Hospice Program Integrity Ideas

Recommendations submitted to CMS by LeadingAge, National Association for Home Care and Hospice, National Hospice and Palliative Care Organization, and National Partnership for Healthcare and Hospice Innovation
January 13, 2023 – Updated August 15, 2024

PROGRAM INTEGRITY IDEA	WHAT PROBLEM DOES THIS IDEA ADDRESS?	NEW PROVIDERS	EXISTING PROVIDERS	NOTES	STATUS UPDATE
LIMITING ENROLLMENT OF NEW PROVIDERS					
1. **Targeted moratorium on new hospices:** Use existing CMS moratorium authority to limit enrollment of new hospice providers in counties with highest concentration in enrollment in the impacted states where the numbers of providers exceed the level appropriate to ensure access, quality, and choice. Allow for appropriate exceptions. • **Service area:** Address service area concerns; include surrounding counties, not just county where hospice is based.	Inappropriate and/or unnecessary growth of hospices.	X		CMS has existing authority Look to CMS' Medicare Home Health (HH) moratoria for details on how to potentially implement for hospice. Example includes criteria for targeting certain areas (i.e. number of providers per 10,000 Medicare Fee-for-Service (FFS) beneficiaries; compounded annual growth rate in provider enrollments; ''churn rate''—the rate of providers entering and exiting the program—as measured by the percent of the target provider or supplier community continuously receiving Medicare payments; Average amount spent per beneficiary who used services furnished by the targeted provider type).	
ENFORCEMENT AGAINST NON-OPERATIONAL HOSPICES					
2. **Revocation of Medicare enrollment:** Can be accomplished without the involvement of state survey agencies. This proposal may involve CMS flagging providers as potentially non-operational based on aberrant gaps in Medicare billing. Revoking enrollment of non-operational hospices prevents them from being sold to inexperienced providers for a profit.	Proliferation of hospices that exist primarily to be sold.	X	X	CMS has existing authority	CMS announced in a June 2024 MLN article (MLN7867599) that hospices in CA, AZ, NV & TX who reactivate their Medicare enrollment after being in a deactivated status will be subject to a period of enhanced oversight to reduce fraud, waste, and abuse. This period began on July 13, 2023. In the CY 2024 HH proposed rule (7/10/23), CMS noted it has detected many fraud schemes which involve multiple enrollments with multiple billing numbers, moving from one billing number to another if one becomes the subject of investigation, among other schemes. CMS states "to protect the Trust Funds against improper payments, [CMS] must be

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					able to move more promptly to deactivate these "spare" billing numbers so the later cannot be inappropriately used or accessed. Also see National Site Visit Project described in item 4
3. Organizational Deactivation: Revoke Medicare billing privileges if provider has not billed any claims in specified timeframe (consider 12 months without billing).	Proliferation of hospices that exist primarily to be sold.		X	CMS has existing authority May need additional guidance/resources to focus attention on states/counties with troubling patterns (e.g. CA, TX, NV, AZ) As an alternative to not billing within 12 months, consider revocation based on not filing any Notices of Election (NOEs) within 6 months (this may be a quicker way to non-operational hospices than looking at billing claims)	In the CY 2024 HH final rule (11/1/23), CMS finalized its proposal to authorize deactivation of providers after six months of Medicare non-billing (down from 12 months). A deactivated provider is not revoked from Medicare but will be required to submit information to restore billing privileges.
4. Increased site visits for hospices suspected of being non-operational: CMS may direct its Site Visit Contractors ("SVCs") to perform increased site visits of those hospice providers flagged as potentially non-operational, and to proceed with revocation if indeed they are not operational.	Proliferation of hospices that exist primarily to be sold.	X	X	CMS has existing authority	Earlier in 2023, CMS initiated a National Site Visit Project to visit every Medicare certified hospice in the country. In a meeting with CMS on July 12, 2023, CMS announced the visits were nearly complete and a final report would be released in the near future. In August 2023, CMS announced that over 7,000 hospices were visited, with nearly 400 hospices considered for potential administrative action. In its FY23 Agency Financial Report, HHS indicated that In FY 2023, CMS visited more than 6,700 hospices and took action against 28 hospices. In addition, 537 non-operational practice locations were removed for hospices that had multiple locations.
MEDICARE CERTIFICATION					
5. Develop hospice "*red flag*" list criteria: Initial Medicare certification application "triggers" related to specific areas of concern. CMS must take additional steps to investigate further **before** certification or revalidation approved. Potential "red flags" include:	Proliferation of hospices that exist primarily to be sold.	X	X With modification – applicable to revalidation	Uncertain if CMS has existing authority Should define "shell company" situations	

