March 30, 2026

The Honorable Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave SW,
Washington, D.C. 20201

RE: CMS-6098-NC: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

The National Partnership for Healthcare and Hospice Innovation (NPHI) is the member organization for nonprofit, community-based hospice and advanced illness care providers, with 125+ spread throughout the nation. In addition to serving as the safety net end-of-life providers in their communities for decades, many of our members have diversified their service offerings to provide care in the domains of home health, PACE, geriatric primary care, and various other care offerings.

NPHI is pleased to submit responses to the questions posed in CMS-6098-NC, CRUSH, on behalf of our members and the hospice patients and families they serve. Fraud and abuse remains a core issue facing our members, particularly in the western portion of the country. NPHI commends CMS for their efforts to address fraudulent actors and ensure that Medicare beneficiaries at the end-of-life have access to the high-quality care and dignity they are entitled to.

A. Modifications to Program Integrity Requirements

NPHI strongly supports CMS's goal of using existing statutory authorities to prevent bad actors from defrauding the Medicare hospice benefit. Fraud in hospice care is not merely a financial crime; it causes direct, measurable harm to dying patients and their families by diverting resources, eroding trust, and subjecting vulnerable individuals to unnecessary or inappropriate interventions. CMS should use every lawful tool at its disposal to remove fraudulent operators from the program.

- ***Are there ways in which CMS could better use existing statutory authorities to expeditiously prevent bad actors from engaging in fraud, waste, and abuse?***

NPHI Recommendations

1. Impose a temporary, national moratorium on new providers

A targeted moratorium on new hospice enrollments should be implemented as a time-limited policy, paired with clearly defined criteria for its conclusion. This approach would enable CMS to concentrate resources on identifying and removing fraudulent providers currently operating within the system while preventing the entry of new bad actors during the intervention period. To avoid unintended consequences for patient care, the policy should explicitly preserve access to existing Medicare telehealth flexibilities, which play a critical role in ensuring timely and high-quality care delivery, particularly in underserved and rural areas.

2. Expand enrollment verification requirements

CMS provider enrollment activities should be expanded prior to Medicare enrollment approval. These activities could be conducted by the State Survey Agency (SA) or Accrediting Organization (AO), or following their review when the application is under consideration by the Medicare Administrative Contractor (MAC) and/or CMS Provider Enrollment. Recommended enhancements to pre-approval enrollment activities include:

- Require verification of operational physical office location.
- Confirm that the agency phone number is staffed and there is an administrative presence.
- Verify legitimacy of the applicant's business address and identify co-located Medicare entities, including the number of hospices at the same address.
- Require documentation of clinical staffing and operational readiness.
- Review the patients being served as a part of the certification process to ensure that the same patient information is not being used by multiple hospices.

3. Establish minimum office standards

Today, there are no minimum office requirements in the Medicare hospice regulations at 42 CFR 418. As investigations into hospice fraud and abuse continue, we believe that minimum office standards must be developed and added to the Medicare hospice regulations. DMEPOS providers are already required to maintain a facility and the governing regulation is found at 42 CFR § 424.57(c)(7). These regulations could be adapted for hospice providers. Recommendations for minimum office standards for hospice include:

- A minimum square footage.

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- Hospice office in virtual offices, executive office suites, shared shell office space or residential areas without operational capacity. Medicare certification of hospices operating exclusively from one of these locations is prohibited.
- Accessible to the public, Medicare beneficiaries, CMS, and its agents (no gated/restricted access).
- Space for meetings with Medicare beneficiaries and staff must be available.
- Space for storing business records (licenses, business documents, beneficiary communication records).
- Accessible and staffed during posted hours of operation.
- Appropriate signage:
  - Must maintain a **permanent visible sign** with the name of the hospice and posted hours of operation.
  - Require minimum 20-point font. No handwritten signs will be approved.
  - If hospice location is in an office building, the hospice entity is required to be listed in the building directory, with both the name of the hospice and its specific and unduplicated suite number.
  - Verification of signage, including pictures of signs and building directory listing must be provided as a part of the survey or enhanced visit.
- **Email:**
  - No Gmail, Yahoo or other common personal email domains allowed; hospice company must ensure HIPAA-compliant email.
- **Phone:**
  DMEPOS providers currently have provisions about phone access at 42 CFR 424.57(c)(9). These regulations could be adapted for hospice providers. DMEPOS requirements at 424.57(c)(9) include:
  (i) Maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll-free for beneficiaries.
  (ii) Cellular phones, beepers, or pagers must not be used as the primary business telephone.
  (iii) Calls must not be exclusively forwarded from the primary business telephone listed under the name of the business to a cellular phone, beeper, or pager.
  (iv) Answering machines, answering services, facsimile machines or combination of these options must not be used exclusively as the primary business telephone during posted operating hours.

