National Hospice Audit 2023 Survey Findings: Report

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INTRODUCTION

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), collectively, the National Hospice Organizations, are pleased to share findings of a 2023 hospice audit survey conducted for hospice providers nationwide (the "Survey").

We remain committed to preserving the integrity of the hospice benefit,[1] and strongly support the appropriate delivery

[1] On November 9, 2022, the National Hospice Organizations submitted a letter to the Centers for Medicare & Medicaid Services emphasizing the need for increased oversight to address hospice fraud and abuse in the Medicare and Medicaid programs. https://www.nhpco.org/wp-content/uploads/National_Hospice_Stakeholders_to_CMS_regarding_Certification_Activity_November_2022.pdf. In this letter, we noted that "increased federal oversight is needed to protect hospice patients and their families, *as well as the vast majority of hospice providers that properly observe Medicare and Medicaid laws and regulations*." (emphasis added). The National Hospice Organizations followed this letter with the submission of 34 program integrity recommendations to better protect hospice patients and their families. https://www.nahc.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Recommendations_Jan-2023.pdf

of hospice care in accordance with Medicare and Medicaid laws and regulations. While we welcome efforts to detect, address and prevent instances of apparent fraud, waste, and abuse, concerns have been raised by hospice providers regarding hospice audit practices that have resulted in substantial operational and financial challenges and undue costs, impairing these providers' ability to continue to provide access to medically appropriate hospice care for Medicare and Medicaid beneficiaries.

The Survey was initiated to collect feedback in response to concerns about the auditing and adjudication processes of Medicare hospice benefit claims. While the survey was largely focused on what are commonly known as technical denials, the Survey was also intended to address issues such as the focus of audits of hospice claims, the knowledge and conduct of the Centers for Medicare & Medicaid Services (CMS) contractor and HHS OIG auditor staff, and the burdensome nature of the audit and appeals process. These concerns, raised by hospice provider members of all four National Hospice Organizations for over five years, highlight the need for a more balanced and informed audit approach that supports the continued delivery of high-quality and medically appropriate hospice care while effectively addressing program integrity considerations.

Specifically, the Survey collected information directly from hospice providers regarding their experiences with all types of audits conducted by the following audit contractors on behalf of CMS or HHS OIG:

- Medicare Administrative Contractor (MAC)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractor (UPIC)
- Recovery Audit Contractor (RAC)[2]
- Comprehensive Error Rate Testing (CERT) Contractor
- U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG)[3]

The majority of Survey respondents indicated that they have been **subject to more than one audit simultaneously** with most of these being a MAC Targeted Probe & Educate (TPE) and concurrent SMRC audits. Audits from two different contractors were also experienced in close succession by many respondents and many reported having the same record reviewed under more than one audit type. Seventy-seven percent of Survey respondents indicated that they have been subjected to a TPE audit over

[2] Recovery Audit Contractor was mistakenly referred to as Review Audit Contractor in the Survey, but the terminology has the same meaning.

[3] It is our understanding that HHS OIG relies on one or more medical review contractors for hospice audits that involve clinical record reviews.

the past five years. Of these hospices, 32% were under the **TPE audit for an extended period of time** (18 months to 2 years) in order to meet the 40-claim minimum threshold. About 80% of these audits were for the General Inpatient (GIP) level of care.

Survey results indicate that **SMRC audits are especially challenging** for hospice providers due primarily to the large volume of requested records and the 45-day timeframe in which they need to be submitted. For instance, 24-30 months of records requested for 9 or more beneficiaries is a significant response burden in a 45-day timeframe. This is especially true when the sole SMRC contractor, Noridian Healthcare Solutions, LLC, would reportedly not accept responsive records electronically. According to Survey respondents, Noridian granted some hospices an extension to respond but not all.

Numerous Survey respondents reported that **audit contractors were frequently delayed** in completing their audits and responding with some Survey respondents not receiving results for nine months or more after submission of records, while others never received a response. Conversely, some hospice providers reported a very quick turnaround. However, for some of these quick turnarounds, hospices questioned whether the records submitted were fully examined as they noted the timeframe seemed impossibly short for the number of records submitted. For these and all audit results, hospice providers reported that **documentation submitted was frequently overlooked or missed by the reviewer** up to and including full patient charts. Respondents also noted frequent copying and pasting of cursory denial reasons as well as patterns of denials (i.e. every 8th chart was denied).

The number of **audits appears to have increased over the past two years**, perhaps in response to the winding down of the COVID-19 Public Health Emergency (PHE). Regardless of the reason, the uptick in audits may be creating a burden not just for providers but also for the audit contractors, thereby impairing efforts to conduct timely and thorough medical reviews. This is evidenced by untimely responses as well as situations where reviewers have misapplied or misinterpreted Medicare hospice coverage requirements.[4]

Related to GIP care, hospices experienced an uptick in the denial of coverage and payment for related physician visits. The reasons for those denials were confusing and often erroneous.

[4] For instance, one respondent reported that GIP care was denied because the patient was not actively experiencing pain, even though the patient was experiencing uncontrolled emesis and on the day of admission to GIP needed surgery to correct an issue with their ostomy.

