AXXESSHospice

THE NEW COMPLIANCE ERA:

SURVIVING THE CMS CRACKDOWN

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INTRODUCTION

The recent federal moratorium on new home health and hospice agency enrollments represents one of the most significant regulatory actions the federal government has taken against the post-acute care industry in years. Announced by the Centers for Medicare & Medicaid Services on May 13, 2026, the nationwide six-month moratorium temporarily stops new home health and hospice agencies from enrolling in Medicare. The action was implemented as part of a broader federal anti-fraud initiative targeting what CMS describes as widespread fraud, waste and abuse within the industry.

For current hospice organizations already enrolled in Medicare, the moratorium does not stop operations or reimbursement. Existing agencies can continue providing care, billing Medicare, admitting patients and operating normally as long as they remain compliant with federal and state regulations. However, CMS has made clear that oversight will intensify during the moratorium period.

CMS has stated it will intensify investigations, site visits, claims reviews, ownership scrutiny and data analytics during the moratorium period. Agencies should expect closer examination on eligibility documentation, billing patterns, referral relationships, ownership structures and compliance programs. In high-risk states such as California, Texas, Arizona, Nevada, Georgia and Ohio, providers may face even greater regulatory attention due to previously identified fraud concerns (Fig. 1).

Operationally, the moratorium may create both opportunities and challenges for established agencies. Because no new competitors can enter the Medicare market during the freeze, current providers may temporarily experience reduced market competition and increased referral opportunities. Hospitals, physicians and discharge planners may rely more heavily on established organizations that already have Medicare certification and proven compliance histories.

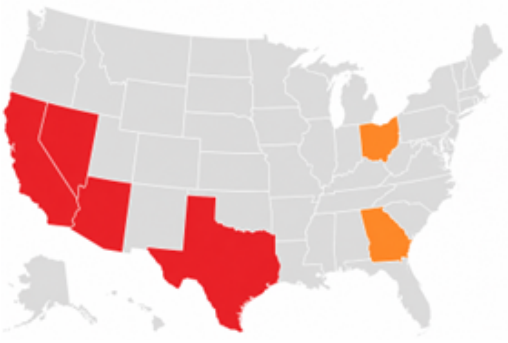

Fig. 1 - High Risk States

INTRODUCTION

At the same time, the moratorium raises concerns about access to care, workforce expansion and future growth. Industry leaders warn that blocking new agencies could reduce care availability in rural and underserved communities where provider shortages already exist. Existing agencies may experience higher patient volumes, staffing pressures and increased demand for services.

The moratorium also affects mergers, acquisitions and ownership transitions. Certain ownership changes that require new Medicare enrollment approval may now be delayed or denied during the moratorium period. Organizations pursuing expansion strategies, de-novo locations or restructuring transactions must carefully evaluate regulatory risk and timing.

Most importantly, the moratorium sends a clear message that compliance has become a strategic priority for survival and growth in hospice care. Agencies must strengthen internal auditing, documentation accuracy, eligibility verification, coding integrity and staff education. Organizations with strong compliance cultures, transparent operations and effective leadership will likely be better positioned to withstand increased federal scrutiny.

Overall, while the moratorium does not shut down existing hospice agencies, it fundamentally changes the regulatory environment. Current providers must prepare for more aggressive oversight, stricter enforcement and a healthcare landscape where operational integrity and compliance readiness are more important than ever.

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Seven Steps to Safeguard Your Organization

Hospice agencies should take immediate and proactive steps to strengthen compliance, clinical integrity and operational oversight in response to increasing federal scrutiny of the hospice industry. Recent CMS enforcement actions and the nationwide enrollment moratorium signal a clear shift toward more aggressive monitoring of hospice eligibility, billing practices, ownership structures and quality outcomes. Agencies that fail to address vulnerabilities now may face audits, payment suspensions, civil penalties and reputational damage later.

