The hospice industries fraud crisis jus got a reckoning: reading the FY 2027 CMS proposed rule against the backdrop of operation never say die

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Abstract

CMS published its FY 2027 Hospice Wage Index and Payment Rate Update as a proposed rule (CMS-1851-P) on April 6, 2026, two days after Operation Never Sa

arrests in LA

Operation Never Say Die: 15 defendants charged, 8 arrested, $60M in alleged Medicare fraud across LA County; one nurse had an 85% non-death discharge ra nearly 5x the national average

More than 700 of approximately 1,800 hospice providers in LA County alone hav triggered multiple fraud red flags; CMS Administrator Dr. Oz stated in April 20 that he believes roughly half of LA's hospices are fraudulent

CMS has revoked 220 hospice approvals in California in 10 weeks; suspended 22 providers in a single week (up from 70 the prior week)

Estimated $3.5B in fraudulent Medicare reimbursements from LA County alone House Oversight Committee

Total estimated financial impact of FY 2027 rule: $785M in increased payments hospices

Proposed payment update: 2.4% (hospital market basket 3.2% minus 0.8% produ adjustment)

New payment rates: RHC days 1-60 rises from $230.83 to $236.56; RHC days 61+ $181.94 to $186.53; GIP from $1,199.86 to $1,232.71; hospice cap to $36,210.11

Non-hospice spending during a hospice election hit $2.8B+ in FY 2024 across Pa B, and D, up from $1.3B in FY 2020

Skin substitute billing during hospice stays went from $18M to $714M in four y

For-profit hospices averaged 167% higher non-hospice spending per day vs. non- profits in FY 2024, up from 60% in FY 2022

CMS introduces SSVI (Service and Spending Variation Index), a 0-16 score acros metrics for each hospice, scoring 6,642 to 6,735 providers; published for FY 202 FY 2025

Election statement addendum proposed to become mandatory for all elections, r
just on request

RFI on BLS-based hospice-specific wage index to replace the IPPS hospital wage

RFI on MAID, currently legal in 11 states and DC

Care Compare tool to get a non-compliance icon for quality reporting failures, n
earlier than FY 2028

Non-compliance with quality reporting was 23.53% of hospices in FY 2025, desp
4-point APU penalty

Enhanced CMS oversight already active in AZ, CA, NV, TX, GA, and OH; more t
200 Medicare enrollment revocations in the four original states alone

The Timing Is Not a Coincidence

On April 2, 2026, FBI agents in Los Angeles fanned out across Covina, Anaheim
Glendale, and Lakewood before 6 a.m., executing arrest warrants on doctors, nu
chiropractor, and a psychologist. By the time the press conference wrapped
downtown, federal prosecutors had charged 15 people in a scheme they called
Operation Never Say Die, a $60 million Medicare hospice fraud ring spanning ni
separate investigations across Southern California.

The same day, CMS published its FY 2027 Hospice Wage Index and Payment Ra
Update proposed rule. That timing was not accidental. CMS Administrator Dr. (
stood at the Operation Never Say Die press conference alongside FBI and DOJ
officials and said publicly that he believes roughly half of the hospice providers
operating in Los Angeles County are fraudulent. For context, LA County has
somewhere around 1,800 hospice providers. Nationwide there are about 6,600. T
means roughly one-third of all hospices in the entire country are concentrated ir
single county, which Dr. Oz called out by name as immediately suspicious. One
building in Van Nuys had 197 registered hospice companies on a single address.
Another plaza housed 89.

The proposed rule and the enforcement action are best read as companion docu
The rule codifies the measurement infrastructure and transparency mechanisms
arrests show what the measurement infrastructure is meant to catch.

