August 11, 2023

Dara Corrigan
Deputy Administrator & Director
Center for Program Integrity (CPI)
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services (HHS)
200 Independence Ave, SW
Washington, DC 20201

Dear Director Corrigan,

We are writing with regard to Centers for Medicare & Medicaid Services' (CMS) auditing of Medicare hospice benefit claims and the process in place for recovering overpayments and adjudicating recoveries. As organizations representing both not-for-profit and for-profit hospice providers, and the hospice and palliative medicine community, the American Academy of Hospice and Palliative Medicine, LeadingAge, the National Association for Home Care & Hospice (NAHC), the National Hospice and Palliative Care Organization (NHPCO), and the National Partnership for Healthcare and Hospice Innovation (NPHI) appreciate the importance of a robust program integrity regime that protects both patients and providers. We welcome and support the efforts CMS has initiated this year to address issues related to certification of what appear to be fraudulent hospice organizations. Specifically, the provider enrollment provisions included in the CY 2024 Home Health proposed rule and the announcement of enhanced oversight of new hospice organizations in targeted states are actions that are likely to decrease the prevalence of fraud, waste, and abuse. We will continue to assist with and support reforms that address Medicare certification and survey issues nationwide and will work with stakeholders at the state level to identify ways that licensing requirements and processes can be improved to address program integrity concerns.

While the current focus on instances of apparent fraud is welcome and necessary, we continue to be concerned about more fundamental, longstanding problems related to the targeting of audits and the corresponding adjudication processes. We urge CMS and its audit contractors to shift the focus of current audit and recovery practices from obtaining large initial "overpayment" recoveries to halting billing practices and patterns that clearly reflect failure to comply with fundamental requirements of the program. In so doing, we expect CMS to reduce the disproportionate audit burden that has been placed on hospice organizations that have a history of providing high-quality care. The intense scrutiny that entangles mostly high-performing hospices is inadvertently allowing problematic and often newer providers to fly under CMS's program integrity radar, to the detriment of patients, their families, and the Medicare program as a whole. The problems with the current audit environment exist in three areas:

- **Audit focus:** Current audit activity appears to be overwhelmingly focused on two areas: billing for the General Inpatient (GIP) level care and billing for long lengths of stay (LLOS)

where the patient fails to show decline on a trajectory the auditor views as consistent with a terminal prognosis.

- **GIP level of care:** Providers report that CMS and its contractors are sending mixed and contradictory messages regarding their goals for the GIP level of care. The list of GIP indicators, target measures and audits includes:
  - The Hospice Care Index (HCI) score which takes into account whether any GIP or continuous home care (CHC) has been provided.
  - The Hospice PEPPER which provides target measures for no GIP or CHC as well as LLOS in GIP.
  - The Medicare Administrative Contractor (MAC) Targeted Probe and Educate (TPE) program reviews claims with a GIP inpatient stay of seven days or longer. Medical necessity for each day of the inpatient stay must be documented.
  - The Supplemental Medical Review Contractor (SMRC) (Project # 01-084) provides post-payment review of claims for Medicare Hospice General Inpatient (GIP) Level of Care in CY 2020, based on an OIG report that cited overpayments for higher levels of care.
  - Recovery Audit Contractor (RAC) approved topic: *Hospice General Inpatient Care: Medical Necessity and Documentation Requirements* (4/1/23).
  - In the FY 2024 Hospice Wage Index and Quality Reporting proposed rule, the CMS statement on the uses for the information gathered under the Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making specifically state "lower rates of hospitalization."

- Given the various GIP audit activity, it appears that at times CMS is simultaneously concerned with "not enough" GIP, "too much" GIP, GIP for "too long", poor GIP documentation, lack of proof of medical necessity, and an overall goal of reducing hospitalizations. The data published in the FY 2024 Hospice Wage Index and Quality Reporting proposed rule[1] shows a drop in the use of GIP and an increase in the number of hospices providing no GIP days at all, which we believe is directly related to these mixed messages and the level of scrutiny on GIP care. For a level of care that is utilized less than 1 percent of the days of care and 5 percent of expenditure, it is perplexing that, as August 2023, there are six different audits and reviews of hospice GIP care. In some cases, hospices are also being subjected to multiple simultaneous audits of GIP care by different CMS audit contractors. Our members are especially concerned about the lack of any audit review for the 56.3% of Medicare certified hospices who did not provide a single day of GIP care in FY2022.