1. Ensure Accurate Eligibility Documentation
2. Strengthen Live Discharge Oversight and Length-of-Stay Monitoring
3. Conduct Immediate Audits of General Inpatient (GIP) Level-of-Care Utilization
4. Review Referral Source Relationships and Marketing Practices
5. Strengthen Education Across All Departments
6. Re-evaluate Your Quality and Compliance Activities
7. Focus on Preserving Mission-Driven Care

Step 1

Ensure Accurate Eligibility Documentation

Regulators continue to focus heavily on whether patients truly meet the six-month terminal prognosis requirement.

ACTION STEPS:

- ☐ Clear documentation of disease progression, decline, functional deterioration, comorbidities and supporting clinical indicators by:
  - Physicians
  - Nurse practitioners
  - All members of the IDG
- ☐ Provide ongoing LCD training at IDG.
- ☐ Frame clinical data with AEB (as evidenced by).
- ☐ Audit 10% of long length of stay patients quarterly.
- ☐ Dedicated admission nurses to set "fresh eyes" on long length of stay patients.
- ☐ Clinical director audit of IDG for training opportunities around decline.

"Documentation should paint a consistent clinical picture across certifications, recertifications, visit notes and care plans."

WHAT TO AVOID:

- **Vague or generic phrases** like "declining," "stable but appropriate," or "continues to meet criteria" without specific clinical support.
- **Copying and pasting narrative** across certifications, recertifications and visit notes.
- **Relying on a terminal diagnosis alone** without showing functional decline, disease progression and supporting comorbidities.
- **Inconsistencies** between physician narratives, nursing notes, IDG documentation and the plan of care.
- **Recertifications with weak or incomplete physician narratives.**
- **Failing to document measurable changes** in weight, intake, cognition, mobility, symptom burden and ADL dependence.
- **Using boilerplate language** that does not reflect the patient's current condition.
- **Documentation gaps** during face-to-face encounters or recertification.
- **Assuming eligibility is obvious** without clearly connecting the clinical facts to a six-month terminal prognosis.
- **Waiting until an audit** to identify unsupported eligibility records.

Step 2

Strengthen Live Discharge Oversight and Length-of-Stay Monitoring

CMS and federal investigators increasingly analyze agencies with unusually long lengths of stay, high live discharge rates and patterns suggesting inappropriate admissions.

ACTION STEPS:

- [ ] Create process for routine review patients approaching long stays, especially those without clear evidence of continued decline.
- [ ] Ensure documentation supports live discharges.
- [ ] Eligibility review committees or physician-led recertification audits can help ensure continued appropriateness of hospice services.
- [ ] Assign your sales team to strengthen relationships with validated home health / palliative care providers to ensure smooth transitions and follow up of discharged patients.

WHAT TO AVOID:

- **Long-stay** patients who remain on service **without updated evidence of decline.**
- **Treating recertification as routine paperwork** instead of a true eligibility review.
- **Ignoring patterns** in live discharges, revocations and extended lengths of stay.
- **Failing to investigate outliers** by diagnosis, referral source, physician and care team.
- **Vague documentation** that does not clearly support continued terminal prognosis.
- **Delaying physician or IDG review** when a patient's decline is unclear or patient has stabilized.
- **Keeping patients enrolled primarily to preserve census rather than eligibility.**
- **Overlooking repeated live discharges followed by rapid readmissions.**
- Focusing only on **aggregate agency data** without reviewing **individual high-risk charts.**
- Failing to **document why a live discharge occurred** and whether it was clinically appropriate.

Step 3

Conduct Immediate Audits of General Inpatient (GIP) Level-of-Care Utilization

General Inpatient (GIP) claims remain a major target for scrutiny because they carry higher reimbursement rates.

ACTION STEPS:

- [ ] Documentation of uncontrolled symptoms supports that it requires intensive nursing interventions that cannot be provided on Routine Home Care (RHC).
- [ ] Ensure GIP documentation shows ongoing symptom burden requiring frequent reassessment and active clinical management to maintain GIP eligibility.
- [ ] Ensure that discharge planning to RHC is initiated for all patients regardless of prognosis at admission to GIP.
- [ ] Audit GIP IDG for evidence for ongoing assessment of GIP eligibility.
- [ ] Engage hospice medical director to provide quarterly GIP eligibility to clinical staff.