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Additional minimum phone requirements for hospice providers should include:

- Confirmation that the phone is operational 24/7 with after-hours response to a call for patient emergencies. The surveyor should be required to received a response to the call as applicable.
- Ensure phone number is a working number and that an employee answers it during business hours.
- Confirm that the phone is answered with the name of the hospice.
- Use of “secret shopper” tests to confirm phone availability during business hours and after.
- Contact number clearly available in print materials and advertising.

4. **Expand ownership transparency requirements:**
   - Require full disclosure of ownership, related-party arrangements, and shared administrative or clinical staff across entities.
   - Identify co-owned referral sources and vertically integrated ownership arrangements.
   - Implement ownership-based risk screening protocols.

- ***Are there ways to modify provider enrollment (including revocation), medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility to expeditiously prevent bad actors from engaging in fraud, waste, and abuse? (See, for example, Title 42 Code of Federal Regulations (CFR) 405.371 et seq. (payment suspension), part 424, Subpart P, especially 424.510 (general requirements), 424.516 (additional requirements), 424.530 (enrollment denial), 424.535 (revocation), and 424.540 (deactivation of billing privileges).***

  NPHI believes the provider enrollment process could be strengthened with a partnership between the federal and state governments, including a much larger role from state licensing agencies in their initial review of an applicant for licensure. The application process could provide a first stop for review and compliance before an applicant is eligible to proceed to the application for Medicare certification.

  In 46 states and the District of Columbia, hospice licensure is required before opening and operating a hospice. In the three states that do not require a state hospice license, Idaho, Kansas, and South Dakota, there is still the federal Medicare/Medicaid certification requirement to operate and receive reimbursement.

NPHI Recommendations

1. **Increased engagement with state licensing agencies:**
   - Engage with state licensing agencies to review options for the state licensure process to be the first stop before hospice Medicare enrollment, including the in-depth review of a possible hospice's licensure application. It is possible that some licensure applications could be denied before the applicant moves to the Medicare enrollment process. NPHI has produced a guide for *Hospice Program Integrity at the State Level*, which is a useful resource on what to look for before Medicare certification is approved.

   - CMS could provide a list of data points that should be considered during the licensure review. They could include, at a minimum, the following:

     - Confirm articles of incorporation and filings with the state's Secretary of State.
     - Confirm ownership status of 5% or greater.
     - Address of the hospice and assessment of co-location with other hospices or healthcare facilities. If other facilities located at the same address, conduct additional licensure review, including maximum number of offices for building occupancy.
     - Review state licenses of staff identified in the licensure application, including physician, nursing, social work and any other licensed disciplines.
     - After review, provide assessment of the ability of the applicant to move to the next step in the Medicare certification process. This could include a confirmation statement by the state to CMS that the licensing application has been reviewed and approved.

2. **Add additional SA or AO review during Medicare certification process**
   Require the SA or AO to increase particular focus as follows:

   - The survey process focuses on the five CoPs directly related to patient care. As a part of this focus, the CoP related to patient's rights and the patient/family interview should include discussion that the patient/family is knowledgeable that they signed up for hospice, how they came to choose this hospice and what their rights are.
   - Review the ability of the applicant to deliver all 4 levels of care, including the review of contracts for GIP and respite care. This will ensure that all CoPs are able to be met upon need.

- Review the credentials of key hospice personnel, including, but not limited to, the administrator, medical director and nursing director, checking to see that these individuals meet the applicable standards defining the qualifications CMS requires that they must have in order to hold that position. CMS could add definition of the requisite elements to the standards. Evaluate the PECOS enrollment to determine the number of hospices where the named medical director is also the medical director.
- While the accuracy of the listed address and phone number are already completed during the SA or accreditation process, one additional step must be included to confirm that the address includes a suite number, and confirmation of the number of hospices at the address. In some areas, more than 100 hospices are located at the same address and were approved for Medicare certification. Additional confirmation of the address is needed to curtail this practice.
- Check signage on the office or the location within a building with the hospice listed in the building directory will require an addition to Medicare hospice regulations. This additional requirement is needed to ensure that the hospice office is visible and identifiable and that co-location is kept to a minimum.

