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Hearing on Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud
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Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to testify today.

My name is Sheila Clark, and I serve as President and Chief Executive Officer of the California Hospice and Palliative Care Association (CHAPCA). CHAPCA has over 250 hospice and home health provider members supporting more than 2,000 clinicians. For more than thirty years, I have advocated for hospice patients and their families and worked with providers committed to delivering compassionate, high-quality end-of-life care.

I appear before you as someone who believes deeply in the hospice benefit and equally deeply in the government's responsibility to protect it from abuse.

My central message is straight forward: hospice and home health fraud are not merely billing problems. They are beneficiary protection failures. They expose vulnerable people to exploitation, deny them appropriate care, undermine trust in Medicare, and, when left unchecked, distort the data and assumptions federal policymakers rely upon to oversee these benefits.

California is the clearest current warning sign, but this is not simply a California problem. It is a federal Medicare program-integrity problem and a state-federal oversight problem. When scammers are allowed to enter the system, remain in the system, and shape the claims and cost-report environment used by CMS, beneficiaries and taxpayers across the country bear the consequences.

This hearing is not simply about improper payments or paperwork violations. It is about the exploitation of vulnerable Medicare beneficiaries.

In hospice, fraud can mean enrolling someone who is not terminally ill, enrolling a beneficiary without meaningful consent, misrepresenting what hospice is, or billing for services not provided.[1] But one of the most important lessons we have learned is that hospice election does not happen in isolation. It is part of a beneficiary's broader medical journey.

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[1] Senior Medicare Patrol, *Hospice Fraud*, warning about false terminal certifications, enrollment without permission, inducements, and billing for higher levels of care or services not furnished, available at https://smpresource.org/medicare-fraud/fraud-schemes/hospice-fraud/.

A legitimate hospice election is usually preceded by recognizable patterns of clinical decline and health care use, including escalating specialist care, increasing inpatient or emergency room use, pharmacy claims, and ancillary services. When those surrounding facts are missing, or when the pattern does not fit the billing claim, the context changes.

What may look ordinary on a single claim often looks very different when you follow the beneficiary over time.

That beneficiary-centered approach has been transformative. When you follow the beneficiary rather than just the provider or the claim, the suspicious relationships and interdependencies become much clearer. You can see the role of the attending physician, the sequence of admissions and discharges, and the ways beneficiaries are cycled across hospices and home health agencies. That is often where the real story is.

A single claim may not look problematic standing alone. But once placed in the context of the beneficiary's broader utilization pattern, the underlying fraud becomes much easier to identify.

My Perspective as a Hospice Leader and Advocate

For more than three decades, I have worked on behalf of hospice patients and their families. In my current role, I hear directly from providers across California who are trying to preserve the integrity of the hospice benefit, and from families who are confused, frightened, and trying to understand what happened when a loved one was fraudulently enrolled.

That dual perspective matters. Fraud does not only injure the individual beneficiary. It poisons public confidence in the benefit, undermines legitimate providers, and forces honest organizations to operate in a system where criminal conduct can distort the rules under which everyone else must function.

I also want to be clear about what this is not. This is not a for-profit versus nonprofit issue. In fact, framing explosive hospice growth primarily as growth in for-profit providers allowed criminal organizations to hide under a rhetorical umbrella that diverted attention from the real problem. The real problem was not ownership category. The real problem was sophisticated networks that were not functioning as legitimate providers at all.

Every Step Along the Way, the Protective Structure Failed

One of the hardest truths in this matter is that the problem did not result from a single missed signal. It grew because the protective structure failed repeatedly.

- It failed at licensure, when entities entered the system that never should have been approved.
- It failed at accreditation and certification, when gatekeeping mechanisms did not reliably stop scammers.

- It failed at Medicare enrollment, when providers obtained billing privileges despite warning signs that should have triggered much greater scrutiny.
- It failed in oversight, when complaints, suspicious patterns, and signs of beneficiary harm did not produce intervention fast enough to prevent additional damage.
- It failed even after the fraud was identified, because the response remained too slow and too fragmented to match the urgency of the harm.

Once credible fraud indicators emerged, the obligation should have been clear: protect the beneficiary first.