The suspects in Operation Never Say Die follow a pattern that is by now disturb
familiar to anyone tracking hospice fraud enforcement. Recruiters approach peo
grocery stores, offering them $300 a month to pose as dying patients. A nurse na
Lolita Minerd ran a hospice in Artesia that submitted over $9.1 million in fraud
Medicare claims, collecting $8.5 million. Her hospice had a survival rate of 85%,
which is approximately five times the national average for a population supposed
have a six-month prognosis. A couple named Gladwin and Amelou Gill, both of
had prior tax evasion convictions that should have barred them from operating a
hospice, opened one using their daughter's name and collected over $4 million i
Medicare payments. A 76-year-old woman named Nita Palma allegedly ran three
fraudulent hospice operations while simultaneously incarcerated in a federal pri
Seattle and free on bond for a separate prior fraud case. A single dermatologist v
associated with 63 different hospice facilities across California and billed Medic
more than $35 million in 2025 alone.

The House Oversight Committee estimates that Medicare was defrauded roughl
billion in LA County alone from fraudulent hospice reimbursements. JD Vance's
Fraud Task Force, which led the Operation Never Say Die coordination, has
suspended 221 hospice providers in a single week, up from 70 the prior week. Fe
authorities have said they expect clusters of similar takedowns every few months
the 2026 enforcement initiative continues to audit high-billing hospice agencies
nationwide. CMS has already revoked 220 hospice approvals in California in just
weeks, a pace Dr. Oz noted was approaching what the Newsom administration
accomplished in four years.

> All of that is the fire. The FY 2027 proposed rule is the sprinkler system. Nei
> one alone is sufficient.

The 2.4% Update and What the Numbe Look Like

The proposed payment update of 2.4% is the hospital inpatient market basket in of 3.2% reduced by a 0.8 percentage point productivity adjustment. CMS uses IC fourth quarter 2025 forecast and reserves the right to revise if better data arrive before the final rule, which typically lands in August. The total financial impact estimated at $785 million in increased payments over FY 2026.

Broken out by level of care: RHC days 1 through 60 moves from $230.83 to $236 RHC days 61 and above goes from $181.94 to $186.53. Continuous home care at hour full rate moves from $1,674.29 to $1,728.02, or about $72 per hour. Inpatie respite care goes from $532.48 to $546.46. General inpatient care, which is the a symptom management level, goes from $1,199.86 to $1,232.71.

Hospices that do not meet quality data submission requirements get the inverse: -1.6% update instead, which is the 2.4% payment increase minus the 4-point APU penalty. Non-compliant RHC day 1-60 rate drops to $227.32. Non-compliant GI drops to $1,184.56. This penalty structure was increased from 2 to 4 percentage beginning in FY 2024, and as discussed later, it has not moved the needle on compliance rates.

The aggregate cap, which limits total annual Medicare payments per patient, is proposed at $36,210.11, up from $35,361.44. The Consolidated Appropriations A 2026, signed in February 2026, extended the market basket-based cap update methodology through 2035, meaning the CPI-U approach that originally governe increases will not return until at least then.

The Service Intensity Add-On budget neutrality factors for FY 2027 are propose 0.9999 for both RHC categories, meaning SIA utilization is essentially flat year c year. SIA pays for direct RN or social worker care in the last seven days of a pati life under RHC conditions, capped at four hours per day at the CHC hourly rate Budget neutrality requires that SIA payments be offset by a slight reduction in t base RHC rate to keep total RHC spending constant.

The Non-Hospice Spending Crisis Nobo Talks About

Buried inside the same proposed rule is a data story that is frankly remarkable i bluntly CMS tells it. Non-hospice Medicare spending for beneficiaries already enrolled in hospice grew from $790 million in FY 2020 to over $2 billion in Part and B alone in FY 2024, a 160% increase in four years. Adding Part D drugs brir combined FY 2024 total above $2.8 billion. The single-year jump from FY 2023 2024 was $770 million, or 60 percent growth in one year.

This matters because the hospice per diem is explicitly designed to be all-inclus When a patient elects hospice, they waive Medicare payment for services related their terminal illness outside the hospice benefit. The hospice receives a daily ra covering essentially everything. Every dollar billed outside the hospice benefit d a hospice election is, at minimum, a compliance question and, at worst, a fraud s

The driver that stands out most aggressively in the CMS data is carrier and phys supply claims. Those grew 317.5% from FY 2020 to FY 2024. The largest single diagnosis within that category is pressure ulcers, almost entirely from skin substitutes, which went from $18 million to $714 million, a roughly 4,000% incr over four years. CMS made major changes to skin substitute reimbursement effe January 1, 2026, transitioning most products to a national unified rate of approximately $127.14 per square centimeter under a new incident-to classificat designed to end the ASP-plus-6-percent billing model that created this runaway incentive. The problem is that the 2020 through 2024 data shows the escalation and CMS is not pretending it was accidental.

