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August 4, 2026

Congressional Research Service
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R49060

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SUMMARY

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The Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness for Medicare beneficiaries with a life expectancy of six months or less. In 2023, approximately 1.8 million Medicare beneficiaries received hospice services. Through the Medicare benefit, hospice services must be provided through Medicare-certified hospice agencies. Over the past decade, the number of Medicare-certified hospice agencies has increased from 4,840 in 2019 to 6,706 in 2024.

The Centers for Medicare & Medicaid Services (CMS) has reported that certain states have had rapid growth in the number of Medicare-certified hospice agencies and the agency has received reports of hospice fraud in these states. In response, CMS has taken actions to increase program oversight and engaged in enforcement activities, which has resulted in some hospice providers losing their Medicare participation status while raising questions about the potential effects on provider burden and beneficiary access to hospice services.

Policymakers are often interested in Medicare hospice fraud because the issue intersects with other areas of federal policy, such as Medicare program integrity and the federal budget. To assist Congress in its oversight of the Medicare program, this report briefly outlines the Medicare hospice benefit federal certification requirements and provides examples of hospice fraud. It then describes CMS's regulatory authorities to combat hospice fraud and details several of its actions to do so in recent years. Finally, it concludes with selected considerations for Congress regarding Medicare hospice program integrity.

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Introduction

The Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness for Medicare beneficiaries with a life expectancy of six months or less.[1] When electing the hospice benefit, beneficiaries agree to receive palliative care for their terminal condition rather than curative care.[2] This benefit includes a broad range of services such as skilled nursing care, medical social services, physician services, counseling, and hospice aide and homemaker services.[3] Services are primarily provided in the home, but they may also be provided in institutional settings such as long-term care facilities.[4] In 2023, approximately 1.8 million Medicare beneficiaries received hospice services.[5]

Through the Medicare benefit, hospice services must be provided through Medicare-certified hospice agencies.[6] Research has shown that over the past decade the number of hospice agencies has increased from 4,840 in 2019 to 6,706 in 2024.[7] In a February 2026 report, the Centers for Medicare & Medicaid Services (CMS) reported that it has "received numerous reports of hospice fraud, waste, and abuse" in certain states that have had significant increases in the number of Medicare enrolled hospices.[8] In response, CMS has taken actions to increase program oversight and engaged in enforcement activities, which has resulted in some hospice providers losing their Medicare participation status.[9]

Policymakers are often interested in Medicare hospice fraud because the issue intersects with other areas of federal policy, such as Medicare program integrity and the federal budget.[10] Several characteristics of the Medicare hospice benefit may increase its vulnerability to fraud relative to some other Medicare care settings. First, most hospice care takes place at home rather than in a health facility, so it is more difficult to provide oversight and monitoring of services. In addition, hospice eligibility depends upon a clinical determination that a beneficiary is terminally ill, which is a prognosis that may involve professional judgment rather than objective diagnostic criteria. Medicare also generally pays hospices a per diem rate for each day a beneficiary is enrolled in hospice, capped per year based on the number of patients seen, creating payment incentives that

[1] Social Security Act (SSA) Section 1861(dd) (42 U.S.C. §1395x(dd)); 42 C.F.R. §418.200, §418.202. Palliative care is defined in 42 C.F.R. §418.3 as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

[2] For more information on the Medicare hospice benefit, see Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy; Hospice Services,* Washington, DC, March 12, 2026, p. 297, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch10_MedPAC_Report_To_Congress_SEC.pdf.

[3] SSA Section 1861(dd)(1) (42 U.S.C. §1395x(dd)(1)); 42 C.F.R. §418.202.

[4] SSA Section 1861(dd)(1)-(2) (42 U.S.C. §1395x(dd)(1)-(2)); 42 C.F.R. §§418.102 and 418.112.

[5] Centers for Medicare & Medicaid Services (CMS), "CMS Program Statistics—Medicare Hospice," Last modified January 30, 2026, https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/cms-program-statistics-medicare-hospice.

[6] SSA Section 1861(dd)(2) (42 U.S.C. §1395x(dd)(2)).

[7] MedPAC, *Report to the Congress: Medicare Payment Policy; Hospice Services*, Table 10-1, p. 299.

[8] CMS, *Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, Texas, Georgia & Ohio*, MLN7867599, February 2026, https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas-georgia-ohio.pdf. Fraud, waste, and abuse differ in nature, and this report focuses on potential fraud. For more information, see CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report, MLN4649244*, January 2021, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf.

[9] CMS, *Hospice Fast Facts*, January 2026, https://www.cms.gov/files/document/hospice-fact-sheet-1-28-26.pdf.

[10] U.S. Congress, House Ways and Means Committee, *Full Committee Hearing on Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud*, 119th Cong., 2nd sess., April 21, 2026.

differ from those of many fee-for-service Medicare providers.[11] If a hospice agency receives payments that exceed its annual cap it must return such payments after the fact; however, audits suggest that this does not always occur, which could suggest susceptibility to fraud.[12] These structural characteristics do not, by themselves, indicate fraud; however, they may increase the importance of effective program oversight.

To assist Congress in its oversight of the Medicare program, this report briefly outlines the Medicare hospice benefit federal certification requirements and provides examples of potential fraud and abuse in hospice as related to these requirements. It then describes CMS's regulatory authority to combat hospice fraud and noncompliance and details several of its actions to do so in recent years. Finally, it includes selected fraud prevention-related activities focused on the Medicare hospice benefit that Congress could consider when evaluating future oversight or legislative proposals.