Several Survey respondents reported **significant challenges with audits associated with long lengths of stay**. Many respondents reported that the time and resources necessary to respond to these audits are substantial – several thousand pages long in some cases. There also appears to be a misunderstanding on the part of the audit contractors about the hospice benefit relative to the requirement that a patient must be certified as being terminally ill with a life expectancy of six months or less if the illness runs its normal course. This does not mean that a hospice should discharge a patient on the 180th day, or that a beneficiary is no longer terminally ill and eligible for the hospice benefit if they are on service for longer than 180 days.

CMS itself has acknowledged the challenges of predicting when death will occur for hospice patients, and affirmed that the benefit is not time-restricted, as long as the patient continues to meet the prognosis requirement.[5] And yet, we hear frequently from our members that contractors' reasoning around denials imply that lengths of stay longer than 180 days are de facto inappropriate.

The intense audit focus on patients with longer lengths of stay has resulted in a very real and cognizable fear amongst hospices that stays for patients with terminal illnesses that make prognostication more difficult may be denied. Unchecked, further increased scrutiny of longer hospice stays has the potential to restrict hospice access for beneficiaries with these conditions, such as Alzheimer's disease and related dementias (ADRD). In fact, recent academic research indicates that policies intended to reduce long lengths of stay have indeed likely reduced access to hospice for patients with ADRD.[6]

Overall, **hospices experience a significant burden** in responding to audits to the point of having to hire additional staff – both temporary and permanent - only to then experience a high overturn rate for denied claims during the appeals process. Primary audit targets have been eligibility for hospice care, long lengths of stay and GIP care. It is exceptionally confusing that many of the hospices targeted for these audits do not fall outside normal parameters, nor represent outliers, according to PEPPER reports. Ultimately, there is concern about access to quality hospice care, at the appropriate level, due to the impact on hospices from these audits.

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[5] See CMS, Transmittal AB-03-040, Change Request 2570, Provider Education Article: "Hospice Care Enhances Dignity and Peace As Life Nears Its End" (Mar. 28, 2003).

[6] Gianattasio KZ, Moghtaderi A, Lupu D, Prather C, Power MC. Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons With ADRD. JAMA Health Forum. 2022;3(5):e220900. doi:10.1001/jamahealthforum.2022.0900

Survey Approach

Our Survey was conducted from September 27, 2023 through October 31, 2023. A total of 133 responses were received from Survey respondents with some hospices not responding to all questions. Survey respondents largely include hospice providers, generally represented by one or more of the four National Hospice Organizations. Respondents were not required to be a member of a national or state association to participate in the survey.[7] Respondents were not required to answer every question in the Survey.

The Survey asked for information on various audits of hospice claims, particularly with a focus on technical documentation denials. Respondents were asked to provide anonymized hospice audit examples with detailed information (with no protected health information), as well as additional information including, but not limited to, the respondent's applicable Medicare Administrative Contractor (MAC), whether the respondent had experienced multiple audits at the same time or within six months of each other, specific MAC denial codes for claim denials, whether the respondent was subject to a TPE review in the past five years, whether the respondent has been subject to a SMRC audit, and how burdensome audit documentation requests were for the respondent's organization.

Survey results show nationwide hospice audit experiences associated with audit review entities, including MACs, SMRCs, UPICs, RACs, CERT contractors, and OIG audits. Data were not extrapolated from hospice audit survey responses and may not be representative of the entire hospice sector.

Survey Themes

Survey responses highlight common themes in challenges associated with the audit process, including but not limited to the following areas:

- a misapplication of regulatory requirements or the relevant legal standard,
- audit contractors not following proper policies and procedures,
- frequent substitution of the audit reviewer's clinical judgement in place of the physician responsible for the patient,
- Hospice providers being subjected to concurrent audits or audits being conducted in close proximity,
- physician service denials,
- the lack of effective TPE education with inadequate or inconsistent guidance, and
- high claim denial overturn rates on appeal, which emphasizes a need to not only look at initial error rates,

[7] One respondent was not a member of any hospice trade association.

but the final error rate following the appeal process.

SURVEY FINDINGS

Misapplication of Regulatory Requirements or the Relevant Legal Standard

Multiple hospice provider Survey respondents raised concerns that auditors denied claims based on regulatory requirements that do not exist or based on a misapplication of the regulatory requirements. Some examples include:

- One respondent reported receiving multiple denials due to the face-to-face attestation not including benefit period dates. However, 42 CFR 418.22(b)(4) does not require the benefit period dates to be included on the face-to-face attestation. These dates are required to be included on the certification or terminal illness itself. See 42 CFR 418.22(b)(5).
- Another respondent reported receiving a denial for the sole reason that there was no documentation that the hospice interdisciplinary group (IDG) held a meeting to discuss the patient's care plan. However, according to this respondent, the record included specific documentation that the IDG collaborated to review and update the care plan at least every 15 days in accordance with 42 CFR 418.56. There is no reference that the IDG must hold a "meeting" in regulation or subregulatory guidance, though IDG meetings may be a common approach.
- Multiple respondents reported routinely receiving denials of physician visits that occur on the same day as a face-to-face encounter, even when there is separate documentation and evidence supporting a billable evaluation and management (E&M) code because the auditor indicated a physician visit at the time of a face-to-face is not billable. CMS billing guidance related to hospice physician professional services clearly establishes that physician service billing may be appropriate if reasonable and necessary and separately documented from the face-to-face encounter.