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a. Co-location of multiple hospices at single address b. Hospice administrator overseeing multiple hospices c. Other hospice leadership staff or patient care manager serving multiple hospices d. If hospice company appears to be hidden behind a shell company.					
6. Put certain new hospices into "high risk" survey category: Based on developed "red flag" criteria, elevate targeted new hospices to a "high risk" category for surveys ("enhanced scrutiny").	Proliferation of hospices that exist primarily to be sold.	X	X With modification – applicable to revalidation	CMS has existing authority	In the CY 2024 HH final rule (11/1/23), CMS finalized its proposal to revise § 424.518 to move initially enrolling hospices and those submitting applications to report any new owner (as described at § 424.518) into the "high" level of categorical screening; Revalidating hospices would remain subject to moderate risk-level screening.
7. Prohibit individuals with convictions for certain crimes from serving as hospice administrators or owners: Prohibit individuals with convictions for certain kinds of crimes from serving as hospice administrators (e.g. financial crimes).	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues	X	X	Uncertain if CMS has existing authority Some state licensure regulations already have these kinds of requirements.	In the CY2024 physician fee schedule/provider enrollment proposed rule, CMS proposed to expand reason for revocation of a provider's or supplier's enrollment if they, or any owner, managing employee or organization, officer, or director thereof, have been convicted (as that term is defined in 42 CFR 1001.2) of a misdemeanor under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. CMS did not finalize its proposal that the enrollment may be revoked for managing employees or organizations who have been convicted of a misdemeanor within the past 10 years. However, CMS did finalize other revocation reasons, including civil judgments under the False Claims Act (not settlements) and non-compliance with Medicare enrollment standards.
8. Ask CMS to implement changes in 2019 final Medicare Provider Enrollment rule.	Inappropriate and/or unnecessary growth of hospices.	X	X	CMS has existing authority	CMS is addressing some of the provisions in the final rule through proposals in the CY2024 physician fee schedule final rule and in the CY2024 home health final rule.

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	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues				
9. Ownership disclosure: If the company is not publicly traded, require disclosure of ownership and control, major investors over a certain threshold. a. Require that the CMS Certification Numbers (CCNs) of subsidiaries to a parent organization number be clearly denoted as related to the umbrella agency in a manner that is accessible to consumers. b. Require CMS to reevaluate the methodology by which CCNs are assigned to hospice agencies to enable fair and equitable oversight.	Lack of transparency makes accountability for poor performance difficult and makes it harder for patients/families to choose quality providers	X	X Upon revalidation	CMS has existing authority	On September 1, 2023, CMS issued updates to the Form CMS-855A Medicare provider enrolment application to collect additional information, including: • Requiring the provider/supplier/hospice to specifically identify via a checkbox whether a reported organizational owner is itself owned by another organization or individual. • Requiring the provider/supplier/hospice to explicitly identify whether a listed organizational owner/manager does or does not fall within the categories of entities listed on the application (for example, holding company, investment firm, etc.), with “private-equity company'' and “real estate investment trust'' being added to this list of organization types. In the CY 2024 HH final rule (11/1/23), CMS revised its current managing employee definition in § 424.502 to include hospice medical directors and administrators. The inclusion of these roles in the definition will require the hospice to identify individuals serving in these roles to CMS. Also in the FY 2024 hospice proposed rule, CMS published a Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making. Through this RFI, CMS requested feedback on how to

