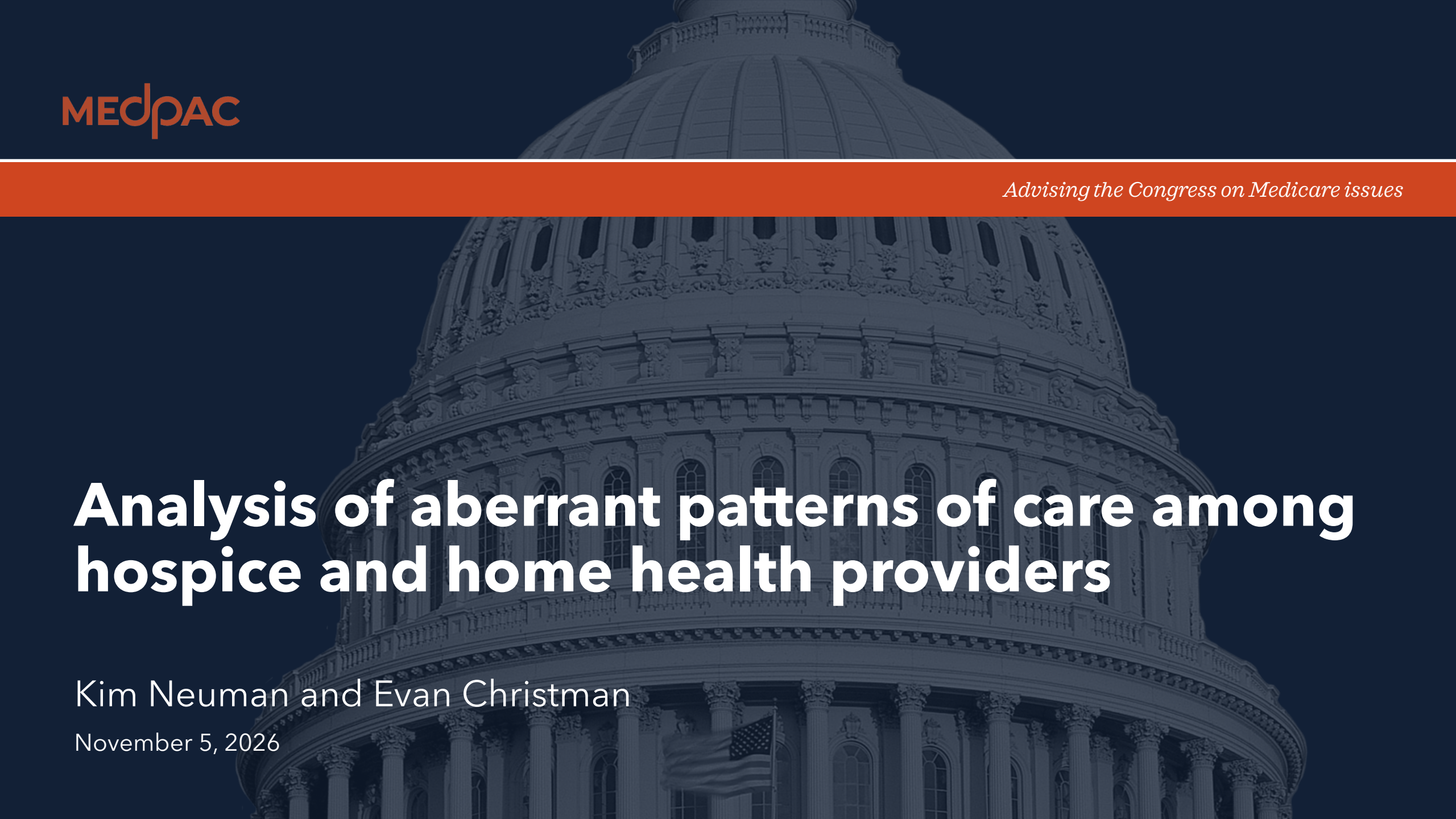
MEDPAC

Advising the Congress on Medicare issues



Analysis of aberrant patterns of care among hospice and home health providers

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Presentation roadmap

1. Background on hospice and home health
2. CMS moratoria and program integrity initiatives
3. Exploratory analysis of aberrant patterns
4. Hospice aggregate cap trends
5. Discussion

Background: Home health benefit

- Skilled care in the home to recover, maintain function, or slow decline
- Eligibility criteria:
  - Beneficiary must be homebound and need nursing or physical therapy, occupational therapy, or speech-language pathology; covered services include medical social services and home health aide
  - Care must be ordered by an eligible practitioner; need for care is recertified every 60 days for longer spells of home health
- No cost sharing in FFS Medicare for home health care services
- FFS Medicare paid $16B for home health care provided to 2.7M beneficiaries in 2024

Note: FFS (fee-for-service).
Source: MedPAC analysis of Medicare home health claims data.