WHAT TO AVOID:

- **Using GIP as a default placement** when symptoms could be managed at RHC.
- Admitting patients to GIP **without clear documentation of uncontrolled symptoms** requiring intensive nursing intervention.
- Failing to document **why symptom management can't be provided in another setting.**
- Allowing **GIP stays to continue without daily evidence** of ongoing crisis-level symptom burden and active clinical management.
- Using **vague terms** like "pain uncontrolled" or "symptoms unmanaged" without describing severity, interventions and response.
- **Neglecting frequent reassessment** of symptom status, treatment effectiveness and continued GIP eligibility.
- Failing to **initiate discharge planning early** for transition back to RHC.
- **Keeping patients at GIP for convenience,** caregiver stress alone and placement issues without meeting clinical criteria.
- **Inconsistent documentation** between nursing notes, provider notes, medication changes and level-of-care decisions.
- **Assuming initial eligibility justifies the entire stay** without ongoing support for each day billed as GIP.

Step 4

Review Referral Source Relationships and Marketing Practices

Federal investigators remain highly focused on potential violations of the Anti-Kickback Statute, particularly involving marketers, assisted living facilities, nursing homes and physician relationships. Compensation arrangements tied to census growth or referral volume present significant risk.

ACTION STEPS:

- [ ] Review all referral-related, skilled nursing and hospital contracts and compensation arrangements to ensure they are not tied to patient volume, admissions and census growth.
- [ ] Audit relationships with marketers, assisted living facilities, nursing homes, hospitals and physician groups for Anti-Kickback Statute and Stark Law risk.
- [ ] Require legal/compliance review of marketing agreements, vendor contracts and liaison compensation models before execution and on a routine schedule.
- [ ] Standardize documentation of referral interactions and business development so the organization can demonstrate legitimate, compliant relationship management.
- [ ] Train admissions, marketing and leadership staff on prohibited inducements, improper gifts, free services and other high-risk referral practices.
- [ ] Keep accurate and timely record of any gifts to ensure meeting Stark Law requirements.
- [ ] Monitor referral patterns and outliers by source, geography, diagnosis mix and admission volume to identify unusual trends that may suggest compliance concerns.
- [ ] Establish a clear approval process for community outreach, sponsorships and promotional activities to reduce the risk of inappropriate financial relationships.
- [ ] Conduct periodic internal audits of referral arrangements, marketing practices and related payments, with corrective action taken when concerns are identified.
- [ ] Ensure that the “Promise Makers” (Sales Team) and “Promise Keepers” (Clinical Services) are aligned.
- [ ] Be prepared for your marketer, liaison or vender compensation model to be reviewed by surveyors.

Step 4

Review Referral Source Relationships and Marketing Practices

WHAT TO AVOID:

- **Paying or accepting anything of value in exchange for referrals.**
- Offering free services, gifts, rent subsidies, staffing support and other benefits to referral sources that **could be seen as inducements.**
- Using **vague or poorly documented contracts** that do not clearly describe fair-market-value services.
- Maintaining **referral relationships without legal or compliance review.**
- Ignoring referral source outliers such as **unusually high admission volume** from a single facility, physician and marketer.
- Allowing marketers or liaisons to **make promises about eligibility, coverage and services that are misleading or inaccurate.**
- **Providing routine benefits** to facilities or physicians that are **not equally available or not commercially reasonable.**
- **Failing to document legitimate business purposes** for outreach, sponsorships and community partnership activities.
- **Assuming long-standing relationships are low risk** without periodic auditing and review.

Step 5

Strengthen Education Across All Departments

All hospice staff must understand hospice eligibility standards, documentation expectations, Conditions of Participation, fraud and abuse laws and survey readiness requirements. Training should extend beyond clinicians to include admissions staff, marketers, executives and board members. Compliance education should be ongoing, documented and tied to accountability measures.