3. Develop safeguards for patients in hospices with fraudulent activity

We also recommend that CMS adopt a "patient-first" framework when exercising existing authorities against hospice providers. To effectuate this, CMS should:

- Issue updated guidance requiring its contractors to conduct a patient impact assessment before initiating any payment suspension affecting a hospice provider, evaluating the number of actively enrolled patients, the acuity of their conditions, and the availability of alternative hospice providers in the service area.
- Require that any enforcement action against a hospice provider be accompanied by a concurrent transition-of-care plan ensuring continuity of services for enrolled patients.
- Establish an expedited appeal pathway for hospice providers if applicable, so that erroneous actions can be corrected within days rather than weeks, months or years.
- Create a real-time notification system to inform patients and families when their hospice provider is subject to an enforcement action.
- Designate ombudsman-style patient advocates within CMS who are specifically trained in end-of-life care issues and can intervene when enforcement actions threaten to disrupt care for terminally ill beneficiaries.

- ***Are there existing requirements or policies, including those issued through regulations, memoranda, administrative orders, subregulatory guidance documents, or policy statements that could be altered to increase CMS' ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace®?***

  We believe several existing regulatory requirements and subregulatory guidance documents could be modified to better protect the integrity of the Medicare hospice benefit while simultaneously safeguarding the interests of terminally ill patients and their families.

  ## NPHI Recommendations

  1. CMS should revise its memoranda and guidance governing payment suspensions under 42 CFR 405.371 to include explicit hospice-specific provisions. The current framework does not differentiate between suspending payments to a hospital or physician practice and suspending payments to a hospice that is the sole provider of comfort care for dying patients.
  2. CMS should strengthen the COPs for hospice programs (42 CFR Part 418) by adding requirements for more robust patient and family notification when a provider is subject to enforcement actions. Families of hospice patients are frequently unaware that their provider is under investigation or subject to payment suspension until services are abruptly discontinued. A regulatory requirement for proactive disclosure would empower families to plan ahead and reduce the harm caused by sudden care disruptions.
  3. CMS should revisit its subregulatory guidance on hospice medical review to ensure that clinical reviewers have adequate training in hospice and palliative medicine and understand the clinical rationale for hospice-specific interventions. Too often, claims are denied based on acute-care standards that do not reflect evidence-based hospice practice. Revising these policies would promote both payment accuracy and the continued availability of appropriate comfort care for beneficiaries with terminal diagnoses.

- ***What changes could CMS or its contractors make to existing processes to promote their ability to effectively deter fraud, waste, and abuse and promote payment accuracy and efficiency, including by more expeditiously gathering actionable information?***

  We appreciate CMS's interest in process improvements that enhance the ability of the agency and its contractors to deter fraud, waste, and abuse while promoting payment accuracy and efficiency.

NPHI Recommendations

1. **Track and publish audit performance metrics for all auditor types:**
   - Track audit denial rates and appeal overturn rates.
   - Publish audit contractor performance metrics.
   - Use results to improve contractor oversight and selection.

2. **Improve audit contractor training and expertise:**
   - Require standardized training on hospice eligibility and coverage requirements.
   - Ensure that medical review auditors have a working knowledge of the requirements in the Medicare hospice benefit and make decisions accordingly;
   - Improve consistency across audit contractors.
   - CMS should revisit its subregulatory guidance on hospice medical review to ensure that clinical reviewers have adequate training in palliative medicine and understand the clinical rationale for hospice-specific interventions. Too often, claims are denied based on acute-care standards that do not reflect evidence-based hospice practice. Altering these policies would promote both payment accuracy and the continued availability of appropriate comfort care for beneficiaries with terminal diagnoses.

3. **Improve coordination across audit entities:**
   - Identify specific issues and COPs for each hospice audit entity to prioritize to reduce duplicative audit activity among MACs, RACs, SMRCs, UPICs, and OIG.

4. **Focus on providers less than five years old or those older that five years that have chosen not to submit quality data:**
   - Extra oversight is needed for hospices that are less than five years old to ensure accurate billing and understanding and compliance with Medicare Hospice Conditions of Participation.

5. **Churn and burn:**
   - Determine how to identify hospices who are moving patients between provider numbers with the same owner or to hospices owned by family and friends.
   - Develop a process for identifying "hospice surfing" where patients are moved between small hospices.
   - Create a process by which to monitor claims activity from hospices that deliberately remain small specifically to avoid audit scrutiny.

6. **Stop payments after beneficiary death:**
    - Develop analysis and implement a process that will stop payments when the beneficiary has died. Identify algorithms that search for a death date and identify what entities may be working together to "hide" the death date to continue reimbursement.