Background: Hospice benefit

- Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll
- Eligibility criteria:
  - Life expectancy of 6 months or less if disease runs its normal course
  - Physician(s) certifies prognosis at outset of each hospice benefit period: Two 90-day periods, then an unlimited number of 60-day periods
- Beneficiary agrees to receive palliative care under hospice benefit and forgo care for terminal illness and related conditions outside of hospice
- No cost sharing (except hospices may charge limited cost sharing for inpatient respite care and for drugs)
- FFS Medicare paid $28.3 B for hospice care for 1.8M beneficiaries in 2024*

Note: FFS (fee-for-service) . ***Hospice benefit is carved out of Medicare Advantage (MA) and paid by FFS; in 2024, a small share of beneficiaries received hospice paid for by MA plans under the MA Value Based Insurance Design (VBID) model that ended in 2024.

Source: MedPAC analysis of Medicare hospice claims data.

Relationship between hospice and Medicare spending

- Most important benefit of hospice is its effect on patient care
- When hospice benefit was established, it was also thought that it would be less costly than conventional care at the end of life
- Literature mixed on hospice's effect on Medicare spending, depending, in part, on methodology
  - 2015 MedPAC contractor study found hospice did not reduce overall Medicare spending (Direct Research 2015)
- MedPAC contracted with Urban Institute to conduct updated study
- Hospice's effect on Medicare spending does not factor into our annual assessment of payment adequacy

Source: Direct Research. 2015. Spending in the last year of life and the impact of hospice on Medicare outlays (updated August 2015).

Relationship between hospice and Medicare spending: Study approach and findings

- Study compares overall Medicare spending for FFS hospice and nonhospice users over 18-months using variation in distance to hospice providers to estimate effects of hospice
- Study results varied depending on assumptions about hospice's effect on length of life
  - Model with no controls for mortality: Hospice use associated with lower overall Medicare spending, driven by estimated fewer days alive
  - Model controlling for days alive: No statistically significant effect of hospice use on overall Medicare spending

Source: Garrett, B., D. Wissoker, and L. Skopec. 2026. The effects of hospice on Medicare spending.

Relationship between hospice and Medicare spending: Important considerations when interpreting study estimates

- Results depend on assumption that hospices do not strategically locate
- Estimates are for a subset of beneficiaries whose decision to use hospice is induced by closer proximity to a hospice, and are not generalizable to broad hospice population
- Interpreting estimates of hospice's effect on length of life warrants caution because reduction in survival time does not necessarily indicate a poor outcome if it reflects a terminally ill beneficiary's preference for hospice care over conventional care

Source: Garrett, B., D. Wissoker, and L. Skopec. 2026. The effects of hospice on Medicare spending.

CMS moratoria and program integrity initiatives

Recent concerns about program integrity in hospice and home health

- Hospices and home health agencies provide valuable care for Medicare beneficiaries
- In recent years, the Commission, CMS, and industry stakeholders have raised concerns about aberrant patterns of utilization suggesting potential fraud, waste and abuse
- In 2026, CMS implemented several new policies to address fraud, but concerns remain; CMS also launched CRUSH fraud initiative to collect stakeholder ideas to improve program integrity across Medicare program

Note: CRUSH (Comprehensive Resources to Uncover Suspicious Healthcare).
Source: Centers for Medicare & Medicaid Services. 2026. "Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)." *Federal Register* 91:9803–9808, February 27

Commission's prior recommendations related to hospice program integrity

- March 2009 report to Congress:
  - Require face-to-face physician visit before the 180th day and subsequent recertifications
  - Require that certifications include a physician narrative on patient's prognosis
  - Medical review for hospices with a large share of long stays
  - Secretary should direct OIG to study several program integrity issues (i.e., financial relationships with long-term care facilities, hospices with unusual patterns of use, nursing home referrals to hospice)
- Subsequent legislative changes or CMS/HHS actions in each of these areas, including face-to-face visit and physician narrative requirements

Note: OIG (Office of Inspector General), HHS (Health and Human Services).
Source: MedPAC March 2009 Report to Congress.