The Medicare Hospice Benefit: Federal Certification Requirements

Overview of Federal Hospice Agency and Beneficiary Certification Requirements

To receive Medicare payment, hospice services must be provided through Medicare-certified hospice agencies. To be federally certified, hospice agencies must comply with the *Conditions of Participation* (CoPs), which establish federal health and safety standards governing the operation of hospice agencies. Medicare CoPs are distinct from state licensing requirements and include requirements described in the Social Security Act (SSA) and its implementing regulations.[13] The CoPs range from services to be provided, patients' rights, and the organizational environment of the agency, such as staff qualifications.[14]

Before hospice services may be provided to a beneficiary, a beneficiary must elect the hospice benefit. The hospice must obtain, for each period of benefit coverage, written certification of the beneficiary's *terminal illness*, defined as having a life expectancy of six months or less should the illness run its normal course.[15] The certification must be made by both a hospice physician and the beneficiary's attending physician and meet specified requirements.[16] The initial hospice certification lasts up to 90 days; after that, recertification is needed for a beneficiary to maintain their hospice eligibility—first for another 90-day benefit period, followed by an unlimited number of 60-day benefit periods. Each certification must include a written form stating that the

[11] For more information on Medicare hospice payments, see CMS, *Hospice Payments: FY 2026 Update*, MM14190, September 19, 2025, https://www.cms.gov/files/document/mm14190-hospice-payments-fy-2026-update.pdf. MedPAC, *Hospice Services Payment System,* November 2025, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_hospice_FINAL_SEC.pdf.

[12] U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), *National Government Services, Inc., Accurately Calculated Hospice Cap Amounts But Did Not Collect All Cap Overpayments*, A-06-21-08004, November 2022, https://oig.hhs.gov/documents/audit/8310/A-06-21-08004-Complete%20Report.pdf.

[13] SSA Section 1861(dd) (42 U.S.C. §1395x(dd)). 42 C.F.R. Part 418.

[14] 42 C.F.R. Part 418.

[15] 42 C.F.R. §418.22.

[16] 42 C.F.R. §418.22. If the beneficiary does not have an attending physician, the certification can come from the hospice physician alone. CMS, *Medicare Benefit Policy Manual, Chapter 9*, p. 5, March 5, 2026, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf.

beneficiary continues to meet eligibility criteria (i.e., terminal illness) with the practitioner's signature. The beneficiary must also agree to receive palliative treatment rather than curative treatment for their terminal condition and can disenroll from hospice at any time.[17]

In addition to the hospice-specific CoPs, Congress has established requirements for the Medicare provider enrollment process and revalidation process (meaning the administrative process CMS uses to require providers to resubmit and update ownership, control, and management information) for a variety of service providers and suppliers, including hospice providers.[18] These include program integrity-related requirements, such as disclosure of certain affiliations, and other information relevant to identifying potential fraud, waste, or abuse, as discussed further below.

Additionally, Congress has established enforcement mechanisms that may be used to address fraud, abuse, and noncompliance by providers and suppliers, including hospice providers. These include exclusion from participation in Medicare, which can be due to reasons related to fraud and abuse.[19] Moreover, Congress has established instances where payments cannot be made to providers that have not furnished adequate information for such payment or have been excluded from participation in Medicare.[20]

Because provider enrollment represents the point at which individuals or entities gain access to Medicare reimbursement, CMS has emphasized enrollment screening and verification as a front-end strategy for preventing fraudulent providers from entering the Medicare program. Many of the agency's recent hospice program integrity initiatives, discussed later in this report, focus on strengthening oversight during the enrollment and revalidation process.

The certification, enrollment, and beneficiary eligibility requirements described above establish the foundation for participation in the Medicare hospice program. They also define many of the requirements that CMS monitors during program integrity activities.

Selected Examples of Medicare Hospice Fraud

Within hospice, numerous types of potential fraud have been cited. First, there is potential improper enrollment of new hospice agencies, as has been indicated by a high volume of newly certified agencies relative to the population and the co-location of these agencies within the same address. This can reflect nonoperational hospice agencies being established as Medicare providers in order to obtain billing privileges.[21] Second, there is potential improper certification of terminal illness, as has been indicated by long lengths of enrollment, high live discharge rates (i.e., being discharged from hospice alive), and reported incidence of improper enrollment by health care practitioners.[22] This may reflect beneficiaries being enrolled unknowingly into hospice without

[17] 42 C.F.R. Part 418.

[18] SSA Section 1866(j) ((42 U.S.C. §1395cc(j)).

[19] CMS, "Medicare Program; Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment," 71 *Federal Register* 20754, April 21, 2006, https://www.federalregister.gov/documents/2006/04/21/06-3722/medicare-program-requirements-for-providers-and-suppliers-to-establish-and-maintain-medicare.

[20] SSA Section 1833(e) (42 U.S.C. §1395l(e)). SSA Section 1862(e)(1) (42 U.S.C. §1395y(e)(1)).

[21] U.S. Government Accountability Office (GAO), *Medicare: CMS's Use of Data Analytics to Identify and Prevent Fraud*, GAO-26-107799, March 30, 2026, https://files.gao.gov/reports/GAO-26-107799.

