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July 2026 | A-09-23-03004

Hospice of the Valley – West Received at Least $8.6 Million in Medicare Overpayments

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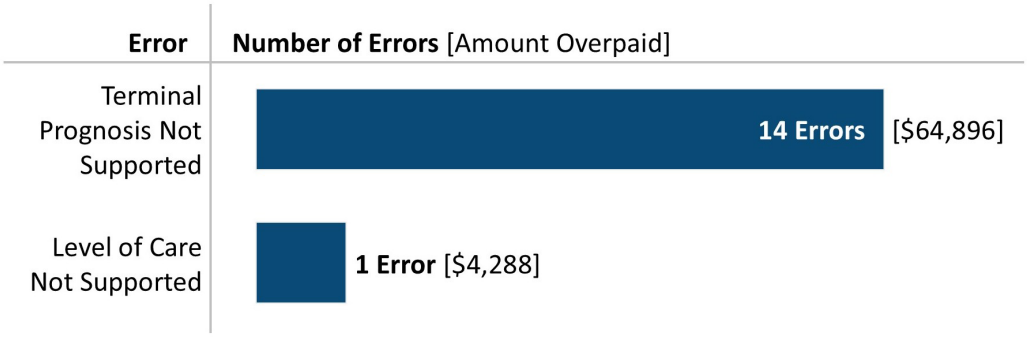
Why OIG Did This Audit

- The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less who have elected hospice care.
- Previous Office of Inspector General audits and evaluations found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.
- This audit report, part of a series of hospice compliance audits, determined whether hospice services provided by Hospice of the Valley – West (HOV) complied with Medicare requirements.

What OIG Found

- HOV complied with Medicare billing requirements for 85 out of the 100 hospice claims we reviewed. However, the remaining 15 claims did not comply with Medicare requirements, resulting in overpayments totaling $69,184 from July 1, 2020, through June 30, 2022 (audit period).



- The errors occurred primarily because HOV did not always follow its policies and procedures to prevent the incorrect billing of Medicare claims for hospice services.
- On the basis of our sample results, we estimated that, of the $86 million Medicare paid HOV, HOV received at least $8.6 million in unallowable Medicare reimbursement for hospice services for the audit period.

What OIG Recommends

We made three recommendations, including that HOV refund to the Federal Government the $8.6 million in estimated overpayments. Our complete recommendations are found in the audit report.

HOV did not concur with any of our recommendations.

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WHY WE DID THIS AUDIT

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less who have elected hospice care. Previous Office of Inspector General (OIG) audits and evaluations found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements. This audit is part of a series of hospice compliance audits.[1] Using computer matching, data mining, and data analysis techniques, we identified hospices at risk of noncompliance with Medicare requirements. For this audit, we selected Hospice of the Valley - West (HOV).

OBJECTIVE

Our objective was to determine whether hospice services provided by HOV complied with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Medicare Part A, also known as hospital insurance, provides for the coverage of various types of services, including hospice services.[2] CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Medicare hospice claims in four home health and hospice jurisdictions.

The Medicare Hospice Benefit

To be eligible to elect Medicare hospice care, a person enrolled in Medicare (enrollee) must be entitled to Medicare Part A and certified by a physician as being terminally ill (i.e., as having a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal

[1] See the OIG Work Plan summary: "Series: Review of Hospices' Compliance with Medicare Requirements" which includes hospice compliance audit reports issued by the OIG.

[2] The Act §§ 1812(a)(4) and (5).

course).[3] Hospice care is palliative (supportive), rather than curative, and includes, among other things, nursing care, medical social services, hospice aide services, medical supplies, and physician services. The Medicare hospice benefit has four levels of care: (1) routine home care, (2) continuous home care (CHC), (3) inpatient respite care, and (4) general inpatient care (GIP). Medicare provides an all-inclusive daily payment based on the level of care.[4]

Enrollees eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice.[5] Upon election, the hospice assumes the responsibility for medical care of the enrollee's terminal illness, and the enrollee waives all rights to Medicare payment for services that are related to the treatment of the terminal condition or related conditions for the duration of the election, except for services provided by the designated hospice directly or under arrangements or services of the enrollee's attending physician if the physician is not employed by or receiving compensation from the designated hospice.[6]

The hospice must submit a notice of election (NOE) to its MAC within 5 calendar days after the effective date of election. If the hospice does not submit the NOE to its MAC within the required timeframe, Medicare will not cover and pay for days of hospice care from the effective date of election to the date that the NOE was submitted to the MAC.[7]

Enrollees are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.[8] At the start of the initial 90-day benefit period of care, the hospice must obtain written certification of the enrollee's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the enrollee's attending physician, if any.[9] For subsequent benefit periods, a written

[3] The Act §§ 1814(a)(7)(A) and 1861(dd)(3)(A) and 42 CFR §§ 418.20 and 418.3.

[4] 42 CFR § 418.302. For dates of service on or after January 1, 2016, there are two daily payment rates for routine home care: a higher rate for the first 60 days and a lower rate for days 61 and beyond (80 Fed. Reg. 47142, 47172 (Aug. 6, 2015)).

[5] 42 CFR § 418.24(a)(1). After our audit period, § 418.24(a)(1) was redesignated to § 418.24(a) at 89 Fed. Reg. 64202, 64272 (Aug. 6, 2024), effective Oct 1, 2024.

[6] The Act § 1812(d)(2)(A) and 42 CFR § 418.24(e). During our audit period, § 418.24(e) was redesignated to paragraph (f) at 86 Fed. Reg. 42528, 42605 (Aug. 4, 2021), effective Oct. 1, 2021, and, after our audit period, § 418.24(f) was redesignated to paragraph (g) at 89 Fed. Reg. 64202, 64272 (Aug. 6, 2024), effective Oct 1, 2024.

[7] 42 CFR §§ 418.24(a)(2) and (a)(3). After our audit period, § 418.24(a)(2) and (a)(3) were redesignated to paragraphs (e) and (e)(1) at 89 Fed. Reg. 64202, 64272 (Aug. 6, 2024), effective Oct 1, 2024.

[8] 42 CFR § 418.21(a).

[9] A hospice interdisciplinary group consists of individuals who together formulate the hospice plan of care for terminally ill enrollees. The interdisciplinary group must include a Doctor of Medicine or Osteopathy, a registered nurse, a social worker, and a pastoral or other counselor, and may include others, such as hospice aides, therapists, and trained volunteers (42 CFR § 418.56).

certification by only the hospice medical director or the physician member of the hospice interdisciplinary group is required.[10] The initial certification and all subsequent recertifications must include a brief narrative explanation of the clinical findings that supports a medical prognosis with a life expectancy of 6 months or less.[11] The written certification may be completed no more than 15 calendar days before the effective date of election or the start of the subsequent benefit period.[12]

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice enrollee whose total stay across all hospices is anticipated to reach a third benefit period. The physician or nurse practitioner conducting the face-to-face encounter must gather and document clinical findings to support a medical prognosis with a life expectancy of 6 months or less.[13]

Effective for dates of service beginning January 1, 2016, hospices can claim a service intensity add-on (SIA) payment for direct patient care provided by a registered nurse and/or a social worker to an enrollee receiving routine home care during the last 7 days of life.[14]

Hospice providers must establish and maintain a clinical record for each hospice patient.[15] The record must include all services, whether furnished directly or under arrangements made by the hospice. Clinical information and other documentation that support the medical prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course must be filed in the medical record with the written certification of terminal illness.[16]

Limitation on Recovery of Overpayments

Medicare contractors may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[17] National Government Services, Inc. (NGS), HOV's

[10] 42 CFR § 418.22(c). After our audit period, § 418.22(c) was revised to permit the physician designee (as defined in § 418.3) to certify terminal illness when the medical director is not available. 89 Fed. Reg. 64202, 64272 (Aug. 6, 2024), effective Oct 1, 2024.

[11] 42 CFR § 418.22(b)(3).

[12] 42 CFR § 418.22(a)(3).

[13] 42 CFR §§ 418.22(a)(4), (b)(3)(v), and (b)(4).

[14] To be eligible for an SIA payment, the enrollee must be discharged from the hospice due to death (42 CFR §§ 418.302(b)(1)(i) and (ii)).

[15] 42 CFR §§ 418.104 and 418.310.

[16] 42 CFR §§ 418.22(b)(2) and (d)(2).

[17] 42 CFR § 405.980(b)(2).

Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims.

Section 1870 of the Act prohibits the recovery of Medicare fee-for-service overpayments if the provider was without fault with respect to the overpayment.[18] A provider is presumed to be without fault for Medicare fee-for-service overpayments if the overpayment determination is made by the Medicare program after the fifth year following the year in which notice of such payment was sent to the provider.[19] MACs typically waive recovery in accordance with this presumption, but have the authority to determine whether there is sufficient evidence to rebut the presumption.

Hospice of the Valley - West

HOV is a not-for-profit hospice provider located in Phoenix, Arizona. From July 1, 2020, through June 30, 2022 (audit period), HOV provided hospice services to approximately 7,000 enrollees and received Medicare reimbursement of about $86 million.[20]

HOW WE CONDUCTED THIS AUDIT

Our audit covered 20,780 claims totaling $85,867,467 in payments for services provided during our audit period.[21] We reviewed a random sample of 100 of these claims, totaling $419,336, to determine whether hospice services complied with Medicare requirements. Specifically, we evaluated compliance with selected billing requirements and submitted these sampled claims and the associated medical records to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[18] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

[19] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); *Medicare Financial Management Manual*, chapter 3, §§ 70.3 and 80.

[20] Claims data for the period July 1, 2020, through June 30, 2022, was the most current data available when we started our audit.

