care providers and the workforce that delivers compassionate, community-based care to New Yorkers facing serious illness and the end of life.

Once again, the Executive Budget proposal fails to address the unique issues facing New York State's hospice industry. Therefore, I am here today to strongly urge the Legislature to include the HOSPICE CARE Initiative in both one-house budget bills, to fully fund and enact the initiative in the final State Fiscal Year 2026–27 budget, and to take affirmative steps to ensure the integrity of hospice care in New York State.

The HOSPICE CARE Initiative

The HOSPICE CARE Initiative is a coordinated, five-bill legislative package that modernizes New York’s serious-illness and end-of-life care system. It strengthens the hospice workforce, improves hospital–hospice coordination, expands advance care planning, and removes statutory barriers that fragment care, all without creating new Medicaid entitlements.

The Initiative includes a targeted $31 million HCRA-eligible investment focused on workforce stabilization, care coordination, and community-based advance care planning. These are modest, strategic investments that will strengthen an existing system, improve patient outcomes, and reduce avoidable and costly hospital utilization.

New York currently has one of the lowest hospice utilization rates in the nation, despite a strong network of community-based providers. This is not attributable to a lack of need or providers, but to systemic constraints within the current care delivery framework. At the same time, our population is aging, and more New Yorkers are living longer with serious and chronic illnesses.

For too many New Yorkers, this means entering the final months of life without timely access to pain management, caregiver support, or meaningful conversations about their goals and wishes.

In addition, New York has now enacted Medical Aid in Dying (MAiD). Experience in other states demonstrates that when MAiD is implemented, hospice utilization increases, as patients seek comprehensive symptom management and supportive services. Without targeted investment, New York’s hospice system will not be positioned to meet this growing demand.

New York State’s work on Medical Aid in Dying is neither consistent nor complete unless it is accompanied by appropriate investment in hospice and palliative care infrastructure. Enactment of MAiD is only the beginning if its core intent—to support patient choice and autonomy at the end of life—is to be realized in practice. Without a strong and stable hospice and palliative care system, patients, families, and providers will lack the comprehensive support necessary to make end-of-life choices meaningful.

System Integrity and Certificate of Need (CON)

It is important to be clear: increasing the number of hospices does not increase utilization. Evidence from other states demonstrates that unchecked growth—particularly among for-profit and private-equity-backed hospice providers—leads to fraud, workforce instability, and diminished quality of care, without improving access for patients and families.

If the Legislature’s goal is to increase appropriate hospice utilization and facilitate access to and delivery of high-quality end-of-life care, the solution is to invest in New York’s existing community-based hospice infrastructure, not to proliferate providers.

For this reason, HPCANYS supports efforts to preserve hospice integrity by preventing the creation of new or the expansion of existing for-profit hospices in New York State, including the inclusion of language consistent with A.565 of 2025 in the Assembly One-House budget. Allowing further for-profit expansion in hospice care would undermine quality, destabilize the workforce, and divert limited resources away from patient-centered care at a time when demand is increasing.

To increase utilization and protect care quality, modernizing New York’s Certificate of Need process must remain a priority. New York’s CON framework has played a critical role in preserving hospice integrity and quality. We have submitted a white paper, included as an addendum to this testimony, outlining recommendations to modernize the CON methodology while maintaining strong oversight and preventing the abuses documented in other states. We have been working on this reform methodology for six years and are subject-matter experts on what will and will not work for New York State in the end-of-life care space.

Conclusion

New York is at a defining moment for hospice and palliative care. With a rapidly aging population, increasing healthcare system consolidation, competing profit motives, and the implementation of Medical Aid in Dying, the need for decisive legislative action and targeted budget investment has never been greater. Caring for the dying in our state is not only a deeply personal experience—it is a critical component of the healthcare system that requires real investment, not platitudes or verbal support.

When implemented alongside a protected and modernized Certificate of Need framework—and with clear statutory limits on for-profit hospice expansion—the HOSPICE CARE Initiative provides a comprehensive, evidence-based approach to strengthening New York’s hospice and palliative care system at a pivotal moment. By addressing workforce capacity, access, equity, coordination, and system integrity, the Initiative ensures that New Yorkers with serious illness can receive compassionate, high-quality end-of-life care aligned with their values, goals, and needs.

Thank you for your leadership and your continued commitment to compassionate care. I am happy to answer any questions from the Committees at this time.

ADDENDUM A

The Hospice Workforce Stabilization and Innovation Act

The Hospice Workforce Stabilization and Innovation Act

BILL TEXT

AN ACT to amend the public health law, in relation to establishing the hospice workforce stabilization and innovation program.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short Title. This act shall be known and may be cited as the "Hospice Workforce Stabilization and Innovation Act."

Section 2. Legislative Findings and Purpose. The legislature finds that hospice and palliative care services are essential components of New York's health care delivery system and play a critical role in improving quality of life, supporting families and caregivers, and reducing avoidable hospitalizations. The legislature further finds that New York State faces a significant shortage of hospice nurses, aides, social workers, chaplains, and other interdisciplinary staff, resulting in reduced access to hospice services, delayed referrals, provider strain, and inequities in the availability of high-quality end-of-life care, particularly in rural and underserved communities.

The legislature additionally finds that hospice providers licensed under article forty of the Public Health Law have been excluded from major statewide workforce initiatives, insofar as those initiatives have relied on Medicaid funding, and hospice providers are primarily reimbursed by Medicare rather than Medicaid. This has contributed to workforce instability and undermined the State's ability to improve hospice utilization and access. The purpose of this act is to establish a coordinated, statewide investment to stabilize the hospice workforce, strengthen long-term training pipelines, and expand workforce education.

