Department of Health and Human Services
Office of Inspector General
Office of Audit Services

June 2026 | A-06-22-09003

Medicare Could Have Saved $255.1 Million Related to Hospice Services for Certain New Hospice Enrollees

REPORT HIGHLIGHTS

June 2026| A-06-22-09003

Medicare Could Have Saved $255.1 Million Related to Hospice Services for Certain New Hospice Enrollees

Why OIG Did This Audit

- The Medicare hospice benefit allows hospice providers to claim Medicare reimbursement for hospice services provided to enrollees with a life expectancy of 6 months or less who have elected hospice care.
- Previous OIG audits found that Medicare paid individual hospice providers for services provided to enrollees who were not eligible for hospice services.
- This audit assessed whether CMS made Medicare payments for hospice services provided in fiscal year 2021 in accordance with Medicare requirements for certain new hospice enrollees.

What OIG Found

CMS made Medicare payments to hospices for certain new hospice enrollees who did not meet hospice eligibility requirements. Of the 100 initial certification periods we reviewed, the documentation for 45 did not meet Medicare hospice requirements. Specifically:

- For 21 periods, the clinical information in the enrollee's medical records did not support that the enrollee had a terminal illness, resulting in $251,067 in unallowable payments.
- For 24 periods, the medical records did not meet hospice eligibility documentation requirements, resulting in $294,432 in unallowable payments.

Based on our sample results, we estimated that Medicare could have saved $255.1 million in hospice claim payments associated with the new hospice enrollees in our sampling frame if the hospice Medicare Administrative Contractors (MACs) had eligibility review procedures for enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care.

What OIG Recommends

We recommend that CMS work with the hospice MACs to consider this high-risk area in their hospice eligibility reviews and possibly develop pre- or postpayment review procedures for new hospice enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care, which could have saved an estimated $255.1 million during our audit period.

CMS concurred with our recommendation.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

Hospice care can provide great comfort to Medicare enrollees, families, and caregivers at the end of an enrollee's life. The Medicare hospice benefit allows hospice providers to claim Medicare reimbursement for hospice services provided to enrollees with a life expectancy of 6 months or less who have elected hospice care. Some previous Office of Inspector General (OIG) audits found that Medicare paid individual hospice providers for services provided to enrollees who were not eligible for hospice services.[1]

A hospice enrollee's health will typically decline before starting hospice care. During this decline in health, an enrollee will likely have emergency room visits or inpatient hospital stays. However, we identified hospice services provided to certain new enrollees (i.e., those that did not have an emergency room or inpatient claim in the 18 months prior to starting hospice care).

OBJECTIVE

Our objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) made Medicare payments to hospices for certain new hospice enrollees in accordance with Medicare requirements.

BACKGROUND

The Medicare Program

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

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

[1] Appendix B contains a list of these OIG audit reports.

[2] The MACs are National Government Services, Inc. (two jurisdictions); CGS Administrators, LLC (one jurisdiction); and Palmetto GBA, LLC (one jurisdiction).

Hospice Care Requirements

To be eligible for Medicare hospice care, an enrollee must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course.[3] For eligible enrollees, a payment is made to the hospice for each day that the enrollee is eligible.[4] Coverage under the Medicare hospice benefit requires that hospice services be reasonable and necessary for the palliation and management of a terminal illness and related conditions.[5, 6]

An enrollee eligible for the Medicare hospice benefit may elect hospice care by filing a signed election statement with a hospice. The election statement contains, among other things, information such as the identification of the particular hospice that will provide care to the enrollee and the enrollee's acknowledgment that the enrollee has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment.[7] Each enrollee's medical record must include the election statement.[8]

Section 1814(a)(7) of the Act specifies that certification of the terminal illness for hospice benefits must be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group and the enrollee's attending physician, if he or she has one, regarding the normal course of the enrollee's illness.[9] No one other than a Doctor of Medicine or Osteopathy can certify or recertify a terminal illness. A complete written certification must include, among other things, the statement that the enrollee's medical prognosis is a life expectancy of 6 months or less, if the terminal illness runs its normal course, and specific clinical findings and other documentation supporting a life expectancy of 6 months or less.[10]

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[3] 42 CFR § 418.20.

[4] 42 CFR § 418.302.

[5] 42 CFR § 418.200.

[6] 42 CFR § 418.3 defines palliative care as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care provides comfort to the patient but is not intended to be curative.

[7] 42 CFR §§ 418.24(a)-(b).

[8] 42 CFR § 418.104(a)(2).