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					improve transparency around ownership trends. On April 6, 2023, CMS released the Hospice All Owners public use file (PUF). This data set provides a first step in ownership transparency; however, the methodology and accuracy of the data needs to be improved.
10. Ask OIG and/or GAO to study use of consulting entities' role in creation of Medicare hospice agencies and potential inappropriate practices by these entities.	Consultants that guarantee Medicare certification/use the "hospice in a box" Address concerns that some hospices pending certification use the same 5 patients concurrently to meet initial certification requirement	X	X		
11. Site visits to confirm operations: Implement mandatory, unannounced site visits/survey requirements for all new providers to locate office, signage and confirm that the office and the business entity exist and meet standard requirements for an office location.	Proliferation of hospices that exist primarily to be sold.	X	X Upon revalidation	CMS has existing authority	Earlier in 2023, CMS initiated a National Site Visit Project to visit every Medicare certified hospice in the country. In a meeting with CMS on July 12, 2023, CMS announced that the visits were nearly complete and that a final report would be released in the near future. In August 2023, CMS announced that over 7,000 hospices were visited, with nearly 400 hospices considered for potential administrative action. In its FY23 Agency Financial Report, HHS indicated that In FY 2023, CMS visited more than 6,700 hospices and took action against 28 hospices. In addition, 537 non-operational practice locations were

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					removed for hospices that had multiple locations.
12. Require a hospice agency to have specified personnel categories on a CCN application or revalidation and require the hospice agency to provide certain information for each individual for those positions.	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues	X	X Upon revalidation	Uncertain if CMS has existing authority	CMS sent an MLN Matters update MM13333 (12/7/23) indicating that if a hospice hasn't reported its medical director or administrator as a managing employee, it must do so immediately. In the CY24 HH final rule (11/1/23), CMS revised its current managing employee definition in § 424.502 to include hospice medical directors and administrators. The inclusion of these roles in the definition will require the hospice to identify individuals serving in these roles to CMS. In the FY 2024 hospice final rule (7/28/23), CMS included hospice in § 424.507(b), which requires ordering/certifying physicians to be enrolled or validly opted-out of the Medicare program as a condition of payment.
RECOMMENDATIONS FOR NEW PROVIDERS					
13. Require new hospices to undergo more frequent surveys. • Once/year for first 3 years for new providers.	Ensuring new hospices are delivering high-quality care and meet health and safety requirements	X	X With modification –	CMS needs authority Note that surveyors do not have the authority to determine if a provider is committing fraud – they only survey to the Conditions of Participation (CoPs).	
14. Increase scrutiny for initial patients: Increase the scrutiny for performing an initial Medicare enrollment survey to at least 5 authentic patients that are being provided hospice care, and surveyors connect with hospice patient or family.	Inappropriate and/or unnecessary growth of hospices. Address concerns that multiple hospices pending certification use the same 5 patients concurrently to	X		CMS has existing authority	

