Regulatory Deep Dive – Up to the Minute Hospice Regulatory Issues

Judi Lund Person, MPH, CHC

LundPerson & Associates, LLC

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LundPerson & Associates Hospice Consulting

Learning Objectives

- What recommendations is MedPAC considering for ESRD patients, or those needing palliative radiation, chemotherapy, or blood transfusions?
- What are the topics for CMS-contracted auditors? What do we know about their results?
- List the hospice data that should be gathered in your state to describe hospice services in your state in detail.

Hospice Program Integrity

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Ways and Means Committee Hearing April 21

- **Topic:** Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud
- April 21, 2026, 10:00AM ET
- **YouTube video of the hearing**
  - **Note: Sheila Clark testimony starts at the minute marker 34 min 30 sec**

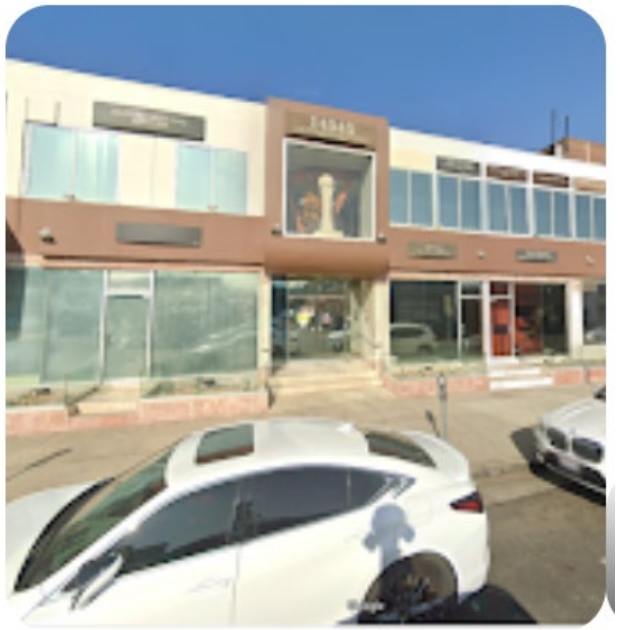
Panelists

- **Dr. Lynn Ianni, PhD - Medicare beneficiary and Medicare fraud victim; download testimony**
  - Dr. Ianni reported on her experience having her Medicare number stolen and enrolled in hospice without her knowledge. She received help in resolving the issue from the Senior Medicare Patrol in California.
- **Ms. Sheila Clark - President and CEO, California Hospice and Palliative Care Association; download testimony**
  - In her testimony, Sheila stated that "hospice and home health fraud are not merely billing problems. They are beneficiary protection failures." She went on to say that "home health and hospice fraud is not just a California problem, but rather a Medicare program integrity problem and a state-federal oversight problem."
- **Mr. David Klebonis - Chief Operating Officer, Palm Beach ACO; download testimony**
  - Mr. Klebonis shared the experience of Medicare fraud and systemic schemes experienced in the ACO where he is the COO, including billing patterns, products that are clinically unnecessary, and the work of his ACO to identify and report suspected fraud.
- **Mr. Christopher Deery - Director of Corporate and Financial Investigation, Independence Blue Cross; download testimony**
  - Mr. Deery is at a Blue Cross plan serving the Philadelphia area. He described the work of his corporate and financial investigation unit using machine learning and data analytics to monitor claims and payment dashboards on a daily basis, and includes validation of billed services and confirming clinical appropriateness.
- **Ms. Kristi Martin - Principal, Highway 136 Consulting; download testimony**
  - Kristi worked at CMS for several years, particularly focused on making prescription drug prices more affordable. In her testimony, she focused on incentives in Part D that caused total Part D spending to increase at an annual growth rate of 5.5% between 2007 and 2018. She shared her concern about lowering prescription drug costs and encouraged the committee to consider an expansion of policies that benefit Medicare beneficiaries.