Commission's prior recommendations related to home health

- March 2010 and 2011 reports to Congress:
  - Congress should direct the Secretary to review home health agencies with unusual claims patterns
  - Congress should authorize additional program safeguards in high-risk areas, such as provider moratoria, prior authorization, and suspension of prompt payment requirements
- Subsequent legislation enacted two policies:
  - Face-to-face requirement for home health
  - Moratorium authority to suspend enrollment of new providers if necessary to address program integrity
    - Several Medicare moratoria in selected states and counties were in effect from 2013 to 2019; included home health and ambulance services

Source: MedPAC March 2010 and March 2011 reports to the Congress.

Commission noted concerns about hospice and home health program integrity in March 2026

- Program integrity is important for beneficiaries and the Medicare program
  - Unnecessary Medicare expenditures increase premiums and deplete Medicare's finances
  - Hospice fraud can expose beneficiaries to difficulty accessing care or result in care that is not aligned with the beneficiary's preferences or needs
- Also noted aberrant patterns of utilization in selected areas
  - Hospice: Arizona, California, Nevada, and Texas
  - Home health: Los Angeles County, California
- Commission indicated that these patterns warranted additional scrutiny

Source: MedPAC 2026 March Report to Congress

CMS implemented a moratorium on new hospice and home health agencies

- 6-month nationwide moratorium on enrollment of new hospices and HHAs in Medicare beginning May 2026
- CMS's rationale:
  - Rapid provider growth in some geographic areas not matched by growth in beneficiary population
  - CMS stated some growth includes potentially fraudulent providers
  - Concerns that fraudulent activities are "viral" and migrate across country
- Two states also have moratoria on new state licensure: California (hospice) and Nevada (hospice and home health)

Note: HHA (home health agency).
Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026. Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of nationwide temporary moratoria on enrollment of home health agencies (HHAs). Notice. *Federal Register* 91, no. 94 (May 15): 27954–27961.

Additional CMS program integrity initiatives for hospice

- Hospice medical review initiatives focused on 6 states
  - Arizona, California, Nevada, and Texas since 2023; Geogia and Ohio since late 2025
  - New hospices:100% prepayment review of claims for up to 1 year (PPEO)
  - Existing hospices: Expanded prepayment review program
- Increased scrutiny of new and re-enrolling hospice providers
- In spring 2026, CMS reported:
  - Revoking Medicare enrollment of 200+ hospices under the PPEO (CMS 2026a)
  - Suspending payments for 800+ hospices and HHAs in Los Angeles (CMS 2026b)
- Streamlined beneficiary processes to disenroll from hospice when enrolled without consent or deceptive practices in 2026

Note: PPEO(Provisional Period of Enhanced Oversight).
Source: CMS. 2026a. https://www.cms.gov/newsroom/press-releases/cms-proposes-new-transparency-measures-strengthen-oversight-hospice-providers. CMS 2026b. https://www.cms.gov/newsroom/press-releases/cms-announces-aggressive-nationwide-crackdown-fraud-six-month-hospice-home-health-agency-enrollment

CMS Review Choice Demonstration for home health

- RCD: Additional claims review of all HHAs in certain states
- Currently active in 5 states through 2029
  - Florida, Illinois, Ohio, Oklahoma, North Carolina
- All HHAs in state submit all claims for additional review for a 6-month period (HHA can choose pre- or post-payment review)
- HHAs with 90% or higher affirmation rate can choose to have less stringent reviews of only a sample of claims

Note: Review Choice Demonstration (RCD), HHA (home health agency).

Hospice and home health industry stakeholders have been concerned about program integrity

- Several provider associations have expressed concern about fraudulent providers in certain geographic areas
- Stakeholders have advocated for targeted program integrity efforts
  - E.g., the industry has cited PPEO as an example of a targeted approach, and suggested that RCD should be evaluated and possibly expanded if appropriate
  - Some stakeholders advocate for actions to increase provider surveys in certain geographic areas and strengthen provider enrollment procedures