Section 3. The public health law is amended by adding a new section 4013-a to article 40 to read as follows:

§ 4013-a. Hospice workforce stabilization and innovation program.

1. Definitions.

(a) "Hospice provider" means any hospice program licensed under this article.

(b) "Eligible employee" means any full-time or part-time employee of a hospice provider.

(c) "Educational institution" means a school district, board of cooperative educational services, community college, university, or other accredited educational entity approved by the department.

2. Hospice workforce retention and training grants.

(a) The department shall administer a hospice workforce retention and training grant program.

(b) Subject to appropriation, the program shall be funded at ten million dollars annually.

(c) Grants shall be allocated on a per-full-time-equivalent basis or such other equitable methodology as determined by the department.

(d) Grant funds may be used for staff retention incentives, continuing education, professional certification, including board certification in hospice and palliative care, workforce wellness initiatives, and other workforce support activities approved by the department.

(e) In allocating grant funds, the department shall prioritize hospice providers that demonstrate financial strain or serve rural, medically underserved, or high-need communities.

3. Regional hospice workforce pipeline programs.

(a) The department shall establish regional hospice workforce pipeline programs.

(b) Subject to appropriation, such programs shall be funded at five million dollars annually.

(c) Grants may be awarded to hospices and educational institutions in partnership with one or more hospice providers to expand training aligned with hospice-specific competencies, including home health aide certification, licensed practical nurse training, and registered nurse advancement.

(d) Grant funds may be used for recruitment and outreach, tuition subsidies, faculty support, and paid hospice orientation and training programs of up to six months.

4. Public education collaborative.

(a) The department, in consultation with the state education department, shall establish a public education collaborative to support outreach and education regarding hospice and palliative care within the New York State public education system.

(b) Subject to appropriation, such collaborative shall be funded at one million dollars annually.

(c) Awards may be made to educational institutions partnering with local hospice providers to support age-appropriate education, career awareness, and general awareness of hospice and palliative care.

5. Administration; reporting.

(a) The department shall promulgate regulations necessary to implement this section.

(b) The department shall submit an annual report to the governor and the legislature detailing program expenditures, participation, outcomes, and recommendations.

Section 4. Severability. If any provision of this act shall be adjudged invalid, such judgment shall not affect the validity of the remainder thereof.

Section 6. Effective Date. This act shall take effect on April 1 next succeeding the date upon which it shall have become a law.

SPONSOR’S MEMORANDUM

PURPOSE OF BILL

To establish a hospice-specific workforce stabilization and innovation program to address critical staffing shortages, strengthen long-term training pipelines, expand public education and career awareness, and improve integration between hospice providers and health systems, thereby increasing timely access to high-quality hospice and palliative care across New York State.

SUMMARY OF PROVISIONS

This bill adds a new section 4013-a to Article 40 of the Public Health Law to establish the Hospice Workforce Stabilization and Innovation Program, administered by the Department of Health. The program includes:

- Workforce retention and training grants;
- Regional workforce pipeline development programs;
- A public education collaborative; and
- Annual reporting requirements.

JUSTIFICATION

New York State maintains a strong network of hospice programs licensed under Article 40 of the Public Health Law, yet consistently ranks last nationally in hospice utilization and length of stay. Many patients are referred to hospice only in the final days or hours of life—far too late to benefit from comprehensive, comfort-focused care.

This challenge is not due to insufficient hospice capacity, but rather to systemic workforce instability driven by long-standing underinvestment and the exclusion of hospice providers from major statewide workforce initiatives, state-funded retention grants, and workforce training and pipeline development programs available to other health care sectors.

This bill establishes a coordinated, hospice-specific workforce investment strategy to stabilize and expand the interdisciplinary workforce that delivers expert end-of-life care. These targeted investments are essential to improving access, reducing avoidable hospitalizations, and ensuring that every New Yorker can receive timely, compassionate, high-quality care at the end of life.

PRIOR LEGISLATIVE HISTORY

New bill.

FISCAL IMPLICATIONS

$16 million.

EFFECTIVE DATE

This act shall take effect on April 1 next succeeding the date upon which it becomes law.

ADDENDUM B

THE PALLIATIVE AND HOSPICE CARE ACCESS ACT

THE PALLIATIVE AND HOSPICE CARE ACCESS ACT

BILL TEXT

AN ACT to amend the public health law, in relation to strengthening access to palliative care and hospice services.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 2997-d of the public health law is amended to read as follows:

§ 2997-d. Hospital, nursing home, home care, special needs assisted living residences and enhanced assisted living residences palliative care support.

1. Definitions.

(a) "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

(b) "Appropriate" has the same meaning as paragraph (a) of subdivision one of section 2997-c (Palliative care patient information).

(c) "Community-based palliative care" means palliative care services delivered by a specialty-trained team of physicians, nurses, social workers, and others in a patient's residence or other community setting, to provide symptom management, psychosocial support, advance care planning, care coordination, and referral to hospice services, as appropriate

(d) "Hospice" means a program licensed under article forty of this chapter.

(e) "Administrator" shall mean a statewide, membership-based, not-for-profit organization whose primary mission is to promote access to quality end-of-life care for all New Yorkers and that is contracted by the Department of Health to administer the grant program established pursuant to this section.

