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Pierre M. Désy, MPH CAE

March 27, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-6098-NC
7500 Security Boulevard
Baltimore, MD 21244

Subject: Request for Information (RFI) Related to Comprehensive
Regulations to Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment in response to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

AAHPM recognizes the challenges that fraud, waste, and abuse impose on CMS programs, including through excessive and unnecessary spending, wasteful and inappropriate procedures, added oversight burden on providers, and erosion of public trust. When fraud, waste, and abuse target hospice care, the toll can be particularly devastating, as they affect beneficiaries at a time when they are most vulnerable. AAHPM therefore appreciates the Administration's emphasis on preventing and rooting out fraud, waste, and abuse in CMS programs, and its interest in working with stakeholders to find and implement solutions that can have a meaningful impact.

At the same time, we underscore the need to act judiciously, including to ensure that policies do not have unintended consequences or result in unnecessary and excessive burden – or even harm – for patient and provider communities. We also urge CMS to consider the impact of its policies on hospices, palliative care practitioners, and interdisciplinary teams to furnish care to patients with serious illness, including those at the end of life, who are among the most vulnerable – to ensure that patients are not subject to unnecessary friction or distress in accessing the serious illness care they need to minimize pain and suffering and maximize quality of life.

We offer our comments below with these considerations in mind, including comments focused on the challenges facing the Medicare hospice benefit as well as comments focused on the broader Medicare program.

Modifications to Program Integrity Requirements

CMS seeks information on ways to strengthen its fraud-fighting toolbox, including ways to better use its existing statutory authorities and to update its existing requirements and policies. AAHPM recognizes that hospice-related fraud and abuse have grown to alarming levels, and that stronger oversight, enforcement, and accountability measures are urgently needed to ensure that Medicare beneficiaries have access to the end-of-life care and supports they need and deserve. Our recommendations for modifications to program integrity requirements below offer concrete solutions to effectuate this goal. We also offer recommendations related to the use of artificial intelligence in addressing fraud, waste, and abuse.

New Hospice Providers

Given the escalation of new hospices being established across just a few states, with numbers far exceeding that needed to ensure access, choice, and quality of care, action is clearly needed to address the associated risk. In too many cases, these hospices are not serving patients. Therefore, and allowing for appropriate exceptions, ***we recommend that CMS use its authority to limit the enrollment of additional hospices in counties where established hospice programs are adequate to serve the population, with targeted moratoria based on state and local data.***

CMS should review an initial certification application for certain “red flags” that would trigger more careful investigation prior to approval. These might include multiple hospices located at a single address (versus a single hospice entity operating at multiple sites, which is a legitimate practice and not atypical); an administrator overseeing numerous hospices; a medical director overseeing numerous hospices; or a history of unresolved regulatory infractions. An unannounced physical inspection should occur to confirm the legitimacy of the entity with a working office. ***Where troubling indicators are identified, new hospices should be flagged as high risk, providing for enhanced survey scrutiny.***

CMS should also establish requirements for initial capitalization, to demonstrate viability, and require administrator attestations of compliance with applicable regulations before they may open to patient care as a Medicare-certified hospice program. ***AAHPM also believes that initial certification should be probationary.***

AAHPM also supports statutory changes that would:

- ***provide the Secretary the ability to establish provisional periods of enhanced oversight (PPEOs) for new hospices to two years, compared to the one year that is allowed under existing statute;***

- and*
- *increase survey frequency for new hospices (e.g., to require surveys every 15 to 18 months), until initial surveys do not result in enforcement action for being non-compliant.*

While we support enhanced scrutiny of new hospices consistent with our recommendations above, ***we caution against requirements that would put new rural or frontier hospice programs at a disadvantage.*** For example, requiring a minimum number of patients before payment is permitted may pose undue burden for rural providers who are caring for a patient or two but have yet to reach an initial threshold (e.g., five or more patients). Rural and frontier areas often lack adequate access to hospice services, and care should be taken to ensure that program integrity initiatives do not inadvertently impede access to high-quality end-of-life care for patients in these communities.

Existing Hospice Providers

AAHPM and our members understand that routine and thorough review of all hospice providers is essential to ensure that terminally ill beneficiaries receive comprehensive, skilled, and compassionate care centered on their needs, values, and preferences. AAHPM's role in establishing a [Hospice Medical Director Certification](#) (HMDC), is an example of our commitment to leading efforts to increase quality and improve outcomes for all hospice patients.

To aid in its review, ***CMS should define what constitutes a "non-operational" hospice entity (e.g., programs that are not properly staffed, are unable to submit valid Medicare claims, etc.) and restrict Medicare privileges for these organizations, including voluntary termination of the provider agreement, deactivation of billing privileges, and revocation of Medicare enrollment.*** Revoking enrollment of non-operational hospices will discourage the practice of creating them for the sole purpose of selling them for profit. Frequent visits by CMS site visit contractors would identify non-operational programs for which revocation is appropriate.