Under Medicare, survey and certification is a federal-state partnership. The federal government establishes the health and safety standards that providers must meet to participate in Medicare and Medicaid. State Survey Agencies conduct inspections on behalf of CMS, investigate complaints, and assess compliance with Conditions of Participation.[2] CMS has also made clear that state survey agencies remain responsible for meeting federal requirements even when contractors are used to perform survey functions.[3]

For hospices and home health agencies it is one of the core mechanisms by which beneficiaries are supposed to be protected from unsafe, illegitimate, or noncompliant providers. When complaint investigations do not lead to timely action, when scammers remain active after serious concerns are known, and when regulators of the system do not move quickly enough to protect beneficiaries, that partnership is not functioning the way Congress intended.

That is why I have emphasized that every step along the way, the system failed. By the time fraud of this scale becomes visible to patients, families, legitimate providers, and law enforcement, multiple layers of oversight have already missed opportunities to intervene.

California as a Warning Sign for Federal Policymakers

California is the clearest current case study of what happens when oversight weaknesses are exploited at scale. The warning signs included explosive provider growth, troubling survey findings, excessive clustering of hospices and home health agencies, unusually long durations of

[2] Centers for Medicare & Medicaid Services, *Quality, Safety & Oversight - Certification & Compliance*, stating that State Survey Agencies, under agreements between the state and the HHS Secretary, carry out the Medicare certification process, available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance; Centers for Medicare & Medicaid Services, *Quality, Safety & Oversight - General Information*, available at https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information.

[3] Centers for Medicare & Medicaid Services, *Reminder of State Survey Agencies' Responsibility to Oversee Contract Surveyors* (Apr. 5, 2024), explaining that CMS holds State Survey Agencies responsible under the section 1864 agreement whether survey functions are performed by state staff or contractors, available at https://www.cms.gov/files/document/admin-info-24-13-all.pdf.

service, and patterns inconsistent with ordinary clinical reality. Those signals should have prompted earlier intervention.[4]

They matter not only because they affected California beneficiaries, but because once these providers enter Medicare, bill Medicare, and are incorporated into the claims and cost-report environment used by CMS, the effects become national. Federal payment policy, quality oversight, and broader program-integrity decisions rely on aggregated national data. If those data are contaminated, the consequences do not stay local.

I also want to highlight a point that is too often overlooked in discussions about hospice fraud. Live discharge can be a warning sign, but one of the clearest indicators across fraudulent hospice agencies is often little to no deaths under the hospice's care. Sophisticated actors can manipulate some surface indicators more easily than they can manipulate the basic reality that hospice serves people at the end of life. We are also hearing disturbing reports that some individuals who have already died are being enrolled retroactively with backdated notices of election. That makes beneficiary-level analysis, death attribution, and site visits more important.

The Human Harm to Beneficiaries and Families

The people at the center of these schemes are victims.

A beneficiary may be enrolled in hospice without meaningful understanding or without true eligibility. A family may believe a loved one is receiving appropriate care when that is not happening. Needed treatment may be delayed or disrupted. Records may be manipulated. Families may be left confused, powerless, and unable to determine who is accountable.

There has been meaningful progress in some beneficiary protections. CMS has streamlined hospice disenrollment in appropriate cases from six months to less than twelve days, enhanced triaging of 1-800-MEDICARE hospice complaints, and implemented targeted beneficiary messaging.[5] In California, the beneficiary notification letter has been especially effective. Beneficiaries are notified shortly after electing hospice and instructed to call 1-800-MEDICARE if they did not sign up.[6] That kind of direct beneficiary communication is one of the clearest examples of a protective measure that works.

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[4] California State Auditor, *California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse*, Report 2021-123 (Mar. 29, 2022), available at https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf.

[5] Centers for Medicare & Medicaid Services, *Hospice Fast Facts* (Jan. 28, 2026), describing streamlined beneficiary disenrollment, targeted beneficiary messaging, and enhanced triaging of hospice complaints, available at https://www.cms.gov/files/document/hospice-fact-sheet-1-28-26.pdf.