[22] HHS-OIG, *Medicare Could Have Saved $255.1 Million Related to Hospice Services for Certain New Hospice Enrollees*, A-06-22-09003, June 2026, https://oig.hhs.gov/reports/all/2026/medicare-could-have-saved-2551-million-related-to-hospice-services-for-certain-new-hospice-enrollees/. Also see the following additional resources: OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, OEI-02-17-00020, pg. 4, July 2019, https://oig.hhs.gov/ (continued...)

their agreement.[23] Both improper enrollment of new hospice agencies and certification of terminal illness can also lead to potentially fraudulent billing of services, which at times has occurred using stolen identities of medical personnel or beneficiaries.[24] In a recent example, a California man was found guilty of both impersonating others' identities to open hospices and improperly billing Medicare for hospice services that were never provided.[25]

CMS actions may vary based on the type of fraud or abuse identified.[26] CMS states that "the difference between 'fraud' and 'abuse' depends on specific facts, circumstances, intent, and knowledge."[27] The agency provides examples of fraud and abuse and lists differences between the two such as intent and knowledge. For instance, CMS provides as an example of fraud "knowingly billing for services at a level of complexity higher than services provided," whereas it provides as an example of abuse "charging excessively for services or supplies."[28] CMS often works with the U.S. Department of Health and Human Services-Office of the Inspector General (HHS-OIG) when combatting hospice fraud, in combination with efforts from the Department of Justice's Health Care Fraud Unit.[29] This report focuses specifically on selected examples of recent CMS actions in response to "likely fraudulent behavior" by hospice agencies and does not comprehensively discuss federal fraud and abuse laws or agency enforcement more generally.[30]

Federal Authorities and CMS Actions

This report includes selected examples of CMS's implementing regulations for statutory requirements related to hospice oversight and fraud. It first describes CMS oversight of the Medicare hospice benefit (summarized in **Table 1** below) and then describes CMS enforcement actions focused on hospice fraud and abuse. It provides examples of CMS actions in recent years as it pertains to hospice fraud and abuse and is not intended to be comprehensive in nature.

Program Oversight

Screening of Hospice Providers

The first opportunity to prevent fraud occurs before a hospice provider begins billing Medicare. Medicare statute directs CMS to establish screening procedures for Medicare providers and

documents/evaluation/2677/OEI-02-17-00020-Complete%20Report.pdf. California State Auditor, *California Hospice Licensure and Oversight*, p. 15, March 2022, https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf.

[23] MedPAC, *Report to the Congress: Medicare Payment Policy; Hospice Services*, Washington, DC, March 12, 2026, p. 306, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch10_MedPAC_Report_To_Congress_SEC.pdf.

[24] California State Auditor, California Hospice Licensure and Oversight, p. 15.

[25] DOJ, *Man Pleads Guilty in Connection with $17M Medicare Hospice Fraud and Home Health Care Fraud Schemes*, Press Release Number: 25-135, February 3, 2025, https://www.justice.gov/opa/pr/man-pleads-guilty-connection-17m-medicare-hospice-fraud-and-home-health-care-fraud-schemes.

[26] Fraud and abuse are related but distinct concepts. For more information, see CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report*, MLN4649244.

[27] CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report*, MLN4649244, p. 7.

[28] CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report*, MLN4649244, p. 6-7.

[29] One of HHS-OIG's primary aims is to prevent and detect fraud, waste, and abuse within Medicare and Medicaid. For more information, see HHS-OIG, *About OIG*, https://oig.hhs.gov/documents/root/1140/About-OIG-Fact-Sheet.pdf. U.S. Department of Justice (DOJ), *Health Care Fraud Unit*, January 30, 2026, https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit.

[30] For more information on federal fraud and abuse laws, see HHS-OIG, *Fraud & Abuse Laws*, https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/.

suppliers, including hospice providers.[31] Since 2011, CMS has included in regulations different levels of risk-based screening for providers and suppliers based upon the agency's determination of their potential risk of fraud, waste, and abuse (limited, moderate, and high risk) posed by a particular provider or supplier type.[32] Under these regulatory requirements, the Medicare Administrative Contractor (MAC) screens Medicare providers and suppliers upon new enrollment, revalidation, and certain changes in ownership.[33] Across all risk levels, screenings include licensure checks and verification that providers and suppliers meet federal and state requirements. For both moderate and high-risk providers the screening process also includes onsite visits, and for high-risk providers, it also requires that individuals with a 5% or greater ownership interest submit fingerprints for a criminal background check.[34]

In 2023, CMS engaged in a nationwide site visit effort to Medicare-enrolled hospices and, as of August 2023, announced that it had visited over 7,000 hospices in order to determine operational status, thus going beyond the requirement of site visits for hospices that were seeking new enrollment in Medicare, revalidation, or a change in ownership.[35] In August 2023, CMS announced that "nearly 400 hospices [were] being considered for potential administrative actions" such as deactivation or revocation of Medicare billing status as a result of the site visits (discussed further in "Enforcement Strategies").[36] These nationwide site visits represented an expansion beyond routine enrollment screening activities and reflected CMS's increased emphasis on program integrity. Additionally, in November 2023 CMS elevated hospice providers to the "high-risk" screening level given fraud-related concerns; previously, they had been considered "moderate risk" since the screening levels were established in 2011.[37]

Provisional Period of Enhanced Oversight (PPEO) for New Hospices

Medicare statute authorizes CMS to put new providers in a provisional period (of between 30 days to one year) of enhanced oversight (PPEO) by program instruction or otherwise.[38] A PPEO includes activities such as prepayment review (i.e., medical review of claims prior to Medicare payment to ensure medical necessity and sufficient documentation).[39] CMS has implemented the statutory directive by issuing (1) regulations defining "new" providers and suppliers that may be subject to PPEO as those that were newly enrolling in Medicare, currently certified and

[31] SSA Section 1866(j)(2) (42 U.S.C. §1395cc(j)(2)).

[32] 42 C.F.R. §424.518.

[33] *Change in ownership* is defined in 42 C.F.R. §489.18.

[34] 42 C.F.R. §424.518. Under 42 C.F.R. §424.517, CMS also "reserves the right, when deemed necessary" to perform onsite reviews of providers and suppliers.

[35] CMS, "CMS Is Taking Action to Address Benefit Integrity Issues Related to Hospice Care," August 22, 2023, https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care.

[36] CMS, "CMS Is Taking Action to Address Benefit Integrity Issues Related to Hospice Care."

[37] CMS, "Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements," 88 *Federal Register* 77676, November 13, 2023, https://www.federalregister.gov/documents/2023/11/13/2023-24455/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh.

