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SPECIAL INVESTIGATION

Protecting Hospital Care from Fraudsters

False hospice enrollment can turn Medicare identity theft into a barrier to ordinary treatment, leaving patients and hospitals to repair a coverage crisis they did not create.

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A fraudulent hospice election can alter a beneficiary's clinical identity before the patient knows anything has changed. Original editorial illustration from the investigative report.

THE CENTRAL FINDING

Fraud can change a patient's clinical identity before it steals a dollar.

When a beneficiary is enrolled in hospice without informed, voluntary consent, the transaction does more than generate an improper claim. Medicare's record can shift responsibility for terminal-condition services to a hospice, and ordinary hospital or physician claims may collide with a system that now says the patient elected end-of-life care.

The human consequence surfaced in an Associated Press investigation involving Linda Henry, a 71-year-old California retiree who considered herself healthy. She learned Medicare showed her enrolled in hospice with heart failure only after a physician claim was denied. The account described months of calls, delayed appointments, and a postponed colonoscopy, with ordinary coverage not fully restored for about a year.

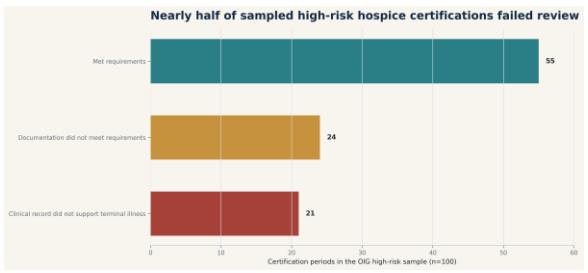
The imbalance is stark: enrollment can move quickly through provider and claims systems, while reversal may require an older adult to prove that no election was signed, no provider was authorized, and no terminal condition exists. Hospitals discover the problem downstream, often after treatment has already been interrupted.

Hospice is not the villain

Legitimate hospice remains one of healthcare's most humane benefits. It coordinates comfort care, nursing, medications, equipment, and family support near the end of life. The fraud problem is dangerous partly because it can erode trust in care that seriously ill patients genuinely need.

REPORTING NOTE | Criminal charges are allegations unless a plea or conviction is identified. Improper payment is not automatically fraud, and ownership is a risk signal, not a verdict.

THE EVIDENCE



OIG's deliberately selected high-risk sample. These findings are not a national hospice failure rate.

Audit exposes a reviewable pattern

In June 2026, the HHS Office of Inspector General reviewed 100 initial certification periods selected from a high-risk population. Forty-five failed Medicare requirements: 21 records did not support terminal illness, and 24 lacked required eligibility documentation. OIG estimated that targeted review in this cohort could have saved $255.1 million during the audit period.

$28.3B
MEDICARE HOSPICE SPENDING IN 2024

82%
SHARE OF HOSPICES WITH KNOWN OWNERSHIP THAT WERE FOR-PROFIT IN 2024

6 MONTHS
NATIONWIDE ENROLLMENT MORATORIUM THAT BEGAN MAY 13, 2026

MedPAC reported 6,706 Medicare-participating hospices in 2024, up from 4,840 in 2019. For-profit providers drove most of the growth. Expansion is not evidence of wrongdoing, but oversight has not kept pace with an increasingly commercial and difficult-to-trace market.

SOURCES | HHS OIG, CMS and MedPAC, 2026. Full citations and peer-reviewed references appear in the underlying investigation.

THE HOSPITAL RESPONSE

Hospitals inherit the consequences

Hospitals rarely control the original hospice election, yet they encounter the damage at registration, emergency intake, utilization management, coding, billing, and discharge planning. The first visible sign may be a denied claim, a beneficiary who denies being in hospice, or a family unable to identify the provider allegedly responsible for care.

Treating the dispute as a routine revenue-cycle exception is unsafe. The correct operating model protects clinical access while the administrative record is investigated.

What should hospitals do now?

- Verify the active election, provider, effective date, and terminal diagnosis at intake.
- Ask the beneficiary or authorized representative whether hospice was knowingly elected and whether care was ever delivered.
- Preserve medically necessary scheduling and clinical triage while financial responsibility is clarified.
- Create one accountable case owner and a rapid escalation path across operations, compliance, and payer relations.
- Track delayed, canceled, or forgone care as a patient-safety outcome, not only a billing loss.

A moratorium is only a pause

CMS's six-month moratorium may slow sham entities and ownership transfers. It cannot validate existing providers, reverse a false election, or restore care to a stranded patient. The longer-term answer is affirmative beneficiary confirmation, rapid dispute status, transparent ownership, and near-real-time review.

"Fraudsters do not need to enter a hospital to interrupt care. They need only to manipulate the record on which the hospital depends."

INSIDE THE INVESTIGATION | Payment incentives, ownership transparency, investor acquisition evidence, hospital controls, policy architecture, and complete references.