West Coast Health Care Fraud Strike Force

- Part of DOJ National Fraud Enforcement Division
- Includes
  - DOJ Health Care Fraud Section
  - U.S. Attorney's Offices for the District of Arizona, District of Nevada, and Northern District of California
  - DEA and FBI
- Data analytics hubs in California, Arizona, and Nevada will track how fraud patterns shift across state lines
- Goal: better coordination and earlier detection as fraudulent operators shift operations from state to state to stay ahead of regulators.
- HHS-OIG can now apply investigative tools with "strategic precision" rather than waiting for fraud to fully develop before acting

14545 Friar Street, Van Nuys, CA



Number of Medicare certified hospices at this address: 197 as of March 2026

Number of Medicare certified home health agencies at this address: At least 85


Merabi Organization
Medical Building
14543 Friar St
ANA'S
14545

NBCLA


BELL'S
AUTO PARTS
& WRECKING
8777
Save $$$ Save $$$ Save
Bells Auto Parts
Tire Sale
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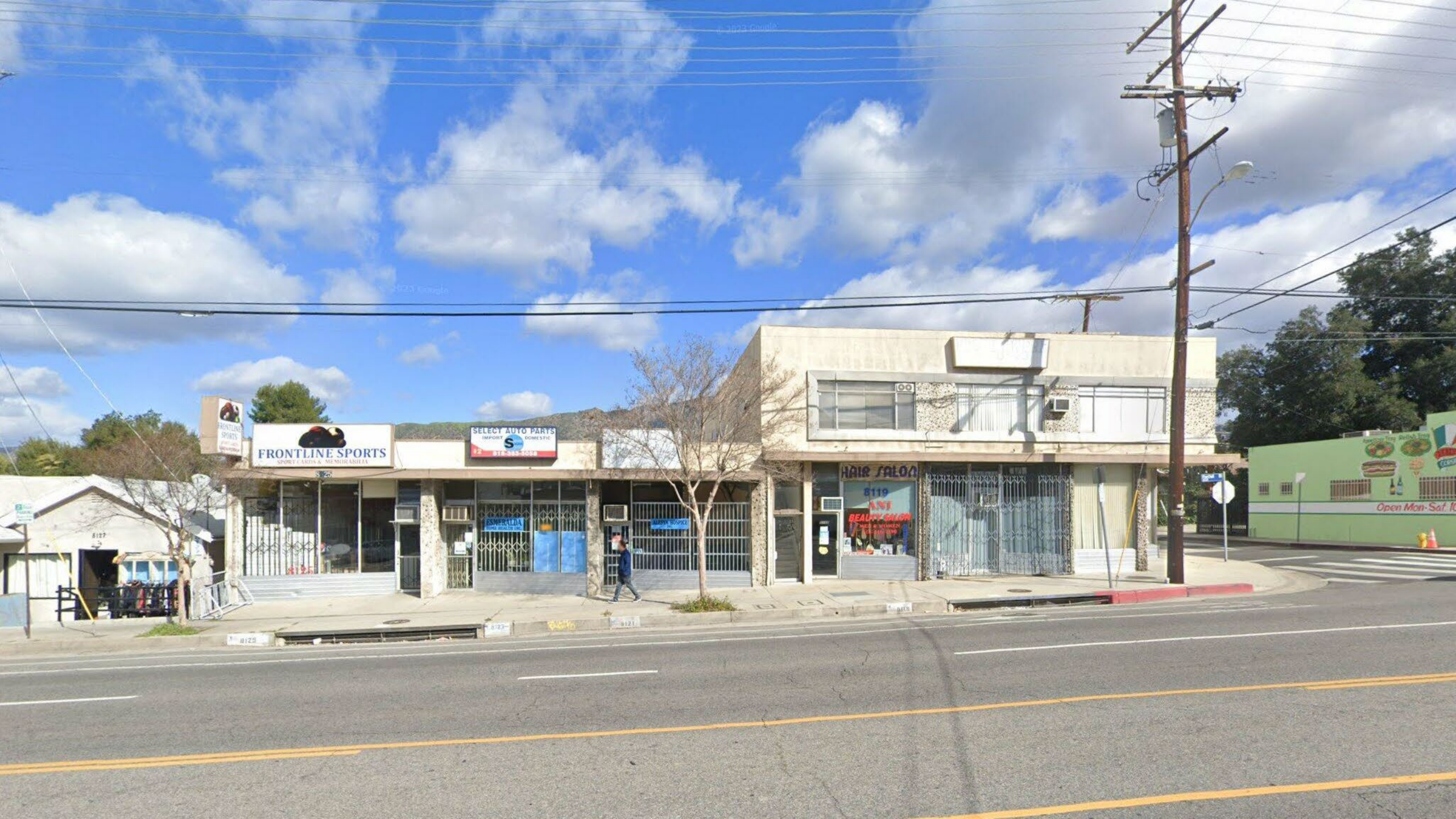
FRONTLINE SPORTS
SPORT CARDS & MEMORABILIA
SELECT AUTO PARTS
IMPORT DOMESTIC
ESMERALDA
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Estrella St