[9] A hospice interdisciplinary group consists of individuals who together, in consultation with the enrollee's attending physician, formulate the hospice plan of care for terminally ill enrollees. The interdisciplinary group must include, but is not limited to, a Doctor of Medicine or Osteopathy, a registered nurse, a social worker (marriage and family therapist or a mental health counselor), and a pastoral or other counselor (42 CFR § 418.56).

[10] 42 CFR § 418.22(b).

Enrollees are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.[11] At the start of the initial 90-day benefit period of care, the hospice must obtain written certification of the enrollee's terminal illness. A written certification must be on file in the hospice enrollee's record prior to submission of a claim to a hospice MAC and may be completed no more than 15 calendar days before the effective date of election or the start of the subsequent benefit period.[12]

Hospice Medicare Administrative Contractors

CMS contracts with hospice MACs to process and pay Medicare Part A claims submitted by hospices. In addition to processing claims, hospice MACs' contractual responsibilities include performing hospice eligibility reviews. For the reviews, the hospice MACs told us they review hospice claims that meet various criteria. For example, Palmetto GBA, LLC, and National Government Services, Inc., select hospice providers based on various factors (e.g., hospices with unusual billing patterns) and then select a sample of claims from that provider for review. CGS Administrators, LLC, selects hospice claims that meet certain criteria such as claims for hospice enrollees with lengths of stay longer than 730 days or hospice claims submitted by relatively new providers. None of the eligibility reviews the MACs performed specifically targeted enrollees without an inpatient or emergency room claim prior to starting hospice care.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $580.5 million in Medicare payments for 46,767 new hospice enrollee initial certification periods comprised of 125,329 paid hospice claims in Federal fiscal year (FY) 2021 (October 1, 2020, through September 30, 2021).[13, 14] Our sampling frame included the initial hospice 90-day certification period for new hospice enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care.[15] Each enrollee associated with the sampling frame had at least one paid hospice claim in FY 2021 and was still alive 180 days after starting hospice care. We selected for review a simple random sample of 100 new

[11] 42 CFR § 418.21(a).

[12] 42 CFR § 418.22.

[13] This was the most recent complete data set when we started the audit.

[14] For the purposes of this audit, new hospice enrollees are those who did not have a hospice claim in the 12 months prior to starting hospice care in our audit period.

[15] We selected 18 months to provide an adequate and conservative timeframe for identifying claims without services.

hospice enrollee initial certification periods associated with 100 enrollees, which included 260 total hospice claim payments totaling $1.2 million.[16]

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

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains our audit findings for each sample item.

FINDINGS

CMS made Medicare payments to hospices for certain new hospice enrollees who did not meet hospice eligibility requirements. Of the 100 initial certification periods we reviewed, the documentation for 55 met Medicare hospice eligibility requirements; however, the documentation for the remaining 45 did not meet requirements. Specifically:

- For 21 periods, the clinical information in the enrollee's medical records did not support that the enrollee had a terminal illness, resulting in $251,067 in unallowable payments.

- For 24 periods, the medical records did not meet hospice eligibility documentation requirements, resulting in $294,432 in unallowable payments.

CMS relied on the hospice MACs to perform hospice eligibility reviews. The hospice MACs had not considered new hospice enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care as a high-risk area; therefore, the hospice MACs had not conducted reviews of the claims associated with these enrollees.

Based on our sample results, we estimated that Medicare could have saved $255.1 million in hospice claim payments associated with new hospice enrollees in our sampling frame if the hospice MACs had eligibility review procedures for enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care.[17]

[16] Hospices bill for hospice services on a monthly basis. Each enrollee initial certification period had up to three claims and their associated payments (up to 3 months or 90 days); those enrollees' certification periods that were close to the end of FY 2021 (e.g., August 2021 or September 2021) would have only had one or two claims and payments.

[17] The exact amount of estimated savings is $255,113,489.

The Medical Records Did Not Support That the Enrollee Had a Terminal Illness

To be eligible for the Medicare hospice benefit, an enrollee must be certified as being terminally ill. At the start of the initial 90-day benefit period, the hospice must obtain written certification of the enrollee's terminal illness from the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician, if any.[18, 19] Clinical information and other documentation that supports the enrollee's prognosis for a life expectancy of 6 months or less if the terminal illness runs its normal course must accompany the physician's certification and be filed in the medical record with the written certification of terminal illness.[20]

For 21 of the 100 sampled new hospice enrollee initial certification periods, the clinical information and other documentation did not support that the enrollee had a terminal illness, resulting in $251,067 in unallowable payments. The independent medical review contractor determined that the medical records did not contain sufficient clinical information to support the medical prognosis of a life expectancy of 6 months or less if the terminal illness ran its normal course.

