

March 25, 2026

Dr. Mehmet Oz

Administrator

Kimberly Brandt

Deputy Administrator and Chief Operating Officer

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20001

Re: NPHI Calls for Temporary Nationwide Moratorium on New Hospice Provider Enrollments

Dear Administrator Oz and Deputy Administrator Brandt,

NPHI urges CMS to implement a **temporary, nationwide moratorium on new hospice provider enrollments** in response to the continued growth of fraudulent providers in the hospice community. These bad actors exploit vulnerable patients, undermine trust, and threaten the integrity of the Medicare hospice benefit.

NPHI represents the nation's leading mission-driven, safety-net, community-based hospice and advanced illness providers, many of whom were instrumental in shaping the Medicare hospice benefit and all of whom remain committed to its original intent. These organizations are the original architects of care in the home, delivering high-quality, interdisciplinary, patient-centered care to communities across the country. Our members are deeply troubled by the continued growth of fraudulent operators in the hospice community and the harm they cause to patients and families.

We appreciate your leadership and the Administration's focus on addressing hospice fraud and abuse. Given the attention you and your team have devoted to this issue in recent months, we believe a moratorium should be explicitly **time-limited** and accompanied by a **clear off-ramp**, allowing CMS to focus its attention on identifying and removing fraudulent providers currently operating within the system while preventing new fraudulent actors from entering. It is also critical that any action **maintains access to Medicare telehealth flexibilities**, which are essential to ensuring timely, quality care for all patients.



One area of particular importance is the preservation of telehealth flexibilities under a moratorium.

Despite NPHI’s support for a temporary, nationwide moratorium, current statutory language governing the use of telehealth under a moratorium would result in a significant disruption in patient access to care. As outlined in the **Consolidated Appropriations Act 2026, Section 6209 (f)(1)(B)**, the ability for a hospice to complete the face-to-face encounter via telehealth does not apply if an *“individual [beneficiary] is located in an area that is subject to a moratorium on the enrollment of hospice programs under this title pursuant to section 1866(j)(7).”* As written, a national moratorium would prevent hospice providers from using telehealth to complete required recertifications under the Medicare hospice benefit, limiting their ability to deliver timely care. This would be particularly challenging in rural communities, where clinicians would be required to travel long distances to complete what is largely an administrative requirement, despite no demonstrated decline in quality since these telehealth flexibilities were introduced.

Targeted Solutions

In addition to the moratorium, we would like to share an updated perspective building on our prior recommendations to you, outlining additional steps that can be taken to protect patients, strengthen the integrity of the Medicare hospice benefit, and safeguard patients and other vulnerable individuals from abuse and neglect by fraudulent operators. As part of these efforts, **we recommend focusing audit resources on consistently poor-performing hospices and lowering the hospice aggregate cap to deter the targeting of long length-of-stay patients.**

We detail these recommendations below.

1. Targeting Audits to Focus on Poor Quality Hospices

NPHI is very concerned with Medicare beneficiaries that receive no care or substandard care after a hospice election and urges CMS to identify those hospices and plan for additional reviews and audits to improve performance or, if necessary, terminate them from the Medicare program. Many poorly performing hospices can escape scrutiny by not reporting quality data and by remaining too small to attract audit scrutiny.

- **Audit Burden on High-Quality Hospices:**

Established, high-quality providers with a record of accurate billing are often targets for repeated audits. Three Medicare Administrative Contractors (MACs) conduct hospice audits. These areas include use of General In-Patient (GIP) care, minor technical errors, and eligibility challenges for patients exhibiting a “failure to decline” within an arbitrarily determined time frame (which differs from the physician’s judgment in determining the prognosis on which eligibility is based).

- **Live Discharges to Safety Net Hospices:**

Well-established mission-driven community hospices that serve as a safety net for their community are receiving patients transferred from other hospices who cannot provide or will not provide the care needed by the patient in their final days of life. It is an indication that in some communities, there are large numbers of hospices that provide substandard care or no care at all, but continue to receive Medicare reimbursement.

- **NPHI recommends that review of hospice claims specifically target those hospices with high percentages of live discharges. One example would be hospices who discharged 50% or more of their patients before death.**

- **Inconsistency in Understanding of Hospice Regulations:**

Hospice providers have expressed significant concern about the knowledge of auditors on the Medicare hospice benefit.

- **NPHI recommends that additional training be available and required for auditors before beginning hospice audits.**

- **Audit Appeals Process:**

Hospices that appeal the audit decisions frequently have them overturned at the Administrative Law Judge level, at great legal expense and burden on staff. While the MACs track the overturn rates at each level of appeal, they do not make them public except for one. CMS/CPI does not currently track the overturn rates nationwide.