[38] SSA Section 1866(j)(3) (42 U.S.C. §1395cc(j)(3)).

[39] For more information on prepayment review, see CMS, Medicare Program Integrity Manual, Ch. 7—MR Reports, 7.2.2.5 Rev. 721, p. 17, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c07.pdf.

undergoing a change in ownership, or reactivating their Medicare enrollment status, and (2) sub-regulatory guidance.[40]

In July 2023, CMS put four states (Arizona, California, Nevada, and Texas) in a PPEO for the Medicare hospice benefit.[41] Through December 2025, 817 hospices went through enhanced review under the PPEO.[42] In December 2025, CMS announced that it expanded its hospice PPEO to also include Georgia and Ohio. CMS has stated that for the hospice PPEO, 100% of claims will be audited for a period of time—and the timeframe will depend upon findings.[43] CMS has also announced that the hospice PPEO has resulted in revocations of enrollment, or prohibition from participation in Medicare, as discussed further below ("Revocation of Medicare Enrollment").

Enhanced Prepayment Review (EPR) for Existing Hospices

CMS has stated that under Medicare statute, which prohibits the payment of Medicare benefits to any providers or suppliers unless the information necessary to determine payments has been furnished, it can apply enhanced prepayment review (EPR) to existing hospice providers.[44] EPR is distinct from the PPEO, as it applies to existing hospice providers rather than new hospice providers and may involve review of selected claims rather than 100% of claims.

In September 2024, CMS put the same four states in an EPR as the PPEO, and in December 2025 added Georgia and Ohio after they were added to the PPEO as well.[45] It has not been announced how many existing hospices have been subject to EPR in these states; however, this is another mechanism for preventing improper payments and identifying potential fraud or abuse before Medicare funds are disbursed.[46]

Disclosures of Affiliation

Current law states that providers or suppliers that are newly enrolled or revalidating their Medicare enrollment must disclose certain affiliations with any providers or suppliers that have had a "disclosable event."[47] A disclosable event includes any uncollected debt to Medicare,

[40] 42 C.F.R. §424.527. *Change in ownership* is defined as meeting the regulatory requirements under 42 C.F.R. §489.18 or undergoing a 100% change in ownership. See also CMS, "CY 2024 HH PPS Rate Update," 88 *Federal Register* 77676.

[41] CMS, *Medicare Fee-for-Service Compliance Programs, Hospice*, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-education/hospice.

[42] CMS, *Hospice Fast Facts*, January 2026.

[43] CMS, *Medicare Fee-for-Service Compliance Programs, Hospice*.

[44] SSA Section 1833(e) (42 U.S.C. §1395l(e)). See also CMS, *Period of Enhanced Oversight for New Hospices*, MLN7867599.

[45] CMS, *Period of Enhanced Oversight for New Hospices*, MLN7867599.

[46] For more information on improper payments, see GAO, *Payment Integrity: Agencies' Estimated Improper Payments Increased to $186 Billion in Fiscal Year 2025*, GAO-26-108694, April 27, 2026, https://www.gao.gov/products/gao-26-108694.

[47] SSA Section 1866(j)(5) (42 U.S.C. §1395cc(j)(5)). See also CMS, "Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process," 84 *Federal Register* 47794, September 10, 2019, https://www.federalregister.gov/documents/2019/09/10/2019-19208/medicare-medicaid-and-childrens-health-insurance-programs-program-integrity-enhancements-to-the. 42 C.F.R. §424.519. 42 C.F.R. §424.502 defines affiliation, for purposes of applying 42 C.F.R. §424.519, as (1) a 5% or greater direct or indirect ownership interest that an individual or entity has in another organization; (2) a general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization; (3) an interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization; (4) an interest in which an individual is acting as an officer or director of a corporation; or (5) any reassignment relationship under §424.80.

Medicaid, or Children's Health Insurance Program (CHIP); any previous payment suspension; an HHS-OIG exclusion from participation in Medicare, Medicaid, or CHIP; and, any denial, revocation, or termination of enrollment.[48] CMS then determines whether any of the providers' disclosed affiliations pose an "undue risk of fraud, waste, or abuse," which can lead to denial or revocation of Medicare enrollment.[49]

By requiring disclosure of ownership and organizational relationships, these provisions may enable CMS to monitor relationships between different providers and suppliers and take action if such affiliations pose an undue risk to the Medicare program.

Temporary Moratorium on New Providers

Medicare statute authorizes CMS to impose a temporary moratorium on the enrollment of new providers and suppliers in Medicare, meaning new providers and suppliers cannot enroll in Medicare during this time if the agency "determines such moratorium is necessary to prevent or combat fraud, waste, or abuse."[50] Since 2011, CMS has promulgated general rules for the imposition of temporary moratoria.[51] These moratoria can be specified to include certain provider or supplier types, may be based upon designated geographic regions, and initially may last for six months, which can be extended as necessary.[52] Like the PPEO, temporary moratoria generally apply only to new providers and suppliers; such moratoria generally do not apply to hospice providers undergoing changes in ownership, except when a hospice undergoes a change in majority ownership within 36 months of its enrollment in Medicare.[53]

CMS has used this authority to impose temporary moratoria limited to targeted geographic areas, and, in 2026, nationally, for several provider and supplier types. For instance, in 2013 CMS imposed temporary moratoria on the enrollment of new Medicare home health providers and ambulance suppliers in several geographic areas.[54] These were extended and expanded to additional geographic areas several times until ultimately expiring on January 30, 2019.[55] In February 2026, CMS implemented a temporary moratorium on Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) medical supply companies.[56] In May 2026, CMS

[48] As defined in 42 C.F.R. §424.502.