[1] In the FY 2024 Hospice Wage Index and Quality Reporting proposed rule, CMS published that 1.8% of days of care were at the GIP level in 2013 and had dropped to 0.8% of days of care in 2022. Expenditures for the GIP level of care dropped from 7.3% in 2013 to 5.0% in 2022.

- **Utilizing a "decline standard" or stability as the basis for denial:** Hospice providers are consistently being audited for hospice patients that contractors see as "not declining" or stable. Examples range from a patient not losing enough weight to being able to go out to a special event with family. We are collectively concerned about the chilling effect of contractors looking at stability as the only sign that a person is no longer terminally ill. Some disease processes have a longer trajectory of decline and the patient's condition improves in the short-term because hospice is providing high-quality care and addressing symptoms. Our members receive audits across the duration of a hospice stay – both during the initial 6 months and for patients who are recertified to stay on for longer than 6 months – citing a lack of documentation to support the terminal illness that is really saying that the patient is not showing signs of decline that support terminality. As with GIP, CMS and the audit entities' actions seem to leave hospices in a difficult bind; either do not admit patients who fail to meet every criteria listed on a MAC's Local Coverage Determination (LCD), which is meant to be guidance rather than a requirement, or discharge them because they are "living too long". Such live discharges are disruptive to patient care, and, in the Hospice Care Index (HCI), CMS has identified certain kinds of live discharges as "burdensome transitions" that negatively impact quality of care.
    - **Long Lengths of Stay:** While these "decline standard" audits are occurring across lengths of stay, we want to underscore that it should be recognized that hospices are NOT required to discharge the patient at the 180-day mark, but rather document the patient's continued eligibility through a recertification encounter. Moreover, the standard employed by auditors to justify these denials is not specified in statute, regulation, or sub-regulatory guidance from CMS. Meanwhile, research has shown that federal policies aimed at increasing scrutiny of longer hospice stays creates a kind of "chilling effect", wherein hospices may be reluctant to serve eligible patients with conditions that may result in stays longer than 180 days, primarily those with Alzheimer's Disease and "Related Dementias (ADRD)[2].
    - **"Stable" primary diagnosis:** Some of our members have recently been targets of a new type of routine home care audit, under which auditors are claiming that if the primary diagnosis is "stable," the patient should be discharged regardless of the status of the secondary diagnoses. This

[2] *Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons with ADRD*. Gianattasio, et al. (May 2022): https://jamanetwork.com/journals/jama-health-forum/fullarticle/2791963. Not only have researchers found that this aggressive focus on auditing hospices with long stays likely reduces the quality of life for those who would otherwise be served by hospice but are not because providers are nervous about taking them on, but they have also concluded that not having these patients appropriately served by hospice costs Medicare money in the aggregate. See *The Value of Hospice in Medicare*. NORC with the National Association for Home Care and Hospice and the National Hospice and Palliative Care Organization (March 2023): https://www.nhpco.org/hospiceworks/ and *Dying or Lying? For-Profit Hospices and End of Life Care*. Gruber, et al. (March 2023): https://www.nber.org/system/files/working_papers/w31035/w31035.pdf

ignores the variability of the disease process in many non-cancer diagnoses and does not necessarily mean that the patient is no longer eligible for hospice. This is in direct contrast to CMS' payment policy that "virtually all" care for hospice patients should be considered "related to the terminal prognosis and its related conditions". This, like GIP, is another area in which payment policy and enforcement policy are not aligned.