Other common denials reported by respondents were due to the absence of an IDG meeting even though there is no requirement for an IDG meeting, requiring a physician to countersign the initial certification of a patient's terminal illness, a reliance upon Local Coverage Determinations (LCDs) as strict criteria instead of clinical guidelines intended to aid certifying physicians, among other considerations.

One respondent reported appealing a denial related to certification, which was sustained at both the redetermination and reconsideration levels. However, the Administrative Law Judge (ALJ) provided a favorable decision for this respondent: "In this case, a preponderance of the evidence demonstrates that the beneficiary's physician submitted a verbal order for hospice services . . . **The regulations and Medicare policy do not require a statement of terminal illness to be included in an oral certification. Further, the regulations and Medicare policy do not require the benefit period dates be included in an oral certification.**" - *Survey respondent*

Audit Contractors Not Following Proper Policies and Procedures

Many Survey respondents shared concerns that auditors copied denial reasoning from one claim review findings to another, overlooked or missed submitted records, and/or failed to timely process or notify providers of audit review outcomes. Some examples include:

- Multiple respondents indicated that denial reasoning appears to have been copied and pasted from one claim to the next and/or appears as if the review contractor did not actually examine the documentation that was sent. Here, time frames for audit documentation review were exceptionally short, suggesting that not all charts were thoroughly reviewed.
- Denials for missing documentation that was demonstrably present upon the providers' documentation submission.
- Providers receiving notice from the auditor that they were late on their audit documentation submission prior to the response due date.
- Several cases of untimely review processing were reported, for example, a TPE review conducted in spring 2022 while results were not generated until the end of summer 2023, or records submitted for a SMRC audit in August 2020, while results were not issued until April 2021.
- Several Survey respondents reported they received untimely results of audit reviews. For example, one respondent reported that the results of a RAC review were communicated more than 90 days past when the results were stated to be available.
- Respondents also reported unclear instructions from audit contractors. For example, one respondent reported that RAC language used on requests is confusing to hospices, which may be standard

language adopted for other care settings.[8]

- Denials due to how documentation was submitted rather than the content of the documentation. For example, one respondent reported that the hospice election statement was fully present but because the content was split across pages of the records submission, the claim was denied, even though CMS has never issued an approved election statement (or hospice certification of terminal illness) OMB-approved form. This respondent reported submitting the same documents a second time with all documents together in a PDF and they were accepted.

Commonly, respondents reported inconsistencies in how each audit contractor accepts records and how they communicate results. It is understandable that due to human error, some items may be missed upon review; however, the frequency of multiple documents being missed in one record reported by respondents is an indicator that the chart review lacked any quality review, and raises questions of whether the audit reviewer is unsure what types of documentation meets regulatory requirements. In other words, this may suggest that some auditors may be looking for a particular form instead of documentation content to satisfy a regulatory requirement.

Inappropriate Substitution of the Audit Reviewer's Clinical Judgement in Determining Whether a Patient is Terminally Ill

Respondents reported multiple cases where the medical reviewer inappropriately substituted their own judgement to determine a hospice patient was not terminally ill, trumping the real-time clinical determination of the hospice physician. Some examples include:

- One respondent reported that while under a TPE review, a MAC asserted that a patient with untreated pancreatic adenocarcinoma with dementia was not terminally ill. However, the patient expired four days later following the TPE education.
- Claims were denied on the basis the patient was not terminally ill

[8] For example, the phrase "documentation to support each of the look back periods which may fall outside the billing period under review" was reported, and it is unclear if this references an additional billing period, certification period, or something else entirely. The respondent noted that the RAC failed to respond to their inquiry to the RAC on this question and the provider was instructed to send all documentation. Similarly, a respondent reported that under RAC "Instructions", Number 11, "Please do not include Powers of Attorney, Living Wills, Correspondence, or Prior Episodes of Care." However, on the list of applicable documentation (which is over a page and a half long, double columned), "Power of Attorney paper or health surrogate papers. [if applicable.]" were requested.

because, according to the reviewer, the hospice was only managing chronic illness issues, while the patient expired only two weeks later.

- One respondent reported that claims were denied while under a CERT audit on the basis that the patient was not terminally ill, even though the patient expired during the audit.

In one particularly egregious example, a GIP stay was denied by the SMRC based on the patient's apparent lack of uncontrolled pain. A Survey respondent stated ***"[t]he patient was actively hemorrhaging with blood in vomit and blood per rectum, tachycardic with respiratory rates in the 30s and 40s. Required multiple doses of IV haldol and ativan for uncontrolled nausea/vomiting, multiple doses of IV morphine for respiratory distress. Extensive skilled nursing care for bleeding.***"

The patient lived less than 72 hours, and the respondent reported this denial was reversed after a teleconference with the contractor in which they reiterated the patient's uncontrolled symptoms and emphasized that the absence of pain does not preclude GIP care.

Providers Subject to Simultaneous Audits or Audits in Quick Succession

Respondents reported significant challenges and burdens with being subjected to frequent audits at the same time or in close proximity of each other. Some examples include:

- According to respondents, two RAC audits were conducted within six months of each other and they had multiple overlapping hospice patients as part of the review.
- Respondents also reported being subjected to multiple audits for the same claims with different audit results. For example, as part of a SMRC GIP audit, a respondent reported that a record was requested that had been reviewed as part of TPE. For the TPE audit, the MAC approved coverage and payment for the record but the SMRC denied it. In a separate case, a respondent reported that it received audits for the same patient three times from three different contractors (CERT, RAC, and TPE) with three different results.