[49] 42 C.F.R. §424.535(a)(19).

[50] SSA Section 1866(j)(7) (42 U.S.C. §1395cc(j)(7)). CMS is also authorized to do so for Medicaid and CHIP.

[51] 42 C.F.R. §424.570.

[52] 42 C.F.R. §424.570(b). CMS can also lift a moratorium at any time in situations described in 42 C.F.R. §424.570(d).

[53] Hospices and home health agencies with a change in ownership, as described in 42 C.F.R. §424.550(b), must complete new Medicare enrollment applications. Such entities, under 42 C.F.R. §424.570(a)(1)(iii)(C), would be subject to a moratorium. This is also true for DMEPOS suppliers under 42 C.F.R. §424.551.

[54] CMS, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Temporary Moratoria on Enrollment of Ambulances Suppliers and Providers and Home Health Agencies in Designated Geographic Areas," 78 *Federal Register* 46339, July 31, 2013, https://www.federalregister.gov/documents/2013/07/31/2013-18394/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-temporary-moratoria-on.

[55] CMS, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in Designated Geographic Locations," 79 *Federal Register* 6475, February 2, 2014, https://www.federalregister.gov/documents/2014/02/04/2014-02166/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary.

[56] CMS, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Medical Supply Companies," 91 *Federal Register* 9855, https://www.federalregister.gov/documents/2026/02/27/2026-03971/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-nationwide-temporary. See also CMS, "Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies," https://www.cms.gov/medicare/payment/fee-schedules/dmepos.

also announced a six-month nationwide temporary moratorium on new Medicare hospice and home health agency enrollment.[57]

Table 1. Selected Examples of Hospice Program Oversight Activities

Program Oversight Activity	Applicable to New Providers[a] Existing Providers, or Both	Relevant Authority
Enhanced Screening	Both[b]	SSA Section 1866(j)(2); 42 C.F.R. §424.518
Provisional Period of Enhanced Oversight (PPEO)	New	SSA Section 1866(j)(3); 42 C.F.R. §424.527
Enhanced Prepayment Review (EPR)	Existing	SSA Section 1833(e)[c]
Disclosures of Affiliation	Both[b]	SSA Section 1866(j)(5); 42 C.F.R. §424.519
Temporary Moratorium on Enrollment	New	SSA Section 1866(j)(7); 42 C.F.R. §424.570

Source: CRS analysis of statutory and regulatory text.

a. New enrollment includes certain changes of ownership, including those pursuant to 42 C.F.R. §489.18.

b. Upon new enrollment and revalidation (meaning the administrative process CMS uses to require providers to resubmit and update ownership, control, and management information, typically every five years).

c. No regulations identified, though CMS includes sub-regulatory guidance for prepayment review in its Medicare Program Integrity Manual, Ch. 7.

Enforcement Strategies

Medicare statute and implementing regulations provide a range of tools to CMS to address instances of noncompliance, fraud, or abuse by Medicare providers and suppliers, including hospices. This section discusses some of these tools as applied to hospices—specifically, Medicare payment suspensions and exclusion from participation (stays of enrollment, deactivation of Medicare enrollment, and revocation of Medicare enrollment).[58]

Medicare Payment Suspension

Medicare statute authorizes CMS to suspend payments to providers or suppliers, including due to suspected fraud.[59] Under 42 C.F.R. Part 405, CMS details instances in which Medicare payments to providers and suppliers may be suspended. Payment suspension does not terminate a provider's Medicare enrollment. Rather, it temporarily withholds Medicare reimbursement while the provider is under investigation to determine whether incorrect payments, overpayments, or fraud has occurred. Procedures for suspending payments vary by reason for suspension. For example, while in general prior to suspending payments CMS or a Medicare Administrative Contractor

[57] CMS, "CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice and Home Health Agency Enrollment Moratoria," May 13, 2026, https://www.cms.gov/newsroom/press-releases/cms-announces-aggressive-nationwide-crackdown-fraud-six-month-hospice-home-health-agency-enrollment. See also CMS, "Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices," 91 *Federal Register* 27946, May 15, 2026, https://www.federalregister.gov/documents/2026/05/15/2026-09718/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-nationwide-temporary.

[58] Providers and suppliers suspected of fraud and abuse may also be subject to civil and criminal enforcement actions, which are out of scope of this report. For more information, see, for example, SSA Sections 1128A and 1128B.

[59] SSA Section 1862(o) (42 U.S.C. §1395y(o)).

(MAC) must provide a prior notice to the provider or supplier of the intent to suspend payments and the rationale for doing so, a prior notice is not required if CMS has determined that doing so would harm the Medicare Trust Fund.[60] In cases of suspected fraud, CMS consults with HHS-OIG prior to imposing the suspension and determines whether a prior notice is required. In instances both with and without prior notice, providers and suppliers have the opportunity to submit a rebuttal.[61] Medicare payment suspensions are generally on a temporary basis and limited to an initial 180 days (with exceptions), during which CMS or a MAC will investigate to determine whether an overpayment exists.[62]

In a May 2026 press release, CMS announced that payments to approximately 800 hospices and home health agencies have been suspended in Los Angeles, which, as previously mentioned, is within one of the states where enhanced oversight has occurred due to fraud concerns.[63]

Stays of Enrollment

CMS may also place a provider or supplier's Medicare enrollment in a temporary "stay" status, which has been described by CMS as "a preliminary, interim status representing a pause in enrollment" when the provider or supplier fails to satisfy certain enrollment requirements that can be corrected administratively.[64] Under a stay of enrollment, which can occur for instances of noncompliance with Medicare enrollment requirements that can be remedied via certain forms, providers or suppliers stay enrolled in Medicare but claims will be rejected until they have resumed compliance with enrollment requirements. The stay can last up to 60 days, and providers and suppliers can rebut stays of enrollment, typically within 15 calendar days. CMS described a stay of enrollment as an action that can be submitted via a form change of information or revalidation application and that is "less burdensome on providers and suppliers than deactivating or revoking Medicare enrollment," both of which are described below.[65]

Deactivation of Medicare Enrollment

CMS can deactivate Medicare billing privileges, which may occur due to lack of operational status, lack of compliance with enrollment requirements, and voluntary withdrawal, among other reasons.[66] When a provider or supplier has their Medicare billing privileges deactivated, they

[60] 42 C.F.R. §405.372(a)(3).