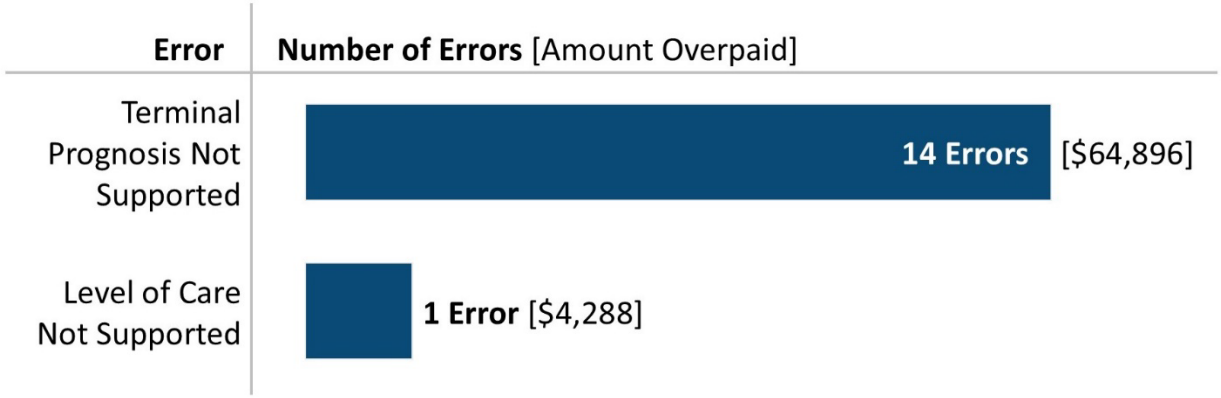
[21] In developing this sampling frame, we included hospice claims for which a payment was made from the Medicare Trust Fund and claims that were not identified in the Recovery Audit Contractor data warehouse as having been reviewed by another party.

Appendix A describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the results of our audit by sample item.

FINDINGS

HOV complied with Medicare billing requirements for 85 of the 100 hospice claims we reviewed. However, the remaining 15 claims did not comply with Medicare requirements resulting in overpayments totaling $69,184. The figure below provides a breakdown of the error types, number of claims in error and the associated overpayments.

Figure: Hospice Billing Errors



These errors occurred primarily because HOV did not always follow its policies and procedures to prevent the incorrect billing of Medicare claims for hospice services.

On the basis of our sample results, we estimated that HOV received at least $8.6 million in unallowable Medicare reimbursement for hospice services for the audit period.[22]

TERMINAL PROGNOSIS NOT SUPPORTED

To be eligible for the Medicare hospice benefit, an enrollee must be certified as being terminally ill (i.e., as having a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course). Enrollees are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. At the start of the initial 90-day benefit period of care, the hospice must obtain written certification of the enrollee's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician, if any. For subsequent benefit periods, a written certification from the hospice medical director or the physician

[22] Specifically, we estimated that HOV received at least $8,614,887 in overpayments. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total at least 95 percent of the time.

member of the hospice interdisciplinary group is required. Clinical information and other documentation that supports the enrollee's terminal prognosis must accompany the physician's certification and be filed in the medical record with the written certification of terminal illness.[23]

For 14 of the 100 sampled claims, the clinical records provided by HOV did not support the associated enrollee's terminal prognosis. Specifically, the independent medical review contractor determined that the records for these claims did not contain sufficient clinical information and other documentation to support the medical prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course. Overpayments associated with these 14 claims totaled $64,896.

LEVEL OF CARE NOT SUPPORTED

Medicare reimbursement for hospice services is made at predetermined payment rates—based on the level of care provided—for each day that an enrollee is under the hospice's care. The four levels are: (1) routine home care, (2) CHC, (3) inpatient respite care, and (4) GIP care.[24] GIP care is provided in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings, such as the enrollee's home, and is intended to be short-term.[25] Routine home care is the least expensive level of hospice care, followed by inpatient respite care, GIP care, and CHC, which is the most expensive level of hospice care.

For one claim in our sample, the associated enrollee's clinical record did not support the need for the claimed GIP level of care. For the 8 days of GIP that were billed, the enrollee's medical condition supported a short-term inpatient stay for pain control or acute or chronic symptom management that could not feasibly be provided in other settings for 3 of those days. However, the other 5 days should have been billed at a routine level of care. Specifically, the associated enrollee's hospice care needs could have been met if HOV had provided services at the less expensive routine level of care.[26] Overpayment associated with this claim totaled $4,288.

[23] 42 CFR §§ 418.22(b)(2) and 418.104(a).

[24] Definitions and payment procedures for specific level-of-care categories are codified at 42 CFR § 418.302. For dates of service on or after January 1, 2016, there are two daily payment rates for routine home care: a higher rate for the first 60 days and a lower rate for days 61 and beyond (80 Fed. Reg. 47142, 47172 (Aug. 6, 2015)).

[25] 42 CFR §§ 418.302(b)(4) and 418.202(e).

[26] We used the applicable payment rates and questioned the difference in payment amounts between the GIP and routine levels of care.

HOSPICE OF THE VALLEY - WEST DID NOT ALWAYS FOLLOW PROCEDURES TO PROPERLY CLAIM HOSPICE SERVICES

The 15 inappropriately billed claims did not comply with Medicare requirements because staff did not consistently follow HOV's written procedures designed to ensure that enrollees have a terminal prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course and the enrollees received the appropriate level of care. HOV had written procedures to identify and prevent noncompliance with Medicare requirements related to clinical review, proper coding, and billing of hospice claims. Additionally, HOV stated that its billing team attends online Medicare training webinars to stay up to date on hospice billing regulation changes. Despite establishing these procedures and ongoing training, we determined that 15 sampled claims did not comply with Medicare requirements.

RECOMMENDATIONS

- We recommend that HOV refund to the Federal Government the estimated $8,614,887 in overpayments for claims for hospice services that did not comply with Medicare requirements, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision.[27, 28]

- We recommend that HOV consider conducting one or more internal audits or investigations for claims after our audit period, based on the findings identified by this audit, to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program.

- We recommend that HOV provide additional training to clinical personnel on its policies and procedures to continually validate that the enrollees met the requirements for hospice (i.e., terminal prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course and the enrollees received the appropriate level of care).

[27] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

[28] NGS retains the authority to determine whether there is sufficient evidence to rebut the Section 1870 "fifth year following" "without fault" presumption that might limit the recovery of any of these overpayments.

HOSPICE OF THE VALLEY – WEST COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, HOV, through its attorney, did not concur with our findings and recommendations.[29] Specifically, HOV said that it strongly disagrees with our determination for the 15 sampled claims questioned in our draft report. Also, HOV disagreed with our first recommendation stating that it does not believe it was overpaid for hospice services. For the second recommendation, HOV stated that it has not identified any issues that would compel HOV to conduct additional reviews, and for the third recommendation, HOV stated that it already has a dedicated team of professionals to train staff on compliance.

HOV provided additional documents as an attachment to the written comments. The additional documents for each of the 15 sampled claims included: (1) rebuttal of the denial reasons from HOV's medical director, (2) attestation from HOV's hospice physician who certified the patients' terminal illness and oversaw the patient care, and (3) letter from HOV's independent medical reviewer concurring with HOV's assessments. HOV's comments, excluding the attachment, are included as Appendix E.[30]

After reviewing HOV's comments and additional documents, we maintain that our findings and recommendations are valid. We note that our audit recommendations do not represent final determinations by the Medicare program but are recommendations to the Department of Health and Human Services' action official. The action official—in this case, CMS—may reexamine the 15 sampled claims that we recommended for disallowance and determine whether an overpayment exists.

HOSPICE OF THE VALLEY – WEST DISAGREED WITH OUR DETERMINATIONS FOR 15 SAMPLED CLAIMS

In regard to our determination for the 15 sampled claims, HOV stated that it believes our medical reviewer misapplied applicable Medicare hospice regulations and standards and did not give great weight to certifying physicians' clinical judgment of terminal illness. HOV also indicated that it was not given the opportunity to engage directly with our medical reviewer and that we did not consider impact of the COVID-19 public health emergency (PHE). In addition, HOV objected to, and raised concerns about, our use of extrapolation and stated that we should forgo extrapolation.

[29] The comments to our draft report consisted of two separate letters: one from HOV's Executive Director, and one from its attorney. We considered comments from the two letters as HOV Comments.

[30] The attachment is not included in this report because it contains personally identifiable information.

Application of Medicare Hospice Requirements

Hospice of the Valley – West Comments

HOV stated that our medical reviewer misapplied the applicable Medicare hospice regulations, misinterpreted clinical documentation, and overlooked key aspects documented within the medical records. Specifically, HOV stated that our medical reviewer: (1) applied inconsistent and erroneous clinical standards when determining whether documentation supported a terminal prognosis or a higher level of care; (2) "cherry-picked" certain cognitive symptoms from the documentation, and (3) relied on record notations that were after the claim review period for some instances and provided sparse responses, which demonstrated that the medical reviewer did not consider the totality of the patient's conditions.

Office of Inspector General Response

We disagree with HOV's assertions that our independent medical review contractor misapplied the applicable Medicare hospice requirements (i.e., laws, regulations, and guidance) when conducting its review.

Our medical review contractor properly used the appropriate statutory and regulatory hospice criteria, including applicable Local Coverage Determination (LCD) guidelines, as the framework for its determinations. Specifically, the medical review contractor applied standards set out in 42 CFR § 418.22(b)(2), which require clinical information and other documentation that support the medical prognosis to accompany the certification and be filed in the medical record. Additionally, our medical review contractor evaluated the entire medical record provided by the hospice for each sample claim to determine whether Medicare requirements were met. This included, but was not limited to, hospice election records; the initial certification of terminal illness; recertifications that covered the sample claim; plans of care; medication records; physician, nurse, hospice aide, and social worker notes; hospital medical records (if applicable); and billing documents. When the medical records and other available clinical factors supported the physician's medical prognosis or the level of hospice care provided, the medical review contractor determined that Medicare requirements were met. Therefore, we maintain that the medical review contractor consistently and appropriately applied Medicare hospice eligibility requirements.