Such organization shall:

(i) demonstrate recognized expertise in hospice and palliative care delivery, policy, and programmatic support within New York state;

(ii) maintain an established presence through statewide representation of hospice and/or palliative care providers across diverse care settings;

(iii) demonstrate active collaboration with the state’s hospice and palliative care infrastructure, including providers, educators, and workforce development partners;

(iv) possess demonstrated familiarity with workforce development, education, and training needs specific to hospice and palliative care providers statewide;

(v) have experience supporting or administering public awareness and education initiatives related to hospice and palliative care or advance care planning;

(vi) demonstrate a history of excellence in patient and family advocacy for serious illness, palliative, and end-of-life care; and

(vii) otherwise meet the requirements of this section.

2. Policies and procedures for access to palliative care.

General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article forty-six-B of this chapter shall establish and implement written policies and procedures to [provide] ensure that patients with advanced life limiting conditions [and] or illnesses who might benefit from palliative care, including associated pain management, [services] are identified and provided with timely access to information, [and] counseling [regarding such options appropriate to the patient], and such services, including community-based palliative care. Policies must include provision for patients who lack capacity to make medical decisions, so that access to such information and counseling shall be provided to the persons legally authorized to make medical decisions on behalf of such patients.

3. Facilitation of access to palliative care services.

General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article 46-B of this chapter shall facilitate access to appropriate palliative care consultations and services, including associated pain management consultations and services, and ensure referrals are made consistent with patient needs and preferences. [The department shall take into account access and proximity of palliative care services, including the availability of hospice and palliative care board certified practitioners and other related workforce staff, geographic factors, and facility size that may impact development of palliative care services.] Facilities subject to this subdivision shall ensure that eligible patients are informed of the availability of hospice services and other community-based palliative care services, and afforded the opportunity to receive a timely referral to such services.

4. Identification and referral standards.

(a) NYS DOH will monitor and report to each hospital the hospice utilization for patients that died within 30, 60, and 90 days post-discharge from their respective institutions to determine access to hospice prior to death.

(b) Such data will be used to inform future pay-for-performance incentives based on improved hospice utilization through patient education and referral.

5. Hospice–palliative care health system demonstration projects.

(a) The department shall, in consultation with the commissioner, enter into an agreement with the administrator to administer the grants and provide oversight of a hospice–palliative care integration demonstration program to support improved coordination between hospitals, health systems, and hospice providers. Such agreement shall provide for the administration of the grants, in accordance with the requirements of this section, the commissioner, and all applicable laws, rules, regulations, and other requirements.

(b) Subject to appropriation, such program shall be funded at five million dollars annually.

(c) Grants may be awarded on a competitive basis to hospitals or health systems, in partnership with one or more hospice providers, to implement projects designed to improve transitions of care, advance timely hospice referral, and enhance coordination of serious illness care.

(d) Demonstration projects may include, but need not be limited to, development of standardized referral pathways, integration of hospice expertise into discharge planning, staff education, interdisciplinary training, and quality improvement initiatives related to hospice access.

Each participating general hospital shall implement policies and procedures, consistent with standards established by the commissioner, to identify patients who may benefit from palliative care services.

(b) Such policies shall include evidence-based clinical triggers, including but not limited to advanced cancer, progressive organ failure, advanced dementia, repeated hospitalizations, or prolonged intensive care stays.

(c) Hospitals shall document in the medical record: (i) whether a patient met one or more identification criteria; (ii) whether palliative care or hospice information was provided; (iii) whether a referral was offered; and (iv) whether the patient accepted or declined such referral.

(d) Documentation under this subdivision shall be subject to review by the department.

(e) The department shall establish performance measures appropriate to the goals of the demonstration program and may include performance-based components based on measurable improvement over baseline.

6. Data collection and transparency.

Facilities subject to this section shall submit data to the department, in a form and manner prescribed by the commissioner, regarding palliative care and hospice identification and referral practices. The department may publicly report facility-level or system-level data, provided such reporting complies with applicable privacy laws.

9. Regulations.

The commissioner shall promulgate regulations necessary to implement this section, including but not limited to minimum identification standards, documentation requirements, reporting specifications, and enforcement procedures.

Section 2. Effective Date. This act shall take effect on April 1st next succeeding the date upon which it shall have become a law.

SPONSOR'S MEMORANDUM

TITLE OF BILL

An act to amend the public health law, in relation to strengthening access to palliative care and hospice services.

PURPOSE OF BILL

To modernize and strengthen New York's Palliative Care Access Act by establishing clear identification and referral standards, improving access to hospice services, requiring documentation and data reporting, supporting hospital-hospice coordination, and reinforcing oversight and enforcement.

SUMMARY OF PROVISIONS

This bill amends section 2997-d of the Public Health Law to:

- Update and expand statutory definitions, including the addition of "community-based palliative care" and explicit recognition of hospice as a form of palliative care.
- Require hospitals and other covered facilities to implement written policies and procedures to identify patients who may benefit from palliative care or hospice services.
- Establish evidence-based clinical triggers for identification and require documentation of identification, counseling, and referral decisions in the medical record.
- Ensure that eligible patients are informed of hospice services and afforded timely referral to hospice programs.
- Create a hospice–palliative care integration demonstration program, funded at $5 million annually, to support improved coordination between hospitals, health systems, and hospice providers.
- Require facilities to submit data to the Department of Health regarding palliative care and hospice identification and referral practices, and authorize public reporting of such data.
- Strengthen oversight by authorizing the Department of Health to require corrective action, conduct targeted reviews, and take enforcement action.
- Establish civil penalties for failure to comply with documentation, reporting, or other statutory requirements.
- Direct the commissioner to promulgate regulations necessary to implement the amended section.