A majority of Survey respondents (52.9%) indicated they were subject to different audits within six months of one another. Thirty-one percent of respondents indicated they needed to submit the same charts for the two different audits.

Physician Visit Denials

Survey respondents reported confusion regarding the denial of physician visitsSome examples include:

- According to survey respondents, denial reason code 5PM07[9] is often used; however, the verbal explanation given is often that the physician's Evaluation & Management note content is essentially equivalent to the nurse's documented note of the same date, and therefore, not reasonable and necessary.
- Respondents also reported they have been told that the physician could have obtained the information from a phone call with the nurse instead of evaluating the patient's condition in person. This same reasoning was reportedly reiterated recently by a MAC Medical Director. In all healthcare settings, physicians commonly see patients for the same reason that a nurse sees the patient. Physician services have a Medicare coverage benefit while nurse services are part of the hospice benefit. Medicare audit contractors seem to misapprehend this core benefit Medicare beneficiaries are entitled to when reasonable and necessary. In these cases, it is the complaint/diagnosis that is the reason for the visit. Hence, we would expect documentation to be similar.
- One respondent reported errors primarily related to unnecessary physician visits for a TPE audit of GIP stays at 7 or more days. For example, this respondent reported they were informed by the MAC these physician visits were not billable because they were simply not required, contrary to visits which are required under the hospice benefit but not separately billable, such as administrative and general supervisory activities.
- Incorrect application of reasoning by the audit contractor regarding billable physician visits.

Denials for similarity in documentation and symptom observations of a nurse and physician seems illogical and it is unclear why this rationale is being used.

Audit Overturn Rates on Appeal

Many survey respondents shared that they have appeal overturn rates exceeding 70% of denials, with several having multiple audits with 90 – 100% of initial denials overturned. In addition, Survey respondents reported that overturned claims are often not taken into account in subsequent audits.

[9] 5PM07 - According to Medicare Hospice requirements, the physician services were not reasonable and necessary or were administrative in nature including review, supervision and update of the care and services noted in the hospice care plan.

For example, a provider would be subject to a further round of TPE even if appeals overturned every initial TPE audit denial. Worse, providers that have a high denial rate on, for example, a UPIC probe audit are subject to a highly intense audit with potential for extrapolation even if every denial in the original probe is overturned on appeal. Given these patterns, it appears that auditors may have incentives to deny claims without regard to whether those denials might later be overturned. Given the high appeal overturn rate, this sense of skepticism among hospice providers erodes confidence in the CMS contractor audit results.

> "**It has been an incredibly frustrating and time-consuming process**, and it all honestly seems so silly because these patients have actually passed away within six months of the claim period under review or indeed within six months of their admission to our hospice program, and our documentation, while not perfect, does indeed support terminality. . . .
>
> To be honest, **we are exhausted**, and while we are still trying to fight these original wrongly-denied claims, we are now being moved in to round 2 of TPE. **It is draining so much time, energy, and resources from our organization**."
>
> - *Survey respondent*

Inadequate Educational Assistance

Several Survey respondents' primary concern was that there was no assistance or education on how to resolve, prevent, or address technical claims issues. Some common examples include:

- Several hospice providers reported that MAC TPE sessions after a round of MAC audits consisted of simply a recitation of the denial reason with the presenter not being able to answer any general, let alone specific, questions about how to improve documentation. In some cases, respondents reported that the education presenter could not answer specific questions about denials because they did not have the documents in front of them. Rather, respondents reported they were reading from a prepared PowerPoint presentation. This defeats the purpose of the educational process that is part and parcel of TPE audits.
- Many Survey respondents indicated that MACs provided varied and inconsistent information on how to resolve a technical billing issue, such as how to process a correction to missing information on an election statement or election addendum. For example, respondents indicated that one MAC might say that the provider could use a non-billable code for days not covered and obtain a

corrected election statement, while another would say that the patient must be "administratively discharged" but with no instruction on which discharge reason code to use.
- One respondent reported that the educator was unable to answer questions from their medical director regarding guidance about documentation for patients who wax and wane and who may be plateauing.

> "TPE educator was very nice but limited to what we failed. How to succeed was not covered. We had to ask questions. They **would not answer general questions**. They also **would not answer specific questions** because the documentation was not in front of her. All she had was the report of the findings. . . ." - *Survey respondent*

RECOMMENDATIONS

Overall, the current oversight environment is one where providers face inconsistent policies, a lack of educated reviewers, and are taking on substantial compliance and financial risk in order to stay true to their missions. These effects are particularly startling in an environment where there is *true* fraud occurring – and we are hopeful that this survey and its accompanying recommendations can help CMS to better target their oversight efforts to places within the benefit truly deserving of more scrutiny.

The chilling impact cannot be understated - we have concerns that hospice providers may be discharging or turning away beneficiaries who are eligible for hospice out of the fear that services may be ultimately denied or subject to costly audits under the Medicare program due to misguided auditing practices. The large volume of hospice medical review activities that occurred in 2023 has caused significant strain and stress for the hospice community. While it is important to have guardrails in place to protect the integrity of the hospice benefit, it is equally important to ensure that these guardrails don't serve as bars that inappropriately restrict access to hospice care for Medicare beneficiaries.