Certifying Physician's Clinical Judgment of Terminal Illness

Hospice of the Valley – West Comments

HOV stated that its certifying physicians' clinical judgments are correct and that the hospice records supported the certification of terminal illness. HOV stated that our medical reviewer glossed over the role of the certifying physician. HOV indicated that physicians are not required to predict with 100 percent certainty in order for the hospice care to meet Medicare requirements. According to HOV, the *AseraCare* decision stated that the certifying physician's

certification of terminal illness (CTI) must be given great weight and that the CTI does not have to chronicle every detail of the hospice patient's clinical condition that "proves" the patient was terminally ill.[31]

Office of Inspector General Response

Our medical review contractor considered the certifying physician's terminal diagnosis and evaluated the medical records (including necessary historical clinical records) for each hospice claim, when determining whether the certified terminal prognosis was supported. In addition, the *AseraCare* decision that HOV referenced addressed whether a difference in clinical judgment can render a physician certification false for purposes of False Claims Act liability; therefore, it is not applicable to OIG audit recommendations and CMS recoveries arising from OIG audits.

Engagement With Office of Inspector General's Medical Review Contractor

Hospice of the Valley – West Comments

HOV stated that it was denied the opportunity to engage directly with our medical reviewer and was informed that the direct engagement is not part of the OIG's audit process. Furthermore, HOV stated that our medical reviewer did not reach out to the certifying physicians to obtain HOV's perspective for the 15 sampled claims that were found to have insufficient clinical support on the medical records.

Office of Inspector General Response

We acknowledge HOV's concern regarding its opportunity to engage directly with our medical reviewer. Generally Accepted Government Auditing Standards require auditors to maintain independence in both fact and appearance to ensure impartiality and public confidence. Because we are not medical review experts, we relied on our medical review contractor. Our medical review contractor maintained their independence and made their determination by reviewing the documentation in the medical records. Additionally, in response to our preliminary findings, HOV provided its independent medical reviewer analysis (letter from HOV's independent medical reviewer concurring with HOV's assessments) for the 15 sample claims. Our medical review contractor reviewed HOV's independent medical reviewer's analysis and determined that the 15 sample claims continued to be noncompliant with Medicare requirements.

We previously notified HOV that "OIG audit recommendations do not represent final determinations by Medicare. After we issue the final report, CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any

[31] *United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019).

overpayments consistent with its policies and procedures. Any determinations made by CMS or its contractors regarding overpayments remain subject to the standard Medicare appeals process."

COVID-19 Public Health Emergency

Hospice of the Valley – West Comments

HOV stated that we did not mention that the hospice services were furnished during the COVID-19 PHE. HOV indicated that during the COVID-19 PHE, it was difficult for hospices to gather information and dispatch workers, and hospices faced severe staffing challenges. HOV questioned whether we took into consideration the COVID-19 PHE regulatory flexibilities.

Office of Inspector General Response

We worked closely with our independent medical review contractor to ensure that relevant waiver provisions in place during our audit period due to the COVID-19 PHE were considered. Although we acknowledge that hospices were granted certain flexibilities during the COVID-19 PHE, hospices were required to continue complying with Medicare requirements. At the beginning of the COVID-19 PHE, CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities aimed at reducing the administrative burden on hospices. For example, CMS waived strict timeframes for updating the comprehensive assessment of patients to provide hospices more time to update assessments. However, hospices were still required to complete the assessments and updates.

Office of Inspector General's Extrapolation Methodology

Hospice of the Valley – West Comments

HOV objected to, and raised concerns about, our use of extrapolation. HOV stated that we should forgo extrapolation because: (1) the findings do not reflect a high or sustained level of payment error for which extrapolation is justified, (2) the Medicare statue only permits extrapolation in "sustained or high" level of payment error, and (3) NGS reopened all of the claims in the sampling frame regardless of whether the claims were in the sample review.

Office of Inspector General Response

Our sampling methodology and extrapolation are statistically valid. The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[32]

The Act and *Medicare Program Integrity Manual* (MPIM) requirement that a determination of a sustained or high level of payment error must be made before extrapolation can be used applies only to Medicare contractors—not OIG.[33] Moreover, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[34] We properly executed our statistical sampling methodology because we defined our sampling frame and sample unit, selected a sample of claims at random, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation.

In response to HOV's position regarding the reopening of claims, NGS reopened the claims based upon its authority under 42 CFR section 405.980. Specifically, a claim may be reopened within 4 years from the date of the initial determination or redetermination for "good cause." This audit is part of a series of OIG hospice compliance audits. Using computer matching, data mining, and data analysis techniques, the OIG identified certain providers that rendered hospice claims which may be at risk for noncompliance with Medicare billing requirements. OIG selected HOV for further review based upon certain risk factors and notified NGS. After receiving this additional information, NGS reopened the claims.

HOSPICE OF THE VALLEY – WEST DID NOT CONCUR WITH OUR RECOMMENDATIONS

Hospice of the Valley – West Comments

HOV did not concur with any of our recommendations.

Regarding our first recommendation, HOV stated that it disagrees and does not believe that hospice services were overpaid for the claims within the four-year claims reopening period.

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[32] *See John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[33] See the Act § 1893(f)(3); and CMS' *MPIM*, Pub. No. 100-08, chapter 8, § 8.4.

[34] *See Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

HOV disagrees with our medical review contractor's determination that the services did not comply with Medicare requirements.

Regarding our second recommendation, HOV stated that it has complied with its obligations to assess information related to potential overpayments and has not identified any issues that would compel HOV to conduct additional reviews.

Regarding our third recommendation, HOV stated that it already has a dedicated team of hospice and compliance professionals to develop, implement, and train staff on its compliance and clinical operations.

Office of Inspector General Response

We clarified in the footnote to our first recommendation that our audit recommendations do not represent final determinations by Medicare. Action officials at CMS, acting through a MAC or other contractor, will determine whether potential overpayments exist and will recoup any overpayments consistent with CMS's policies and procedures. If a provider disagrees with any CMS adverse determination, a provider has the right to appeal that determination (42 CFR § 405.904(a)(2)). An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

We maintain that the improper payments of 15 sampled claims occurred, and we continue to recommend that HOV consider conducting additional reviews to identify potential overpayments and provide training clinical personnel to continually validate that the enrollees have met the requirements for hospice.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 20,780 hospice claims for which HOV received Medicare reimbursement totaling $85,867,467 in payments for services provided from July 1, 2020, through June 30, 2022 (audit period). These claims were extracted from CMS's Integrated Data Repository (IDR).

We evaluated compliance with selected Medicare coverage and billing requirements and submitted the sampled claims and the associated supporting documentation to an independent medical review contractor to determine whether the associated services met medical necessity and coding requirements.

We limited our review of HOV's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims.

To assess the reliability of the data obtained from CMS's IDR, we: (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 hospice claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Medicare laws, regulations, and guidance
- Reviewed HOV's policies and procedures for hospice services and met with HOV officials to gain an understanding of HOV's policies and procedures related to providing and billing Medicare for hospice services and reviewed those policies and procedures
- Created a sampling frame consisting of 20,780 hospice claims from the CMS IDR, totaling $85,867,467, for the audit period[35]
- Selected a simple random sample of 100 hospice claims from the sampling frame
- Reviewed data from CMS's Common Working File and other available data for the sampled claims to determine whether the claims had been canceled or adjusted

[35] The sampling frame included claims for which a payment was made from the Medicare Trust Fund and claims that were not identified in the RAC data warehouse as having been reviewed by another party.

- Obtained medical records for the 100 sampled claims and provided them to an independent medical review contractor, which determined whether the hospice services complied with Medicare requirements

- Reviewed the independent medical review contractor's results and summarized the reason(s) a claim was determined to be improperly reimbursed

- Used the results of the sample to calculate the estimated amount of the improper Medicare payments in the sampling frame made to HOV for hospice services (Appendix C)

- Discussed the results of our audit with HOV officials

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 20,780 Medicare Part A reimbursed claims totaling $85,867,467 in payments for hospice services provided by HOV during our audit period.[36] The data was extracted from the CMS IDR.

SAMPLE UNIT

The sample unit was a Medicare Part A hospice claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 Medicare Part A hospice claims.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame by the IDR_LINK_NUM (a claim identification number) field, and we consecutively numbered the hospice claims in our sampling frame. After generating random numbers in accordance with our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of improper Medicare payments made to HOV for unallowable hospice services in the sampling frame. To be conservative, we recommend recovery of overpayments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[36] The sampling frame included claims for which a payment was made from the Medicare Trust Fund and claims that were not identified in the RAC data warehouse as having been reviewed by another party.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Sampling Frame Size	Value of Sampling Frame	Sample Size	Value of Sample	Number of Unallowable Claims in Sample	Value of Overpayments in Sample
20,780	$85,867,467	100	$419,336	15	$69,184

Table 2: Estimated Value of Overpayments in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$14,376,458
Lower limit	8,614,887
Upper limit	20,138,029

APPENDIX D: RESULTS OF AUDIT BY SAMPLE ITEM

Sample Number	Terminal Prognosis Not Supported	Level of Care Not Supported	Overpayment
1			-
2			-
3			-
4			-
5			-
6			-
7			-
8			-
9			-
10			-
11			-
12			-
13			-
14			-
15			-
16			-
17			-
18			-
19	X		4,795
20			-
21			-
22	X		5,255
23	X		4,640
24			-
25			-
26			-
27			-
28			-
29			-
30	X		4,779
31			-
32			-
33			-
34			-
35			-
36			-
37			-

Sample Number	Terminal Prognosis Not Supported	Level of Care Not Supported	Overpayment
38			-
39			-
40			-
41			-
42	X		4,795
43			-
44	X		4,889
45			-
46			-
47			-
48			-
49			-
50	X		4,640
51			-
52	X		2,320
53			-
54			-
55	X		4,795
56	X		4,795
57			-
58			-
59			-
60			-
61			-
62			-
63			-
64			-
65			-
66			-
67			-
68			-
69			-
70			-
71	X		4,889
72			-
73			-
74			-
75			-
76			-