JUSTIFICATION

New York enacted the Palliative Care Access Act to ensure that individuals with serious illness receive timely information and access to palliative care services. Despite this intent, compliance has been inconsistent, and many eligible patients continue to experience delayed identification, inadequate counseling, and missed opportunities for hospice referral. These gaps contribute to avoidable suffering, unnecessary hospitalizations, and care that does not align with patient goals and preferences.

This bill strengthens the Palliative Care Access Act by establishing clear, enforceable standards for identification, counseling, documentation, and referral. It ensures that hospice—an evidence-based, person-centered model of care—is consistently presented to eligible patients as an option. The bill also enhances transparency through data reporting and supports system-level improvements through a targeted demonstration program.

By reinforcing the Department of Health's oversight authority and establishing a monetary enforcement mechanism, the bill ensures that statutory obligations are meaningful and that facilities are accountable for compliance. These reforms will improve the quality of care, promote patient autonomy, reduce avoidable high-acuity utilization, and support more equitable access to palliative and hospice services across New York State.

PRIOR LEGISLATIVE HISTORY

New bill.

FISCAL IMPLICATIONS

The bill authorizes $5 million annually, subject to appropriation, for a hospice–palliative care integration demonstration program. Other provisions are expected to be cost-neutral or cost-saving over time due to reduced avoidable hospitalizations and improved care coordination.

EFFECTIVE DATE

This act shall take effect on April 1st next succeeding the date upon which it shall have become a law.

ADDENDUM C

THE SERIOUS ILLNESS CARE EQUITY ACT

THE SERIOUS ILLNESS CARE EQUITY ACT

BILL TEXT

AN ACT to amend the public health law, relating to the statewide advance care planning public awareness campaign, and to establish a community-based advance care planning outreach grant program.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short Title. This act shall be known and may be cited as the "Serious Illness Care Equity Act."

Section 2. Legislative Findings and Purpose. The legislature finds that advance care planning is essential to ensuring that individuals with serious illness receive care aligned with their values, preferences, and goals. Although chapter four hundred six of the laws of two thousand twenty-two authorized a statewide advance care planning public awareness campaign, such a campaign has neither been funded nor implemented. The purpose of this act is to operationalize that authority, expand equitable access to advance care planning education, and establish a community-based outreach grant program to address persistent racial, cultural, and linguistic disparities.

Section 3. Paragraph e of subdivision one of section 207 of the public health law, as amended by chapter four hundred six of the laws of two thousand twenty-two, is amended, and a new paragraph e-1 is added to read as follows:

(e) Advance care planning public awareness campaign.

(1) The commissioner shall establish a statewide advance care planning campaign to:
(i) promote public awareness of hospice and palliative care services[;], and palliative care options for patients with a terminal illness or condition;
(ii) inform the public of the importance of advance care planning and the individual's right to direct and participate in health care decisions affecting the individual;
(iii) educate individuals on the tools available to ensure their health care decisions are honored; and
(iv) highlight the need and importance for consumers and patients to have an advance directive, particularly a health care proxy, and the need and importance for health care providers to play a leadership role in discussing end-of-life care preferences and values with patients and to provide patients with health care proxy forms.

(2) The department shall implement the statewide advance care planning public awareness campaign authorized pursuant to this paragraph, both directly and via the community-based outreach grants authorized pursuant to paragraph (e-1) of this subdivision. Such a campaign shall include statewide media outreach in multiple languages; culturally tailored messaging for underserved communities; dissemination of

written, digital, and broadcast educational materials; development of tools to support advance directives and serious illness decision-making; and enhancement of digital navigation resources.

(e-1) Advance care planning community-based outreach grants.

(1) The department shall establish a community-based advance care planning outreach grant program to fund not-for-profit community-based organizations, faith-based organizations, immigrant-serving organizations, senior-serving agencies, housing-based organizations, and other trusted community partners to conduct advance care planning education, outreach, and navigation.

(2) The department shall, in consultation with the commissioner, enter into an agreement with the administrator to administer the grants and provide oversight of a community-based advance care planning outreach grant program. Such agreement shall provide for the administration of the grants, in accordance with the requirements of this section, the commissioner, and all applicable laws, rules, regulations, and other requirements.

(3) “Administrator” shall mean a statewide, membership-based, not-for-profit organization whose primary mission is to promote access to quality end-of-life care for all New Yorkers and that is contracted by the Department of Health to administer the grant program established pursuant to this section.

Such organization shall:

(i) demonstrate recognized expertise in hospice and palliative care delivery, policy, and programmatic support within New York state;

(ii) maintain an established presence through statewide representation of hospice and/or palliative care providers across diverse care settings;

(iii) demonstrate active collaboration with the state’s hospice and palliative care infrastructure, including providers, educators, and workforce development partners;

(iv) possess demonstrated familiarity with workforce development, education, and training needs specific to hospice and palliative care providers statewide;

(v) have experience supporting or administering public awareness and education initiatives related to hospice and palliative care or advance care planning;

(vi) demonstrate a history of excellence in patient and family advocacy for serious illness, palliative, and end-of-life care; and

(vii) otherwise meet the requirements of this section.

2. Policies and procedures for access to palliative care.

(4) Grant funds may be used for multilingual and culturally appropriate educational materials; advance care planning navigator programs; home-based counseling and education; community workshops, outreach events, and public engagement activities; and partnerships with hospice programs, palliative care providers, and health care systems.