[6] Centers for Medicare & Medicaid Services, *Sample Beneficiary Hospice Notification*, directing beneficiaries to call 1-800-MEDICARE for questions or if they did not elect hospice, available at https://www.cms.gov/files/document/sample-beneficiary-hospice-notification.pdf.

There is another consequence this Committee should not overlook. Fraud in hospice does not necessarily end when the billing stops. Under the current billing structure, the fraudulent hospice controls the paperwork needed to revoke or terminate a hospice election. If a fraudulent provider is uncooperative, unreachable, or no longer operating, the beneficiary may remain reflected in Medicare systems as if an active hospice election still exists. That can interfere with access to curative treatment, prescription drugs, and other needed services.[7]

For that reason, I urge the Committee to consider a federal remedy that holds harmless beneficiaries who were fraudulently enrolled in hospice and later face barriers to legitimate hospice access because of aggregate-cap consequences tied to that fraudulent utilization.

Looking Beyond the Billing Claim

The patterns seen in hospice and home health are not consistent with isolated billing mistakes. They reflect organized, adaptive, and sophisticated schemes.

Fraudulent hospices and home health agencies often do not look or operate like legitimate providers. They do not maintain real websites. Their phone numbers do not work. They do not have legitimate referral partners or relationships with hospitals or health systems. That should prompt an obvious question: how are they getting their patients?

The answer, reflected in claims patterns and law-enforcement findings, is deeply troubling. It appears to be a combination of uninformed or coerced consent, stolen identities, and payments to beneficiaries in exchange for use of Medicare numbers.

The warning signs are familiar: provider clustering at common addresses, rapid enrollment growth in saturated markets, repeated use of the same medical directors or certifying physicians, invalid or unverifiable contact information, exclusive fee-for-service Medicare billing in home health in high Medicare Advantage markets, and billing patterns that diverge sharply from clinical reality.

These schemes exploit the seams between licensure, certification, enrollment, survey activity, claims monitoring, and law enforcement. They are designed to outpace case-by-case prosecution. That is why the solution cannot depend solely on retrospective enforcement. CMS must use its administrative authorities earlier and more aggressively.

There are existing laws that address inducements, kickbacks, false claims, and self-referral. But what is occurring in California and certain other markets should not be viewed as routine provider noncompliance. It is large-scale criminal fraud carried out by sophisticated

[7] Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, ch. 9, sec. 20.2.1.3, providing that, to establish the hospice election in the Medicare claims processing system, the hospice must submit a Notice of Election; see also *Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum*, MLN Matters No. MM12015 (Nov. 6, 2020), available at https://www.cms.gov/files/document/mm12015.pdf and https://www.cms.gov/files/document/r10437bp.pdf.

organizations capable of moving beneficiaries across hospice and home health agencies in ways that maximize billing opportunities while obscuring the underlying network.

Why This Matters for National Payment Policy

When fraudulent or highly suspect claims and cost reports are incorporated into federal payment modeling, they do not remain local. They can distort national benchmarks, recalibrations, assumptions about utilization, and policy judgments about what constitutes ordinary provider behavior. Over time, fraud can become embedded in the dataset in ways that make it appear normal inside the model even though the underlying conduct is illegitimate.

That concern is especially acute when oversight remains too provider-centric. Fraud can be beneficiary-centric as well. Serial reenrollment, abnormal movement across providers, tranche-based admissions, implausibly low death rates, and provider cycling may not appear extraordinary if claims are viewed one provider at a time or one claim at a time. But they become visible when beneficiary journeys are followed longitudinally across providers and over time. That is the kind of analysis the federal government should be investing in.

Congress should insist on a simple principle: data that are too corrupted to trust for program-integrity purposes are too corrupted to trust for national rate-setting purposes.

It is also imperative that CMS begin auditing cost-report data in both home health and hospice. Any future modernization or structural reform depends on claims that reflect legitimate care and cost reports that reflect actual service delivery. Those assumptions cannot simply be accepted without verification in a fraud-saturated environment.

Unrelated Hospice Spending Should Not Be Treated as the Burden of the Hospice Provider

I want to address one related point very directly. Spending that occurs outside the hospice provider's control should not be treated as if it were the hospice's own conduct or burden.