Sample Number	Terminal Prognosis Not Supported	Level of Care Not Supported	Overpayment
77	X		4,731
78			-
79			-
80			-
81			-
82			-
83			-
84			-
85			-
86			-
87			-
88			-
89			-
90			-
91	X		4,794
92			-
93			-
94	X		4,779
95			-
96			-
97		X	4,288
98			-
99			-
100			-
Totals	**14**	**1**	**69,184**

APPENDIX E: HOSPICE OF THE VALLEY – WEST COMMENTS[37]

HOSPICE of the VALLEY

April 24, 2026

BY SECURE ELECTRONIC MAIL

Jessica Yun Kim
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Hospice of the Valley - West's Response to Draft OIG Audit Report A-09-23-03004

Dear Regional Inspector General Yun Kim,

A legacy of *caring* since 1977

Hospice of the Valley - West (HOV), a not-for-profit hospice, has proudly served our Arizona community for nearly 50 years. Our mission: *providing comfort, dignity and compassionate care* pre-dates even the establishment of the Medicare hospice benefit, beginning with a few dedicated volunteers in 1977. Over the years, we have been committed to providing the highest standards of hospice care— being strong stewards of the Medicare Hospice Benefit by following Medicare's regulations, providing excellent patient care, and as a not-for-profit never turning away hospice patients due to lack of financial resources. HOV serves as a critical safety net for our community, and it has been an honor to fulfill this role with integrity and beautiful care.

HOV respects the role of government audits in assessing government program risk. Throughout our history we have been advocates for protecting the Medicare Hospice Benefit as illustrated through our excellent Medicare reported results. While we greatly respect the role of government audits in assessing government program risk, we respectfully and strongly disagree with the Office of Inspector General (OIG) medical review contractor's claim determinations for 15 claims in the OIG sample, with an estimated overpayment totaling $69,184 according to the draft OIG Audit Report. Following a comprehensive internal evaluation of the hospice record for each denied claim, we stand firm that HOV's documentation indeed meets all Medicare hospice requirements and level of care standards in support of those claims.

To further ensure objectivity, we engaged an independent, board-certified hospice physician, [redacted], to conduct an additional review. [redacted] has decades of clinical experience in all areas of hospice and palliative medicine and an expert level understanding of the clinical indicators of eligibility for the Medicare Hospice Benefit. He independently reviewed each of the 15 hospice records in dispute with OIG's medical review contractor and unequivocally concluded that each of these HOV hospice records supported hospice eligibility under Medicare requirements.

Based on the denial reasons provided by the OIG medical review contractor, we believe the reviewer misapplied applicable Medicare hospice regulations and standards as the

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[37] **Office of Inspector General Note:** The deleted text has been redacted because it is personally identifiable information.

denial reasons do not reflect the totality of the documented clinical assessments. We remain confident that our certifying hospice physicians, who oversaw the care of our patients during the OIG's audit period (July 1, 2020, through June 30, 2022) – during the height of the COVID-19 Public Health Emergency – appropriately certified and recertified hospice eligibility for each patient included in this OIG audit. Each HOV hospice physician who cared for these 15 patients has included in our attached response a personal attestation summarizing why they continue to support their original and ongoing eligibility and level of care determinations.

As you may be aware, because we felt so confident in our clinical care and conclusions on Medicare hospice compliance, as part of the OIG audit process, we requested on several occasions the opportunity to meet with the OIG's medical review contractor to present our internal review findings and the conclusions of HOV's independent physician reviewer. At each turn, we were informed that such a meeting was not permitted under OIG audit protocol. While we understand OIG establishes its own audit protocols, this was disappointing given our longstanding commitment to compliance and our sincere belief that the contractor findings reflect an incomplete understanding of the hospice records and benefit. For efficiency's sake alone – a core focus of this Administration – we believe it would have been helpful to engage in that direct communication with the OIG's medical review contractor.

We are confused and alarmed by the contractor's stated draft denial reasons, which are inconsistent with Medicare's hospice benefit. **We raise these significant concerns because, if these initial denials are upheld, we believe the hospice industry will be measured by a new yardstick that deviates from existing regulations**. Two of the 15 patients at issue were over 100 years old, and almost half were over 90 years old. While age alone is not a determinant of hospice eligibility, very advanced age combined with compelling clinical evidence of terminal illness supports such eligibility. Additional concerning matters include one denial citing a 3.2-ounce weight gain on one day, and another referencing the ability to walk 10 feet with a walker as supportive of clinical ineligibility. All of the denial comments contain equally concerning language. Notably, the denials missed critical clinical documentation available within the patient record, which is why we believe a thorough re-review of the records by the contractor will overturn all denials.

Medicare program guidelines have repeatedly recognized that determining end-of-life prognosis is not an exact science, and Medicare regulations appropriately allow for an ongoing, holistic assessment of eligibility, which we consistently perform. HOV appreciates the opportunity in its comprehensive response to the OIG's draft Audit Report to highlight what appears in HOV's hospice records and what the OIG medical review contractor appears to have either missed or inexplicably devalued.

The determinations made by the OIG's medical review contractor are also inconsistent with the findings of our independent physician reviewer, our comprehensive internal review, and our longstanding history of strong Medicare audit outcomes. Over the past eight years, claims audited at random under the Comprehensive Error Rate Testing (CERT) program have consistently resulted in a zero percent error rate. In addition, both Medicare and state surveys and audits over many years have demonstrated our strong compliance with the Hospice Medicare Benefit and our high-quality care metrics.

The attached detailed response from our legal counsel at Morgan Lewis and the supporting documentation provides a thorough, record-by-record analysis demonstrating compliance with Medicare's hospice requirements for coverage and payment. We respectfully request that the OIG's medical review contractor

thoroughly review all of the clinical information and documentation furnished in the attachments to our submission. Much of this information was previously furnished to OIG, but we now include additional support and observations on the hospice records for the 15 patients at issue in the draft OIG Report. We appreciate that as part of its audit response process, OIG has committed to analyzing our entire submission. At a time when the Medicare Hospice Benefit is under significant pressure from bad actors and criminals, especially in states like Arizona, it is more important than ever that audits are conducted in a manner that will strengthen the Medicare Hospice Benefit, and not erode beneficiary's trust in that program.

HOV has followed all Medicare guidelines throughout our nearly 50-year history as well as during this two-year audit period. While we appreciate that the OIG's draft Audit Report acknowledged our strong internal controls, we believe it is important to note that our clinical education and compliance practices have also been consistently praised by both Medicare and the State of Arizona – and we followed these practices for all patients including those that were denied. We take this seriously and we are proud to have the largest number of hospice and palliative care certified physicians, nurses, social workers, and certified nursing assistants in Arizona. Our teams take great pride in their accurate assessments and high standards of care.

As noted above, the OIG's two-year audit period covers hospice care we furnished during the height of the COVID-19 public health emergency. This was an extraordinarily challenging time, not just for patients and their families, but for all healthcare providers. Our leadership team was on-site seven days a week, supporting staff and patients while navigating unprecedented circumstances. Our employees did not leave the agency due to fear or uncertainty from the pandemic; instead, they leaned in, demonstrating extraordinary dedication to our patients. Throughout this period, we followed all applicable Medicare guidelines and HHS waivers, ensured that we continued to conduct a thorough review of each admission, and adhered rigorously to our established processes and compliance standards.

We respectfully request that the OIG and its contractor conduct a thorough and comprehensive review of all previously submitted materials as well as the additional enclosed information. Our detailed response follows this letter. While we understand the contractor will examine the documentation provided, we also ask that the OIG Office of Audit Services review the clinical summaries, as they offer clear insight into eligibility. We are confident that this documentation will demonstrate the appropriate eligibility of each patient included in the audit and support the reversal of all denials. Thank you for your consideration of our comments and response. Please feel free to contact us with any questions as the OIG finalizes the draft Audit Report.

Sincerely,

Debbie Skamway

Executive Director

April 24, 2026

Morgan Lewis

Howard J. Young
Partner
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April 24, 2026

BY SECURE ELECTRONIC MAIL

Jessica Yun Kim
Regional Inspector General for Audit Services
U.S. Dep't. of Health & Human Services, Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Hospice of the Valley – West; Report No. A-09-23-03004

Dear Ms. Kim:

Hospice of the Valley – West ("HOV") has served Maricopa county as an essential non-profit hospice provider for almost 50 years. Through its counsel,[1] HOV submits this letter to provide its disagreement or nonconcurrence with the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General's ("OIG") draft audit report (A-09-23-03004) dated February 24, 2026 (the "Draft Report"). HOV appreciates OIG's extension through April 27, 2026, to respond to the Draft Report.

OIG's 100 hospice claim sample covered the period from July 1, 2020 through June 30, 2022 (the "Audit Period") which examined hospice care provided during the time period when the HHS Secretary had afforded various flexibilities due to the COVID-19 public health emergency ("PHE").[2]

HOV strongly disagrees (nonconcurs) with each of the Draft Report's claim denials related to hospice eligibility (14 claims) and clinical need for a higher level of care (1

[1] The individuals listed in **Attachment A** hereby authorize the release of their personally identifiable information included in this letter and consequently OIG need not redact such information in its final audit report. **Attachment A – Authorizations for PII.**
[2] See, e.g., Hospice: CMS Flexibilities to Fight COVID-19.

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claim).[3] The payments for those fifteen (15) Medicare claim denials totaled $69,184.00. HOV's hospice physicians who oversaw the hospice care of each of the 15 patients at issue and its independent physician expert believe each of the claims met Medicare requirements. HOV respectfully requests that OIG work with its independent medical review contractor ("IMRC") to review the original records and additional supporting documents which include:

- Specific substantiation of clinical eligibility rebutting the denial reasons set forth in the Draft Response (the "Contemporaneous Clinical Evidence and LCD Analysis");
- HOV hospice physician attestations for each patient by the certifying hospice physician who oversaw the patient's care; and
- Letter of concurrence from HOV's independent hospice physician expert reviewer ("[redacted] Attestation").