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	meet initial certification requirement				
AGGRESSIVE OR INAPPROPRIATE MARKETING OR SOLICITATION					
15. Modify CoPs to include requirement for a policy on ethical marketing practices and include IG guidance for surveyors: Each hospice must develop a policy on ethical marketing practices that will be followed in all marketing materials. Policy must contain info on: a. Prohibition of kickbacks and inappropriate inducements for referrals (ex. bonuses for longer stay patients or those more likely to be longer stay) b. Disclosure about any incentive compensation arrangements for marketers. CoPs should include a list of mandatory items that must be included by hospice in their marketing materials, including explanation of the hospice election statement that includes: a. Clear explanation of waiver of curative care b. Clear explanation of requirement for 6-month prognosis **c.** Clear explanation that hospice services are of palliative and not considered curative.	Inappropriate marketing practices that may be misleading to patients/families	X	X	CMS has existing authority	
16. CoPs should require that hospices explain, both verbally and in writing that is in language and a manner that is understandable to the patient and/or representative, that the Medicare Hospice Benefit entails: a. 6-month prognosis b. Palliative nature of MHB services c. Waiver of curative care coverage	Inappropriate marketing practices that may be misleading to patients/families	X	X	CMS has existing authority	
HOSPICE QUALITY					
17. Care Compare Website – Include the following additions: a. Date of hospice certification and/or change of ownership should be closer to the top of the listing and have a mechanism for regular and timely updates. b. Hospice Quality Reporting Program (HQRP): Show participation in HQRP (both Hospice Item Set [HIS] and Hospice Consumer Assessment of Healthcare Providers and Systems [CAHPS]). c. Indicate whether hospice was subject to payment penalty for non-participation in HQRP and the year of penalty. d. Identify which survey entity did the hospice's certification survey (state survey agency or accrediting organization).	Difficult for consumers and families to easily access comprehensive information on hospice providers (including info relevant to program integrity concerns)	X	X	CMS has existing authority Making certain hospice survey results public is part of the mandated hospice survey reforms (guidance forthcoming) from the HOSPICE Act and included in the Consolidated Appropriations Act, 2021.	The GAO issued a report (5/8/24) recommending, among other things, that CMS should make hospice survey results available publicly on Care Compare. The Department of Health and Human Services concurred with this recommendation. While the CY 2024 HH final rule (11/1/23) does not address Care Compare directly, it finalized a proposal to post all the following data about hospices in the Hospice Special

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e. Information on contacting Medicare complaint hotline. f. Information on contacting a Quality Improvement Organization (QIO) with complaints or concerns. g. Make HCI Score more prominent/easy to find. h. Elevate placement of *Quality of Patient Care* data to below the *Family Caregiver Survey* rating on pages comparing multiple providers. i. Prioritize *Quality* on the menu bar of the individual hospice pages rather than *Conditions Treated*. j. If a hospice does not receive a star rating for their CAHPS survey, indicate on overview pages whether they have reviewable CAHPS data.					Focus Program at least annually on a CMS public-facing website: • A subset of 10 percent of hospice programs based on the highest aggregate scores as determined by the algorithm used by CMS. • Hospice SFP selection from the list in paragraph (f)(1) of this section as determined by CMS. • SFP status as defined in § 488.1105.
18. Medicare Handbook: Review annual Medicare handbook each year for the summary of program coverage requirements. Refer consumers to that handbook. Handbook currently does not contain program integrity alerts/red flags – consider adding this category to the hospice section of the Medicare handbook.	Difficult for consumers and families to easily access comprehensive information on hospice providers (including info relevant to program integrity concerns)	X	X	CMS has existing authority	
19. Require states to improve access to hospice complaint hotlines: In keeping with the *HOSPICE Act,* which requires states to improve access to the complaint hotline in each state. Consider developing collateral materials that states and providers could use. In addition to its use by consumers, hospices could use the hotline to report suspected fraudulent activity in the field.	Lack of clarity for consumers and families around how to report complaints about poor-quality care	X	X	CMS has existing authority	
MEDICARE REGULATIONS AND SURVEYS					
20. Require an onsite survey within one year when there is a change in ownership.	Proliferation of hospices that exist primarily to be sold		X	CMS has existing authority	
21. Prohibit sale or transfer of hospice certification number for specified timeframe: a la home health's "36-month" Change in Ownership (CHOW) rule. (Allow appropriate exceptions as exist for HH).	Proliferation of hospices that exist primarily to be sold		X	CMS has existing authority – "hospice" needs to be added	In the CY 2024 HH final rule (11/1/23), CMS finalized its proposal to expand the scope of § 424.550(b)(1) to include hospice • The definition of "change in majority ownership" in § 424.502 was expanded to incorporate hospices.