The breakdown by diagnosis is even more pointed. For patients with neurologic degenerative conditions like Alzheimer's and Parkinson's, there was roughly $57 million in non-hospice DME and carrier claims in FY 2024, plus $205 million in D. For circulatory and cerebrovascular patients, about $590 million in non-hosp DME and carrier claims plus $276 million in Part D. CMS asks directly in the ru why are bronchodilators being billed to Part D for a respiratory hospice patient is oxygen being billed separately when the hospice per diem is supposed to cove

Why are anticoagulants, beta blockers, and vasodilators appearing as outside cla for heart failure patients in hospice?

The for-profit versus non-profit split is the most politically damaging data point Beneficiaries receiving hospice services from for-profit providers averaged 167% higher non-hospice spending per day compared to patients in non-profit hospice in FY 2024. That same gap was 60% in FY 2022, meaning it nearly tripled in two years. And 67% of all non-hospice spending occurred after election day 60, mean this is not a phenomenon concentrated in the enrollment adjustment period. It i chronic and systematic.

Operation Never Say Die: When the Da Becomes a Mugshot

The $2.8 billion non-hospice spending figure and the 167% for-profit premium c outside billing are aggregate statistics. Operation Never Say Die translates that aggregate into individual criminal defendants.

The structural pattern is consistent across the LA cases: open a hospice using someone else's name or credentials if your own history makes you ineligible, rec non-dying patients via cash kickbacks paid to referral agents and directly to beneficiaries, submit claims to Medicare for services that are either medically unnecessary or never happened, and collect reimbursements until you get caugh go out of business. The beneficiaries collecting $300 a month from Lolita Miner the supply side of a demand driven entirely by Medicare's per diem payment structure.

The per diem pays whether or not any service is rendered on a given day. Under routine home care level, which is the dominant billing category, a hospice can cc $236 per day for a patient who is visited once a week for 20 minutes. The incenti enroll ineligible, relatively healthy patients who do not require intensive service to keep them enrolled as long as possible is not subtle. An 85% survival rate at o the defendant hospices, when the eligibility standard is a six-month terminal prognosis, is not a statistical outlier. It is business model documentation.

The clustering patterns CMS and DOJ identified in LA County make this worse. When 197 hospices share a single address in Van Nuys or 89 share a single comn plaza, what you are looking at is a systematic exploitation of CMS's enrollment processes. California instituted a moratorium on new hospice licenses in 2021, b enforcement gap between when fraud begins and when licenses get revoked gave existing fraudulent operators years to run at scale. Authorities found that initial fraudulent activity in the Operation Never Say Die cases goes back as early as 20 with some cases not reaching arrest stage until April 2026, an eight-year window

Federal authorities have explicitly said they expect this to become a rolling natic enforcement campaign, with clusters of similar takedowns across high-billing h markets every few months. CMS has already expanded enhanced oversight beyor original four states, Arizona, California, Nevada, and Texas, into Georgia and Ol The pattern recognition work CMS is doing at the aggregate level in the propose rule, particularly the SSVI, is designed to create the targeting infrastructure for campaign nationally.

SSVI: CMS Finally Gets a Fraud Scoreca

The SSVI, or Service and Spending Variation Index, is a new scoring system pub for the first time in this proposed rule. Each of the roughly 6,600 active hospices a score between 0 and 16, calculated from nine claims-based metrics. CMS is publishing FY 2024 and FY 2025 SSVI data alongside the proposed rule, coverin million and 156.5 million hospice days respectively.