The Medical Records Did Not Meet Hospice Eligibility Documentation Requirements

Hospice providers are required to establish and maintain a medical record for each hospice enrollee that includes the written certification of terminal illness and an election statement.[21, 22] The certification of terminal illness helps to ensure that hospice services are provided only to those who meet hospice eligibility criteria; specifically, those with a life expectancy of 6 months or less if the terminal illness runs its normal course.[23] An enrollee who meets the eligibility requirements may file an election statement with a particular hospice. The election statement is a critical document because it initiates a Medicare enrollee's election to receive hospice services. The election statement must include certain elements (e.g., the identification of the hospice and the attending physician providing the care, an acknowledgement that the enrollee understands that hospice care is palliative rather than

[18] 42 CFR §§ 418.20 and 418.22.

[19] Enrollees are entitled to receive hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.

[20] 42 CFR §§ 418.22(b) and (b)(1).

[21] 42 CFR § 418.104(a)(2).

[22] 42 CFR § 418.22(d)(2).

[23] 42 CFR § 418.22(b).

curative, and the signature of the enrollee).[24] Each enrollee's medical record must include the election statement.[25]

For 24 of the 100 sampled new hospice enrollee initial certification periods, the medical records provided by the hospice did not meet hospice eligibility documentation requirements, resulting in $294,432 in unallowable payments. Specifically, the hospice providers did not provide any supporting documentation (no records were received) for seven enrollees. Also, the record was completely missing the election statement (three enrollees) or was missing required elements from the election statement (seven enrollees). The certification of terminal illness was missing (five enrollees), or the elements of the certification were missing, such as enrollee or physician signatures (two enrollees).

RECOMMENDATION

We recommend that CMS work with the hospice MACs to consider this high-risk area in their hospice eligibility reviews and to possibly develop pre- or postpayment review procedures for new hospice enrollees without an inpatient or emergency room claim 18 months prior to starting hospice care, which could have saved an estimated $255.1 million in hospice claim payments during our audit period.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and stated that it would share the report with hospice MACs to use in their risk analysis and work planning to determine whether the risk area identified in this audit report should be prioritized. CMS also provided technical comments, which we addressed as appropriate.

CMS comments, excluding the technical comments, are included as Appendix F.

[24] 42 CFR § 418.24.

[25] 42 CFR § 418.104(a)(2).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $580.5 million in Medicare payments for 46,767 new hospice enrollee initial certification periods comprised of 125,329 paid hospice claims in Federal FY 2021 (October 1, 2020, through September 30, 2021).[26] Our sampling frame included the initial hospice 90-day certification period for new hospice enrollees without an inpatient or emergency room claim 18 months prior to starting hospice care. Each enrollee associated with the sampling frame had at least one paid hospice claim in FY 2021 and was still alive 180 days after starting hospice care. We selected for review a simple random sample of 100 new hospice enrollee initial certification periods associated with 100 enrollees, which included 260 total hospice claim payments totaling $1.2 million.

We discussed the hospice eligibility review process with CMS and contacted each hospice MAC to learn how and when they perform eligibility reviews. However, because the auditee is CMS, we did not perform any further internal control testing at the hospice MACs.

We performed testing of CMS's Integrated Data Repository (IDR) hospice claims data (e.g., verified control totals and reviewed the criteria for the data pull) and determined that the data were reliable.[27]

We contacted the hospices providing services during the sampled new enrollees' initial certification periods and requested the supporting medical records. We submitted these medical records to an independent medical review contractor to determine whether: (1) hospice care was medically necessary for the enrollee and (2) the enrollee's medical record met certain documentation requirements to be enrolled in hospice.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal hospice laws, regulations, and CMS and hospice MAC procedures

- Discussed the hospice eligibility review process with CMS and the hospice MACs

[26] For the purposes of this audit, new hospice enrollees are those who did not have a hospice claim in the 12 months prior to their first hospice claim in the audit period.

[27] CMS's IDR contains a wide range of Medicare-related data including Medicare Part A hospice claims.