ACTION STEPS:

- [ ] Leverage Axxess Training & Certification platform to expedite staff training.
- [ ] Develop a role-based education plan for clinicians, admissions staff, marketers, executives and board members so each group receives training relevant to its compliance responsibilities.
- [ ] Provide regular education on hospice eligibility criteria, documentation standards, Conditions of Participation and fraud and abuse laws to reinforce regulatory expectations.
- [ ] Require onboarding and annual refresher training for all staff, with additional focused sessions when regulations, internal policies and audit findings change.
- [ ] Track training completion, competency validation and attendance to demonstrate accountability and readiness during audits or surveys.
- [ ] Use real case examples, documentation audits and denial trends to make education practical and tied to actual organizational risk areas.
- [ ] Train leaders and managers to reinforce expectations consistently and escalate concerns when documentation, billing and referral practices create compliance risk.
- [ ] Incorporate mock surveys, chart reviews and interdisciplinary case discussions to strengthen staff readiness and identify gaps before regulators do.
- [ ] Align education with internal auditing and corrective action plans so recurring issues are addressed through targeted retraining and monitoring.

Step 6

Re-evaluate Your Quality and Compliance Activities

Federal regulators are increasingly focusing on hospice Quality Assessment and Performance Improvement (QAPI) and Compliance programs as key indicators of organizational oversight, patient safety and compliance effectiveness. Hospices are expected to demonstrate that QAPI and Compliance programs are active, data-driven processes that identify risks, implement corrective actions and drive measurable improvements in patient care, operational performance and regulatory compliance.

ACTION STEPS:

- [ ] Increase internal auditing and data monitoring efforts.
- [ ] Routinely evaluate PEPPER reports, CAHPS® Hospice scores, HOPE and HQRP quality measures, claim denials, live discharge patterns and utilization outliers.
- [ ] Maintain documentation that supports all staff completes new hire and annual compliance training.
- [ ] Proactive chart reviews and mock audits can identify vulnerabilities before regulators.
- [ ] Maintain a clear corrective action process when concerns are identified.
- [ ] Ensure compliance officers are empowered, board members receive regular compliance reporting and ethical decision-making is integrated into daily operations.

WHAT TO AVOID:

- **Treating QAPI as a "check-the-box"** regulatory requirement rather than an active performance improvement program.
- **Collecting quality data without utilizing it** to analyzing trends, identifying root causes and implementing measurable corrective actions.
- **Delaying responses to negative quality indicators,** survey findings, complaints and audit results.
- **Inconsistent or undocumented corrective action plans** that cannot demonstrate follow-through or sustained improvement.
- Conducting audits only after a problem, complaint and investigation occurs instead of **using proactive internal auditing processes.**
- **Incomplete chart reviews** that fail to validate hospice eligibility, documentation integrity, physician narratives and recertification support.

[cont]

Step 6

Re-evaluate Your Quality and Compliance Activities

WHAT TO AVOID:

[cont]

- **Ignoring patterns** of long lengths of stay, high live discharge rates and unusually high utilization compared to peers.
- Allowing **compliance officers to operate without** authority, leadership access and organizational support.
- Limiting compliance reporting to isolated departments instead of **involving executive leadership and governing boards.**
- **Poor board engagement** or failure to provide regular compliance, quality and risk oversight reporting.
- **Siloed decision-making** where clinical, operational, compliance and quality teams **do not collaborate effectively.**
- Failing to **educate staff on QAPI responsibilities,** documentation standards and fraud-prevention expectations.
- **Minimizing or dismissing employee concerns,** hotline reports and internal compliance findings.
- Creating operational cultures where census growth or financial performance **outweigh patient-centered and ethical care decisions.**
- **Failing to document** how performance improvement activities led to measurable operational or patient care improvements.

"In today's environment, hospice compliance is no longer just a regulatory function—it is a core operational strategy essential for financial stability, public trust and long-term sustainability."

Step 7

Focus on Preserving Mission-Driven Care

Hospice organizations can preserve mission-driven care by intentionally aligning clinical, operational and leadership decisions with the core principles of comfort, dignity, compassion and patient-centered support. In today's highly regulated environment, agencies that remain grounded in their mission are often better positioned to sustain staff engagement, family trust, quality outcomes and long-term organizational stability.