- ***What types of analytics, methodologies, or data-driven approaches would be most effective in identifying indicators of potential fraud, waste, or abuse? We welcome feedback on specific analytical techniques, models, technologies, mechanisms, or data sources that could strengthen our ability to proactively detect and prevent fraudulent activity.***

NPHI welcomes CMS's focus on analytics and data-driven approaches to identify indicators of potential fraud, waste, or abuse in the Medicare hospice benefit. Sophisticated analytical tools have the potential to target truly fraudulent operators more precisely, reducing the collateral harm to legitimate providers and their patients that results from blunt, broad-based enforcement actions.

NPHI Recommendations

1. **Require universal hospice quality reporting program (HQRP) participation:**
    - Conduct a review of provider rationale for non-participation and publish the results publicly:
        - Too small:
            - Develop appropriate statistical adjustments for small providers as needed.
        - Not enough respondents:
            - Consider reducing the number of respondents in an 8-quarter period.
        - Provider willing to take the payment reduction instead of participating.
        - Other rationale as identified by CMS review.
    - Absent universal participation, increase the penalty for hospices that do not participate in any part of the hospice quality reporting program from a 4% payment withhold to 10% or greater.

2. **Develop CMS internal risk stratification dashboards:**
    - Integrate claims, quality, survey, and enrollment data.
    - Identify providers exhibiting multiple fraud risk indicators (see list below).

- Prioritize high-risk providers for audit, survey, and enforcement.

3. **Hospice data elements that could indicate concerning provider behavior:**
   - High live discharge rates significantly exceeding national norms.
   - No live discharges.
   - High discharge rates between days 61-179.
   - High rates of burdensome transitions 1 or 2 or frequent transfers.
   - High proportion of Alzheimer's Disease and Related Dementias (ADRD) diagnoses relative to peers.
   - Low number of nursing visits and intensity relative to peers.
   - Low cost of care per patient relative to reimbursement.
   - High reimbursement per patient relative to peers.

4. **Providing all four levels of care:**
   - Identify hospices failing to provide all four levels of care with particular focus on claims analysis where no days of general inpatient care (GIP) have been provided in a year. While Continuous Home Care (CHC) is provided infrequently as well, the focus should remain on hospices who do not provide a single day of GIP care on the claim during a one-year period.
   - Review Hospice Care Index (HCI) data for high levels of burdensome transition, type 1 or type 2.
   - Review claims for a pattern of live discharge or transfer of patients rather than a GIP claim.

5. **Transparency for all MACs:**
   - Currently each HHH MAC provides information differently about claims reviewed, TPE topics and resolution, PPEO reviews, and appeals, as well as information on the hospice aggregate cap.
   - Require each HHH MAC to release information on each topic listed above so that providers have knowledge about their MAC's performance.

6. **Abnormal "unrelated" billing patterns:**
   - Hospices should retain the ability to decide what services are related and unrelated to the terminal illness. In many cases, another Medicare provider type may bill for services after a beneficiary has elected hospice. The hospice provider often has no idea that another provider has billed and been paid. The other provider may have no idea that the beneficiary has elected hospice.

Communication and hospice election information between providers is critical to reduce the Medicare spending outside the hospice benefit.

- NPHI recommends that hospice claims be reviewed for:
    - Excessive Part B or Part D claims during hospice enrollment.
    - High rates of claims with one or limited diagnosis coding.

7. **CAHPS Hospice Survey patient and family satisfaction data:**
    - Protect data integrity of survey information to prevent CAHPS Hospice fraud. There are reports of providers who are able to adjust or manipulate their CAHPS Hospice survey scores to show a 5-star rating of the hospice.

- ***A core component of crushing fraud to protect taxpayer dollars is transparency to the Americans we serve about CMS' program integrity undertakings. How can CMS improve its transparency about its oversight and enforcement activities?***

Transparency about CMS's oversight and enforcement activities is essential to maintaining public trust in the Medicare hospice benefit and empowering patients and families to make informed choices about their care. We commend CMS for recognizing transparency as a core component of its fraud-fighting mission and offer several recommendations for improvement.

NPHI Recommendations

1. CMS should create a publicly accessible, regularly updated dashboard that reports enforcement actions taken against hospice providers, including revocations, payment suspensions, civil monetary penalties, and exclusions. This dashboard should be designed with patients and families as the primary audience, using clear language rather than regulatory jargon, and should be searchable by provider name, geographic area, and type of action. Families choosing a hospice provider for a terminally ill loved one deserve to know whether that provider has a history of compliance issues.