> ". . . All the money earned and paid for employees, care of the patients, and keeping the agency afloat, had to be paid back. This has almost **bankrupted** my agency and caused us to need to take out massive loans in order not to close. . . ." - *Survey respondent*

Despite hiring multiple staff to respond to and manage hospice audits, many hospices have received multiple audits from both MAC and non-MAC auditors with a high volume of requests which cannot be met with these additional staff. In these audits, hospice providers have

reported that requests for extensions have often not been granted, even for hospice programs that were shut down due to natural disasters.

> ". . . The **stress and anxiety that the external audits produce** is an added burden on top of the immense stress hospice associates already experience while caring for hospice patients. The **huge nursing shortage is felt even more profoundly** when a nurse is pulled away from running a hospice agency to spend time on external audits." - *Survey respondent*

Based on Survey responses and feedback provided from hospice providers, we make several recommendations – many of which are restated from a prior letter we sent to CMS outlining our concerns. We recommend that:

- CMS should **re-focus 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.
- CMS should not only focus on initial claims error rates, but the final error rate after claims adjudication and the appeal process is exhausted, and **implement solutions to address areas of vulnerability** where auditors are too aggressively and improperly targeting hospice providers.
- **CMS should conduct an evaluation of hospice audit frequency and targeting**, as Survey responses report frequent audits on areas untethered to areas of vulnerability.
- CMS should **Increase transparency of audit contractor activity**, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, top denial reasons and compliance with required timeframes for notification and review.
- CMS should **emphasize 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.
- CMS should **require substantive education and training for all auditors** that is consistent with the education given to providers to minimize inconsistencies.
- CMS should modify the audit, recovery, and appeals processes to **reduce the need for lengthy adjudication and reduce the burden** for typically compliant hospice providers. This should include a procedure for centrally monitoring audits across all

contractors to ensure a high bar before a provider goes through multiple audits simultaneously.
- CMS should require each audit contractor **to designate a specific contact to respond to provider inquiries**.
- The CMS Center for Program Integrity (CPI) should **implement a questions and issues resolution team** for providers to access regarding complaints or questions arising from the audit process.
- CMS should conduct a **comprehensive review of hospice claims reason and denial codes** to determine where greater specificity would be helpful: 1) to inform providers as to the reasons for a claim denial, and 2) to ensure providers receive appropriate notice for any denied claim (which is a requirement for a claim reopening and payment denial).
- CMS should implement policies to **prohibit the same Medicare hospice claims from being subjected to multiple reviews** by audit contractors, as a claim can only be denied and recouped once.
- During the appeal process, CMS should **limit denial review reasons strictly to initial audit review findings**. Additional denial reasons should not be added later.
- CMS should implement an informal mechanism **to enable MACs and hospice providers to resolve technical claims denials prior to engaging in the formal appeal process**.
- CMS should require audit contractor medical reviewers **to have an equivalent level of expertise and training in hospice care** as the hospice medical director who certified a patient's terminal illness.

We stand ready to work with CMS to identify solutions and opportunities to provide additional education to ensure the continued delivery of high-quality and medically appropriate hospice care under the Medicare benefit.

ACKNOWLEDGEMENTS

There are many hospice providers who contributed to provide feedback on the Survey. While we have taken a strong stance to protect the identities of those organizations who responded to help ensure that any information shared could not be used against them - our gratitude goes to those providers who were willing to share their specific audit experiences, successes, and challenges. We wish to sincerely thank these organizations, as well as others who shared their feedback, for speaking up on behalf of the broader hospice industry.

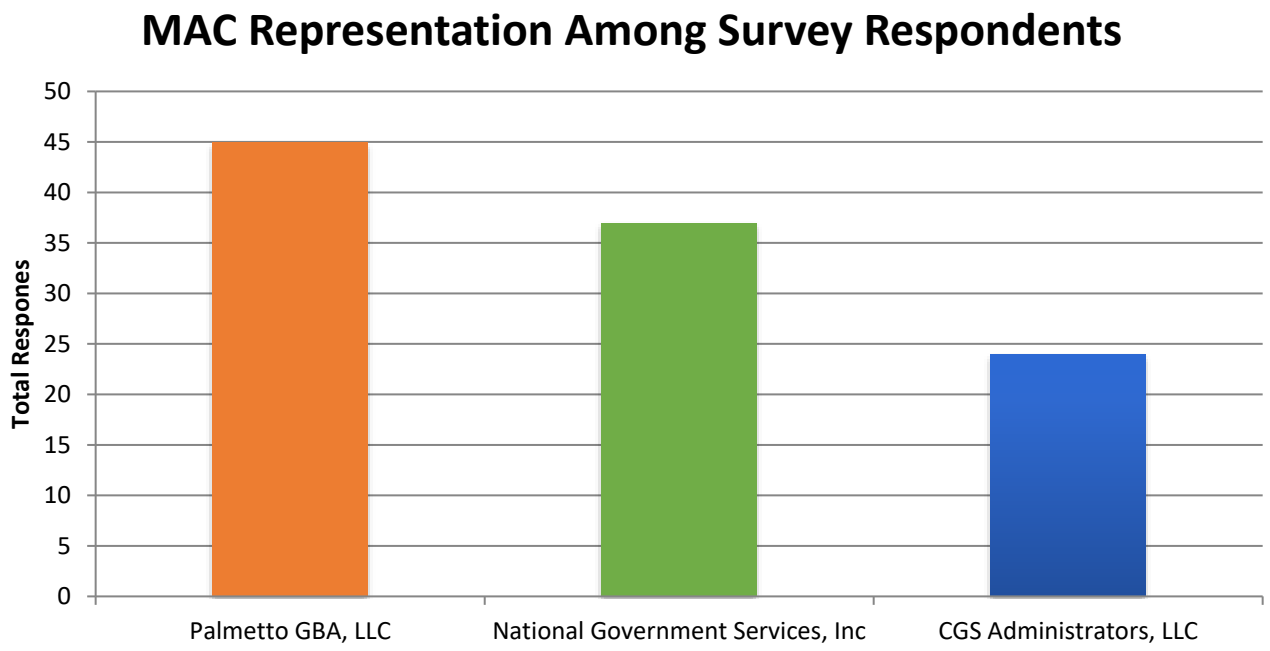
We also want to thank CMS for being receptive to collaboration to identify opportunities to correct any issues and identify ways that the agency can better protect the integrity of the hospice benefit.