For hospices that are actively serving Medicare beneficiaries (i.e., those that would not be considered non-operational), ***we believe that any enhanced scrutiny and policy interventions should be aimed at identifying and holding accountable the lowest-performing programs rather than applied across-the-board to all providers.*** Hospices with good performance indicators should not be overly burdened with responding to audits that divert limited resources from the care of their patients.

Finally, CMS should prohibit changes in majority ownership for new hospices in the first 60 months of an initial certification or the last change in majority ownership, compared to the 36-month prohibition that currently applies in the Medicare hospice regulations.

Targeting Regulatory Scrutiny and Audits of Hospice Providers

In recent years, hospices have been subject to an excessive number of regulatory activities in the name of program integrity. Such activities divert time and resources from caring for patients. For example, if a hospice provides high-quality care to a dying patient but requisite forms are inadvertently missing a date or phone number, reimbursement for all care is denied. While some financial penalty may be in order, the current approach is disproportionate and unfair. Moreover, these technical denials do nothing to improve the care provided to patients and families.

Similarly, the many hospice audits currently in place have no bearing on care quality, nor have they been shown to significantly curtail inappropriate organizational behavior. For example, while eligibility depends on a life expectancy of less than six months, even with application of sound clinical judgment, some patients will live longer than expected. Yet, current regulatory requirements put excessive focus on reviewing this group of terminally ill patients, often denying reimbursement for their care. The struggle to balance providing appropriate care to patients that happen to live longer than expected with concern for potential downstream repayment penalty puts pressure on hospices to discharge eligible patients who happen to have long stays, often leaving them with no adequate alternative services available to meet their care needs. In many cases, the individuals conducting retrospective chart review are insufficiently expert to challenge the determination of the hospice medical director who exercised their best clinical judgment in a prospective fashion as required at the time of certification and/or recertification.

Another example of the undue consequences of broadly applied interventions can be found in the scrutiny of general inpatient (GIP) level of care. GIP is a fundamental component of the Medicare hospice benefit, enabling hospices to provide more intensive support for patients who suffer from complex pain or other acute symptoms that cannot be managed in another setting.

Rather than focus on the hospices that are found not to provide this level of care (which is required of all Medicare-certified providers), current regulatory scrutiny is focused on the hospices that do, often denying coverage for the intensive symptom management that some patients need to be comfortable. This uneven application of scrutiny burdens hospices who have been willing to enroll patients with more complex care needs.

To better focus regulatory scrutiny, ***AAHPM recommends that CMS develop a panel of objective indicators that aim to identify low-performing programs to improve patient safety and eliminate fraud, waste, and abuse. Further research is warranted but, as a start, we recommend consideration of:***

- *High live discharge rate*
- *Low or no volume of in-person visits by hospice professionals*
- *Long average length of stay*
- *Unfavorable Hospice Care Index*
- *Poor performance on measures included in the Hospice Quality Reporting Program*
- *High proportion of patients residing in long-term care settings*
- *Condition-level deficiencies on complaint or routine surveys, and*
- *Limited or no provision of all four levels of hospice care*

We believe the above indicators are far more reliable for detecting true quality and integrity concerns than the outcomes of broad retrospective chart audits focused on questioning eligibility and recouping payment.

Elevating the Role of Hospice Professionals

Ensuring both administrative and clinical hospice personnel are well qualified to perform their roles is essential to protecting vulnerable patients and providing optimal end-of-life care. To this end, minimum education and qualifications for select roles, such as hospice administrator, could be added to the hospice conditions of participation.

AAHPM particularly recognizes the value of physician-led teams. Indeed, eligibility for the hospice benefit

rests on the “physician’s or medical director’s clinical judgement” in certifying a patient has a terminal illness. We believe that determining whether a patient has a life expectancy of less than six months if their disease follows its expected course is a high-order exercise of medical judgment that requires intensive training, careful consideration, and critical thinking. Only physicians have the requisite training and responsibility to make such a high-stakes determination. Thus, ***AAHPM calls for all program integrity efforts to support the exercise of reasonable independent professional clinical judgment by the hospice medical director or hospice physician in determining hospice eligibility or making other medical decisions.***

Mentioned earlier, the HMDC credential signals that a hospice physician has specialized knowledge in the medical, ethical, legal, regulatory, and leadership aspects of the hospice medical director (HMD) role. We would welcome the opportunity to work with CMS to consider how to incentivize physicians working in the field to attain the HMDC credential, keeping in mind that such additional education may not be affordable and accessible by those working in smaller hospices, especially physicians serving as a part-time HMD. In the meantime, simply reporting on Care Compare where HMDs are Board-certified in Hospice and Palliative Medicine and/or HMDC-certified would add to consumers’ understanding of the expertise available within a particular hospice.