Note: PPEO (Provisional Period of Enhanced Oversight), RCD (Review Choice Demonstration).
Source: LeadingAge. 2025. Comment letter on CY 2026 home health NPRM. National Alliance for Care at Home. 2025. *Comment letter to CMS regarding recommendations to strengthen home health and hospice program integrity*. National Alliance for Care at Home et al. 2026. https://leadingage.org/wp-content/uploads/2026/03/Final-Alliance-LeadingAge-PI-Letter-3.25.26.pdf.National Alliance for Care at Home. 2025. https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf

MedPAC exploratory analysis of aberrant patterns

Exploring illustrative indicators of aberrant patterns of care in hospice and home health

- Medicare utilization is complex and influenced by many factors
- Variation across beneficiaries, providers, and regions is expected, and aberrant patterns can reflect normal variation for beneficiaries receiving needed care
- Assessing aberrant patterns can identify areas that warrant further analysis
  - Past instances of fraud, waste, and abuse have been associated with unusual patterns
- Examples in this analysis intended to be illustrative; some aspects of examples may reflect factors other than program integrity

Practitioners ordering unusually high volumes of home health care may warrant additional review

- An eligible practitioner certifies the need for home health care and approves the plan of care (type and number of visits, etc.)
  - "Eligible practitioner" can include physician, nurse practitioner, physician assistant, or clinical nurse specialist
- Practitioners that ordered care for unusually high numbers of beneficiaries was one indicator in prior instances of fraud, waste and abuse
- High-ordering practitioners could reflect patient severity and other factors, and should be weighed in context

Top 1% of practitioners ordered home health care for substantially more FFS Medicare beneficiaries

- Average practitioner ordered home health care for 8.8 FFS Medicare beneficiaries
- Average practitioner in the top 1% ordered care for 149.4 FFS Medicare beneficiaries
- Top 1% of practitioners accounted for 19.5% of 30-day home health periods ordered in 2024

Note: FFS (fee-for-service).
Source: MedPAC analysis of home health standard analytic file.

HHAs with unusually high numbers of 30-day periods per beneficiary may warrant further review

- HHAs with high levels of utilization per beneficiary have previously raised concerns
- Top 1% of HHAs provided substantially more 30-day periods per FFS user in 2024
  - Average HHA: 3.5 periods per FFS user
  - Top 1% HHAs: 8.5 periods per FFS user, on average
- HHAs in the top 1% of 30-day periods concentrated in California and Texas, including areas targeted in past program integrity efforts
- Note: Home health use varies widely across regions and HHAs; expect that some beneficiaries may have greater needs that require more services, and that some HHAs may focus on these patients

Note: HHA (home health agency), FFS (fee-for-service).
Source: MedPAC analysis of home health standard analytic file.

Measures of aberrant patterns of hospice

- CMS, GAO, OIG and others have developed measures that may be indicators of aberrant patterns of hospice care
- Since no single measure provides a complete picture, we drew on measures from across these sources, and developed additional measures for this exploratory analysis
- Measures we analyzed span 3 broad areas:
  - Admissions and certification patterns
  - Discharge patterns
  - Provision of hospice visits

Notes: GAO (Government Accountability Office), OIG (Office of Inspector General).

Some measures vary substantially across hospices

Provider-level measures, 2023	50th	90th
Admissions and certification patterns		
Share of certifications by hospice physician certifying for 6+ agencies	0%	98%
Share of days furnished by provider in CY that are before patient's last year of life	38%	69%
Share of patients with >180 hospice days in CY (excluding days in prior/subsequent years)	17%	30%
Share of provider's new FFS patients without acute care in 18 months before hospice admission	12%	20%
Discharge patterns		
Share of discharges that are live discharges	20%	56%
Share of patients with multiple stays (any provider) in CY	14%	32%

Note: CY (calendar year), FFS (fee-for-service). Percentiles calculated using data only for providers that had 30 or more observations for the population relevant to the measure. The 99th percentile of the number of agencies for which a hospice physician certifies is 6 agencies.

Source: MedPAC analysis of Medicare hospice claims data.

Some hospices provide substantially fewer visits than typical hospice

Provider-level measures, 2023	10th	50th
Provision of hospice visits		
Average total visits per week	2.2	3.7
Share of patients receiving RN or SW visits on at least 2 of last 3 days of life	26%	62%

Note: RN (registered nurse), SW (social worker). Visit measures are for beneficiaries receiving routine home care. Percentiles calculated using data only for providers that had 30 or more observations for the population relevant to the measure.

Source: MedPAC analysis of Medicare hospice claims data.