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					• If there is a change in majority ownership of a home health agency (HHA) or hospice by sale (including asset sales, stock transfers, mergers, and consolidations)
					  ○ **within 36 months after the effective date of the HHA's or hospice's initial enrollment** in Medicare or
					  ○ **within 36 months** after the HHA's or hospice's **most recent change in majority ownership**
					• The provider agreement and Medicare billing privileges do not convey to the new owner.
					• The same exceptions apply to hospice as to HHAs.

22. Ensure survey oversight for ability to provide all 4 levels of care, including General Inpatient Care (GIP) and respite contracts, as well as provision of continuous home care (CHC) and afterhours care: CMS should direct survey oversight to ensure hospices have ability to/contracts in place to provide all 4 levels of care, including provision for afterhours care.	Large number of hospices not providing anything other than Routine Home Care (RHC) and/or concerns with (lack of) services provided after-hours	X	X	<u>CMS has existing authority – this requirement is in statute</u> Would take change in Appendix M: Guidance for Surveyors (Interpretive Guidance - IG) Surveyors already required to assess inpatient care provided directly and/or that a contract is in place and meets requirements to provide inpatient care (§418.108). Assessing for the ability to provide continuous care is not as clear. A revision to IG could remedy this. Surveyors already required to assess the provision of "after hours" care - §418.100(c)(2) requires 24/7 care for nursing, physician, drugs & biologicals, and other services as needed. The surveyor is also tasked with assessing for 24/7 care as part of "Information Gathering". A revision to the IGs could focus the surveyor specifically to assess for "after hours" care.	In the FY 2024 hospice proposed rule (4/4/23), CMS published a Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making. Through this RFI, CMS requested feedback on barriers to providing higher intensity levels of care.

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23. OIG Exclusionary list: Consider whether surveyors could check the OIG exclusionary list (LEIE) for key hospice personnel.	Individuals that should be barred from participating in Medicare programs are slipping through the cracks and continuing to play roles in hospice operations	X	X	CMS has existing authority May need change to IG to direct surveyors to check the list.	
24. Presence of corporate compliance plan: Require OIG to update the hospice corporate compliance recommendations/standards (published in 1999) and require all hospice organizations to have these plans in place to ensure adherence to applicable federal and state laws. Assessment of the presence of a plan that is consistent with OIG guidance should be made part of the CoPs and included in state survey operations manual and reviewed by surveyors, and hospices should be required to train key staff on the plan annually.	Hospices with poor program integrity practices	X	X	Plan updates from OIG CMS has existing authority to change CoPs (may require rulemaking)	On April 24, 2023, OIG announced it would be modernizing its Compliance Program Guidances (CPGs) by the end of 2023, while it would begin publishing industry-specific CPGs in 2024 OIG published general compliance program guidance in November 2023
OTHER SURVEY CONSIDERATIONS					
25. Hospice Special Focus Program: Clearly identify the role of the hospice special focus program in upcoming rulemaking. Include a provision for new hospices with condition level deficiencies.	Hospices with quality issues need additional education and oversight	X	X	CMS has existing authority Consider a reference to new hospices with condition level deficiencies in upcoming Special Focus Program rulemaking.	In the CY 24 HH final rule (11/1/23), CMS finalized its proposal to add a new section to § 488.1135 entitled "Hospice Special Focus Program." This would be implemented through an algorithm "to identify indicators of hospice poor performance, including: • Survey findings (condition level deficiencies and substantiated complaints) • Hospice Quality Reporting Program (Hospice Care Index composite score, CAHPS Survey) Also included are the criteria for selection, survey and enforcement, including progressive enforcement remedies during the time in SFP (not exclusive to hospices in the SFP), completion of the SFP, hospice termination from Medicare, and public reporting of the SFP.