(5) Grantees shall report to the department on measurable outcomes, including the number of individuals reached, advance care planning conversations facilitated, and advance directives or related documents completed or supported.

(6) The department shall submit an annual public report to the governor and the legislature evaluating campaign reach, grant program outcomes, and recommendations to improve equitable access to advance care planning.

(7) Subject to appropriation, such grant program shall be funded at ten million dollars annually.

Section 4. Severability. If any clause, sentence, paragraph, subdivision, section, or part of this act shall be adjudged invalid, such judgment shall not affect, impair, or invalidate the remainder thereof.

Section 5. Effective Date. This act shall take effect immediately.

SPONSOR’S MEMORANDUM

PURPOSE OF BILL

To operationalize the statewide Advance Care Planning Public Awareness Campaign authorized by Chapter 406 of the Laws of 2022 and establish a community-based outreach grant program to promote equitable access to advance care planning.

SUMMARY OF PROVISIONS

This bill amends section 207 of the Public Health Law to:

- Require implementation of the statewide Advance Care Planning Public Awareness Campaign;
- Establish a community-based advance care planning outreach grant program;
- Support multilingual, culturally tailored education and navigation; and
- Require annual public reporting on campaign reach and outcomes.

JUSTIFICATION

Advance care planning enables individuals to make informed decisions about serious illness care and supports alignment between patient preferences and the care they receive. Although the Legislature directed the Department of Health to conduct statewide advance care planning education in 2022, the campaign has not been implemented due to insufficient funding and the absence of a structured program.

This bill fulfills prior legislative intent by providing both funding and authority to operationalize the campaign and engage trusted community partners to expand equitable access to advance care planning resources statewide. Community-based organizations are uniquely positioned to reach populations that have historically experienced disparities in access to information, navigation, and culturally appropriate support.

By strengthening public awareness and supporting community-level engagement, this bill advances health equity, improves serious-illness decision-making, and promotes care that aligns with individual values and goals.

PRIOR LEGISLATIVE HISTORY

New bill.

FISCAL IMPLICATIONS

$10 million, subject to appropriation, including eligibility for Health Care Reform Act resources.

EFFECTIVE DATE

This act shall take effect immediately.

ADDENDUM D

THE HOSPICE EXPANSION AND ACCESS FOR RESIDENTS IN TRANSITION (HEART) ACT

THE HOSPICE EXPANSION AND ACCESS FOR RESIDENTS IN TRANSITION (HEART) ACT

BILL TEXT

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.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 2808 of the public health law is amended by adding a new subdivision twenty-eight to read as follows:

28. Hospice access for residents in residential health care facilities.

(a) Each residential health care facility shall enter into and maintain one or more written agreements with hospice programs licensed pursuant to article forty of this chapter to ensure access to hospice services for residents who are eligible for and elect the hospice benefit.

(b) Such agreements shall provide for coordination of care between the residential health care facility and the hospice program and shall, at a minimum, address:

(i) timely hospice evaluation and referral; (ii) roles and responsibilities of facility staff and hospice personnel; (iii) interdisciplinary care planning and symptom management; (iv) medication management and clinical oversight; (v) after-hours communication and emergency response; and (vi) documentation and information sharing, consistent with applicable law.

(c) The department shall provide guidance and technical assistance to residential health care facilities and hospice programs to support implementation of this subdivision, including model contract provisions and best practice recommendations.

(d) Failure to comply with the requirements of this subdivision shall constitute a violation subject to enforcement pursuant to this article.

(e) To the extent necessary to implement the provisions of this subdivision, the department shall seek any federal approvals required under the Medicaid and/or Medicare program.

Section 2. This act shall take effect one hundred eighty days after it shall have become a law. The commissioner of health is authorized to promulgate regulations and issue guidance prior to such effective date.

SPONSOR'S MEMORANDUM

PURPOSE OF BILL

To ensure that residents of nursing homes have meaningful, timely access to hospice services by requiring residential health care facilities to maintain hospice agreements and coordinate care for eligible residents.

SUMMARY OF PROVISIONS

This bill amends section 2808 of the Public Health Law to:

- Require residential health care facilities to enter into and maintain written agreements with hospice programs licensed under Article 40;
- Establish minimum requirements for coordination of care between facilities and hospice providers;
- Direct the Department of Health to provide guidance and technical assistance, including model contract provisions; and
- Clarify that noncompliance is subject to enforcement.

The bill also authorizes the Department of Health to seek any necessary federal approvals under the Medicaid program.

JUSTIFICATION

Although federal and state law authorize hospice services to be delivered in nursing homes, access to hospice care remains inconsistent across New York State. Many residents with advanced or terminal illness are denied access, experience delayed referral, unnecessary hospital transfers, and care that is misaligned with their goals and preferences.

Hospice programs provide specialized interdisciplinary care that improves quality of life, supports families and caregivers, and reduces avoidable high-acuity interventions. This bill helps assure that patient choice is honored and establishes a uniform statewide expectation that nursing homes maintain hospice agreements to support resident choice, improve care coordination, and promote effective use of health care resources.

By ensuring that every residential health care facility has a formal relationship with one or more hospice providers, the bill strengthens continuity of care, reduces unnecessary hospitalizations, and advances equitable access to high-quality end-of-life care.

PRIOR LEGISLATIVE HISTORY

New bill.

FISCAL IMPLICATIONS

None.

EFFECTIVE DATE

This act shall take effect one hundred eighty days after it becomes law.