We especially appreciate CMS' efforts to address fraudulent hospice organizations, as we are aligned in this aim to protect hospice patients and their families.

We acknowledge that there will always be a continued need for education, and we welcome the opportunity to partner with CMS and the MACs to ensure that hospice providers have a thorough understanding of applicable rules and subregulatory guidance. We similarly encourage CMS to treat audits primarily as opportunities to learn, and to recognize that most hospice providers and CMS share a common goal: to ensure that each and every terminally ill beneficiary has the opportunity to access and receive appropriate and high-quality hospice care.

APPENDIX – GENERAL SURVEY FINDINGS

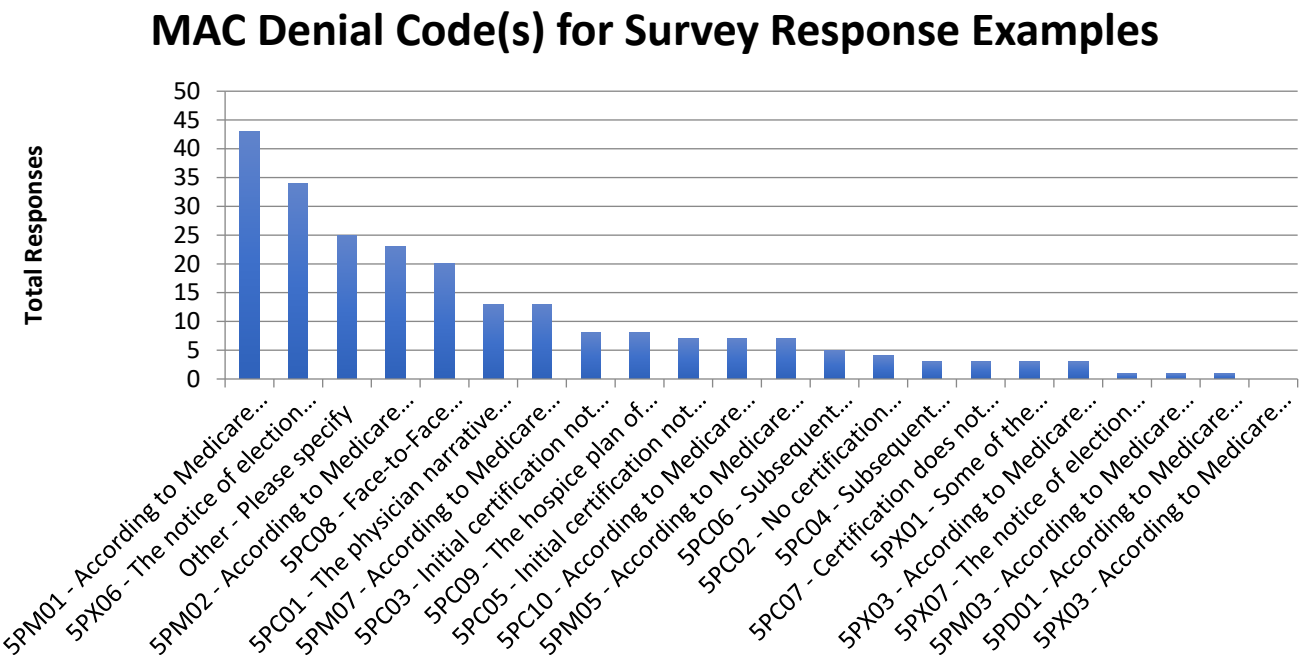
Overall, Survey respondents reported engagement with all three MACs, with the highest representation among Palmetto GBA (50%), and the lowest representation with CGS Administrators (26.7%).



n = 90 | Palmetto GBA: 50.0%; National Government Services: 41.1%; CGS Administrators: 26.7%