[61] 42 C.F.R. §405.374.

[62] 42 C.F.R. §405.372(d). In certain circumstances, payment suspensions can be extended for up to an additional 180 days to complete review of information or investigation. In cases of credible allegations of fraud, as determined by CMS or MAC in consultation with HHS-OIG, the 180-day time limits do not apply, though suspensions must remain temporary and be discontinued following the resolution of an investigation.

[63] CMS, "CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice and Home Health Agency Enrollment Moratoria." According to recent estimates, in the United States as of April 2026, there were 6,852 CMS-certified hospice agencies and as of May 2026 there were 12,460 home health agencies, for a total of 19,312 hospice and home health agencies. CMS, "Hospice – General Information," last modified April 13, 2026, https://data.cms.gov/provider-data/dataset/yc9t-dgbk#data-table. CMS, "Home Health Care Agencies," last modified May 27, 2026, https://data.cms.gov/provider-data/dataset/6jpm-sxkc.

[64] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program," 88 *Federal Register* 78818, November 16, 2023, https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

[65] CMS, *Stay of Enrollment*, MM13449, March 4, 2024, https://www.cms.gov/files/document/mm13449-stay-enrollment.pdf.

[66] 42 C.F.R. §424.540.

cannot receive payments for services or items provided under Medicare. In order to reactivate their Medicare billing privileges, providers are required to recertify their enrollment information, provide any required missing information, and be in compliance with Medicare enrollment requirements.[67] A provider or supplier subject to deactivation may submit—generally with 15 calendar days of receiving a deactivation notice—a rebuttal that specifies why the provider or supplier disagrees with the deactivation imposition.[68] CMS must then review the rebuttal and determine whether the deactivation imposition and effective dates are correct. Deactivation is generally intended to restore compliance rather than permanently remove providers from Medicare, and it is typically considered less severe than revocation.

Revocation of Medicare Enrollment

CMS can also revoke a provider or supplier's Medicare enrollment status, which may occur following periods of enhanced oversight, as discussed above.[69] Revocation includes a re-enrollment ban of numerous years, suggesting this is a more severe consequence relative to deactivation. Implementing regulations include reasons for providers' revocation of Medicare enrollment status and list when revocation dates are effective. They also detail the appeals process following a revocation notice and the process for reapplying for participation in Medicare after revocation.

CMS has used its authority to revoke hospice providers from Medicare following its initiation of enhanced oversight within hospice. On April 2, 2026, CMS announced that over 200 hospices in the initial four states under PPEO had now had their Medicare enrollment revoked.[70]

Reasons for Revocation

CMS lists 23 reasons for revocation in Medicare in regulations that apply to hospice providers and other Medicare providers and suppliers.[71] Some of the reasons have been added or expanded upon in recent years. For instance, as mentioned above, in 2019, "affiliation that poses an undue risk" was added as a reason for revocation. Additionally, in December 2025, CMS added a basis for revocation that "the beneficiary attests that the item(s) or service(s) identified on the provider's or supplier's claim or claims was not or were not rendered or furnished" under the existing reason "abuse of privileges."[72] While prior to this CMS could revoke enrollment if the agency determined the provider submitted a claim that could not have been rendered on the date of service because the beneficiary was deceased or the provider or equipment listed in the claim was not present, CMS noted that this expansion of the definition to include beneficiary

[67] CMS may also require providers or suppliers to submit additional information for reactivation, as described further in 42 C.F.R. §424.540.

[68] 42 C.F.R. §424.546.

[69] 42 C.F.R. §424.535.

[70] CMS, *CMS Proposes New Transparency Measures to Strengthen Oversight of Hospice Providers*, April 2, 2026, https://www.cms.gov/newsroom/press-releases/cms-proposes-new-transparency-measures-strengthen-oversight-hospice-providers.

[71] For more information on revocation reasons, see CMS, *Medicare Program Integrity Manual*, *Chapter 10 - Medicare Enrollment*, August 13, 2025, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c10.pdf.

[72] CMS, "Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies," 90 *Federal Register* 55342, December 2, 2025, https://www.federalregister.gov/documents/2025/12/02/2025-21767/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate.

attestations of abuse of privileges was in response to observed situations where claims did not reflect services received.[73]

Appeals of Revocations and Re-enrollment Bar

When a provider or supplier has their Medicare enrollment status revoked, the revocation notice that they receive becomes an initial determination subject to reconsideration and potential further appeal as detailed further in 42 C.F.R. Part 498. The appeals process can vary based on reason for revocation, and reversals of revocations may be possible.[74] Additionally, after providers have their Medicare status revoked, they typically are under a re-enrollment bar and cannot reapply for a certain period of time—most often ranging from one to 10 years, barring certain exceptions.[75] This 10-year maximum re-enrollment bar was extended from three years in 2019, with CMS citing that it was doing so in the event that "certain behavior could prove so harmful to Medicare, its beneficiaries, and/or the Trust Funds that a very lengthy bar from Medicare is warranted."[76]

In March 2026, CMS added a publicly available dataset on Medicare provider revocations and re-enrollment bars to its website.[77] **Table 2** shows that in the latest full year of available, 2025, CMS invoked the 10-year maximum enrollment ban for 111 of the 149 hospice revocations, meaning that over 75% of 2025 hospice revocations were subject to a 10-year re-enrollment bar.[78]