This information provides the foundation for the IMRC to reconsider its prior denials and to conclude, based on the sound clinical documentation provided by HOV, that these prior denials should be overturned.

Specifically, HOV believes that OIG's IMRC denials did not follow CMS guidance and Medicare hospice coverage standards, several examples of which are summarized below (with expanded examples set forth in Section 2.B.3 and a full patient-by-patient rebuttal contained in **Attachment B – Contemporaneous Clinical Evidence and LCD Analysis**):

- The IMRC **incorrectly** relied on a FAST score – a cognitive measure – for a patient with a terminal illness of heart disease.
- The IMRC implied a patient exhibited a lack of terminal decline because the patient was still eating three small portions (less than 1 cup) of pureed food per day, plainly **ignoring that the patient's overall food intake had decreased** during the month under review and, but for being fed by caregivers, the patient would not eat at all.
- The IMRC identified eligibility concerns because the patient's sleeping decreased from 14 hours per day to 6 hours yet **failed to acknowledge documentation** that loud construction had started at the house next door and that when the construction stopped, the patient resumed sleeping 14-16 hours per day.
- The IMRC evaluated terminality using an **incorrect terminal diagnosis**, including generating its own New York Heart Association (NYHA) classification when

[3] OIG's Draft Report refers to "claims in error and associated overpayments." For brevity, HOV refers to these as "denials."

congestive heart failure was **not** the certified terminal diagnosis for that patient.

In the IMRC denials, it appears that the reviewers missed critical pertinent documentation that supports each patient's eligibility, and in some instances the IMRC relied on record notations that post-dated the claim review period under audit. This is particularly troubling when certifying hospice physicians are expected to make reasonable prognostications on whether the patient is or remains terminally ill based on information available to that physician and the patient's clinical status at the time of the certifications. The LCD guidance for physicians calls out that patients may stabilize or improve and yet remain eligible for the Medicare hospice benefit.

Surprisingly, in its Draft Report, OIG did not even make a single mention of the fact that **all** of the hospice services during the Audit Period were furnished during the COVID-19 PHE. Even the Draft Report's "Background" discussion of the Medicare Hospice Benefit did not make a single reference to the HHS regulatory flexibilities the Secretary accorded to hospices and other providers during the PHE.

While we are confident these claim denials would be overturned at subsequent stages of audit and appeal, the consequential nature of these determinations warrants corrective action at this stage. Accordingly, we respectfully request that the IMRC re-evaluate all determinations to ensure alignment with CMS requirements, OIG audit standards, and certifying physicians' contemporaneous medical judgment, thereby avoiding unfounded reputational damage to our client as well as wasteful taxpayer expense associated with defending flawed claim denials.

HOV also objects and raises significant concerns about OIG's proposed use of a multi-million-dollar extrapolation based on $69,184 of denied claims, including significant concerns about references to the extrapolated dollar estimate in the title of its Draft Report. Inclusion of the extrapolated dollar value in the title of the OIG audit report is inconsistent with OIG's prior hospice audits of Medicare compliance. For every Medicare hospice compliance audit OIG completed between November 19, 2020 to July 14, 2022 (the last published OIG Medicare Compliance Audit of a hospice), OIG has listed the title of the report as "Medicare Hospice Provider Compliance Audit: [Name of Hospice]." For OIG to change its approach for Medicare hospice provider compliance audits and include an estimated overpayment with a statement in the audit report title that HOV had *definitively* received a multi-million-dollar overpayment would be unfairly prejudicial to HOV and inconsistent with OIG's past practice. It would also be inconsistent with the statement in footnote 28 of the Draft Report that "***OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures.***" For OIG to report using a title with the headline that HOV definitively received millions in overpayments based upon an **extrapolated** or estimated figure that is **not final** and which is credibly contested by HOV would be misleading,

unwarranted, and overly prejudicial to HOV. The IMRC's flawed denials in the OIG audit sample have significant consequences for a community-based, not-for-profit hospice, who has excellent compliance results and who is the safety net for beneficiaries in its community.

The audit conclusions in this Draft Report are also inconsistent with HOV's results from other Medicare audits, including those by the CERT program, which have shown a zero percent payment error rate. Additionally, HOV has received outstanding results during its state and Medicare surveys over many years. Notably, the Program for Evaluating Payment Patterns Electronic Report ("PEPPER") data distributed by a CMS contractor for the Audit Period demonstrates HOV was high quality and compares favorably to peer hospice programs in the state of Arizona and within the MAC's jurisdiction. In all PEPPER metrics, including those for live discharges, long length of stay, single diagnoses, long GIP stays, and top terminal diagnoses, **HOV's PEPPER data revealed exceptional results in all categories.** HOV had a live discharge rate between 5.4% and 6.6% during the years under review, whereas the jurisdictional 80th percentile (the threshold for concern on PEPPER data) ranged from 16% to 22.4%. Similarly, HOV's long length of stay population was between 11.2% and 12.9% during the years of this OIG's review period, compared to a jurisdictional 80th percentile of 28.8% and 34.5%. HOV's percentage of cancer patients was 32.2%, and represented HOV's most common principal diagnosis. This is in line with the jurisdictional cancer diagnosis of 28.1% of all decedents.

1. HOV'S RESPONSE TO DRAFT OIG AUDIT REPORT

HOV strongly expresses its non-concurrence with the OIG's determination in its Draft Report related to each of the 15 denials related to the clinical record review of OIG's IMRC.

As an established, leading hospice provider for nearly 50 years—with a history of stellar survey performance and quality measures[4]—HOV recognizes that it operates in a highly regulated environment and serves as a steward of Medicare funds. Since its inception, HOV has believed that hospice care offers beneficiaries who elect the benefit high-quality, patient- and family-centered care for terminal illness in a home or home-like setting, consistent with patients' end-of-life preferences, and at a significant Medicare program cost savings compared to acute care in settings such as hospitals. Because delivering high-quality end-of-life care remains its high priority, HOV has maintained a strong focus on documenting services appropriately and in compliance with Medicare and State regulations. Additionally, over the last five years, HOV has been raising awareness with federal and state agencies regarding the significant concerns they were seeing with

[4] HOV was identified in a study published in the American Journal of Hospice and Palliative Medicine as ranking third in the nation for quality care. *Caregiver and Employee Experience Among Big Hospices—Ranking of the Largest US Hospices by Three Quality Indicators*, Jason Hotchkiss, Emily Ridderman, Brendan Hotchkiss, 2024.

fraudulent hospices in their community. HOV applauds the work that CMS and others are doing to crack down on these fraudulent hospice providers; this is yet another example of how HOV has demonstrated their commitment and strong stewardship of the Medicare hospice benefit.

HOV offers hospice and palliative care services under the overall medical oversight of its Executive Medical Director, [redacted], MD, Board certified in Hospice and Palliative Care, other hospice physicians and nurse practitioners, in addition to a full contingent of highly experienced hospice nursing staff, aides, social workers, chaplains, and volunteers. HOV's internal hospice experts and its external independent hospice physician expert disagree with the OIG IMRC review findings as to whether the hospice records support the determinations by the HOV hospice physicians as to the terminality of these patients and the level of care provided. HOV engaged a highly experienced and credentialed independent hospice and palliative care physician ([redacted], MD, DABIM) to review the same 15 hospice records that form the area of disagreement with OIG's IMRC. [redacted] also strongly disagrees with each of the 15 OIG IMRC denials as to whether the hospice records support the determinations by the certifying hospice physicians that these patients would, more likely than not, die within six months if the illnesses ran their normal course. See **Attachment C – [redacted] Attestation**.

HOV and its independent physician reviewer strongly believe the IMRC medical reviewers have looked past HOV's hospice record information and related documentation that supports the certifying physician's terminal medical prognosis, and/or misunderstood or misapplied the relevant coverage criteria related to the Medicare Hospice Benefit. HOV can only speculate why the IMRC failed to duly consider the HOV clinical record information for the 15 claim denials as OIG furnished HOV very little information regarding the basis for the IMRC's denials. HOV was also denied the opportunity to engage directly with the clinical review team at the IMRC as OIG informed HOV that such an opportunity is never afforded to auditees as part of OIG's audit process. HOV believes such an opaque approach is inconsistent with generally accepted government auditing standards and creates significant inefficiencies and missed opportunities for the hospice auditee (in this case HOV) and the IMRC to understand and discuss the specific basis for clinical disagreements on whether the patients were indeed terminally ill under applicable Medicare hospice benefit standards.

HOV firmly believes: the IMRC's denials did not apply the appropriate hospice standards, misinterpreted clinical documentation, and overlooked key aspects documented within the clinical record which supported hospice eligibility under the Medicare benefit. In addition, the reviewers glossed over the critical role of the certifying physicians under the law governing the Medicare hospice benefit which is based upon the certifying physicians' reasonable clinical belief that the beneficiaries were terminally ill. Within **Attachment B** are attestations from HOV's hospice physicians who provided medical oversight and care to the respective 15 patients.