ADDENDUM E

THE SEAMLESS CARE ENROLLMENT ACT

THE SEAMLESS CARE ENROLLMENT ACT

BILL TEXT

AN ACT to amend the social services law and the public health law, in relation to permitting individuals receiving hospice services to enroll in managed long-term care plans and ensuring coordinated service delivery.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subparagraph xix of paragraph e of subdivision three of section 364-j of the social services law is amended to read as follows:

(xix) individuals receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program, and an individual who elects the hospice benefit under the Medicare or Medicaid program shall not, solely by reason of such election, be deemed ineligible for enrollment in a managed long-term care plan, and the commissioner shall issue guidance to managed long-term care plans, local social services districts, and hospice programs regarding enrollment procedures, continuity of care, and coordination expectations for such individuals;

Section 2. Clause eight of subparagraph v of paragraph b of subdivision seven of section 4403-f of the public health law is amended by adding a new subdivision 12 to read as follows:

(8) a person receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program, and an individual who elects the hospice benefit under the Medicare or Medicaid program shall not, solely by reason of such election, be deemed ineligible for enrollment in a managed long-term care plan, and the commissioner shall issue guidance to managed long-term care plans, local social services districts, and hospice programs regarding enrollment procedures, continuity of care, and coordination expectations for such individuals;

Section 3. Section 4403-f of the public health law is amended by adding a new subdivision 12 to read as follows:

12. Hospice and managed long-term care coordination.

(a) The department shall establish standards to promote coordination of care for individuals enrolled in managed long-term care plans who are also receiving hospice services.

(b) Such standards may include, but need not be limited to:

(i) shared or coordinated care planning; (ii) interdisciplinary communication protocols; (iii) clarification of responsibilities for personal care, transportation, and other community-based services; and (iv) procedures to minimize delays or disruptions in service delivery.

(c) Managed long-term care plans and hospice programs shall exchange information necessary to ensure continuity of care, consistent with applicable state and federal privacy laws.

(d) The department may promulgate regulations and issue guidance necessary to implement this subdivision.

Section 4. Federal approvals. To the extent necessary to implement the provisions of this act, the department shall seek any federal approvals required under the Medicaid program.

Section 5. Effective date. This act shall take effect one hundred eighty days after it shall have become a law. The commissioner is authorized to promulgate regulations and issue guidance before such effective date.

SPONSOR'S MEMORANDUM

PURPOSE OF BILL

To eliminate barriers that prevent individuals receiving hospice services from enrolling in managed long-term care plans and to promote coordinated delivery of hospice and long-term care services.

SUMMARY OF PROVISIONS

This bill:

- Amends section 365-f of the Social Services Law and Section 4403-f of the Public Health Law to clarify that individuals who elect hospice services under Medicare or Medicaid are not categorically barred from enrolling in managed long-term care plans;
- Amends section 4403-f of the Public Health Law to direct the Department of Health to establish coordination standards between managed long-term care plans and hospice providers;
- Requires guidance on enrollment, continuity of care, and coordination expectations; and
- Authorizes the Department of Health to seek any necessary federal approvals.

JUSTIFICATION

Individuals with terminal illness frequently require both hospice care and long-term care supports, including personal care services, transportation, and community-based assistance. Current Medicaid policy effectively forces individuals to choose between hospice care and access to managed long-term care services, resulting in fragmented care, unmet needs, and avoidable hospitalizations.

This bill removes that barrier by allowing individuals who elect hospice to enroll in managed long-term care plans and by establishing standards for coordinated care planning between hospice providers and such plans. These changes will improve continuity of care, support patient dignity and autonomy, and promote more efficient use of Medicaid resources.

PRIOR LEGISLATIVE HISTORY

New bill.

FISCAL IMPLICATIONS

None.

EFFECTIVE DATE

This act shall take effect one hundred eighty days after it becomes law.

ADDENDUM F

Certificate of Need (CON) Recommendations

White Paper:

Strengthening New York State's Certificate of Need Process:

Preserving Integrity in the Hospice Industry and Maintaining Access to Quality End-of-Life Care

BY: **Jeanne M. Chirico, MPA**
President and CEO, HPCANYS

Board of Trustees, HPCANYS, 2024-2026

Legislative and Regulatory Review Committee, HPCANYS, 2024-2026

Updated: January 28, 2026

About the Hospice and Palliative Care Association of New York State (HPCANYS)

The Hospice and Palliative Care Association of New York State (HPCANYS) is the leading association representing New York State's hospice and palliative care programs, allied organizations, and individuals interested in the development and growth of quality, comprehensive care for all confronted with serious illness and their families. HPCANYS collaborates with hospice and palliative care providers, policymakers, community organizations, and other stakeholders to ensure access to high-quality, compassionate care for all New Yorkers with a life-limiting illness.

Underscoring the Association's advocacy and education is a commitment to health equity, patient-centered care, and personal autonomy. HPCANYS promotes policies and practices to ensure access to high-quality serious-illness care for all individuals, aligned with their health care goals and wishes, and to support families, caregivers, and communities.

As the only statewide association exclusively representing New York State's hospice and palliative care industry and its workforce, HPCANYS is uniquely positioned to identify barriers to care, challenges to sustainability, and to propose achievable and measurable solutions.