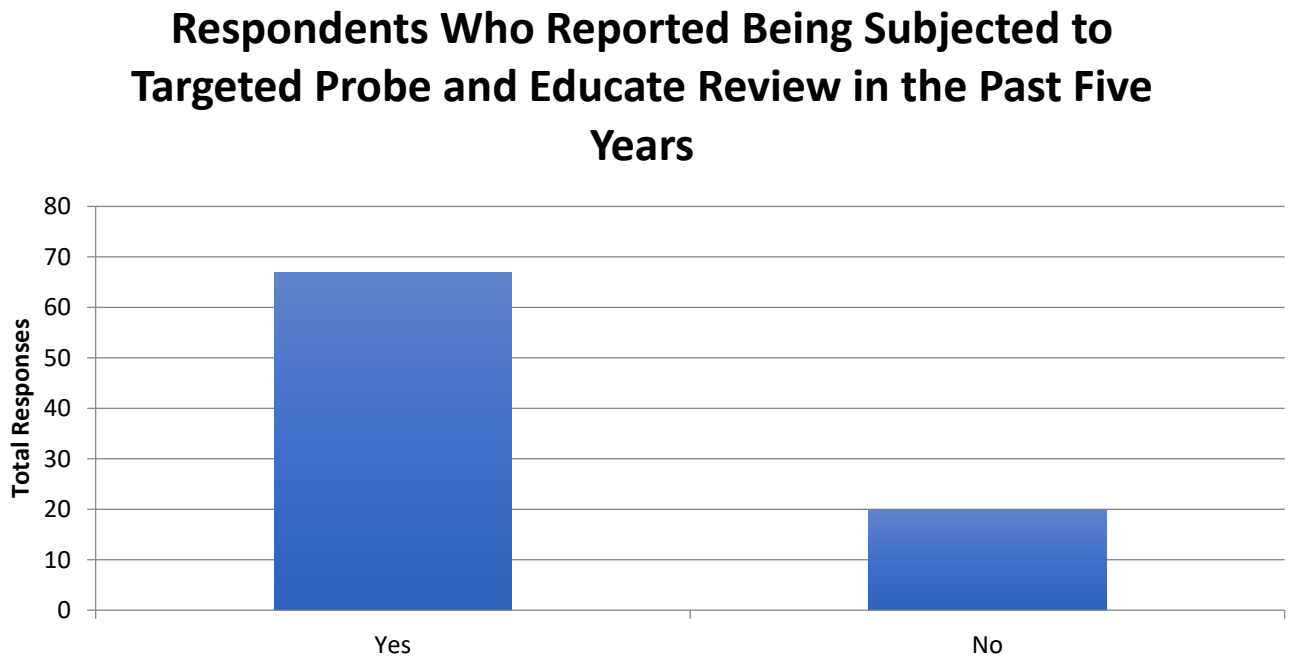
Respondents also provided denial codes for the example challenges they provided. Most common denial codes include:

- 5PM01 - According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less (55.1%),
- 5PX06 - The notice of election is invalid because it doesn't meet statutory/regulatory requirements (43.6%),
- Other (32.1%),
- 5PM02 - According to Medicare hospice requirements, the documentation indicates the general inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate (29.5%), and
- 5PC08 - Face-to-Face Encounter requirements not met (25.6%).



n = 78

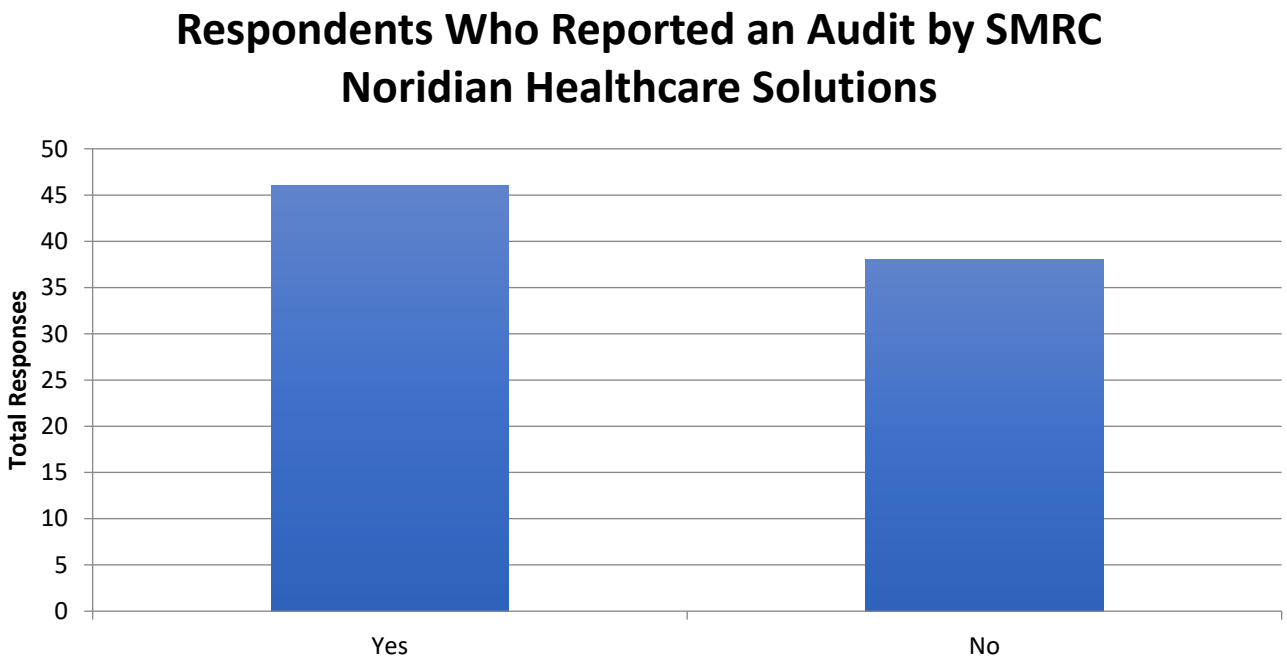
Regarding the TPE program, the vast majority of respondents (77.0%) reported they have been subject to a TPE review in the past five years.



n = 87 | Yes: 77.0%; No: 23.0%

Of those respondents who reported being subject to a TPE review in the past five years, approximately 32% indicated they were subject to a TPE review for an extended period of 18 months to 2 years because they have not met a minimum 40 claim threshold. 81 percent of these respondents indicated this extended TPE review period was due to a review of claims for GIP level of care.