As described in greater detail below, one of the lynchpins to qualifying for the Medicare Hospice Benefit is the reasonable clinical determinations by one or more certifying physicians as to whether an individual is terminally ill, meaning that individual has a life expectancy of six months or less if the illness runs its normal course. The Centers for Medicare & Medicaid Services ("CMS") has specifically noted that terminal prognostication is not an exact science and made clear that hospice claims should not be denied when a certifying physician has a good faith clinical belief that the patient's medical condition will likely result in death in six (6) months or less. Importantly, physicians are not required to prognosticate with 100% certainty in order for the hospice care to meet Medicare requirements. As the United States Court of Appeals for the Eleventh Circuit found in its *AseraCare* decision, under the Medicare hospice benefit the certifying physician's certification of terminal illness ("CTI") must be given great weight and that:

> [T]he relevant regulation requires only that "clinical information and other documentation that support the prognosis . . . *accompany the certification*" and "*be filed in the medical record.*" This "medical prognosis" is, itself, "based on the physician's . . . clinical judgment." 42 C.F.R. § 418.22(b). To conclude that the supporting documentation must, *standing alone*, prove the validity of the physician's initial clinical judgment would read more into the legal framework [of the Medicare statute] than its language allows. . . [t]hat is, the [certifying] physician's clinical judgment dictates eligibility as long as it represents a reasonable interpretation of the relevant medical records."[5]

And yet, OIG's IMRC did not, at any point during the OIG audit, conduct any outreach to the certifying physicians to obtain their perspective on the 15 claims for which the IMRC found there was insufficient clinical support in the hospice records. The Eleventh Circuit Court went on to observe in *AseraCare* "[m]ore broadly, CMS's rulemaking commentary signals that well-founded clinical judgments should be granted deference."[6] In *AseraCare*, the Eleventh Circuit court correctly found that the hospice clinical record in "support" of the physicians' CTI does not have to be a chronicle of every detail of the hospice patient's clinical condition that "proves" the patient was terminally ill.[7]

The OIG IMRC reviewers appeared to have applied a legally unsupportable approach to their hospice clinical record review. In fact, the sparse IMRC response provided to HOV demonstrates that those reviewers did not consider the totality of each of the 15 patients' clinical conditions found within the specific hospice documentation.

HOV respectfully requests that OIG work with its IMRC to review the information in this response and associated hospice records in a manner consistent with the Medicare hospice statute and corresponding regulatory framework of what it means for hospice

[5] *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1294 (2019) (emphasis added).
[6] *Id.* at 1295.
[7] *Id.* at 1293-94.

records to support the certifying physician's certifications that the patients were terminally ill. HOV also has furnished supplemental information for the IMRC to consider with this submission.

HOV believes its certifying physicians' clinical judgments are correct, and contends that the certifying physicians for these 15 patients did exercise sound clinical judgment and that the hospice records provide strong "support" of the physicians' certification of terminal illness. Indeed, the hospice record, as noted by the Eleventh Circuit court of appeals in 2019 – the year prior to the Audit Period – does not have to chronicle every detail of the hospice patient's clinical condition to "prove" the patient was terminally ill.[8]

For the reasons offered in the balance of this response letter (which unlike certain of its attachments, contains no PHI or other identifiable patient information), and in the detailed, claim-by-claim response in the marked confidential attachments (which contain protected health information and which HOV presumes will not be publicly posted by OIG with its final audit report), HOV strongly believes, as does its hospice independent physician expert ([redacted], MD), that the hospice records in fact do support the HOV certifying physicians' prognosis of terminal illness and a higher level of care.

In further support of the informed clinical judgments of the certifying physicians as to terminal prognosis, HOV also provides attestations from those hospice physicians who oversaw the care of these HOV patients. In particular, these physicians continue to affirm their reasonable clinical view that their respective patients at issue in this OIG audit were eligible for Medicare hospice care (or a higher level of care, as applicable) during the period under review. **Attachment B – Hospice Physician Attestations** (which also contain protected health information and which HOV presumes will not be publicly posted by OIG).

2. DETAILED RESPONSE TO OIG DRAFT REPORT

HOV non-concurs with the Draft Report's determination that Medicare requirements were not met for fourteen (14) routine home care claims and one (1) higher level of care (General Inpatient Care or "GIP") claim in the one hundred (100) claim sample. HOV's disagreement relates to the conclusions of the OIG's IMRC reviewers.

The specific responses for each clinical denial reason are contained in **Attachment B – Contemporaneous Clinical Evidence and LCD Analysis**. In addition, for illustrative purposes, several HIPAA de-identified examples of where the IMRC reviewers arrived at incorrect clinical conclusions are set forth below.

[8] *Id.* at 1293-94.

A. SUMMARY OF DRAFT REPORT DENIALS

OIG identified two (2) distinct bases for denial among HOV's claims, both relying upon the IMRC's review findings insofar as OIG did not identify any "technical" violations related to various forms, like the certification of terminal illness or hospice election statement:

1. The medical record did not support a terminal prognosis for the patient (fourteen (14) claims); and

2. The medical record did not support the need for 5 of 8 days of GIP care, a higher level of care than routine home care, for one (1) patient.

The Draft Report correctly asserts that HOV had policies and procedures in place to prevent the incorrect billing of Medicare claims for hospice services. The reviewers indicated that HOV did not consistently follow those policies and procedures for these 15 claims, which HOV strongly disagrees with (non concurrence).

B. HOV RESPONSE TO DRAFT REPORT DENIALS

HOV and its external independent physician expert have previously conducted a comprehensive review of the fifteen records subject to OIG's IMRC denials.[9] Such HOV review, as previously mentioned, concluded that the claims for all 15 patients were incorrectly denied. In furtherance of this assessment, HOV also evaluated its own policies and procedures related to the issues identified by OIG. HOV believes its policies and procedures are effective and support strong Medicare compliance.

HOV respectfully asks the OIG and IMRC to carefully consider the following information related to the Draft Report findings:

- Inconsistencies in Analysis and Approach of the IMRC Reviewers;
- HOV's Contemporaneous Clinical Evidence and LCD Analysis and Hospice Physician Attestations;
- The Independent Expert Physician Reviewer's Attestation;
- HOV's Assessment of Payments;
- HOV's Consistent Adherence to its Compliance Program and Training; and
- HOV's Position Related to the Improper Use of Extrapolation.

1. INCONSISTENCIES AMONG THE OIG'S IMRC REVIEWERS

OIG furnished HOV with its clinical summaries setting forth the determinations

[9] [redacted] CV is included as **Attachment D** – [redacted] **CV.**

made by the IMRC reviewers of the 15 claim denials. Based on its review, HOV believes that the OIG's IMRC reviewers applied inconsistent and erroneous clinical standards when deciding whether documentation supported a terminal prognosis or, a higher level of care.

The review conducted by [redacted] found that the IMRC reviewers did not apply an approach consistent with the legal and regulatory requirements of the Medicare Hospice Benefit to determine clinical eligibility for hospice services.[10] The IMRC clinical reviewers also demonstrated a lack of consistency among the denial summaries furnished to HOV. As discussed in more detail below, the IMRC reviewers did not summarize or synthesize the facts of the patients' comorbidities and other clinical conditions. Given the discrepancies HOV identified in the IMRC's review, as identified above, HOV requested the opportunity prior to OIG circulating its Draft Report to have its clinical team members speak with the IMRC reviewers. HOV believed this to be a reasonable request given each of the IMRC's denials were premised on clinical eligibility. OIG denied this request. Consequently, HOV is providing even more detail in **Attachment B** and below as to why it believes the IMRC's determinations were flawed.

2. HOV HOSPICE INDEPENDENT EXPERT PHYSICIAN'S REVIEW METHODOLOGY AND FINDINGS

[redacted] has decades of clinical experience in all areas of hospice and palliative care medicine and an expert level understanding of the clinical indicators of eligibility for the Medicare hospice benefit. [redacted] frequently assists hospice organizations in understanding terminal disease progression, hospice eligibility issues, and related hospice documentation. [redacted] regularly reviews hospice medical records and compares the contents of those records to applicable local coverage determinations ("LCDs") and other established hospice documentation guidelines. LCDs in the hospice context are merely guidelines; patients can be (and often are) terminally ill without meeting each and every one of the corresponding hospice LCD elements. The NGS hospice LCDs specifically note that "[s]ome patients may not meet these guidelines, yet still have a life expectancy of six months or less" *See* NGS LCD L33393.

HOV provided [redacted] with access to the identical set of hospice records it submitted to the OIG. [redacted] conducted an independent clinical review of each patient's medical record for whom the IMRC reviewers asserted that the beneficiary was ineligible for hospice care or, as applicable, ineligible for a higher level of care. [redacted] determined whether the hospice physician's certification or recertification of terminal illness related to each claim at issue was reasonably supported by the documented

[10] See discussion *supra* at pp. 2-3. [redacted] regularly reviews hospice medical records and compares the contents of those records to applicable local coverage determinations ("LCDs") and other established hospice documentation guidelines. LCDs in the hospice context are merely guidelines; patients can be (and often are) terminally ill without meeting each and every one of the corresponding hospice LCD elements.

clinical indicators and in accordance with the applicable Local Coverage Determination for Determining Terminal Status, LCD L33393.

[redacted] found record support for hospice eligibility in every one of the 14 instances the IMRC had found a lack of hospice eligibility, and found clinical support for all eight days of GIP care where the IMRC determined five of those days should have been furnished at a routine home care level.

More specifically, [redacted] review indicated that during the audited period each patient exhibited a life expectancy of six months or less if his or her disease ran its normal course which qualified each of them for the Medicare hospice benefit. [redacted] also found that, for the one patient where OIG's IMRC asserted a level of care concern related to GIP, that higher level of care provided by HOV was reasonable and necessary given the patient's clinical condition and need for frequent clinical monitoring throughout the GIP care days.

Each of the clinical details and [redacted] assessment related to these 15 patients appear in **Attachment B – September 2025 Response to Medical Determination Letters**, along with the **Supplemental Medical Records** submitted along with the Medical Determination Letters. Further, HOV's Hospice Medical Director ([redacted], MD)[11] has prepared specific clarifications and further refutations of the IMRC's denial reasons, which are attached for OIG IMRC's review in **Attachment B – Contemporaneous Clinical Evidence and LCD Analysis**. This is **new information the IMRC has not previously had the opportunity to consider** and HOV respectfully asks the IMRC to give this additional information its full attention.