- **Auditor knowledge and conduct:** Across all audit types, there is inconsistency in how auditors review claims and in some cases a lack of specific knowledge of the unique aspects of hospice care. The TPE initiative, conducted by the MACs, appears to be aimed more at denying or recovering payment than on educating as well as correcting and reducing denial rates. For other audit entities, the knowledge gap is much more serious. Hospice providers report that some auditors know little about the details of the Medicare Hospice Benefit and apply decisions based on very rudimentary knowledge of the hospice benefit and its intricacies. Providers under review often teach the auditors the basics of hospice, including the regulations and Chapter 9 of the Medicare Benefit Policy Manual, during the audits. The undersigned organizations are prepared to provide CMS with specific examples of denials inconsistent with requirements and instances of lack of auditor knowledge in the coming weeks.

- **Adjudication:** Providers report significant financial and staffing burdens in responding to audits from various CMS auditors, including the MACs, the SMRC, the RAC, and the Unified Program Integrity Contractor (UPIC) among others. As the clinical staffing shortage continues and is compounded by a shortage of administrative staff, hospices report having to add staff and/or pull clinical staff from the field or patient care duties to respond in a timely manner to requests for claims, often receiving 30-40 additional document requests (ADRs) in a single day. The process affords little opportunity to correct audit errors and educate providers despite the existence of the reconsideration and redetermination levels of the appeal process which are meant to provide a venue for this engagement. The process also does not incentivize the contractors' to be accurate or timely in their deliberations[3]. If providers are expected to pull resources to respond to these audits, there should be a responsibility for auditors to be timely in their responses as well as accurate in their assessment of the need to audit at all.

In order to reduce the burden on high-quality hospices and support efforts to address the most problematic program integrity issues with hospice, we request that CMS consider:

[3]One MAC reports that in the first quarter of 2023, 61% of original decisions were upheld at the redetermination level of appeal and 71% of original decisions were upheld at the QIC level of appeal. However, when these claims are appealed to the Administrative Law Judge (ALJ), the Office of Medicare Hearings and Appeals (OMHA) reports that for cases in 2022 or 2023, the case will be heard in 183 to 725 days. In the first quarter of 2023, one MAC reported that 6,089 cases were considered by the ALJ, with an overturn rate of 73.3%. The hospice who eventually receives a reversal of an earlier decision must wait from 6 months to nearly 2 years for that decision and the release of revenue associated with those claims.

- Re-focusing its audit contractors on patterns and practices characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are required under the hospice benefit and fully reimbursed through the per diem payment.
- Placing emphasis on the education of providers rather than recovery of payments and ensuring there are clear definitions and standards communicated effectively to hospice providers and that are applied uniformly in the audit process.
- Requiring substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies.
- Modifying the audit, recovery, and appeals processes to reduce the need for lengthy adjudication and reduce the burden for typically compliant hospice providers. Included in this should be a procedure for centrally monitoring audits across all contractors to ensure a high bar for why a provider must go through multiple audits simultaneously. Additionally, there should be an opportunity for mediation with the MAC to explain the provider's justification for the billing and correct auditor errors before denial or recovery of claims are initiated.
- Increasing transparency of CMS contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, and top denial reasons.

We appreciate your attention to hospice program integrity issues and hope that we can also make progress on our shared concerns related to hospice audit, recovery, and adjudication processes. We would welcome the opportunity to discuss our suggestions in more detail with you and we are anxious to find a productive and practical path forward on these issues. Please contact Joe Rotella, Chief Medical Officer, AAHPM (jrotella@aahpm.org), Mollie Gurian, Vice President, Home-Based and HCBS Policy, LeadingAge (mgurian@leadingage.org), Theresa Forster, Vice President Hospice Policy and Programs, NAHC (tmf@nahc.org), Logan Hoover, Vice President for Policy and Government Relations, NHPCO (lhoover@nhpco.org), and Ethan McChesney, Policy Director, NPHI (emcchesney@hospiceinnovations.org), if you have any questions.

Sincerely,
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National Hospice and Palliative Care Organization
National Partnership for Healthcare and Hospice Innovation