447 Hospices Suspended in LA County

- April 2026: Suspension letters issued through the Unified Program Integrity Contractor (UPIC) Qlarant
- Based on a credible allegation of fraud
- Those suspended: $1 B billed in 2025
- Only 10 rebuttals to suspension
- Many of the hospice notifications cite a pattern or practice of submitting claims that do not meet Medicare requirements:
  - Live discharge rate that is materially higher than national hospice live discharge patterns, with an effective date of suspension prior to notification. The national average live discharge rate is 19.1% for FY 2025
  - Suspension notifications cite live discharge rates, including transfers, ranging from 37% to 74%
  - Other credible allegations of fraud such as co-location (i.e. same address) with another hospice(s)

Other Metrics Being Considered

- No GIP and CHC
- High live discharge rates
- > 40% of patients in SNF or NF
- Percent of beneficiaries discharge with LOS ≥ 180 days
- Average RN visits per day
- % of live discharges where beneficiary returns to same hospice within 7 days

MedPAC Work on Access to Hospice for Beneficiaries Needing Dialysis, Chemotherapy, Radiation and Blood Transfusions

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Summary of prior analyses of Medicare data

- Decedents with ESRD are less likely to use hospice and have shorter hospice stays compared with decedents overall
- Decedents with cancer are more likely to use hospice but have shorter stays; those with blood cancer have shorter stays than those with other cancers
- Limited Medicare data on provision of dialysis, radiation, blood transfusions, and chemotherapy under hospice benefit
  - Hospices were previously required to report information on the drugs they furnished during hospice stays on claims, from April 2014 through September 2018
- Hospice enrollees with cancer received many therapeutic classes of drugs in 2017, but receipt of antineoplastic drugs (i.e., chemotherapy) was <1%

Note: ESRD (end-stage renal disease).
Source: MedPAC analysis of data from Medicare claims and the Medicare Common Environment.

Cost to a hospice providing these services could represent a substantial portion of Medicare's hospice payment for a stay

- We estimated the cost of providing dialysis, blood transfusions, and radiation during a hospice stay relative to Medicare's payment for the stay under two hypothetical scenarios for each type of treatment with assumptions about hospice LOS, treatment frequency, and cost for each service in 2019
- Findings:
  - Dialysis amounted to roughly 40% to 50% of total hospice payments for stay
  - Blood transfusions ranged from roughly 30% to 50% of total hospice payments for stay
  - Radiation ranged from <10% to >30% total hospice payments for stay

Note: LOS (length of stay). Assumptions on hospice LOS and treatment frequency were informed by the literature, our interviews with clinicians, analysis of Medicare data, and input from MedPAC's staff physician. Literature included Ernecoff et al. (2022) and Wachterman et al. (2022) for dialysis; Egan et al. (2023) for blood transfusion; Alcorn et al. (2024) and Yerramilli and Johnstone (2023) for radiation. A proxy for the cost of treatment was estimated based on the average fee-for-service payment rate per dialysis, blood transfusion, and radiation treatment for beneficiaries with end-stage renal disease or cancer in the 30 days before hospice enrollment.

Source: MedPAC estimates for hypothetical scenarios.

Summary of potential policy approaches

Enhanced data reporting	To inform potential policymaking, hospices would report the provision of certain complex palliative care services
Hospice payment policy changes	Two potential payment policy approaches: → *High-cost outlier payment for certain complex palliative services where Medicare pays hospices a portion of costs above a fixed loss amount* → *Add-on payment to hospices for certain complex palliative services in addition to the daily hospice payment rate*
Voluntary transitional program	Voluntary transitional program that would give hospice enrollees the option to receive certain complex palliative services paid for outside the hospice benefit for some transitional period or up to a specified number of treatments

Enhanced data reporting for certain complex palliative services

Advantages

- Data could inform modeling and new payment policy approaches if warranted
- Precedent for such an approach