When CMS examines unrelated (non-hospice) spending during a beneficiary's hospice election, it is often looking at claims submitted by other providers or suppliers. The hospice does not submit those claims. The hospice does not adjudicate those claims. The hospice often does not have real-time visibility into those claims. And the hospice does not control whether Medicare ultimately pays them.[8]

[8] See 42 C.F.R. § 418.402 (individual liability for services not considered hospice care); Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual*, ch. 11, sec. 40.1.3, explaining that independent attending physician services related to the terminal illness may be billed through Medicare Part B and that services not considered hospice care are outside the hospice's Part A billing responsibilities, available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418 and https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c11.pdf.

That matters because attributing unrelated, non-hospice spending back to the hospice can make it appear that the hospice generated, approved, or controlled billing activity that it neither initiated nor managed. In many cases, the questionable spending appears to be concentrated in areas such as durable medical equipment, skin substitutes, transportation, and other supplier-driven billing categories. The visible hospice then bears the reputational burden while the actual drivers of the questionable billing remain obscured.

That does not mean unrelated spending should be ignored. It means it should be analyzed accurately. If the concern is abusive supplier or third-party billing during a hospice election, the solution is to identify the providers or suppliers generating that billing and the beneficiary pathways surrounding it, and not to assume that the hospice controlled the spending outside the hospice benefit. A sound federal oversight and payment policy framework should distinguish clearly between hospice conduct and outside billing activity that occurs around a hospice beneficiary.

Federal Policy Actions This Committee Should Advance

First, strengthen front-end provider screening. CMS should intensify screening in high-risk geographies, use address matching more aggressively, require site verification prior to enrollment, and scrutinize rapid provider growth in saturated markets.

Second, use existing federal authorities earlier and more decisively. CMS already has authority to impose temporary enrollment moratoria where there is a significant potential for fraud, waste, or abuse. It also has authority to suspend payments, revoke enrollment, and impose enforcement remedies through the survey and certification framework.[9] Those authorities should be used before scammers become entrenched, not after.

Third, protect beneficiaries immediately when fraudulent hospice enrollment is suspected. Congress should ensure there is a federal process that allows invalid hospice elections to be corrected promptly, without depending on the scammer provider to cooperate. Beneficiaries should regain full Medicare coverage quickly, and they should be held harmless from consequences of a fraudulent election.

Fourth, require faster and more accountable complaint handling. Because State Survey Agencies investigate complaints on CMS's behalf, Congress should ensure that complaint triage and escalation rules are strong enough to prioritize state action on beneficiary-risk cases that support rapid federal follow-though.

[9] Centers for Medicare & Medicaid Services, *QSO-24-11-HHA & Hospice* (May 3, 2024), describing enforcement remedies for home health agencies and hospice programs, including civil money penalties, directed plans of correction, suspension of payment for new admissions, temporary management, and directed in-service training, available at https://www.cms.gov/files/document/qso-24-11-hha-hospice.pdf.

Fifth, keep fraud-distorted data out of national payment policy and quality reporting. Congress should make clear that CMS must exclude or adjust for known fraud distortions before those data are used in payment systems.

Sixth, improve analytics to detect beneficiary-level fraud dynamics. Payment systems linked to community-based beneficiary care, as in hospice and home health, CMS should build stronger beneficiary linked data capabilities to identify serial recertifications, abnormal beneficiary movement across entities, implausibly low death rates, tranche admissions, and cycling patterns across related providers.

Seventh, require routine cost report auditing in hospice and home health, especially in fraud-exposed geographies. If cost reports are going to influence federal payment policy, CMS must have greater assurance that they reflect real operations and real care delivery.

Conclusion

Medicare beneficiaries should never be used as a vehicle for fraud. Yet that is exactly what happens when vulnerable people are enrolled without informed consent, when complaints do not trigger timely intervention, when sham operators remain active, and when corrupted data are allowed to influence national policy.

Congress should treat this for what it is: a systemic failure of protection.

And Congress should insist on a system that does five things well: blocks scammers before they enter, removes them quickly once identified, protects beneficiaries immediately when harm is suspected, follows the beneficiary rather than only the provider claim, and keeps fraud-distorted data out of federal Medicare policy.

Thank you for the opportunity to submit this testimony.