Executive Summary

The federal government has taken significant steps to improve hospice integrity and combat fraud, particularly in the for-profit sector. The Centers for Medicare & Medicaid Services (CMS) has strengthened oversight mechanisms, including more frequent surveys of new providers and enhanced enforcement actions against non-compliant hospices. The Office of Inspector General (OIG) continues to identify fraudulent billing practices and improper patient enrollment by providers who do not meet hospice criteria. Additionally, the Government Accountability Office (GAO) has issued multiple reports calling for stricter financial accountability, particularly concerning related-party transactions and ownership structures that prioritize profit over patient care. These federal actions underscore the urgent need for New York to strengthen its Certificate of Need (CON) process to prevent fraudulent operators from exploiting the system and to better ensure that hospice care remains a compassionate, high-quality service for those in need.

These profit-seeking hospice providers have been increasingly associated with fraudulent activities, patient neglect, and financial exploitation of Medicare and its beneficiaries. New York State's Certificate of Need (CON) process serves as a critical safeguard against unregulated expansion and potential abuse. However, as evidenced by federal oversight reports, existing CON regulations must be enhanced to prevent exploitation and ensure high-quality end-of-life care. This white paper outlines key recommendations to bolster oversight, restrict for-profit abuse, and uphold the integrity of hospice care in New York.

New York State's hospice community is at a critical and defining moment in our state's history. While New York State's CON guardrails and commitment to regulatory oversight have served as a model to other states and the federal government to reign in the proliferation of fraud and abuse in the hospice industry, New York State's policymakers should be mindful that in 2018 the Trump administration called on individual states to eliminate Certificate of Need (CON) laws – characterizing the statues as anti-competitive and detrimental to consumers.

In a sweeping 120-page report on health care reform, the secretaries of the Health and Human Services, Treasury, and Labor departments accused states of hindering innovation in health care through their laws. As a state, we can expect the current presidential administration to be more forceful in its second term regarding CON statutes. We can expect little oversight of the industry by the current Administration to support long-standing community-based providers with a record of exceptional care. New York State should not expect policy from the current administration that would limit growth for the sake of growth in the hospice industry, which is the largest factor in why fraud and abuse are pervasive in some states and rapidly expanding in others. When states dismantled their CON processes, state regulatory agencies could not maintain the regulatory oversight needed to ensure access to quality hospice care and protect healthcare consumers. Some states are several years behind in their survey process.

State governments need to be vigilant in the current political climate and protect the end-of-life care space. New York State can best protect its hospice community by maintaining its CON guardrails - guardrails that other states and CMS have recommended in their own attempts to rein in the proliferation of hospice fraud and abuse. New York can prevent issues seen in other states by strengthening its regulatory framework.

Further, utilization of the hospice benefit can simultaneously increase by appropriately investing in the hospice workforce and funding the advance care planning initiatives that were signed into law in New York State three years ago. If increasing hospice utilization is the goal, reckless modification or dismantling of the state’s CON process is not the vehicle to encourage use of the hospice benefit. We have seen how this has played out in other states; the results are unconscionable.

Background and Rationale

The federal government has identified significant concerns regarding fraud and abuse in the hospice industry, prompting increased scrutiny and policy changes. The Centers for Medicare & Medicaid Services (CMS) has implemented a targeted strategy to curb fraudulent activity by requiring additional reporting and transparency from hospices, particularly those newly entering the Medicare program. The Office of Inspector General (OIG) has flagged systemic issues, including the admission of ineligible patients and inappropriate financial arrangements between hospice providers and referring entities. The Government Accountability Office (GAO) has recommended stricter financial oversight, noting that many hospices engage in related-party transactions that obscure financial accountability and inflate costs. These actions reinforce the need for New York to proactively strengthen its CON requirements, ensuring that only qualified, ethical providers are permitted to operate within the state. Strengthening these regulations will help protect vulnerable patients and ensure that end-of-life care remains focused on patient well-being rather than financial gain.

Hospice care serves a uniquely vulnerable population, requiring a high level of ethical commitment and compliance with federal and state regulations. Unlike traditional healthcare services, the demand for hospice is not subject to market forces like supply and demand because:

- Hospice reimbursement rates are set by the federal government, eliminating price competition.
- The number of eligible patients is determined by natural mortality rates, not market demand.
- Service delivery requires strict adherence to patient-centered care principles, which can be compromised by profit-driven incentives.

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In states where for-profit hospices have proliferated, increased fraud, patient neglect, and financial mismanagement have been documented (GAO, 2022; OIG, 2023). In January 2026 the number of states included in the CMS Provisional Period of Enhanced Oversight (PPEO) increased to six (6) and include Arizona, California, Nevada, Texas, Georgia, and Ohio. These states, in CMS' opinion did not adequately prevent the "churn and burn" of hospices entering the state and then quickly selling to the highest bidder. Nor did states adequately assure quality oversight upon licensure. As a CON state, New York can prevent these issues by strengthening its regulatory framework. HPCANYS offers the following recommendations to strengthen its hospice industry for the benefit of the state's seriously ill and dying.

Key Recommendations

1. Enhanced Oversight of New Providers

Ensuring the quality and integrity of hospice care begins with rigorous oversight of new providers. Without proper safeguards, newly established hospices may engage in fraudulent activities or provide substandard care. Strengthening the oversight process helps prevent these issues before they take root and ensures patients receive compassionate, high-quality care.