ACTION STEPS:

- [ ] Re-center admissions practices around patient appropriateness and goals of care rather than census growth or financial pressure.
- [ ] Strengthen interdisciplinary team collaboration to ensure physical, emotional, psychosocial and spiritual needs are addressed consistently.
- [ ] Prioritize meaningful patient and family communication, including advance care planning and realistic expectation-setting.
- [ ] Invest in staff support initiatives that reduce burnout, compassion fatigue and turnover among frontline caregivers.
- [ ] Incorporate mission and values into orientation, performance evaluations, leadership development and daily operations.
- [ ] Use Quality Assessment and Performance Improvement (QAPI) programs to measure quality-of-life outcomes, symptom management effectiveness, caregiver satisfaction and care experience—not just regulatory metrics.
- [ ] Empower medical directors and clinical leaders to guide ethical decision-making and reinforce appropriate hospice eligibility practices.
- [ ] Maintain transparent compliance and governance structures that support ethical operations and accountability.
- [ ] Strengthen bereavement and caregiver support services to reinforce the hospice philosophy beyond the patient's death.
- [ ] Regularly gather patient, family and staff feedback to identify where operational pressures may be drifting the organization away from its mission.
- [ ] Consider using the 4Ms Framework of Age-Friendly Care to standardized care.

Step 7

Focus on Preserving Mission-Driven Care

WHAT TO AVOID:

- **Admitting patients who do not clearly meet hospice eligibility criteria** or lack documentation supporting a terminal prognosis.
- Allowing census growth goals or financial pressures to **influence clinical decision-making.**
- Creating **compensation structures tied directly to admissions volume** or referral generation that could trigger Anti-Kickback concerns.
- **Treating QAPI as a paper exercise** rather than an active performance improvement process.
- **Ignoring staff burnout,** turnover and interdisciplinary communication breakdowns that negatively affect patient care.
- **Failing to investigate complaints,** adverse events, medication issues and live discharge patterns.
- **Delaying corrective action** after identifying compliance or quality concerns.
- Allowing **marketing messages to misrepresent hospice services,** prognosis expectations and coverage benefits.
- Using **aggressive outreach tactics that pressure patients** or families into electing hospice care prematurely.
- **Neglecting bereavement, psycho-social and spiritual support services** in favor of operational efficiency.
- **Operating without strong board oversight,** compliance leadership and ethical accountability structures.

Addendum A

Hospice Compliance Checklist

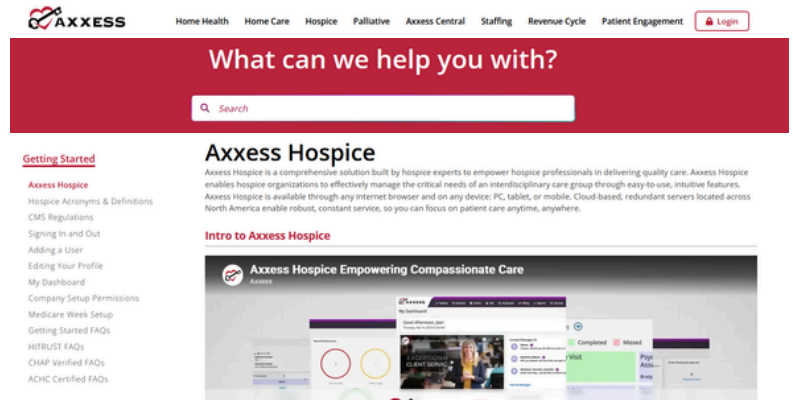
AREA	KEY CHECKS	OWNER	TIMING	STATUS
Eligibility Documentation	Confirm certifications, recertifications, visit notes and care plans show clear decline, comorbidities, functional change and clinical support for a six-month prognosis.	Medical Director / Clinical Leadership	Weekly	☐ Not Started ☐ In Progress ☐ Complete
Live discharge & long stay review	Review long-length-of-stay cases, live discharges, revocations and readmissions; investigate outliers by diagnosis, referral source, physician and team.	Compliance / IDG / QA	Monthly	☐ Not Started ☐ In Progress ☐ Complete
GIP Utilization	Audit GIP admissions and daily notes to verify crisis-level symptom burden, intensive nursing need, reassessment and discharge planning back to routine care.	Clinical Leadership / Billing	Weekly	☐ Not Started ☐ In Progress ☐ Complete
Referral & Marketing Compliance	Review contracts, compensation, gifts, sponsorships and liaison activity for Anti-Kickback and Stark risk; verify fair-market-value support and legal review.	Compliance / Legal / Sales Leadership	Quarterly	☐ Not Started ☐ In Progress ☐ Complete
Education & Competency	Provide role-based training on eligibility, documentation, Conditions of participation, fraud and abuse laws and survey readiness; track completion and competency.	HR / Education / Department Leaders	At Hire + Annual	☐ Not Started ☐ In Progress ☐ Complete
QAPI & Compliance Program	Monitor PEPPER, CAHPS Hospice, HOPE/HQRP, denials, complaints and outliers; document audits, corrective actions, follow-up and board reporting.	Compliance Officer / QAPI Lead / Board	Monthly	☐ Not Started ☐ In Progress ☐ Complete
Mission-Driven Care	Confirm admissions, care planning, communication, bereavement and staffing decisions align with patient-centered goals rather than census or financial pressure.	Executive Team / Clinical Leadership	Ongoing	☐ Not Started ☐ In Progress ☐ Complete
Immediate Priorities	☐ Launch focused chart audits ☐ Review top referral relationships ☐ Validate GIP support ☐ Refresh staff training ☐ Update corrective action tracker ☐ Prepare for survey/audit response	Leadership Team	Next 30 Days	☐ Not Started ☐ In Progress ☐ Complete