Disadvantages/complexities

- Would increase reporting burden on hospice providers

Design considerations

- Which services hospices report
- Length of time for enhanced data reporting
- How hospices report data (e.g., report on claims they submit to CMS)

High-cost outlier payments for certain complex palliative services

Advantages

- Targets funds to providers furnishing costly services
- Maintains bundled nature of hospice payment system
- Helps retain incentives for efficiency

Disadvantages/complexities

- Some may view payments as not sufficiently increasing incentives to furnish high-cost services

Design considerations

- What services are eligible for an outlier payment
- What share of costs above fixed-loss amount would Medicare pay
- What is the target amount of spending that outlier payments would account for
- What type of data sources would be used to estimate provider costs for outlier services

Add-on payments to hospice providers for certain complex palliative services

Advantages

- Targets funds to providers furnishing certain costly services
- Would increase incentives to furnish these services to beneficiaries

Disadvantages/complexities

- Unbundles some hospice services
- Potential for inappropriate provision of services by some hospice providers, spurred by additional payments
- Program integrity safeguards may be needed but challenging to implement

Design considerations

- What services are eligible for an add-on payment
- How to set add-on payment rate
- Size of reduction to hospice base rate needed for budget neutrality
- How to ensure program integrity and provision of services consistent with palliative nature of hospice benefit

Voluntary transitional program for certain complex palliative services

Advantages

- May increase access to hospice for some beneficiaries (e.g., those dependent on dialysis or transfusions)
- Paying nonhospice providers directly for certain complex palliative services may be operationally easier for some hospices

Disadvantages/complexities

- Paying for certain services outside of hospice could lessen hospices' role in managing that care
- May increase Medicare program spending, depending on design

Design considerations

- What services are eligible for transitional program
- What length of time or number of treatments would be appropriate
- How to promote collaboration between the specialist administering transitional treatments and hospice physician
- How to minimize the potential for unintended financial incentives or undermining the hospice benefit criteria

Connecting the Dots

- Rep. Blumenauer (D-OR, Retired) interest in hospice care concurrent with dialysis
- Daniel Lam, M.D., clinical associate professor at the Kidney Research Institute and palliative care medical advisor for the Northwest Kidney Centers
- **Concurrent Care for Comfort Act (H.R.8376)**
  - April 2026
  - Introduced by Reps. Mike Kelly (R-PA) and Suzan DelBene (D-WA)
  - Clarifies Medicare coverage to ensure hospice patients can access dialysis for comfort, aimed at removing the requirement to stop dialysis to receive hospice benefits

2026 MedPAC Report to Congress

March 12, 2026

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MedPAC Recommendation

For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

MedPAC 2026 Report to Congress

Hospice Chapter

Released March 12, 2026

What Does This Mean?

- MedPAC makes recommendations to Congress, which Congress is free to act on or ignore
- Adopting a MedPAC recommendation requires a change in the statute by the Congress
- Hospice payment rates are determined by statute
  - SSA 1814(i), and specifically (i)(1)(C)(iii) and (i)(6) (which requires data collection and revision of payment rates by regulation)
  - Social Security Act §1814
- Regulatory references to payment rates are at 42 CFR 418.306
- CMS has authority to make certain changes, provided they are consistent with statute and existing regulations

TABLE 10–2

In 2024, the share of decedents using hospice increased overall and across all beneficiary subgroups

	Share of Medicare decedents who used hospice						
	2010	2019	2022	2023	2024	Average annual percentage point change 2010–2023	Percentage point change 2023–2024
All decedent beneficiaries	43.8%	51.6%	49.1%	51.7%	52.9%	0.6	1.2
FFS beneficiaries	42.8	50.7	49.1	51.7	52.9	0.7	1.2
MA beneficiaries	47.2	53.2	49.2	51.7	52.9	0.3	1.2
Dually eligible for Medicaid	41.5	49.3	43.9	46.7	48.1	0.4	1.4
Not Medicaid eligible	44.5	52.4	51.1	53.6	54.6	0.7	1.0

TABLE 10–2

In 2024, the share of decedents using hospice increased overall and across all beneficiary subgroups