The nine metrics are: providing no CHC and no GIP service at all, which gets 1 p percentage of RHC days delivered in a nursing home or skilled nursing facility a or above, 1 point; percentage of last two RHC days of life with visits at or below 25th percentile (which was 85.7% in FY 2025), 1 point; live discharge rate at or a the 75th percentile (47.5% in FY 2025), 1 point; percentage of discharges with le of stay over 180 days at or above the 75th percentile (33.2% in FY 2025), 1 point; average skilled nursing minutes per RHC day at or below the 25th percentile (9.8 minutes per day in FY 2025), 1 point; weekend RHC days with a skilled visit at c

below the 25th percentile (4.8% in FY 2025), 1 point; live discharges where the beneficiary returns to the same hospice within 7 days at or above the 75th percer (15% in FY 2025), 1 point; and total non-hospice spending, scored on an 8-tier sc worth up to 8 points.

The non-hospice spending scoring structure is where the index gets most of its discriminatory power. The tiers run from 1 point for any non-hospice spending l $6,352 per year up to 8 points for the highest-spending eighth of hospices, whicl starts above $517,204. Because this single component can contribute up to 8 of t possible points, SSVI scores are heavily loaded toward the non-hospice spending signal. That design is not accidental. The other metrics capture operational patt like thin visit volumes, high live discharge rates, and long stays, which are the utilization signatures that federal investigators found in every Operation Never Die defendant's claims history.

The SSVI was clearly not designed as a quality improvement instrument, despite framing it carefully that way. CMS says directly in the rule that a high score sign hospice that may require additional targeted education or oversight, including medical review, education, and investigations that could result in payment suspe and revocation if fraud, waste, or abuse is identified. That is law enforcement language dressed in program integrity clothing. The SSVI is the data infrastructu that gives CMS a ranked list of providers to hand to enforcement teams for prioritization.

For context, the defendant hospice with an 85% non-death discharge rate would near the maximum on at least two or three SSVI metrics immediately: the live discharge rate metric, almost certainly the length of stay distribution metric, an potentially the non-hospice spending metric depending on how much outside bi accompanied the phantom care. That kind of multi-metric clustering is exactly v CMS says it is looking for.

For health tech investors, the SSVI is a new public data asset that creates an enti product category. Provider benchmarking, competitor quality intelligence, refer network risk assessment, post-acute analytics, and M&A diligence for hospice

operators all now have a publicly available claims-derived 0-to-16 score updated annually. Companies that can contextualize that score alongside payer mix, staff ratios, length of stay distributions, and operational benchmarks have a product v obvious buyers across payers, IDNs, referral platforms, and PE-backed hospice r ups trying to distinguish clean assets from liability-laden ones.

Making the Election Addendum Mandatory

The hospice election statement addendum explains to patients in plain language the hospice benefit covers, what it does not cover, and what happens to their Me coverage for outside services once they elect hospice. Since the FY 2020 rule cre it, hospices have only been required to provide it upon patient request. That pro is remarkably toothless given the information asymmetry between a patient enro in hospice during a medical crisis and a provider who knows exactly what the be covers and what they intend to bill elsewhere.

CMS is now proposing to make it mandatory at the time of every hospice electio This is procedurally straightforward but operationally significant at scale. Every intake workflow across 6,600 providers needs to be updated to include delivery, documentation, and patient or representative acknowledgment of the addendum connection to the fraud backdrop is direct: an informed patient who understand her hospice is supposed to be covering wound care is better positioned to ask uncomfortable questions when that same care suddenly appears as a separate Medicare charge.

For technology vendors operating in hospice intake, documentation, and compli this is a clear new workflow requirement. The implementation window before th 2027 effective date of October 1, 2026 is short enough that any provider without streamlined addendum delivery and documentation process is already late.

The Wage Index Problem and the BLS I

The hospice wage index has used the pre-floor, pre-reclassified hospital inpatien wage index as its base since the mid-1990s. The problem with this proxy is that

hospital labor cost data is built around acute inpatient staffing, primarily physic specialists, and inpatient nurses, while hospice labor is predominantly hospice a registered nurses working in community settings, and social workers. The occupational mix is fundamentally different, and in many labor markets, especia rural ones, the divergence between hospital wages and community home-based c wages is substantial.