3. SEVERAL ILLUSTRATIONS OF INCORRECT INITIAL CONCLUSIONS OF THE IMRC[12]

The clinical illustrations provided below are a representative sample of all 15 errors identified by the IMRC. The *Contemporaneous Clinical Evidence and LCD Analysis* contained within **Attachment B** highlight the specific clinical factors at issue for each beneficiary.

- Patient 23 – a Patient with Very Advanced Age with heart disease, unspecified, a Palliative Performance Scale (PPS) of 30% and significant comorbidities including, but not limited to, Stage III chronic kidney disease, coronary artery disease, hyperlipidemia, hypertension, gastrointestinal bleed, deep vein thrombosis and trigeminal neuralgia. *The IMRC reviewer*

[11] [redacted] CV is included as **Attachment D – [redacted] CV.**

[12] To avoid including any Protected Health Information ("PHI") in this response letter, all patients aged 89-years-old and older are referred to as "Patients with Very Advanced Age," aggregating their ages consistent with the HIPAA regulations at 45 C.F.R. § 164.514(b)(2)((i)(C).

concluded the patient was not terminally ill on the basis that the patient's pain was "managed," the patient was "chatty and alert" which contradicted the patient's FAST of 7D, and the patient had a PPS of 30% yet was described as both bedbound and chairbound.

Despite the IMRC reviewer's statement that the patient's pain was "noted to be 0/10" for every visit, the clinical documentation provided by HOV in fact demonstrates that the patient was having repeated episodes of breakthrough pain. Indeed, at every nursing visit throughout the month under review, **HOV documented that the patient needed breakthrough pain medication at each of the nine nursing visits that occurred within the month under review**. The IMRC's erroneous observation that the patient's pain was "managed," and therefore did not support a finding of terminality, minimizes the pain management regimen established by the hospice interdisciplinary team and discounts the repeated need for breakthrough pain medication. The IMRC's conclusion that managed pain negated terminal status overlooks the goal of hospice care, symptom palliation, and discounts the interdisciplinary team's approach to pain management. As the IMRC would have it, a hospice that successfully manages breakthrough pain risks a post-pay audit finding that the patient was ineligible for hospice.

Beyond the failure of the IMRC's reviewer to recognize sustained documentation of pain management by the care team, the reviewer also appeared to have cherry-picked certain cognitive symptomology from the record. The reviewer attempts to negate terminality by challenging an assessment that the patient's FAST score was a 7D – a prognostication tool for cognitive decline. Yet there is only a single reference to FAST in the hundreds of pages of hospice records provided for this patient. The record is otherwise replete with documentation regarding the patient's worsening cognition, as is consistent with end-stage heart disease. The record includes documentation of increased confusion and agitation (on three occasions), increased fatigue, and increased forgetfulness – consistent with the decreased cerebral blood flow that is emblematic of late-stage heart disease. The reviewer's focus on their objection to a single clinical measure (FAST score), used merely once by the care team, rather than analyzing the copious documentation discussing ongoing cognitive decline, which was reflective of an overall decline in the patient's terminal condition, is baffling.

Moreover, the IMRC reviewer appears to assert that notations reflecting the patient as being both bedbound and chairbound are contradictory. This assertion reflects another misunderstanding of the documentation. In this circumstance, documentation of the patient being "chairbound" reflected

the patient's Hoyer-assisted positioning from bed to chair – not mobility. In fact, there is no evidence of the patient's regained ambulation, weight-bearing ability, or independent transfers in any of the documentation during the period under review. This in fact demonstrates how a high-quality hospice achieves goals of care; assisting a bedbound terminally ill patient so they can enjoy some time in a chair at end of life.

- Patient 55 – a Patient with Very Advanced Age with senile degeneration of the brain, with a PPS of 40% and significant comorbidities including a systolic murmur, history of deep vein thrombosis (DVT), glaucoma, hypertension, anxiety and a deviated trachea. *Some of the factors the IMRC reviewer used to conclude that the patient was not terminally ill include that the patient's PPS remained stable, the patient was ambulatory with a walker at admission and during the period under review, and the patient remained able to follow simple commands from the time of admission through the period under review.*

  The IMRC reviewer misconstrues a stable PPS score to mean that the patient themself did not exhibit decline. However, a stable PPS score does **not equate to clinical stability**, nor does the LCD require continued numeric decline in PPS to establish terminality. During the period under review, the patient demonstrated qualitative decline in areas such as strength, gait, stamina, and cognition. These findings represent **qualitative decline within the same PPS category**. There are no gradations within PPS score intervals and as such PPS score alone does not capture day-to-day decline.

  In addition to the patient's PPS, the IMRC minimizes other areas which documented functional decline by using oversimplified descriptions of nuanced clinical criteria. For example, the IMRC indicated that the patient was ambulatory with a walker both at admission and during the period under review. However, the record documented that the patient transitioned from a front wheeled walker at admission to a four wheeled walker during the review period due to increased weakness and began requiring assistance to stand and transfer. As another example, the IMRC indicated the patient remained able to follow simple commands at admission and during the period under review. However, the record documented that, at admission, what manifested was the patient's difficulty following commands, worsening into only being able to follow simple one-step commands, then simple commands only with cueing, to the patient being unable to follow commands without cueing or demonstration during the period under review. To ignore the progressive functional decline this patient experienced in the months between admission and the review period applies an erroneous view to a patient

at end-of-life.

- Patient 97 – a Patient with Very Advanced Age with heart failure with a PPS of 30%. *In its denial of the general inpatient level of care for this patient for multiple days during the patient's GIP stay, the IMRC mistakenly applied the standards used to assess a patient for acute inpatient hospital care, not for hospice general inpatient care.*

  For example, the IMRC reasoned that a GIP level of care was not appropriate for this patient on several consecutive days of their GIP stay because medications were administered orally or sublingually rather than parenterally. Yet CMS GIP standards do not include any requirement as to the route of medication administration for purposes of demonstrating GIP level of care eligibility.[13] Skilled management and oversight of symptoms addressed during the patient's GIP days were necessary and could not feasibly have been provided in a home or residential setting because of the patient's continuous need for skilled nursing assessments, required at some points as often as every 30 minutes, and the frequency of the care team's orders for PRN doses of pain medication. The IMRC reviewer failed to recognize that medication monitoring by a skilled professional is among the valid bases to support a hospice GIP level of care. Moreover, the IMRC failed to account for CMS guidance in effect while the patient was on service – during the height of the PHE – which discouraged providers from unnecessary or destabilizing transfers from inpatient facilities to other residential settings, and instead to prioritize infection prevention and patient safety during the COVID-PHE. In this instance, the patient's symptoms never resolved to the point where it was safe and medically appropriate to change the patient's level of care during the GIP stay. Indeed, the IMRC concluded that the last two days of GIP level of care were appropriate.

Expanding on this last point, during the entirety of all claims subject to OIG's Review Period, HOV was on the front lines of assisting the Phoenix, Arizona community in battling through the COVID-19 PHE. The dates of service for the sampled claims all fall squarely within the height of the PHE from July 1, 2020 through June 30, 2022. And yet, OIG's IMRC did not once attempt to address or even mention that the Audit Period fell within the PHE, a time when CMS had granted various flexibilities to healthcare providers.[14] HOV's independent physician expert noted a distinct lack of recognition from the IMRC reviewers that the majority of claims subject to denial were for dates of service in the early days of the COVID-19 PHE.

[13] *See, e.g.,* CMS, Medicare Benefit Policy Manual, Chapter 9, Section 40.1.5.
[14] See, e.g., Hospice: CMS Flexibilities to Fight COVID-19.

HHS divisions, including the Centers for Disease Control and Prevention ("CDC") and CMS, explicitly addressed infection control and prevention concerns related to visitation limitations in facilities. For instance, just ahead of the OIG's Audit Period, CMS directed that "[f]acilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation."[15] Further, the Arizona Department of Health Services directed that congregate living facilities implement visitor restrictions.[16] As was widely reported at the time, residential facilities were severely limiting applying this prohibition to extend to hospice staff who were attempting to schedule in-person visits to nursing home hospice patients, and to any vendor who may be tasked with drawing blood or taking weight or other measurements. Indeed, CMS issued FAQs in 2020 to address this access concern.[17]

Accordingly, especially during the first year of the COVID-19 PHE, it was difficult for hospices to gather patient weights or dispatch social workers due to facility limitations in permitting vendors and non-nursing personnel onsite, in addition to the severe staffing challenges associated with infected or exposed nurses and other hospice staff. And yet, remarkably, OIG's draft Audit Report makes not a single mention of the hospice care realities during COVID-19 PHE or related CMS flexibilities. The failure to consider these factors raises numerous concerns and questions about how the IMRC applied relevant hospice care standards during the Audit Period. This begs the question – did the IMRC review the claims and records from the Audit Period with the realities of hospice care and CMS PHE regulatory flexibilities in mind? Did OIG consider the extenuating circumstances associated with providing hospice care during the PHE, especially in the early days of the COVID-19 pandemic? Given the draft Audit Report is completely silent on the COVID-19 PHE and hospice care furnished during that time, it appears this was not considered.

Local Coverage Determination for Determining Terminal Status

The applicable Local Coverage Determination (L33393 – Hospice – Determining Terminal Status) for Arizona hospices are guidelines created by the Medicare Administrative Contractor applicable to certain disease categories. However, these are guidelines – not mandatory standards.[18] HOV applies the L33393 in assessing terminal

[15] See QSO-20-14-NH - REVISED (March 13, 2020 Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, CMS Memorandum to State Survey Agency Directors).
[16] Long-term Care Facility COVID-19 Guidance 4.8.2022; April 7, 2020 Arizona Governor Executive Order 2020-32 ("*Protection of Vulnerable Residents at Nursing Care Institutions, Residential Care Institutions, ICD-IIDs and DD Medical Group Homes from Covid-19*").
[17] See CMS FAQ #25 and #26 (June 2020) found at Coronavirus Disease 2019 (COVID-19) Frequently Asked Questions (FAQs) for Non Long-Term Care Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs)
[18] L33393 states "The word 'should' in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is required. The only requirement is that the documentation supports

illness and notes that the LCD specifically states:

> Section 322 of BIPA amended section 1814(a) of the Social Security Act by clarifying that the certification of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The amendment clarified that the certification is based on a clinical judgment regarding the usual course of a terminal illness, and recognizes the fact that making medical prognostications of life expectancy is not always exact.