- Obtained hospice claims data from CMS's IDR for FY 2021 (October 1, 2020, through September 30, 2021)

- Verified the reliability of the Medicare hospice claims data by reconciling it to other IDR data

- Identified a sampling frame of 46,767 new hospice enrollee initial certification periods comprised of 125,329 paid hospice claims in FY 2021, totaling $580.5 million in Medicare payments

- Selected a simple random sample of 100 new hospice enrollee initial certification periods and reviewed up to three hospice claims for each enrollee covering the majority of the initial certification period, which in total included 260 hospice claim payments

- Requested medical records from each hospice that provided care to the enrollees during the sampled initial certification period

- Provided the medical records to an independent medical review contractor and compiled the results of its medical review

- Estimated potential cost savings for new hospice enrollees associated with our sampling frame that did not meet hospice eligibility requirements based upon the sample results

- Discussed the results of our audit with CMS

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Hospice Provider Compliance Audit: Hospice of Palm Beach County, Inc.	A-02-20-01001	9/23/2022
Medicare Hospice Provider Compliance Audit: Partners in Care, Inc.	A-09-18-03024	7/12/2021
Medicare Hospice Provider Compliance Audit: Mission Hospice & Home Care, Inc.	A-09-18-03009	7/8/2021
Medicare Hospice Provider Compliance Audit: Northwest Hospice, LLC	A-09-20-03035	6/23/2021

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 46,767 new hospice enrollee initial certification periods from FY 2021 comprised of 125,329 paid hospice claims for services provided in FY 2021 totaling $580,508,276 in Medicare payments. The sampling frame included the initial 90-day certification period for new hospice enrollees that had no inpatient or emergency room claims for at least 548 days (18 months) prior to the enrollee's start of hospice care in FY 2021 and who were still alive 180 days (6 months) after starting hospice care.

SAMPLE UNIT

The sample unit was a new hospice enrollee's initial certification period.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample to select 100 new hospice enrollee initial certification periods and reviewed up to three hospice claims covering the majority of each selected initial certification period.

SOURCE OF RANDOM NUMBERS

We used the Office of Audit Services' (OAS) statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the initial certification periods by the associated new hospice enrollee's unique identification number and then consecutively numbered the sampling units in the sampling frame. We generated the random numbers in accordance with our sample design, and then we selected the corresponding sample units for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total dollar value of potential Medicare cost savings for new hospice enrollees associated with our sampling frame that did not meet hospice eligibility requirements. We used this software to calculate the point estimate and the corresponding lower and upper limits of the two-sided 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Detail and Results

Number of Initial Certification Periods in the Sampling Frame	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Number of Initial Certification Periods with Errors in the Sample	Total Payments for Initial Certification Periods with Errors in the Sample
46,767	$580,508,276	100	$1,197,048	45	$545,499

Table 2: Estimated Dollar Value of Potential Medicare Cost Savings in the Sampling Frame (*Limits Calculated for a 90-Percent Confidence Interval*)

Point Estimate	$255,113,489
Lower Limit	$204,918,573
Upper Limit	$308,786,496

APPENDIX E: DETAILED ERRORS BY SAMPLE NUMBER

Sample Number		Documentation Errors				
	Terminal Prognosis Not Supported by Documentation	No Documentation Provided	No Notice of Election	Notice of Election Missing Required Element(s)	No Certification of Terminal Illness	Certification of Terminal Illness Missing Required Element(s)
1						
2						
3		1				
4			1			
5					1	
6						
7	1					
8					1	
9						
10	1					
11				1		
12						1
13					1	
14		1				
15						
16						
17						
18	1					
19						
20						
21						
22	1					
23						1
24						
25						

Sample Number		Documentation Errors				
	Terminal Prognosis Not Supported by Documentation	No Documentation Provided	No Notice of Election	Notice of Election Missing Required Element(s)	No Certification of Terminal Illness	Certification of Terminal Illness Missing Required Element(s)
26						
27						
28	1					
29	1					
30					1	
31						
32						
33				1		
34						
35	1					
36	1					
37						
38	1					
39						
40						
41						
42						
43			1			
44		1				
45						
46	1					
47		1				
48				1		
49	1					
50						

Sample Number		Documentation Errors				
	Terminal Prognosis Not Supported by Documentation	No Documentation Provided	No Notice of Election	Notice of Election Missing Required Element(s)	No Certification of Terminal Illness	Certification of Terminal Illness Missing Required Element(s)
51						
52						
53						
54			1			
55	1					
56				1		
57						
58						
59						
60					1	
61						
62						
63						
64						
65						
66	1					
67		1				
68						
69						
70						
71						
72				1		
73						
74						
75						