- Implement an 18-month provisional period for new hospices with mandatory surveys at 6- and 18-month post-approval to ensure early detection of non-compliance.
- Define "new hospices" to include:
    - Entities newly enrolling in Medicare or seeking NYS licensure, ensuring that all new entrants undergo rigorous vetting before operating.
    - Providers undergoing a 100% ownership change or a change of ownership (CHOW) under 42 CFR 489.18, to prevent sudden, unchecked transfers of ownership that could facilitate fraud.
    - Previously deactivated hospices seeking reactivation to ensure they meet updated regulatory and quality standards before resuming operations.
- Restrict rapid expansion of new providers to ensure quality control and prevent excessive growth that might compromise care.
    - Limit the approval of new hospices acceptable within each county and each state to assure adequate NYS DOH oversight capabilities, workforce capacity, and adequate census.

2. Financial Safeguards Against Fraud

Financial fraud is a significant concern in the hospice industry, as unscrupulous providers may exploit the system for profit rather than patient well-being. Implementing financial safeguards ensures accountability, prevents unethical billing practices, and maintains the financial stability of hospice care for those who need it most.

- Implement caps on related-party transactions to prevent financial mismanagement and fraudulent billing. The GAO (2022) highlighted cases in which related-party transactions were used to inflate costs.
- Require publicly accessible quality and financial reporting for all hospices to promote transparency and accountability in financial and care quality metrics (CMS, 2023). All hospices in New York must participate in CMS Quality and Satisfaction Reporting unless excluded based on the number of patients served. Voluntary withdrawal from either program will result in immediate decertification.
- Forbid ownership changes within 36 months of initial licensure to prevent speculative acquisitions, ensuring that new hospice providers remain committed to service quality rather than profit-driven motives.
- Require a surety bond for new entrants to ensure financial accountability and prevent fraud. GAO (2021) reports show that surety bonds can serve as a financial guarantee against non-compliance and misconduct.

3. Protecting Vulnerable Populations

Many rural and underserved communities lack adequate hospice care, leaving vulnerable populations without the necessary support at the end of life. Strengthening policies to expand hospice access in these areas helps ensure equitable care and prevent disparities in service availability.

- Enforce the mandate that a hospice must serve all the constituents in a county they are licensed to serve. Article 40 providers should not be allowed to only serve patients in their own value based purchase agreements, health plans, or health system.
- Mandate Medicaid participation for all CON-approved hospices to ensure that low-income populations have access to high-quality end-of-life care, a measure endorsed by the National Association for Home Care & Hospice (2021).
- Establish a minimum percentage of services for indigent and uninsured patients to ensure equitable access to care. MedPAC (2022) recommends such thresholds to maintain fair hospice access for underserved communities.
- Implement state-specific utilization benchmarks for CON renewal, which include:
    - Live discharge rates to monitor and prevent inappropriate discharges for financial gain.
    - Length of stay metrics to detect anomalies where patients are enrolled in hospice care inappropriately.
    - Patient days in assisted living and skilled nursing facilities vs. home settings to ensure appropriate distribution of hospice services and prevent financial exploitation of institutionalized patients.

4. Restricting Conflicts of Interest in Ownership

Allowing hospice providers to be co-owned by nursing facilities has led to well-documented abuses in care quality and financial practices. Limiting such ownership structures eliminates incentives to cut costs at the expense of patient care and ensures that hospice services remain patient-focused rather than profit-driven.

- Prohibit the co-ownership of hospices and skilled nursing facilities (SNFs) to prevent conflicts of interest. Federal reports show that between 2005 and 2015, the number of hospices with common ownership with SNFs quintupled, resulting in lower-quality care and shorter visits (HHS, 2022).
- Establish strict separation requirements between hospice agencies and referring entities to eliminate financial incentives that may lead to unethical referrals and substandard care.

5. Ensuring Compliance and Ethical Leadership

Maintaining ethical leadership within hospice care is crucial to upholding service quality and patient rights. Implementing robust compliance and education requirements ensures hospice administrators have the knowledge and oversight needed to prevent fraud and prioritize patient-centered care.

- Require a mandatory compliance officer for all hospices to oversee adherence to state and federal regulations. The OIG (2023) has identified compliance officers as a key element in preventing hospice fraud and misconduct.
- Implement initial and continuing education requirements for hospice administrators, modeled after best practices in other states:
    - 24-hour training for first-time administrators, including ethics, fraud prevention, and regulatory compliance. This ensures that new leaders have the foundational knowledge required to manage hospice operations effectively.
    - 12 annual hours of continuing education to keep administrators informed of evolving hospice regulations and best practices, ensuring ongoing compliance with quality and ethical standards.
    - Training should cover financial management, risk assessment, patient rights, abuse prevention, and regulatory compliance, reinforcing accountability and patient-centered care.

Conclusion

New York’s CON process must evolve to both address an outdated needs methodology that reduces appropriate utilization and to address the growing presence of for-profit hospice providers. The risks to healthcare consumers and to hospice integrity are well documented. By adopting the enhanced regulations proposed by HPCANYS, New York State can protect its most vulnerable residents, prevent fraud and abuse, and ensure that hospice care remains a service driven by compassion rather than profit. Lowering the guardrails has proven unsuccessful in other states. To protect New York State’s end-of-life care space, strengthened oversight, increased financial accountability, ethical governance, and appropriate investments in workforce and education are essential. We must be vigilant in maintaining the integrity of the hospice care community in New York State.

References

- Centers for Medicare & Medicaid Services (CMS), 2026, 2023
- Government Accountability Office (GAO), 2021, 2022
- U.S. Department of Health and Human Services (HHS), 2022
- Medicare Payment Advisory Commission (MedPAC), 2022
- National Association for Home Care & Hospice (NAHC), 2021
- Office of Inspector General (OIG), 2025, 2023