Finally, AAHPM urges CMS to protect interdisciplinary care models, which are essential in the delivery of hospice and palliative care. AAHPM is concerned that program integrity initiatives could unintentionally restrict team-based care that includes physicians, nurses, certified nursing assistants, social workers, and chaplains.

Artificial Intelligence in Addressing Fraud, Waste, and Abuse

AAHPM recognizes the value that artificial intelligence (AI) can offer in addressing fraud, waste, and abuse. AI-enhanced data analytics could help to identify suspicious billing or referral patterns, without creating additional administrative burden for legitimate clinicians and programs.

At the same time, ***we urge CMS to ensure that there are adequate protections for patients and caregivers when AI is used in guiding program integrity policy.*** For example, policies should require human oversight and uphold physician judgment when considering medical necessity of services; CMS and its contractors should never rely on automated decisions alone, without human review, to determine that a service is not medically necessary. We note that human oversight is particularly important in serious illness care, especially at the end of life, when AI algorithms may suggest poor outcomes or limited benefit of treatment options, and we underscore the importance of honoring independent clinical judgement as an important safeguard in protecting patient’s access to care.

We also recommend that CMS support rigorous evaluation of AI tools both pre-deployment and post-deployment. Such evaluation should include bias audits on medical necessity determinations, cybersecurity and data privacy checks for sensitive information, and routine drift monitoring and outcome tracking.

Evaluation of Program Integrity Initiatives

For any program integrity interventions that CMS puts in place, including in response to any of the recommendations included in this letter, we strongly recommend that CMS evaluate the interventions for their effectiveness, as well as for any unintended consequences – including related to beneficiary access

and provider burden. Such evaluation will help to uncover whether the interventions' benefits meaningfully outweigh drawbacks and enable CMS to better target its program integrity resources.

Enhanced Identity Proofing and Ownership Requirements

CMS seeks information on the value of enhanced identity proofing to protect against fraudulent schemes. Consistent with our recommendations for risk-based oversight, ***we recommend that CMS focus on high-risk entities, including through enhanced ownership transparency and enhanced identity verification.*** This approach would place greater scrutiny on corporate leadership and administrators compared to individual practitioners, in order to prevent the abuse by shell companies and international fraud schemes. It would also limit barriers for clinicians and interdisciplinary staff.

CMS also asks whether criminal background checks should be expanded to include individuals beyond individuals with a 5 percent or greater ownership interest in a company. ***AAHPM believes that background checks on administrators should be added as an additional safeguard.***

Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claims Submissions

CMS contemplates a policy change under which the Medicare Parts A and B 1-calendar year claims filing deadline might be reduced to 90 or 180 days for some subset (or all) of Medicare provider types, in a manner that would better align with private industry norms.

AAHPM disagrees that reducing the claim filing deadline would meaningfully address program integrity vulnerabilities. We would especially object to a 90-day claims filing deadline, which we believe would create significant operational challenges for small and moderate-sized physician practices, as well as for small and moderate-sized hospices. Unfortunately, our members report that a great deal of billing continues to be done on a manual basis, and that many smaller organizations do not have the resources to update and automate workflows. If CMS were to reduce the claims filing deadline to 90-days, these organizations would struggle to file claims timely, leading to lost revenue and insufficient reimbursement that could cripple their ability to provide care.

We also highlight that providers are able to bill for services furnished following submission of Medicare enrollment applications – and sometimes even before submission – but not until after their enrollment is approved. In these cases, meeting a 90-day submission timeline would likely be challenging and force many to forego payment for services duly rendered.

Beneficiary Contact

CMS seeks information on what it could be doing to make it easier for beneficiaries to report a potentially suspicious claim. ***AAHPM recommends that CMS bolster patient and family education regarding what to expect with Medicare services.*** Particularly for services like hospice, improved patient and family awareness will make it easier and more likely to report fraud.

Additionally, consumer-focused complaint hotlines may serve to identify poor-performing or non-operational hospices. While such hotlines are currently operated at the state level, CMS could strengthen

their effectiveness by developing materials to increase awareness and promote their use to report concerns related to patient care and safety, as well as suspicions of unethical or illegal behavior that may warrant investigation. CMS also must ensure adequate financial support for managing these hotlines and providing transparency in how calls are followed up.

Conclusion

Thank you for your consideration of our comments as you consider policies to improve program integrity and crack down on fraud, waste, and abuse. We recognize particularly urgency regarding program integrity among Medicare-certified hospices, and we offer ourselves as a resource to support the identification and implementation of effective, risk-based approaches to tackling this challenge and protecting and promoting beneficiary access to high-quality hospice care. We look forward to working with CMS in this important endeavor. If you have any questions, please feel free to reach out to Wendy Chill, Senior Director, Health Policy and Government Relations, with any questions at wchill@aaahpm.org or (847) 375-6733.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kristina Newport', written in a cursive style.

Kristina Newport, MD FAAHPM, HMDC
Chief Medical Officer, American Academy of Hospice & Palliative Medicine