	Share of Medicare decedents who used hospice						
	2010	2019	2022	2023	2024	Average annual percentage point change 2010–2023	Percentage point change 2023–2024
Age							
<65	25.7	29.5	26.6	28.6	29.8	0.2	1.2
65–74	38.0	41.0	37.7	40.3	41.1	0.2	0.8
75–84	44.8	52.2	49.4	51.9	52.9	0.5	1.0
85+	50.2	62.7	61.8	64.1	65.2	1.1	1.1
Race/ethnicity							
White	45.5	53.8	51.7	54.3	55.6	0.7	1.3
Black	34.2	40.8	37.4	39.7	40.9	0.4	1.2
Hispanic	36.7	42.7	38.2	40.0	40.4	0.3	0.4
Asian American	30.0	39.8	38.0	39.0	39.7	0.7	0.7
North American Native	31.0	38.5	37.2	39.3	41.0	0.6	1.7

TABLE 10–3

Hospice use increased in 2024

	2010	2019	2022	2023	2024	Average annual percent change 2010–2019	Average annual percent change 2019–2023	Percent change 2023–2024
Average lifetime length of stay among decedents (in days)	87.0	92.5	95.3	96.2	99.6	0.7	1.0	3.5
Median lifetime length of stay among decedents (in days)	18	18	18	18	19	0 days	0 days	1 day

TABLE 10–5

Hospices that exceeded Medicare's annual payment cap, 2019–2023

	2019	2020	2021	2022	2023
Estimated share of hospices exceeding the cap	19%	19%	19%	23%	28%
Average payments over the cap per hospice exceeding it (in thousands)	$384	$422	$451	$419	$410
Payments over the cap as a share of overall Medicare hospice spending	1.7%	1.8%	2.0%	2.3%	2.9%

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from CMS claims-processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing vary across contractors. The cap years for 2019 through 2023 are aligned with the federal fiscal year (October 1 to September 30 of the following year).

Source: MedPAC analysis of Medicare hospice claims data, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

Comments on Cap by State

- Hospices that exceed the cap are **disproportionately located in four states—Arizona, California, Nevada, and Texas.**
- Excluding these four states, we estimate that the share of hospices exceeding the cap in **2023 was about 6 percent**, up slightly from 5 percent in 2022.
- In contrast, we estimate that **more than half** of hospices in California exceeded the cap in 2023
- Approximately 30 percent to 40 percent of hospices in Texas, Nevada, and Arizona.

Auditors and Topics

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TPE Topics – Wellpoint Federal

Hospice Care – Q Codes

- Q5002 – Hospice care provided in an ALF
- Q5003 – Hospice care provided in a LTC or NF
- Q5004 – Hospice care provided in a SNF

Hospice LOS > 180 days

Hospice – Increased Reimbursement

Hospice – New Provider

Hospice – General Inpatient > 7 days

Roles for Each Audit Entity

- Medicare Administrative Contractor: TPE and education
- MAC -> UPIC: Fail 3 rounds of TPE
- UPIC: Focus on fraud
- RAC: Worst of the worst

Return on Investment for Fraud

- 2024: 8:1
- 2026: 24:1

Resources for Hospice Program Integrity at the State Level

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Characteristics of Hospices in Your State

Hospice Statutes

- Definition of Hospice
- Protection for the use of the word “hospice”
- Definition of hospice patient
- Other state statutory requirements for hospice operations

Licensure Regulations and Application

Licensure Application

- What information is requested?
- Does it give a full description of the applicant?
- What is missing?

State Due Diligence Before License Granted

- Federal and State tax liens for applicant?
- Same address as other hospices/other healthcare entities?
- Ownership
- Name of medical director
- State limitation on the number of hospices one medical director can serve
- Licensed as other entities in the state

Counties to be served specified?

- Service area
- CON

What is the process for adding topics to the licensure application?

- Would the State allow?
- What other data is important?

Process for Licensure

Process for initial licensure application	• Survey by State? Timeframe from application to survey? • State surveyor conducts initial licensure survey on site?
Process for licensure renewal and termination?	• Site visits for renewal? • Termination timeline
Branch offices? Separately licensed?	• What are the licensure requirements for branch offices? • Any process for notifying the State when there is a new location or change of address?
State provide:	• Additional help for new applicants • Additional scrutiny when care begins?
State data collection	• Collected from all hospices in the state? • Accessible to the public or upon request?