2. Complete the long overdue data migration of hospice data to the CMS.QCOR.GOV website so that information is easily accessible on new providers, terminated providers and enforcement actions. Hospice data has not been updated in QCOR since September 29, 2022. Providers, policymakers and the public need to have up to date information on this website for survey and certification information. Hospice survey report information is available on this

website from October 2021 through December 2025 but is completely unusable in a large and cumbersome Excel format.

3. CMS and its contractors should complete the process of updating the Program for Evaluating Payment Patterns Electronic Report (PEPPER) for hospice. If CMS expects providers to improve their processes and have knowledge of their data, the PEPPER is an important resource.

4. CMS should require direct, timely notification to patients and their designated family members or caregivers whenever their hospice provider becomes subject to a significant enforcement action. Currently, patients and families often learn about enforcement actions only when services are disrupted. This notification should include information about patients' rights, instructions for accessing alternative providers, and contact information for an ombudsman knowledgeable about hospice or patient advocate.

5. CMS should publish annual reports summarizing the outcomes of hospice-specific program integrity activities, including the number of investigations initiated, the number resulting in confirmed fraud, the number of patients affected, and the measures taken to ensure continuity of care during enforcement actions.

This level of transparency would allow stakeholders, including patient advocacy organizations, Congress, and the public, to assess whether CMS's enforcement activities are effectively targeting fraud while minimizing harm to terminally ill beneficiaries.

- ***CMS currently does not have an affirmative, regulatory authority to direct Medicare Advantage (MA) organizations and Part D plan sponsors to suspend payments to providers and suppliers that operate exclusively in Part C or Part D or both. Should CMS establish regulatory requirements that allow MA organizations and Part D sponsors to implement payment suspensions under circumstances similar to the payment suspension authority that exists for Traditional Medicare under 42 CFR 405.371, and require suspensions when directed by CMS?***

  We recognize the policy rationale for extending payment suspension authority to Medicare Advantage (MA) organizations and Part D plan sponsors, as the current regulatory gap may allow bad actors who operate exclusively in Part C or Part D to evade accountability.

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Some hospices use Part D to pay for medications that are related to the terminal illness and related conditions, which are the responsibility of the hospice. There are also hospice patients who rely on Part D coverage for medications that fall outside the hospice benefit's scope - for example, drugs used to treat conditions unrelated to the terminal diagnosis. If a Part D sponsor suspends payments to a pharmacy or provider serving hospice patients, those patients could lose access to medications essential to their comfort and quality of life.

NPHI Recommendations

Should CMS move forward with establishing regulatory requirements in this area, we strongly recommend the following safeguards:

1. A review of a hospice's medication coverage for an individual patient should include the volume of medications covered by the Part D plan, rather than the hospice. The higher volume hospice providers should be identified for additional scrutiny.
2. Any payment suspension authority extended to MA organizations and Part D sponsors must include an explicit exemption or expedited review process for providers serving hospice patients.
3. MA organizations and Part D sponsors should be required to maintain a continuity-of-care protocol ensuring that hospice patients continue to receive medications and services without interruption during any payment suspension.
4. CMS should retain sole authority to direct suspensions affecting providers that serve a significant proportion of hospice patients, rather than delegating this decision to individual plan sponsors.
5. All payment suspensions affecting hospice-related services should trigger an automatic referral to a CMS-designated patient advocate who can ensure that the needs of dying patients are prioritized.

B. Enhanced Identity Proofing and Ownership Requirements

- ***CMS currently requires fingerprinting and criminal background checks for all individuals with a 5 percent or greater ownership interest in a provider/supplier organization that is part of the 'high' risk category as described in 42 CFR 424.518. Should this be expanded to include, for instance, the provider's managing employees, less than 5 percent owners, or other individuals who are affiliated with or working for the organization?***

NPHI strongly supports expanding fingerprinting and criminal background check requirements well beyond the current 5% ownership threshold under 42 CFR 424.518. For hospice providers specifically, this is not merely an administrative question but it is a matter of life, dignity, and irreversible harm to the most vulnerable population in the Medicare program.

When a terminally ill patient is enrolled in a fraudulent hospice, Medicare immediately stops paying for curative treatment of the terminal illness. That harm cannot be undone. It can mean loss of access to Medicare coverage for anything outside the hospice benefit, which are critically important for a patient who was enrolled in hospice without eligibility and without their knowledge. No other Medicare provider type carries this same irreversible consequence.