Sample Number		Documentation Errors				
	Terminal Prognosis Not Supported by Documentation	No Documentation Provided	No Notice of Election	Notice of Election Missing Required Element(s)	No Certification of Terminal Illness	Certification of Terminal Illness Missing Required Element(s)
76						
77						
78						
79						
80						
81						
82	1					
83	1					
84				1		
85						
86	1					
87						
88	1					
89						
90						
91	1					
92						
93	1					
94	1					
95				1		
96		1				
97		1				
98	1					
99						
100						
Totals	**21**	**7**	**3**	**7**	**5**	**2**

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: May 4, 2026

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services

FROM: Dr. Mehmet Oz
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Have Saved $255.1 Million Related to Hospice Services for Certain New Hospice Enrollees (A-06-22-09003)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality end of life care while protecting taxpayer dollars by preventing improper payments.

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments. CMS has focused on the integrity of the hospice benefit and strengthened its monitoring of hospice claims to reduce improper payments. CMS has furthered its prepayment medical review, including targeted probe and educate reviews, of hospice services from certain providers. Further, CMS has taken action to reduce and prevent improper Medicare payments for items and services unrelated to the terminal condition of the beneficiary (i.e., the beneficiary's terminal illness and related conditions) that are paid separate from the hospice service. As part of its strategies, CMS recovers identified overpayments in accordance with agency policies and procedures. Additionally, CMS has taken action to prevent improper payments by educating health care providers on the proper billing of hospice services.[1, 2] For example, CMS published an educational article on the hospice improper payment rate denial reasons, including information on how to prevent improper payments.[3]

CMS is also seeking to bolster transparency and further empower Medicare beneficiaries by proposing to require hospices to provide the hospice election statement addendum to all Medicare beneficiaries upon the election of hospice care in the Fiscal Year 2027 Hospice Wage Index and Payment Rate Update.[4] The addendum explains, in plain language, which items, services, drugs, and conditions the hospice determines are not related to a patient's terminal illness and related conditions and will therefore not be covered under the Medicare hospice benefit. Currently, hospices must provide a hospice election statement addendum only upon

[1] Information about the Hospice Prospective Payment System is available online at: https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice
[2] Information about the hospice payment system and coverage is available online at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospice
[3] Medicare Payment Systems: Hospice Payment System & Coverage (January 2026) https://www.cms.gov/files/document/model-hospice-election-statement-addendum-march-2024.pdf
[4] FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements (May 2026): https://www.federalregister.gov/documents/2026/04/06/2026-06604/medicare-program-fy-2027-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

request by a patient (or their representative). This proposal is intended to reduce confusion and ensure beneficiaries clearly understand coverage decisions at the time of hospice election. The change could decrease beneficiary out-of-pocket costs and lessen the burden created by having to proactively seek out information at a very vulnerable time.

Lastly, CMS created the Service and Spending Variation index (SSVI), which assigns hospices a score based on a variety of metrics CMS gathers from hospice and non-hospice claims. The metrics include: non-hospice spending, percent of beneficiaries discharged with a length of stay of 180 days or more, average minutes per routine home care day, and percent of live discharges where beneficiaries return to the same hospice in seven days, among others. A high SSVI score could signal potential program integrity risks or inappropriate utilization, which may be used to target further oversight. CMS posts this information on CMS's Hospice Center webpage[5], which will provide transparency into the data CMS is collecting and could help beneficiaries make informed decisions.

While OIG did not identify any instances of fraud, CMS is taking significant actions to crush fraud perpetrated by hospices in addition to addressing improper payments in this area. For example, CMS recently suspended payments to nearly 450 hospices in Los Angeles due to a credible allegation of fraud. These providers received approximately $600 million in Medicare payments in 2025. More information about CMS efforts is available at cms.gov/fraud.

CMS thanks OIG for their efforts on this issue and looks forward to continued collaboration with OIG on this and other issues in the future. OIG's recommendations and CMS' responses are below.

OIG Recommendation

Work with the Hospice MACs to consider this high-risk area in their hospice eligibility reviews and possibly develop pre- or postpayment review procedures for new hospice enrollees who did not have inpatient or emergency room claims 18 months prior to starting hospice care.

CMS Response

CMS concurs with OIG's recommendation. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments. CMS will share this audit report with the Hospice MACs to use in their risk analysis and work planning to determine if medical review for new hospice enrollees who did not have inpatient or emergency room claims in the 18 months prior to starting hospice care should be prioritized over other hospice risk areas.

[5] CMS.gov, Hospice Center, Accessed at: https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center

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