Other Considerations

Service area

- CON
- Specified counties or service area

Beneficiary access to hospice

- Available in all counties
- Oversaturation in some, no access in others?

County level hospice patient data available?

State regulations on hospice growth?

Business Requirements

Secretary of State registration

Business license

Building occupancy permit requirement

State-specific healthcare business requirements

Compile Comprehensive Hospice Data for State

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Develop a State-level Database

List of hospices with demographic data	Medicare certification date	Hospices who filed claims for most recent year	Other Information if available
• **Hospice Enrollment**	• **Provider of Services File – IQIES - Hospice**	• **Hospice PUF Data** • Number of patients served • Total patient days	• Location of care (Q codes) • Race and ethnicity • Payments per beneficiary

Hospice Quality Data

CMS Provider Data Catalog

https://data.cms.gov/provider-data/search?theme=Hospice%20care

	Participation in HQRP	% of hospices in state participating
	HIS/HOPE data	
	HCI and HVLDL data	**Provider Data Catalog – Hospice** https://data.cms.gov/provider-data/dataset/eda0-92f0
	CAHPS® Hospice Survey Data	**Provider Data Catalog – Hospice** https://data.cms.gov/provider-data/dataset/a55e-5b88
	Star ratings	

Hospice Surveys and Complaints

- Check newly enrolled and terminated providers (https://qcor.cms.gov)
- Available on State Survey Agency website?
- Publicly available?
- Watch social media and news from individual hospices – surveyors will be checking
- Check addresses for multiple hospices at same address

- Summarize survey data if possible
- Deficiency list by state
- Top 10 deficiencies
- How many/what percentage of hospices last surveyed > 37 months ago
- Complaints
  - Quantity
  - Substantiated?
  - Immediate jeopardy
  - Time from complaint to complaint survey

Identifying and Addressing Fraud

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Possible Fraud Indicators

- Patient volume trends from one quarter to another
- Live discharges – high percentage
- Complaints – trend over time and IJ and substantiated
- Track transfers
- Marketing and advertising in the community
- Social media and job postings
- Report concerns to complaint line

Partnership Opportunities

State hospice organization or state home care and hospice association
State survey agency
State Medicaid agency
Other healthcare associations – nursing home, home health, hospital associations
Senior Medicare Patrol, AARP, nursing home advocacy groups
Elder law attorneys
Connections in legislature and Governor’s office

Other Regulatory Updates

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Revised HIPAA Security Final Rule – Out Soon

- January of 2025: Office of Civil Rights (OCR) published a **proposed rule** to completely revise and update the HIPAA Security Rule
- Will update it to address current information technology practices
- First major update to the rule since the 2013 HITECH Final Rule and is expected to be released in May 2026

Resources for Agency Preparation

- **Start Preparing for New Rule**
- **What's Changed**
- **HIPAA 2026 You Tube videos**
- **DHHS Security Rule Guidance**
- **Article on Fed Weighing Cost vs Security in HIPAA revision**
- **Overview of New HIPAA Regs**

Checking Medicare Beneficiary Eligibility with a Third-Party Vendor

- Announced in MLN Connects April 30, 2026
- You must enroll your vendor with CMS for HIPAA Eligibility Transaction System (HETS) access by **linking the vendor to your NPI no later than May 11, 2026.**
- Steps in enrollment process:
  - Contact your vendor and obtain their unique ID
  - Use the ID to enroll and link the vendor to your NPI so they can continue submitting eligibility inquiries
  - More information is **here**
- If you opt not to enroll, you can still check beneficiary eligibility through your **MAC secure internet portal**.

Hospice NOE Beneficiary Letter

- CMS established a Hospice Election Notification pilot in Nevada in May 2025.
- Pilot expanded into California in December 2026
- When a hospice provider files a Notice of Election, a notification letter is immediately sent to the beneficiary to make sure they know they have been enrolled in hospice
- If they did not enroll, they are instructed to call 1-800-MEDICARE who can help with overturning the election
- More than 25,000 letters have been issued so far
- Copy of the letter is available here.

CMS Hospice Termination Notices Posted

- CMS continues to post Medicare enrollment termination notices for hospices. The most recent posting on May 1, 2026 shows terminations for the last 14 months.
- Public Notices | CMS


why
when
what
QUESTIONS
who
how
where
?