Table 2. 2025 Medicare Hospice Revocations and Re-Enrollment Bars

N = 149 hospices

Revocation Reason	Number of Hospices Revoked	Re-Enrollment Bar Length
Abuse of Billing Privileges: Pattern or Practice (42 C.F.R. §424.535(a)(8)(ii))	71	10 years
Affiliation That Poses an Undue Risk (42 C.F.R. §424.535(a)(19))	35	10 years
False or Misleading Information (42 C.F.R. §424.535(a)(4))	5	10 years
On-Site Review (42 C.F.R. §424.535(a)(5))	10	3 years
Failure to Report (42 C.F.R. §424.535(a)(9))	7	3 years
Noncompliance (Enrollment Requirements) (42 C.F.R. §424.535(a)(1))	3	1-2 years[a]
Multiple reasons listed	18	3-11 years[b]

[73] CMS, "Calendar Year 2026 Home Health Prospective Payment System Rate Update," 90 *Federal Register* 55342.

[74] There are 23 reasons for revocation listed in 42 C.F.R. §424.535. 42 C.F.R. §424.535(e) states that reversals of revocation are possible if the "revocation was due to adverse activity (sanction, exclusion, or felony) against the provider's or supplier's owner, managing employee, managing organization" and certain other personnel if the provider or supplier terminates its business relationship with that party within 15 days of the revocation notification.

[75] There are certain circumstances where re-enrollment bars either do not apply, or when their length can be longer, as described further in 42 C.F.R. §424.535(c). Revocation can be followed by termination by CMS (42 C.F.R. §489.53).

[76] CMS, "Program Integrity Enhancements to the Provider Enrollment Process," 84 *Federal Register* 47794.

[77] CMS, "Revoked Medicare Providers and Suppliers," March 2026, https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/revoked-medicare-providers-and-suppliers. In an email to CRS, CMS stated that "this dataset is best used to identify providers currently barred from re-enrollment and includes only providers that have an active re-enrollment bar that is in effect." CMS also clarified that revocations are published only after the first level of appeal period is exhausted.

[78] CMS, "Revoked Medicare Providers and Suppliers."

Source: CRS analysis of 2025 CMS Revoked Medicare Providers and Suppliers Dataset as of June 2026.

Notes: "N" signifies the number of hospices included. Re-enrollment bar length was estimated by subtracting the revocation effective date from the re-enrollment bar expiration date and rounding to the number of years. Providers included those categorized as "Part A Provider – Hospice."

a. Re-enrollment bar length for Noncompliance (Enrollment Requirements) ranged from 1.2 years to 1.7 years, rounded in the table to 1-2 years.

b. Under certain circumstances, as described further under 42 C.F.R. §424.535(c), the 10-year maximum can be extended. The fact that one revocation with multiple reasons listed shows up as having a re-enrollment bar of 11 years could be due to one of these circumstances or due to a data reporting error.

Revocation bar length varied by reason. In 2025, according to the CMS dataset, the two most common reasons for revocation were (1) abuse of billing privileges: pattern or practice, which accounted for 71 hospice revocations, and (2) affiliation that poses an undue risk, which accounted for 35 hospice revocations.[79] All hospices that were listed as revoked due to one of those two reasons were subject to 10-year re-enrollment bars. This demonstrates that in 2025, CMS has been drawing upon its new ability as of 2019 to extend re-enrollment bars to up to 10 years for hospice providers when deemed necessary. Additionally, as previously mentioned, affiliation that poses an undue risk was added as a reason for revocation in 2019, demonstrating that CMS has been using this new reason to revoke hospices' Medicare participation status. This suggests that hospice providers that were affiliated with other providers or suppliers that had a disclosable event are now being revoked from participating in Medicare.

Preclusion List

Any providers or other entities that are revoked from Medicare, under an active re-enrollment bar, and determined by CMS that their "underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program" are included on a "preclusion list."[80] When on the preclusion list, individuals and entities are not able to receive payment under Medicare Advantage (MA, Part C), which is a private plan-administered alternative to traditional Medicare, or under Medicare Part D, which is Medicare's outpatient prescription drug benefit.[81] Because in 2019 CMS rescinded requirements that providers of MA services and prescribers of the Part D benefit must be enrolled in Medicare, the agency created the preclusion list because otherwise revocation of Medicare enrollment would not automatically bar these providers and prescribers from receiving Medicare payments through MA and Part D.[82] CMS stated that this change was to "reduce the burden on Part D prescribers and MA providers without compromising our program integrity efforts."[83]

[79] For abuse of billing privileges: pattern or practice, 42 C.F.R. §424.535(a)(8)(ii) specifies that "CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements" based upon claim denials, adverse actions, billing noncompliance, and other information.

[80] 42 C.F.R. §422.2. *Revoked from Medicare* is defined as any reason listed in 42 C.F.R. §424.535 other than felonies.

[81] For more information, see CRS In Focus IF13031, *Medicare Coverage: Background and Resources*, by Paulette C. Morgan and Michele L. Malloy.

[82] CMS, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program," 83 *Federal Register* 16440, April 16, 2018, https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare.

[83] CMS, "Medicare Program; Contract Year 2019 Policy and Technical Changes," 83 *Federal Register* 16440.

Providers put on the preclusion list must first be notified and may appeal their inclusion.[84] Providers will not be included on the list until their 60-day period to submit their reconsideration request has expired or their reconsideration request has been denied.[85]

For hospice providers, it is possible that those who have been revoked from Medicare and are under an active re-enrollment bar—for instance, because they have an affiliation that poses an undue risk—have been added to the preclusion list. CMS does not make the list publicly available and has not indicated whether or how many hospice providers have been added to the list recently.