- **NPHI recommends that CMS/CPI begin tracking overturn rates at the various audit contractors to assess the accuracy of the audit finding and identify additional training that may be needed.**
- **NPHI recommends that every auditor type that reviews hospice, including Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractors (SMRC), Recovery Contractors (RAC), and Unified Program Integrity Contractor (UPIC) publish their findings and denial rate, but also publish the rate at which decisions are overturned.**

- **Use of PEPPER:**

The Program for Evaluating Payment Patterns Electronic Report (PEPPER), first made available to hospices in 2012, provides hospices with comparative data across 16 billing practices associated with a high potential for improper payments. Following its recent



pause for review and subsequent reinstatement, PEPPER now serves as a valuable tool for identifying outlier billing patterns at the state, regional, and national levels.

- **NPHI recommends that CMS more systematically integrate PEPPER data into its auditing and program integrity framework by using the reports to identify and prioritize providers that consistently report data associated with high potential for improper payments for targeted review. At the same time, CMS should leverage PEPPER results to inform a more risk-based audit approach by recognizing providers that consistently demonstrate low-risk patterns and considering them for exclusion from future audits of a similar nature, thereby enabling more efficient and targeted use of limited oversight resources.**

2. Lower the Hospice Aggregate Cap to Deter Targeting of LLOS Patients

The hospice Medicare aggregate cap was designed to prevent uncontrolled growth of the hospice benefit by placing a guardrail on Medicare spending at the aggregate provider level so that patient access to care is impacted. MedPAC has previously recommended that Congress reduce the hospice aggregate cap by 20 percent to make the cap more equitable across providers, with a specific focus on reducing payments to providers with long stays and high margins. As noted in the report below, nonprofit hospices typically operate with significantly smaller profit margins than their for-profit counterparts.

According to the [2026 MedPAC report](#) to Congress, this disparity is often linked to an increased likelihood of exceeding the aggregate cap. Lowering the threshold could help mitigate excessively long patient stays and, ideally, curb the high profit margins observed among certain providers. It would be important to incorporate a wage index adjustment into the aggregate cap alongside any reduction to avoid unintended impacts on providers otherwise not at risk of exceeding the cap. NPHI is supportive of a thoughtful, and well-planned approach to lowering the aggregate cap as part of an effort to focus Medicare dollars spent on hospice on the lengths of stay that make up the vast majority of total hospice days on service, all while safeguarding the Medicare program's long-term solvency.

3. Additional Targeted Efforts CMS Should Take

- **Send An EOB Letter to All Medicare Beneficiaries:**
 - Send an EOB letter to every Medicare beneficiary for whom a hospice Notice of Election has been submitted. In the letter, describe the hospice benefit, letting them know that Medicare has received notification that they have chosen hospice. If they believe the election is in error, call 1-800-MEDICARE or another number to immediately cancel their election.



- **Provider Enrollment & Ongoing Patient Care:**
 - Are providers consistently accessible by phone and responsive to patient and caregiver needs? Do they maintain true 24/7 availability to manage pain, address urgent symptoms, and support patients and families at any time — not just during standard business hours?
 - Is the address legitimate?
 - What other business(es) operates at the same address?
 - Are there other Medicare entities at the same address?
 - Does the provider owe the Federal government?

These simple checks could mean that the applications of large numbers of questionable hospices would not be approved or sent back to the applicant for more information.

- **Signage:**
 - Include a regulatory requirement that a hospice must have signage that identifies the hospice. The sign must be clearly visible with the name of the hospice and hours of operation, at a minimum. If in an office building, the name of the hospice must appear in the building lobby directory.
- **Four Levels of Care:**
 - During the initial or recertification visit, add a requirement for the surveyor to confirm that all 4 levels of care are available and can be provided based on the patient's care plan.
- **Definition of Office:**
 - Surveyors report that since there is no definition of “office” in the Medicare Hospice Conditions of Participation, they are not able to cite a hospice who may have only one cubicle in an office building, operates the hospice from their living room, or also runs an unrelated business in the same location.

We Look Forward to Collaborating With CMS

NPHI is encouraged by the decisive steps CMS has taken to crack down on fraud and remove these fraudulent providers from the hospice system, while safeguarding the integrity of hospice care for patients and families nationwide. At the same time, it is critical that any actions are precise and **do not create unnecessary burden for providers who are delivering care the right way every day**. NPHI stands ready to support these efforts and looks forward to continued collaboration with CMS to help strengthen protections for patients and their families at the end of life.

If you have any questions or would like to connect further, please feel free to reach out to NPHI's Senior Policy Director, Ethan McChesney, at ethan@nphihealth.org.



Sincerely,

A handwritten signature in black ink that reads "Tom Koutsoumpas". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

Tom Koutsoumpas,
Founder & CEO
National Partnership for Healthcare and Hospice Innovation

About NPHI

The National Partnership for Healthcare and Hospice Innovation (NPHI) is the leading organization representing nonprofit, community-based hospice and advanced illness care providers. Committed to excellence, NPHI's members ensure patients and families receive compassionate, high-quality care that respects their goals, values, and dignity. NPHI helps nonprofit providers thrive in an increasingly profit-driven healthcare landscape by advancing innovative, person-centered models and strengthening collaboration with leaders, policymakers, and healthcare partners nationwide.

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