Yet, in a number of the IMRC's denials, it appears its reviewers relied on record notations that were outside of the claim review period. Inasmuch as the IMRC applied a Monday Morning Quarterback approach to its chart review, it acted inappropriately.

As noted above, the IMRC's incorrect denials have significant consequences for a community-based organization that has consistently demonstrated strong quality and compliance results. Additionally, there is strong concern that the proposed OIG report title/headline will create unnecessary concern for beneficiaries in Arizona, if not far beyond. Because of the use of its extrapolation methodology, each error by the IMRC reviewer results in a disproportionate effect on the overpayment estimate. The OIG has estimated significant liability for HOV directly resulting from the IMRC reviewers' misunderstanding of the rules governing the Medicare Hospice Benefit, misapplication of the relevant guidelines, and/or a lack of understanding of the clinical significance of the documentation in the clinical record. The OIG should closely scrutinize these IMRC denials, notwithstanding LCD compliance, given the significant misapplication of hospice eligibility standards and applicable hospice clinical guidelines. In either case, the OIG should revise its Draft Report to reflect that the claims at issue met Medicare requirements for patients who were clinically eligible for the Medicare Hospice Benefit.

4. HOV'S ASSESSMENT OF PAYMENTS

HOV is well aware of the requirements under the 60-Day Rule, which generally requires a provider to report and return any identified Medicare overpayment within 60 days of such identification. As expanded by CMS in its 2016 rulemaking preamble to its regulation (42 CFR §§ 401.301 *et seq.*) and further updated in its 2024 final rule (42 CFR § 401.305), under the 60-Day Rule CMS expects providers who "knowingly" receive or retain an overpayment to return such payment within 60 days of identification or after the conclusion of a good-faith investigation.

HOV has considered the OIG audit review's preliminary results and undertaken a careful and diligent review of its technical documentation, policies and procedures, and also completed a detailed and independent clinical review by an outside independent

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the beneficiary's prognosis of six months or less, if the illness runs its normal course."

hospice physician expert related to the fifteen claims that OIG has initially determined were overpaid, as well as other claims in the sample population. For the reasons noted above, HOV disagrees with the denials of the OIG's IMRC, and finds its own expert's findings (and the contemporaneous and reasonable clinical decisions of its certifying hospice physicians) strongly support hospice eligibility. HOV does not believe it received Medicare overpayments based upon the OIG's draft audit results.

5. HOV'S ONGOING COMPLIANCE AND TRAINING

HOV's review of its policies and procedures as well as its comprehensive training and compliance program regimen supports its view that there were no compliance or billing issues with either clinical or technical documentation requirements that would necessitate a material compliance program enhancement. OIG's Draft Audit also appears to recognize that HOV's policies and procedures were appropriate, notwithstanding the OIG's proposed 15 claim denials. HOV regularly provides compliance training, internal audits, and education.

As previously indicated, all PEPPER metrics, including those for live discharges, long length of stay, single diagnoses, long GIP stays, and top terminal diagnoses, revealed exceptional comparative results for HOV in all categories. Simply put, these PEPPER metrics, created and distributed by CMS's former contractor (TMF Health Quality Institute), combined with the intensive and independent expert review HOV conducted, do not provide any indicia that compliance or control enhancements at this hospice program are warranted on account of the errors identified in the OIG Draft Audit.

6. OIG'S USE OF EXTRAPOLATION

As part of its audit, OIG selected 100 claims submitted by HOV between July 1, 2020 and June 30, 2022. During this time, HOV submitted 20,780 Medicare claims for reimbursement for hospice care for which HOV received, according to OIG, an approximate total of $85.9 million in Medicare payments. This reflects an extraordinary amount of care for almost 6,600 patients over 441,523 days of care. From these 100 randomly selected claims the OIG used for its audit, the IMRC determined just fifteen (15) did not comply with one or more Medicare requirements. OIG then extrapolated the financial results of the 15 errors in its sample to the complete universe of Medicare claims during the Audit Period.

From a statistical sampling perspective, OIG should forgo extrapolation for three reasons:

First, in accordance with CMS's 2019 revisions to its extrapolation procedures in the case of Medicare audits, the clinical review findings do not reflect a high or sustained level of payment error for which extrapolation is justified. For example, in Targeted Probe and Educate ("TPE") audits conducted by CMS, a Medicare contractor will deem a

provider to have "passed" if the error rate is less than 15% to 25% (depending on the contractor conducting the audit). Accordingly, even if OIG's IMRC does not acknowledge its clinical review errors that HOV describes in this response, the error rate (15 out of 100) would have been found within an acceptable error rate such that HOV would not have been placed into a subsequent TPE round. While HOV recognizes OIG is not a CMS contractor, a consistent approach across Medicare audits is appropriate.

Second, as noted previously, HOV has an excellent history of compliance. The underlying Medicare statute only permits extrapolation in instances of a "sustained or high" level of payment error, neither of which are the case in this review.[19] Thus, extrapolation is not appropriate. Although OIG may frame its right to extrapolate as separate from the ability of CMS to use extrapolation, the OIG does not itself make a final determination of whether there is an overpayment – as OIG proclaims, CMS will make that determination, and OIG should in its final OIG audit report identify this statutory limitation on the use of extrapolation when making its final recommendations, including with respect to the drafting of the Audit Report title, which HOV contests as noted above.

Third, HOV's Medicare Administrative Contractor (NGS) issued a letter to HOV reopening all 20,780 claims in the sample frame for "good cause" pursuant to 42 CFR § 405.980(b)(2), regardless of whether the claims were subject to OIG's sample review. This NGS reopening action is legally defective inasmuch as it nullifies the statutory four-year reopening limitation based upon what NGS purports was "good cause." And yet, OIG's Draft Audit provides no explanation as to what additional "good cause" information NGS can rely upon to reopen all 20,780 claims from the Audit Period when OIG only selected 100 claims for its audit. This reopening is also inconsistent with OIG recommendations in prior OIG audits, which recognized, appropriately, that the law allowed recoupment based on claims remaining within the four-year reopening period at the time of the audit report's publication. If NGS had not reopened these claims in connection with this audit, only one of the claims subject to denial would even be eligible for repayment given the length of time taken for OIG to complete this audit. Given this shift in Medicare claim reopening practice by the MAC for OIG compliance audits of providers, HOV must note that it is bad policy and inconsistent with applicable law.

Under 42 CFR § 405.986, good cause may be established when "there is new and material evidence that – (i) [w]as not available or known at the time of the determination or decision; and (ii) [m]ay result in a different conclusion." For NGS to base its reopening of all 20,780 claims in the Audit Period on the premise that somehow OIG's sample review of 100 claims (0.48% of the claim population) gives the MAC good cause is improper on its face. HOV's hospice records have not changed since the original claim determinations were made between 2020 and 2022. During this time, NGS could have asked for any one of the 20,780 records for review in an additional documentation request. Simply put, any

[19] 42 U.S.C. § 1395ddd(f)(3).

information now available to NGS was available to the MAC during the four-year reopening period. NGS cannot properly argue the "new" evidence made available to NGS that supported reopening 100% of all HOV claims during the Audit Period was the subsequent (after NGS reopening) identification by OIG of some still undetermined estimated overpayment associated with a final audit report. For NGS to argue it had "new evidence" across all 20,780 claims to justify reopening would strain credulity. OIG, which helps the Secretary operate and oversee its programs, should address this improper use of reopening in its Final Report, particularly because its Draft Report recommendation (discussed immediately below) expressly references the 4-year claims reopening period.

3. RESPONSE TO OIG RECOMMENDATIONS

In its Draft Report, OIG set forth three recommendations. HOV's specific nonconcurrences are set out below.

- *HOV should refund to the Federal Government the portion of the estimated $8,614,887 million for hospice services that did not comply with Medicare requirements, regardless of whether such claims are within the 4-year claims reopening period.*

HOV disagrees with this recommendation as it does not believe it was overpaid for hospice services that are within the four-year claims reopening period, much less all claims subject to the NGS reopening action as identified above. HOV disagrees with OIG's IMRC in every instance where that contractor determined that the services did not comply with Medicare hospice eligibility requirements.

- *HOV should conduct internal audits to identify and return any overpayments to the Medicare program for claims after the OIG Audit Period.*

HOV has to date complied with its obligations to assess information related to potential overpayments. HOV has not identified any hospice service billing issues (related to terminal eligibility or level of care medical necessity) or any billing issue that would compel HOV to conduct additional reviews at this time. HOV will continue to examine its claims and payments after OIG finalizes its audit report.

- *HOV should provide additional training to its clinical personnel on HOV policies and procedures to continually validate that hospice services comply with Medicare requirements.*

This recommendation already reflects what HOV does in the ordinary course. OIG reviewed HOV policies and procedures as part of its review and found these materials to be consistent with regulatory requirements and appropriate clinical standards. HOV has a dedicated team of hospice and compliance professionals to develop, implement, and train

staff on its compliance and clinical operations.

CONCLUSION

HOV, through its counsel, appreciates the opportunity to provide comments to the OIG for its consideration by its Office of Audit Services team, its IMRC, and the inclusion of these comments in OIG's final audit report. HOV respectfully requests that OIG and the IMRC consider the information contained in both this response and its corresponding attachments and, based on a thoughtful review, HOV is confident that the IMRC will reverse all 15 initial denials.

Sincerely,

Howard J. Young
Counsel for HOV

Enclosures

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