CMS convened a Technical Expert Panel in September 2025 and is now formally soliciting comment on a potential hospice-specific wage index using Bureau of L Statistics Occupational Employment and Wage Statistics data. The proposed methodology is detailed: calculate CBSA-level wage estimates for 10 occupationa categories, weight them by a national occupational mix derived from freestandin hospice cost report expense data and claims-based minutes of care, divide by the national aggregate to produce an index value, then apply the existing hospice flo 5% cap on decreases.

The proposed occupational mix from that methodology is revealing. Hospice aid 38.11% of the mix and registered nurses at 28.46% account for nearly two-thirds weighting. That is a very different picture from what drives hospital wage indexe where physician compensation and specialty nursing play much larger roles. The remaining 10 occupational categories cover nursing administration, physician services, LPNs, medical social services, nurse practitioners, and therapists.

A shift to BLS-based hospice-specific wage indexing would produce winners and losers across markets. Rural areas where hospice labor costs diverge significantly hospital labor costs stand to see payment rate changes that could run into the m of dollars annually for larger operators. The transition policy question CMS is explicitly soliciting input on matters enormously for anyone modeling long-run operating economics in the hospice space.

This is a multi-year policy signal rather than a one-year action. But the combina of a completed TEP, a detailed methodology document, and structured public comment questions covering data sources, occupational mix, geographic delinea and transition design suggests this is moving toward implementation within a fe

rulemaking cycles. Anyone doing capital allocation in hospice operations, wheth an operator, a PE sponsor, or an early investor, needs this uncertainty in their underwriting assumptions.

MAID, Palliative Care, and the Policy Frontier

Two RFIs in this rule are genuinely forward-looking in ways that are easy to ove given the fraud enforcement drama surrounding it. The medical aid in dying sec and the community palliative care section both signal a CMS that is actively map the policy edges of end-of-life care.

On MAID: the Assisted Suicide Funding Restriction Act of 1997 prohibits feder funds from paying for any service intended to cause or assist in causing death. T law has not changed. What has changed is the number of states legalizing MAID currently 11 states plus Washington DC, with more moving in that direction. Th eligibility requirement in most state MAID laws is a six-month terminal prognos which is identical to the Medicare hospice eligibility standard. That means a meaningful and growing population of hospice-enrolled patients in MAID-legal are simultaneously eligible for both programs.

CMS wants to understand what actually happens in practice. Do hospices contin providing clinical care while a patient pursues MAID qualification? Do patients remain on service until natural death or revoke election to pursue MAID? What happens with unused lethal medications? The questions are operational rather t philosophical, and the underlying policy concern is making sure federal hospice payments are not directly or indirectly subsidizing MAID services, which the 19 explicitly prohibits. CMS is also asking whether additional oversight mechanism needed to enforce that prohibition more reliably.

The community palliative care RFI is the longer-term signal. Medicare does not standalone palliative care benefit. Patients who need serious illness support but not yet elected or are not eligible for hospice fall into a patchwork of Part B evaluation and management codes, advance care planning CPT codes 99497 and

99498, chronic care management codes, and limited home health coverage. CMS asking whether these existing pathways can be optimized to produce more seaml community palliative care without requiring new legislation or a new benefit cat

For investors and founders building in the serious illness population manageme advance care planning, or community-based palliative care delivery spaces, this l a material signal. CMS is explicitly naming the pre-hospice transition zone as a p priority and asking for detailed input on billing practices, care gaps, documenta burdens, and staffing barriers. The infrastructure built on top of the existing bil code landscape today will be positioned as the natural foundation if a more form palliative care pathway emerges in future rulemaking.

Quality Reporting Gets a Shaming Mechanism

The HQRP section of this rule continues the transition from the old Hospice Ite to the newer HOPE assessment tool with the iQIES platform. The novel proposa the Care Compare icon.

Roughly 20 to 24 percent of hospices have been non-compliant with quality repc requirements in recent fiscal years. In FY 2023 the rate was 20.07%. In FY 2024, first year of the 4-point APU penalty, it rose to 22.06%. In FY 2025 it peaked at 23.53% before settling to 20.37% in FY 2026. The doubling of the financial penal from 2 to 4 percentage points has produced essentially zero improvement, and tl non-compliance rate has never dropped below 20%.