A slight majority of respondents (54.8%) indicated they have been subject to an SMRC audit by Noridian Healthcare Solutions, LLC.

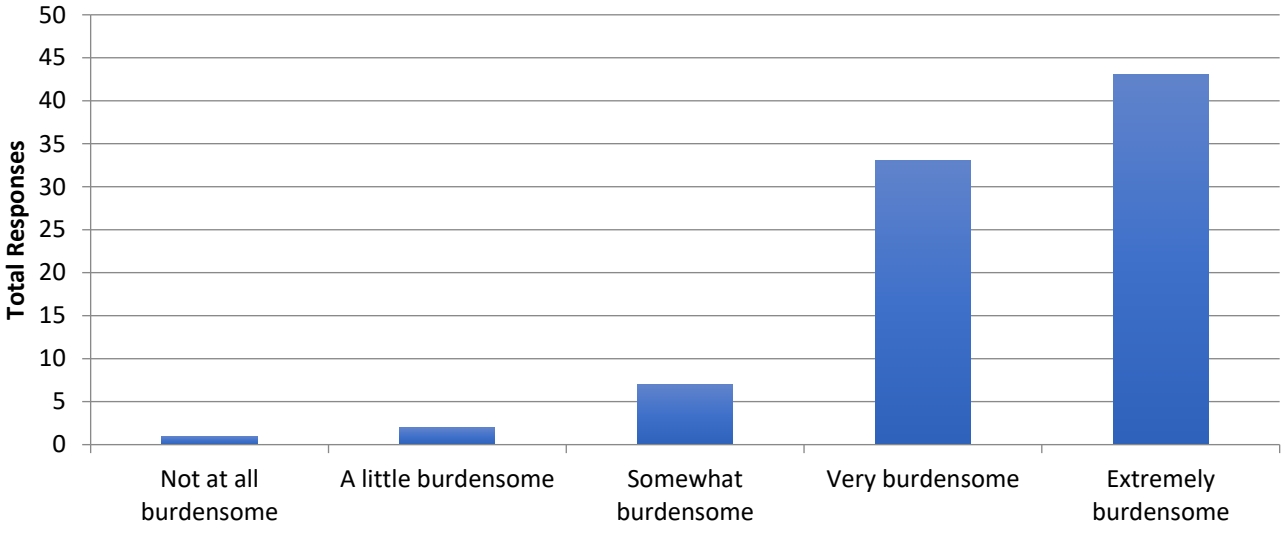


n = 84 | Yes: 54.8%; No: 45.2%

Overall, Survey respondents reported extensive burdens associated with audit review entity documentation requests. 50 percent of respondents reported these requests were extremely burdensome, while 38.4 percent reported these requests were very burdensome.

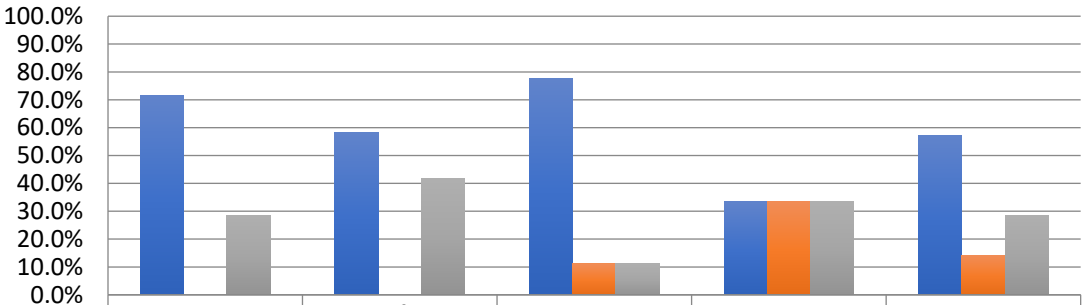
Correlating Survey burden responses to audit review entities reveals that RACs were most commonly associated with extreme burden (77.8% of those in the RAC audit group reported extreme burden), followed by SMRC audits (71.4% of those in the SMRC audit group reported extreme burden).

Audit Review Entity Documentation Request Reported Burden by Organization



n = 86 | Not at all burdensome: 1.2%; A little burdensome: 2.3%; Somewhat burdensome: 8.1%; Very burdensome: 38.4%; Extremely burdensome: 50.0%

Audit Burden Reported by Audit Review Entity



	Supplemental Medical Review Contractor (SMRC)	Unified Program Integrity Contractor (UPIC)	Recovery Audit Contractor (RAC)	Office of Inspector General (OIG)	Comprehensive Error Rate Testing (CERT)
Extremely burdensome	71.4%	58.3%	77.8%	33.3%	57.1%
Somewhat burdensome	0.0%	0.0%	11.1%	33.3%	14.3%
Very burdensome	28.6%	41.7%	11.1%	33.3%	28.6%

Includes respondent selections for audit burden for respondents in each audit contractor group