The documented hospice fraud epidemic demonstrates that the 5% ownership threshold, standing alone, is structurally inadequate to protect this population.

NPHI Recommendations

Hospice providers recommend extending fingerprinting and FBI criminal history checks to the following categories:

1. **All managing employees:**

   CMS already requires managing employees to be disclosed on Medicare enrollment applications (PECOS/Form 855A) meaning the infrastructure for identification exists. Fingerprinting and FBI-based criminal history checks should be required for all individuals meeting the managing employee definition including those engaged under contract or management services agreements at initial enrollment, upon any change of managing employee, and at revalidation. Managing employees covered by this recommendation include, but are not limited to:

   - Chief Executive Officer / Administrator
   - Chief Operating Officer / Chief Financial Officer
   - Compliance Officer / Compliance Director
   - Clinical Director / Director of Nursing
   - Operations Manager / Regional Manager
   - Care Coordination Manager / Location Manager

- Any contracted management services organization representative exercising operational control.

2. **Individuals with any ownership interest, regardless of percentage:**

   The 5% threshold was designed for general provider types. Hospice fraud schemes routinely disaggregate ownership interests below 5% across multiple nominees to avoid detection. CMS should apply the same beneficial ownership standard used in the FinCEN Customer Due Diligence (CDD) Rule which reaches any individual who controls the legal entity regardless of formal percentage ownership to hospice enrollment. Any new owner reported under a change-of-ownership (CHOW) transaction, at any percentage, should trigger fingerprinting.

3. **Authorized officials and delegated signatories:**

   Individuals designated as the authorized official on a hospice's enrollment application and any person authorized to sign hospice election statements on behalf of the organization should be subject to the same screening as 5%+ owners. These individuals control the gateway through which patients enter the benefit and through which Medicare billing is initiated.

4. **Contracted clinical leadership:**

   Medical directors, directors of nursing, and clinical managers engaged through management services organizations or contractor arrangements hold effective clinical control over terminal prognosis certifications that justify all hospice billing. They should not escape screening by virtue of their contractual rather than employment status.

- ***What alternative identity proofing measures could effectively verify the identity and location of owners while balancing program integrity objectives with the operational needs of legitimate Medicare providers and suppliers?***

  The 5% ownership threshold fails to capture the individuals who most commonly execute hospice fraud. Hospice fraud operates through a network of actors who hold no formal ownership stake: medical directors who certify ineligible patients for kickbacks; patient recruiters who enroll beneficiaries without their knowledge (or by stealing Medicare numbers); and managing employees who submit false claims. None of these individuals is captured by the current threshold yet they can be key architects of fraud.

Terminally ill patients are uniquely unable to self-advocate. They are often homebound, often cognitively impaired by illness or medication, and dependent on overwhelmed family caregivers. Background checks on all individuals in direct care, billing authority, and enrollment roles are a minimum safeguard for this population.

NPHI Recommendations

1. Expand fingerprinting and criminal background checks for hospice providers to include all individuals who:
   a. Certify patients for hospice eligibility (medical directors and attending/certifying physicians).
   b. Hold billing authority or are authorized to submit Medicare claims.
   c. Serve as patient recruiters or marketing representatives with direct patient/family contact.
   d. Serve in managing employee roles as defined in 42 CFR 424.502.
2. Implement real-time, continuous background database monitoring rather than point-in-time checks at enrollment only. Fraud perpetrators may have clean records at enrollment but be subsequently convicted.
3. Require hospice providers to report any change in individuals occupying these roles within 30 days, with failure to report treated as grounds for enrollment revocation.

C. Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions

- ***How would a claim filing deadline of 90 to 180 calendar days, consistent with private industry norms, impact your practice?***

  Hospice providers serving terminally ill patients and their families represent a provider type for which shortened deadlines are not feasible and should be explicitly excluded from any such policy.

  #### Key barriers include:

  1. **Physician certification and recertification requirements**. Under 42 CFR 418.22(a)(3)(i), if a hospice cannot obtain written certifications within 2 calendar days after a period begins, it must obtain an oral certification with 2 calendar days and the written certification before it submits a claim for

payment. The paperwork requiring the attending physician's signature is often delayed, and the claim cannot be filed until the written certification of terminal illness is received.