Selected Congressional Considerations

Over the past several years, CMS has announced a number of program integrity-related activities focused on the Medicare hospice benefit such as increased reporting of affiliations upon enrollment or revalidation in Medicare, enhanced oversight through prepayment medical review and site visits, and a nationwide temporary moratorium on the enrollment of new hospice providers.[86] These activities have resulted in various enforcement actions, including 149 hospice revocations of Medicare enrollment status in 2025, and re-enrollment bars for revoked hospices, which were the maximum length of 10 years in over three-quarters of revocations in 2025. For hospice revocations in 2025, the second most common reason for revocation was disclosures of affiliation, and all hospices revoked for this reason received 10-year re-enrollment bars. Additionally, CMS suspended payments to over 800 hospice and home health agencies. CMS also imposed a nationwide moratorium on hospice providers, as well as home health agencies, which along with DMEPOS suppliers are the first three nationwide moratoria of a type of new Medicare provider or supplier. Depending on its priorities, Congress may consider whether to take further action, including oversight of CMS or further specifying CMS's authority to combat hospice fraud while preserving beneficiary access to hospice care. All considerations listed below involve a trade-off between preventing fraud and imposing a burden on providers (and beneficiaries, if their access is affected).

One issue for congressional consideration is the scope and implementation of CMS's affiliation authority. Given that affiliation of undue risk accounted for more than one-quarter of Medicare hospice revocations in 2025, Congress could conduct oversight to better understand how CMS identifies affiliations that present an "undue risk" to Medicare. Depending on how this authority is being used, Congress could consider whether this definition is sufficient or should be broadened or narrowed accordingly. In a proposed rule issued in July 2026, CMS proposed expanding its bases for revocation or denial for several additional circumstances.[87] Given the evolving nature of revocation reasons, Congress could also consider requiring a report detailing how CMS is using its authority to revoke hospice providers based on different reasons each year.

Congress also may consider whether CMS's use of re-enrollment bars is appropriately calibrated to provider conduct. Re-enrollment bars can vary between one to 10 years (with the 10-year

[84] 42 C.F.R. §422.222.

[85] 42 C.F.R. §422.222. CMS also notes that if Medicare revocation and inclusion on the preclusion list occur at the same time, the appeals process must be filed jointly under 42 C.F.R. Part 498.

[86] CMS, *Hospice Fast Facts*, January 2026.

[87] CMS, "Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies," 91 *Federal Register* 41216, July 6, 2026, https://www.federalregister.gov/documents/2026/07/06/2026-13602/calendar-year-2027-home-health-prospective-payment-system-hh-pps-rate-update-requirements-for-the-hh.

maximum being an extension of the previous three-year maximum). CMS used the maximum 10-year bar in most hospice revocations during 2025. Lawmakers could consider whether they think this bar length is sufficient or should be made shorter or longer, particularly as it appears that in 2025 the maximum re-enrollment bar was used for the majority of hospice revocations.

Another area for possible oversight is CMS's expanded use of payment suspensions. Although payment suspensions may limit improper Medicare expenditures while investigations are ongoing, they may also affect providers that are ultimately found to be compliant. Given that CMS announced it has suspended payments to over 800 hospice and home health agencies, Congress could require a report from CMS to understand whether any hospice agencies have had their payments unduly suspended and whether this has affected patient access to services—particularly in areas with limited provider availability.[88]

Congress may also wish to request information on the effects of the May 2026 nationwide temporary moratorium of enrollment of hospice providers for preventing fraud across states. Moreover, Congress could consider whether temporary moratoria should be limited to states or localities that exhibit increased fraud or remain nationwide. In April 2026, several state hospice associations wrote a letter to CMS "urg[ing] CMS to exercise caution before imposing a nationwide moratorium for hospice," stating that this "would impact the ability for legitimate hospices to provide quality care during a time of rising demand" and that "regulatory enforcement should be targeted to geographic fraud hotspots."[89] On the other hand, it's possible that all states may benefit from this moratorium if it reduces opportunities for fraudulent providers to relocate operations to areas not covered by geographically targeted restrictions and enables the reduction of hospice fraud.

Congress and CMS could continue to monitor measures of fraud for indications of whether recent program integrity activities have been effective.[90] An in-progress report from HHS-OIG, estimated to be completed in FY2027, may also lend additional insight into "vulnerabilities related to new Medicare hospice provider enrollments" and may help to inform CMS program integrity and oversight activities.[91] The findings from this review may assist Congress in evaluating whether existing statutory authorities are sufficient or whether additional legislative action may be warranted.

[88] Media reports suggest that some hospice agencies may have unduly had their Medicare payment suspended. Isaac Arnsdorf, "Vance's Fraud Task Force Is Sweeping Up Legitimate Small Businesses," *Washington Post*, June 15, 2026, https://www.washingtonpost.com/politics/2026/06/15/vances-fraud-task-force-is-sweeping-up-legitimate-small-businesses/?itid=sr_0_1952b04c-b19b-49da-bb94-3f184c278f33.

[89] Holly Vossel, "State Associations Urge CMS to Forgo Potential National Hospice Enrollment Moratorium," April 10, 2026, *Hospice News,* https://hospicenews.com/2026/04/10/state-associations-urge-cms-to-forgo-potential-national-hospice-enrollment-moratorium/.

[90] CMS, *CMS Proposes New Transparency Measures to Strengthen Oversight of Hospice Providers*.

[91] HHS-OIG, *Trends and Patterns in Data Related to Newly Enrolled Hospice Providers*, OAS-25-09-034, April 15, 2025, https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/trends-and-patterns-in-data-related-to-newly-enrolled-hospice-providers/.

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