

# Lawmakers, CMS Aim To Mitigate Medicare Hospice Fraud

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Aging advocates are cheering legislation from Democratic lawmakers aimed at preventing fraud in hospice care while incentivizing hospice providers to improve patient care as CMS says it is ramping up its investigations of fraud in the hospice sector.

Sen. Mark Warner (D-VA) and Rep. Linda Sánchez (D-CA) introduced Wednesday (March 18) the Hospice Care, Accountability, Reform and Enforcement (CARE) Act of 2026, which would implement several program integrity reforms like increasing hospice ownership transparency, temporarily preventing certain new hospices from enrolling in Medicare, increasing survey frequency for new hospices, requiring providers to submit data as a condition of payment, and requiring HHS to send patients an explanation of benefits within 15 days of entering hospice care. The bill aims to reduce possible financial conflicts of interest for nurse practitioners and physician assistants when they certify beneficiaries' eligibility to receive hospice care.

The bill would also implement payment reforms like increasing payments to hospices providing certain palliative services, creating a new transitional inpatient respite benefit and adding home respite care to the Medicare hospice benefit.

The legislation would require Medicare to make outlier payments to pay hospice providers who provide certain high-cost complex palliative services, reimbursing them a portion of the service cost plus a fixed loss amount. During its March meeting, the Medicare Payment Advisory Commission discussed whether CMS should create an outlier payment mechanism or an add-on payment to hospice providers when they provide certain costly complex services like cancer or end-stage renal disease treatment. Many commissioners said they preferred the outlier payment structure to establishing an add-on payment.

LeadingAge released a statement supporting the legislation Wednesday, calling the Hospice CARE Act “a positive step forward” in implementing hospice reform that supports beneficiaries and protects against fraud.

“Done right, changes will expand the benefit to support the realities of modern-day hospice care, address the benefit’s vulnerabilities now being exploited, and help ensure quality to support strong funding,” LeadingAge CEO Katie Smith Sloan said.

But the statement also said there “are well intentioned policies that need additional revisions or evaluation for impact on our members.” These concerning policies are reforming payments for routine home care services, the creation of a referring physician role, a five-year national moratorium on hospice enrollment in Medicare and new mechanisms to monitor what LeadingAge refers to as unrelated spending.

The legislation comes as CMS has migrated to a more intense approach for fighting hospice fraud in addition to health care fraud in general. Jeneen Iwugo, acting director at CMS' Center for Program Integrity, told attendees Tuesday (March 16) at CMS' 2026 Quality Conference that CMS has enhanced its site visit process, now completing more detailed checks of hospice facilities to ensure they are not engaging in fraudulent activities.

“What we're finding is that when we do an enhanced site visit -- when we go in, we ask for medical records, we look for documentation, we check more of the information that we expect to be in these hospice businesses -- we're able to revoke fraudulent hospices,” Iwugo said. “We're able to draw better connections to other fraudulent hospices that are either owned or affiliated with those hospices, or we're able to put those hospices on repay review, so that every claim that they submit we look at with the microscope and we make sure that it's legit before we pay it.”

Iwugo says CMS has issued 155 site revocations in its latest period of enhanced site visits, calling the actions “tremendous in the hospice space, because it means that for the hospice organizations that are doing the right thing, that is 155 players who are decreasing the perception that hospice is rampant with fraud.”

CMS is changing its approach to fighting fraud overall, according to Iwugo and CMS Deputy Administrator and Chief Operating Officer Kim Brandt. While testifying before the House Energy & Commerce Committee Tuesday, Brandt said the agency is moving from a “pay and chase” strategy to a “stopped and caught” approach.