2. **Sequential billing may delay billing from the current provider.** Claims for hospice services are required to be processed in sequence by date of service. When a patient revokes, transfers, or is discharged from the first hospice, the second hospice may not bill until the first has submitted its final bill. In some cases, that process may take months to resolve, leaving the second hospice unable to bill for services they have provided until the first hospice completes their billing.
3. **Notice of Termination/Revocation (NOTR) delays.** The hospice provider is expected to file a Notice of Termination/Revocation (NOTR) Section 20.1.2, a mandatory Medicare document filed by the provider within 5 days when a patient is discharged alive or revokes the hospice benefit. Hospice providers report that the 5-day deadline is often not enforced and the NOTR and final bill are delayed. CMS should develop enforcement mechanisms to help providers meet the regulatory 5-day deadline.

- ***Are there certain claim or provider types for which these deadlines would not be feasible?***

Hospice fraud often involves enrollment of non-terminal patients, with claims filed before the patient or family is aware of their fraudulent enrollment. Often, the fraudulent hospice may be required to stop billing, but does not complete their final bill. Even when the patient becomes hospice eligible some time in the future, the new admitting hospice is unable to file claims because the final claim has not been filed and the hospice is now not reachable or out of business. Applying a 90-day or 180-day deadline to file a claim would impact the hospice's financial stability. Sequential billing will not allow a second hospice to file a claim until the first hospice has filed a final claim. This process often takes months and may include mediation.

NPHI Recommendation

CMS should strongly consider a categorical exclusion for Medicare Part A hospice claims from any shortened filing deadline, due to the requirement for sequential billing for hospice claims. This is true in the case of the hospice that has fraudulently enrolled a patient and discharges the patient when still alive. When that same patient needs hospice care some months or years later, the fraudulent

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hospice has not filed a final claim and the second hospice cannot bill until the final claim is filed.

- ***What would be the best way to implement a shorter claim filing deadline for certain high-risk items and services — including for all claims filed by specific high-risk provider or supplier types (e.g., DMEPOS suppliers), for specific high-risk items or services, for specific high-risk providers, or by some other method?***

NPHI Recommendation

We strongly recommend that hospice claims be exempt from a shorter claim filing deadline for the reasons detailed above. CMS should retain the current 12-month deadline for all hospice claims and, if it pursues shorter deadlines for other provider types, should include a clear, explicit exemption for the Medicare Hospice Benefit under Part A.

- ***Would it be beneficial to apply this standard to all items and services rather than only to high-risk items and services, to reduce unnecessary administrative complexity?***

No. NPHI believes that applying a standard claim filing time for all provider types will be detrimental to hospice providers due to timely filing.

NPHI Recommendation

CMS should retain the one-calendar-year claim filing deadline for hospice claims.

- ***Would the current flexibilities in 42 CFR 424.44 or additional flexibilities for a shorter claim filing deadline be appropriate to support such a change, and if so, what would those flexibilities be?***

The existing flexibilities in 42 CFR 424.44(b), which allow for late claims due to administrative error, incorrect processing, or Medicare as secondary payer situations, provide important but incomplete protection for hospice providers.

NPHI Recommendation

If CMS shortens deadlines for any provider type, it must create an explicit hospice-specific regulatory carve-out in 42 CFR 424.44 or 42 CFR 418 (the Medicare Hospice Benefit regulations) that:

- Preserves the 12-month filing deadline for all Medicare Part A hospice claims as the default.

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- Establishes a defined exception pathway to allow for sequential billing issues, where the previous hospice must complete their billing before the new hospice can commence billing.

D. Beneficiary Solicitation

- ***What means of communication do Medicare beneficiaries find are being used to solicit them for their Medicare information? How do beneficiaries respond when they have been contacted by an inappropriate direct solicitation?***

  Hospice providers report that solicitation of hospice services to Medicare beneficiaries comes from a variety of sources, including:

  - Door-to-door solicitation with bonuses to staff and contractors who sign up a certain number of beneficiaries for hospice.
  - Solicitation at assisted living facilities and nursing homes, where hospice staff go door to door within the facility and encourage residents to enroll.
  - Hospice providers offering facilities inducements such as monthly birthday parties, a new television for the common room, or regular lunches provided for staff.
  - Monthly payments to residents of facilities, particularly assisted living facilities, in exchange for enrolling in hospice.
  - Monthly payments to facilities when a certain number of enrolled patients is reached.
  - Hospice offers of doughnuts, lawn care, manicures, housecleaning services, and other inducements contingent on the beneficiary signing up.

  Response from beneficiaries:

  - For many beneficiaries, the offers of services like lawn care or housecleaning are so attractive that the beneficiary has no idea that the offer includes signing up for the Medicare hospice benefit AND losing access to their Medicare benefits.
  - Medicare beneficiaries are frequently unaware that unsolicited outreach and solicitation could be a scam, nor are they aware of the limitations on their Medicare coverage when they enroll in hospice.

