DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

March 28, 2023

The Honorable Brad R. Wenstrup, D.P.M.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Wenstrup:

Thank you for your letter expressing concerns with fraud and abuse within the Medicare hospice program. I appreciate hearing from you on this important issue and want to assure you that the Centers for Medicare & Medicaid Services (CMS) takes our oversight role of the Medicare program seriously. Effective oversight and enforcement are important to protect the integrity of the Medicare program, especially when it comes to end-of-life care.

CMS oversees hospice providers through the survey and certification process, through provider enrollment efforts, and through other payment program integrity work. First, to participate in Medicare, hospices must meet federal requirements called conditions of participation (CoPs), or standards for health and safety. Hospices are surveyed at least once every 3 years to verify their compliance with federal requirements. A primary role of the hospice surveyor is to identify any quality of care concerns that may violate patient's rights. Surveyors conduct home visits and interviews with patients and staff, as well as observe operations. The surveyor documents all findings in an official survey, including citing any deficiencies for correction. Post-survey onsite revisits are conducted as necessary to address any serious deficiencies cited. While hospices are surveyed at a 36-month interval, additional surveys may be conducted at any time for complaint investigations. Depending on the severity of deficiencies cited during a survey or investigation, hospices may be terminated if they are unable to come back into compliance generally within 90 days. CMS has worked to strengthen and improve hospice surveys to ensure that beneficiaries receive quality care. For example, CMS regularly provides training for hospice surveyors to ensure they are familiar with certification requirements.

Further, CMS is in the process of implementing the hospice provisions enacted in the Consolidated Appropriations Act, 2021 (P.L. 116-200), including the Hospice Special Focus Program (SFP) to monitor hospices identified as poor performers based on selected quality indicators. Hospices selected for SFP will be placed under additional oversight to enable continuous improvement.[1] CMS also continues to educate hospices through various channels, including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters, as well as through the Integrated Surveyor Training Website.

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[1] In the CY 2022 Home Health Prospective Payment System Final Rule (86 FR 62240), CMS stated its intention to establish a Technical Expert Panel to further inform the development of the SFP and reiterated that intention in the Fiscal Year 2023 Hospice Wage Index and Payment Rate Update (87 FR 45669). CMS anticipates publishing this report on this website in April 2023.

Additionally, CMS educates hospices on the importance of vetting staff, addressing care needs, coordinating care, and maintaining quality controls as they relate to the hospice conditions of participation.

CMS also routinely assesses program integrity risks and vulnerabilities; prioritizes those with the largest potential for financial loss, harm to individuals, and/or likelihood of occurrence; and creates mitigation strategies to address identified risks and vulnerabilities, including those related to hospice. CMS continuously analyzes claims data to monitor, trend, and respond to existing suspect hospice billing patterns and emerging fraud schemes. The Fraud Prevention System – a predictive analytics technology that runs sophisticated algorithms against Medicare fee-for service claims nationwide – identifies aberrant activity or patterns to automatically generate and prioritize leads for further review and investigation. Based on the results of the information collected, CMS takes appropriate administrative actions to recover improper payments and prevent future loss of funds, as well as refer cases to law enforcement in instances of suspected fraud.

In general, CMS has broad authority to take administrative actions to address and prevent improper payments in the Medicare program. These actions include pre- and post-payment review, recovery of overpayments, payment suspensions, and the revocation of a provider's Medicare billing privileges. CMS recently began a nationwide project to conduct site visits for hospices enrolled in Medicare, focusing on hospices that are co-located at one address. If a provider enrollment site visit reveals that a hospice is non-operational, we will take steps to remove the hospice from the Medicare program. We are in the process of removing Medicare billing privileges for several hospices that were deemed non-operational from site visits in Texas, Nevada, Arizona, and California through this effort.

CMS typically refers instances of suspected fraud to our law enforcement partners, such as the Department of Health and Human Services Office of Inspector General and the Department of Justice, to investigate whether fraud occurred and, if so, to take appropriate enforcement actions. CMS has supported our federal law enforcement partners throughout various fraud investigations, including those related to hospice. CMS continues to meet regularly with law enforcement to discuss new cases, suspected fraud referrals, active law enforcement cases, and paths for various administrative actions.

In addition to investigating suspected fraud and coordinating with law enforcement, CMS prevents improper payments by reviewing a portion of Medicare claims and educating health care providers and suppliers on proper billing practices. For example, CMS educates hospices about payment and coverage requirements through the Targeted Probe and Educate (TPE) program. TPE is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help. Each of the four Home Health and Hospice Medicare Administrative Contractors routinely conducts TPE on hospice claims. CMS has also implemented hospice education initiatives in California, Texas, and Florida. In September 2022, CMS hosted the California Hospice Summit, coordinating with law enforcement and stakeholders in California to increase awareness of suspected hospice fraud schemes and increase coordination and collaboration on regional program integrity hospice activities. In addition, CMS provides

additional education to hospices using comparative billing reports (CBRs) and the Program for Evaluating Payment Patterns Electronic Reports (PEPPER). CBRs and PEPPER provide data on Medicare billing trends, allowing a health care provider to compare their billing practices to peers in the same state and across the nation.

CMS will continue to evaluate and address hospice program integrity issues, which will include our review of the recommendations from the hospice industry attached to your letter. We recently met with the hospice industry to discuss their recommendations. In your letter, you also requested a briefing on CMS hospice oversight. My staff provided a briefing on March 21, 2023.

Protecting Medicare hospice care against fraud, waste, and abuse is critically important. To that end, CMS is working on a holistic approach to address the concerns raised and build upon our current oversight efforts.

I appreciate your interest in this important issue as CMS works towards strengthening and improving end-of-life care for all beneficiaries, and their families and caregivers. If you need further information or have any questions, please contact the Office of Legislation. I also will provide this response to the co-signers of your letter.

Sincerely,

Chiquita Brooks-LaSure