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26. State Operations Manual - Appendix M Hospice Guidance for Surveyors: Before release of revised Appendix M and providing surveyor and provider training, ensure that changes to the interpretive guidelines for program integrity are included.	Hospices with quality issues need additional education and oversight	X	X	CMS has existing authority Changes in Appendix M to include program integrity provisions.	On January 27, 2023, CMS posted QSO-23-08, Revisions to the State Operations Manual, Appendix M – Hospice. The update includes guidance for surveyor training, the inclusion of accrediting organizations in surveyor training, and protocols for surveyor conflict of interest.
PERSONNEL REQUIREMENTS					
27. Administrator education and/or qualifications: Add administrator education and/or qualifications (ex. minimum number of years of experience) to CoPs. Required training/certification for hospice administrators.	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues	X	X	CMS has existing authority Will take rulemaking	
28. Patient care manager education and/or qualifications: Add education and/or qualifications (ex. minimum number of years of experience) to CoPs.	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues	X	X	CMS has existing authority Note that there is language in the Home Health (HH) CoPs for this position Will take rulemaking	
29. Background Checks: Require background checks on hospice agency owners/administrators.	Unqualified and/or risky hospice leadership that could contribute to program integrity or quality-of-care issues	X	X	CMS has existing authority These measures are already part of the existing requirements for the "high priority" risk category for providers	In the CY 2024 HH final rule (11/1/23), CMS finalized its proposal to revise § 424.518 to include newly enrolled hospices and hospices reporting a new owner into the "high" level of categorical screening. This change will require hospice owners with five percent or greater direct or indirect ownership to submit a criminal background check, including fingerprinting.
30. Reporting Abuse and Neglect: Update CoPs to require hospice care providers to report all allegations of abuse and neglect immediately to survey agencies, regardless of whether the alleged perpetrator is affiliated with the hospice.	Ensuring hospices are delivering high-quality care and meet health and safety requirements	X	X	CMS has existing authority As recommended in January 2023 GAO report.	
ACCREDITING ORGANIZATIONS AND DEEMED STATUS					

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31. Strengthen Oversight over Accrediting Organizations and Preventing Conflicts of Interest. Address conflicts of interest and align AO standards with Medicare CoPs.	Hospices with quality issues need additional education and oversight	X	X	CMS has existing authority	CMS issued a notice of proposed rulemaking (2/8/24) that would strengthen oversight of accrediting organizations and prevent conflicts of interest.
ROLE OF MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)					
32. Require newly enrolling providers to complete training from MACs: Topics include introduction to Medicare, basics of the Medicare hospice benefit, billing for the new provider, and other provider-specific education and resources available and provided by the MAC. MAC will receive information about newly certified providers, reach out with resources, and confirm and report attendance and participation in training and provider-specific education.	Hospice confusion and/or ignorance around existing rules and guidance may be contributing to program integrity issues	X		CMS has existing authority	
33. Additional MAC billing scrutiny and audits for co-located hospices: Require MACs to pursue additional billing scrutiny and audits on hospices which are co-located with multiple hospice agencies at a single address.	Address red flags for providers already enrolled and stop what could be continued fraudulent billing.	X	X	CMS has existing authority	
34. Prepay Targeted Probe & Educate (TPE) for new providers: Require prepay TPE by all three MACs for new providers.	Hospice confusion and/or ignorance around existing rules and guidance may be contributing to program integrity issues	X		CMS has existing authority	In MLN 7867599, released on July 11, 2023, CMS announced a provisional period of enhanced oversight (PPEO) for newly enrolling hospices, hospices submitting a CHOW, and hospices with 100% ownership change in Arizona, California, Nevada, and Texas. The oversight includes a prepay review of claims. In its FY23 Agency Financial Report, HHS indicated that In FY 2023, 111 hospices underwent PPEO.

Links to sources:
CY 2024 Home Health Final Rule
FY 2024 Hospice Final Rule
GAO Report-Medicare Hospice: CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys
U.S. Department of Health and Human Services FY23 Agency Financial Report

Yellow highlight indicates items identified as appropriate for utilization by states