Hospice providers with outlier patterns appear concentrated in some states but exist more broadly

- We examined the geographic concentration of providers with outlier patterns
  - For illustrative purposes, outliers were defined as in the top 10% on each measures (or bottom 10% for visits measures)
- California, Nevada, Texas, and Arizona were overrepresented among outlier providers on multiple measures
  - California was most pronounced: More than10% of its providers were outliers on every measures, ranging up to 48% of providers on one measure
- Outliers were also present in other states
- While analyses are limited to hospices with 30+ observations for a measure, we also observed outlier patterns among smaller providers in aggregate
- Potential for additional follow-up analyses if commissioner interest

Source: MedPAC analysis of Medicare hospice claims data.

Hospice aggregate cap trends

Hospice aggregate cap

- When Congress established the hospice benefit, it created a cap that limits the annual aggregate payments a hospice can receive
  - FY 2027 cap = $36,175 x number of patients served (not wage adjusted)
- Hospices that exceed cap must repay excess to Medicare
- Cap is equivalent to an average length of stay for RHC patients of 178 days for a hospice with a wage index of 1
- Because the cap is applied in aggregate (across patients with short and long stays), a hospice can have many long stay patients before exceeding the cap

Note: RHC (routine home care).

Previous MedPAC analysis of hospice aggregate cap

- March 2026 report found that the share of hospices exceeding the cap has been increasing
  - In 2023, an estimated 28% of hospices exceeded the cap; these hospices furnished care to 8% of hospice beneficiaries
- Medicare margin for above-cap hospices was about 18% before and −1% after return of cap overage
- We have conducted follow-up analysis to examine trends in more detail

Note: Estimates of margins after the return of cap overage assume that above-cap hospices return 100% of the cap overage.
Source: MedPAC March 2026 report to Congress.

Hospice aggregate cap: Commission recommendations

- MedPAC has recommended that the hospice aggregate cap be wage adjusted and reduced by 20%
- Wage adjustment would make cap more equitable across providers
- Reducing the cap was recommended as part of update recommendations in 2020 to 2023 in lieu of an across-the-board reduction, with intent of focusing payment reductions towards providers with longer stays and high margins
- Approach aligns with program integrity concerns in prior Commission work; cap creates safeguard if some providers seek to enroll patients who may not meet the eligibility criteria

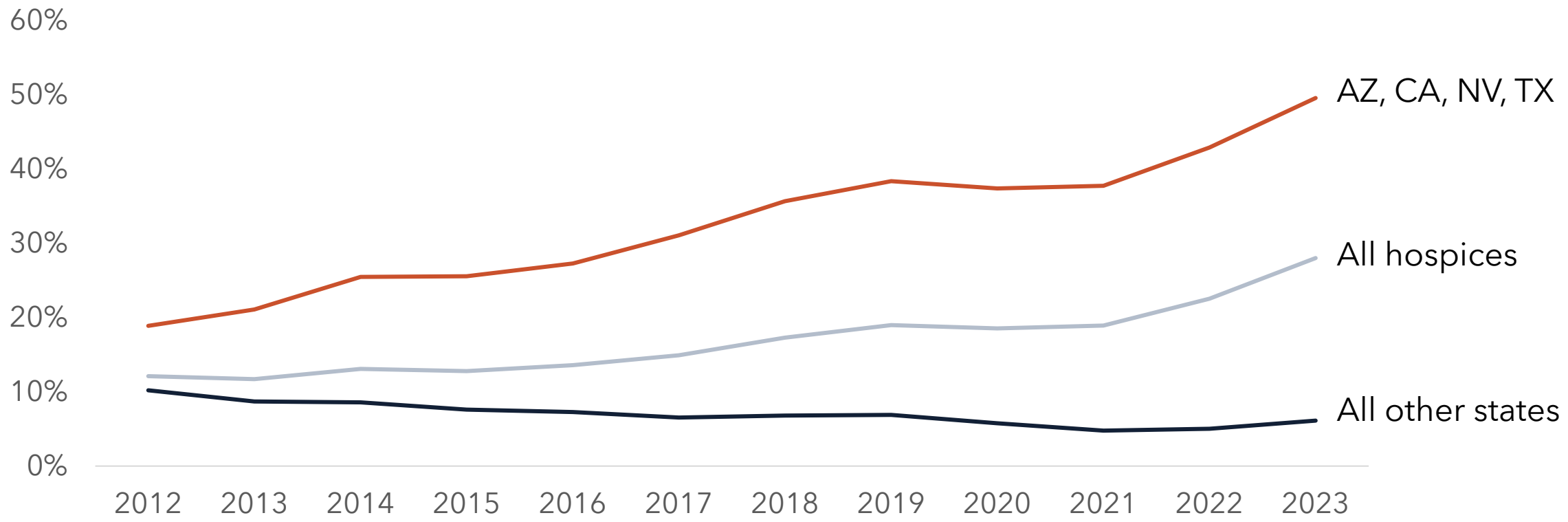
Source: MedPAC March 2020, 2021, 2022, and 2023 reports to Congress.