- ***If the prohibition on unsolicited contact via telephone by DMEPOS suppliers was expanded to other forms of communication, what obstacles would that create for DMEPOS suppliers that could hinder your ability to effectively serve Medicare***

beneficiaries? In what ways could CMS mitigate those concerns while still expanding protections for beneficiaries?

NPHI Recommendation

CMS should consider imposing limitations on other forms of communication used for solicitation, including social media outreach and enrollment sign-up through social media platforms and text messaging.

- ***If CMS were to pursue a legislative proposal to expand the prohibition against unsolicited contact by DMEPOS suppliers to other provider and supplier types, are there other provider or supplier types that should be included?***

NPHI Recommendation

Hospice should be explicitly included in any expansion of prohibitions against unsolicited contact. The documented abuses among hospices make it clear that hospice should be added in the expansion of prohibitions against unsolicited contact, to protect vulnerable beneficiaries and their families.

- ***In what other ways should CMS expand the prohibition on unsolicited contact via telephone by DMEPOS suppliers? For example, should CMS explicitly prohibit DMEPOS suppliers from collaborating with marketing agencies or other third parties acting on their behalf to perform solicitation?***

NPHI Recommendation

We look forward to providing additional comment on this question as CMS develops its proposal. The use of third-party marketing agencies and contractors to perform solicitation on behalf of providers is a significant concern that warrants explicit regulatory attention.

E. Beneficiary Contact

- ***How would beneficiaries prefer to be contacted by CMS or its contractors about potentially suspicious claims? Would they prefer that this contact occur before or after processing the claim?***
  NPHI believes that the beneficiaries and their families may want to be contacted by CMS or a contractor about potentially suspicious claims. However, we don't believe there would be a preference about when the claim is processed.

NPHI Recommendations and Questions

- We recommend evaluation of the current pilot in Nevada and California with a letter being issued to every Medicare beneficiary confirming their hospice election and what to do if they elected the hospice benefit by mistake.
- Evaluate the number and types of calls to 1-800-MEDICARE from beneficiaries receiving this letter. Is it confusing? How many calls per state? Does CMS have the name of the hospice? Is there any CMS fraud detection follow up based on these calls?
- What other steps could CMS take if the volume of calls from a specific provider is higher than a certain number?
- Pending evaluation of effectiveness, expand the EOB pilot to other states under PPEO.

- ***What concerns, if any, would beneficiaries have regarding privacy, burden, or confusion related to prepayment verification outreach? In what ways could CMS distinguish these communications to make them easy to identify and to make it clear that they are legitimate and trustworthy communications and that beneficiaries need to take action? What form(s) of communication (for example, telephone, mail, secure electronic communication) would beneficiaries find acceptable for such verification?***

  NPHI believes that there is no type of communication that would be clear enough about prepayment verification to make this possible for beneficiaries and their families. Privacy, burden and confusion would all be considerations and the beneficiary is likely to be on high alert about the potential that the caller is a scammer or is fraudulent.

NPHI Recommendations

- If this recommendation goes forward, modes of communication should be thoroughly tested to discern the best option for successful communication.
- We recommend that CMS consider other options for prepayment verification that does not involve outreach directly to beneficiaries. Many of our patients would be unable to participate in any prepayment verification outreach, leaving the communication to a representative, POA, or family member.

NPHI

- ***What could CMS be doing that it is not already doing to make it easier for beneficiaries to report a potentially suspicious claim?***

NPHI Recommendations

- Ensure that staff at 1-800-MEDICARE are able to listen carefully and give accurate advice to callers who are worried about their hospice care. Special training may have already been provided, but from the feedback from beneficiaries and their families, more is needed.
- Continue to use the Senior Medicare Patrol in each state to answer beneficiary questions and to be knowledgeable about hospice fraud.
- As a part of the hospice enrollment process, provide guidance and clear instruction to all patients on how to report unauthorized enrollment.
- Require documentation by the hospice confirming beneficiary or authorized representative understanding of hospice election.

Conclusion

As always, NPHI appreciates the opportunity to provide insight and commentary into how proposals such as these may impact the nonprofit hospice and advanced illness care provider community. If you have any questions concerning these comments or would like to discuss these issues further, please contact NPHI's Senior Policy Director, Ethan McChesney, at ethan@nphihealth.org.

Sincerely,

Tom Koutsoumpas
Founder and CEO
NPHI