The proposed response is a consumer-facing icon on the Medicare.gov Care Con tool identifying hospices that failed the 90% HOPE submission threshold. The ic would appear on both the provider search page and individual hospice profile pa similar to how penalty flags appear for nursing homes and hospitals. It is propos go live no earlier than FY 2028, based on CY 2026 submission data.

The logic of public shaming outperforming financial penalties in this setting is actually defensible. The APU penalty hits cash flows that a financially distressed

fraudulent operator may not care about. A visible compliance failure flag on the primary consumer-facing comparison platform hits something different: referral Hospices depend heavily on physician referrals and on family choices made duri acute medical transitions. A red flag on Care Compare, visible to any family mer running a quick search, creates reputational exposure that financial penalties do For fraudulent operators, CMS non-compliance flags are also input data for enforcement prioritization, which makes the icon a dual-purpose tool.

For health IT vendors in the hospice documentation and quality reporting space creates a hard deadline and a clear value proposition. Getting clients above the 9 submission threshold before October 2027 is now a competitive differentiator, because the CY 2026 data used for the FY 2028 icon is being generated right no

So What Does This Mean for Investors and Builders

The FY 2027 hospice proposed rule and Operation Never Say Die land in the sar week for a reason. CMS is simultaneously writing the infrastructure rules and executing the enforcement actions, and both are accelerating. Dr. Oz's statement he believes roughly half of LA's hospices are fraudulent, if anything close to that accurate nationally even at a fraction of the LA intensity, represents one of the la active fraud situations in any Medicare sector.

For investors, there are a few distinct opportunity signals here. The SSVI creates new public data asset for the post-acute analytics market. Provider benchmarkir referral network quality scoring, and M&A diligence for hospice operators now l claims-derived 0-to-16 annual scorecard that did not exist before. Analytics companies that can layer SSVI data against operational benchmarks, payer mix, staffing ratios, and length of stay distributions have obvious buyers across payer IDNs, referral platforms, and PE sponsors managing hospice roll-ups.

The compliance urgency around the mandatory election addendum and the Care Compare icon creates near-term workflow and documentation demand. These ar administrative problems that affect thousands of sites simultaneously, and a

significant share of the hospice market, particularly smaller independent provid
lack the internal infrastructure to handle them cleanly. That is repeatable revenu
documentation platforms, compliance software, and quality reporting tools alrea
embedded in hospice operations.

The non-hospice spending enforcement trajectory and the SSVI together create
genuine demand for care coordination technology that helps hospices manage pa
comprehensively within the per diem. The 167% higher outside spending rate at
profit hospices is not sustainable under the new transparency and enforcement
environment. Hospices that can demonstrate comprehensive care delivery and lo
non-hospice spend ratios will have a competitive advantage in both referral netw
and enforcement priority ranking. Technology that helps document, coordinate,
optimize within-benefit care delivery is building into a regulatory tailwind that
getting stronger.

The BLS wage index transition is a multi-year underwriting risk factor. If finaliz
would change payment rates in specific markets by amounts that could be mater
operating margins, particularly in rural and high-wage urban markets where the
divergence from hospital labor costs is largest. Anyone deploying capital into ho
operations in markets that diverge significantly from their hospital wage index p
should be modeling this exposure explicitly.

The palliative care pre-hospice transition zone is a medium-term market format
signal. CMS is clearly interested in formalizing community palliative care pathw
asking detailed questions about billing and delivery gaps, and has named this as
policy priority. Infrastructure built on the existing code landscape today, spanni
serious illness population identification, ACP documentation, and community-b
care coordination, is well-positioned for the eventual formalization of that pathv

None of this is an argument that hospice is a sector to avoid. End-of-life care is a
demographic inevitability. The need is growing, not shrinking. But the regulator
sophistication required to operate and invest in this space just stepped up
significantly. CMS is building real measurement capability, publishing provider-
scores, designing consumer-facing enforcement mechanisms, and coordinating v

DOJ on criminal prosecutions at a pace and scale the hospice industry has not se before. The operators and technology vendors who understand that this is not a temporary crackdown but a permanent infrastructure shift will find themselves right side of where this market is going.

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