Hospice aggregate cap: Recent studies

- Recent studies have examined how hospices have responded to the cap
  - Gruber et al. (2025): Estimated that patients in hospices facing cap pressure were 2 percentage points more likely to die within 12 months, 1 percentage point more likely to be discharged alive, and were less likely to receive inpatient hospice care
  - Coe and Rosenkranz (2025): Estimated that hospices nearing cap in last quarter of year modestly increased admissions and live discharges, with smaller effects post-2012; service provision did not change; marginally enrolled patients appeared healthier on average
- Studies estimate how hospices have responded to the existing cap, not how they would respond if the cap were changed

Sources: Coe, N. B., and D. A. Rosenkranz. 2025. Provider payment incentives: Evidence from the U.S. hospice industry. *Journal of Public Economics* 248 (August). Gruber, J., D. H. Howard, J. Leder-Luis, et al. 2025. Dying or lying? For-profit hospices and end-of-life care. *American Economic Review* 115, no. 1 (January): 263–294.

MedPAC analysis: A few states are driving growth in overall share of hospices exceeding the cap



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.

Source: MedPAC analysis of data from Medicare hospice claims and Medicare Provider of Services file.

Characteristics of hospices that exceed the cap, 2023

- Above-cap hospices are smaller
  - Average patients per year: 83 (above cap) vs. 366 (below cap)
- Most are for profit (94%), freestanding (97%), and in metropolitan areas (98%)
- Above-cap hospices have longer stays
  - Largely due to longer stays within diagnosis categories
  - Differences in diagnosis category mix also contribute

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

Above-cap hospices have higher live discharge rates and higher survival rates than below-cap hospices, 2023

- New patients admitted to above-cap hospices have higher post-admission survival rates than below-cap providers
  - 6 months: 49% vs. 18%; 12 months: 39% vs. 12%
- Above-cap hospices have higher live discharges rates: 47% vs. 17% of all discharges were live discharges
- Patients discharged alive from above-cap hospice had higher post-discharge survival rates:
  - 6 months: 69% vs. 52%; 12 months: 59% vs. 39%
- Patterns raise questions about whether above-cap hospices are admitting some patients who may not meet hospice eligibility criteria

Note: New patients are defined at the provider-beneficiary level and reflect patients who had not received hospice from the provider in the past 12 months.
Source: MedPAC analysis of data from Medicare hospice claims and Medicare Common Environment.

Hospice aggregate cap: Summary

- Some overlap in cap and CMS program integrity efforts, but approaches may complement each other
- Cap provides a safeguard if some providers seek to enroll patients for long stays who may not meet the eligibility criteria
- Cap recovers some payments from providers that exceed the cap, who otherwise realize substantial profit margins from long stays
- Without the cap, it is difficult to predict the extent to which hospice use and provider entry would shift; long stays would likely increase
- Commission has made recommendation to better target cap by wage adjusting it

Discussion

Aberrant patterns of care in hospice and home health may warrant further examination

- Commission, CMS, and industry stakeholders have expressed concern about fraud
- Program integrity is important to Medicare program and beneficiaries
- CMS has taken several steps in recent years to address fraud and strengthen program integrity
- Our analyses suggest aberrant patterns in certain geographic areas that overlap with CMS program-integrity efforts
- Going forward, an approach that focuses on outlier geographic areas and outlier providers appears valuable

Discussion and next steps

- Questions?
- Commissioners may wish to discuss:
  - Additional analytic suggestions for identifying aberrant patterns
  - Support for program integrity efforts and measures
  - Potential program design vulnerabilities in hospice and home health
- We anticipate including some discussion of aberrant patterns of home health and hospice in March 2027 update chapters



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