Addendum B

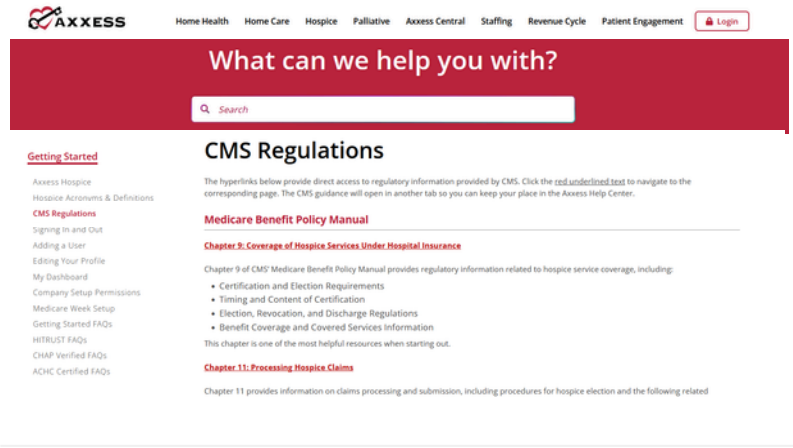
Axxess Tool Kit for Compliance

Axxess provides a robust suite of hospice regulatory and compliance tools and assets that support hospice organizations all in one location.

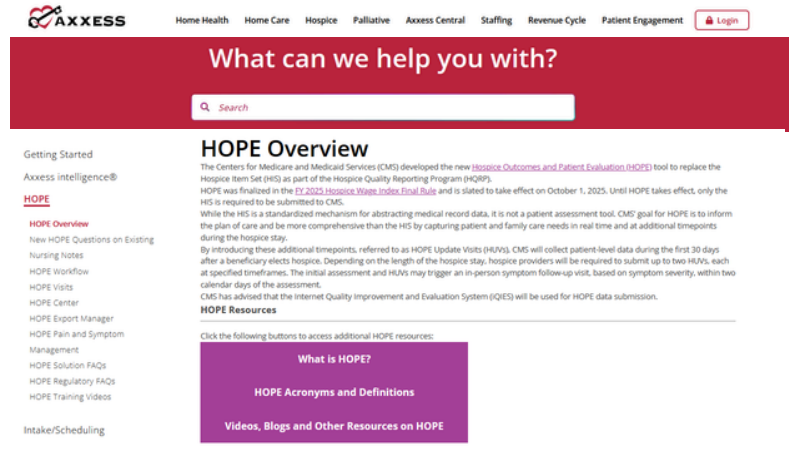
1 Axxess Hospice Help Center



2 Axxess Hospice CMS Regulations



3 HOPE Resources



Addendum C

Axxess Training and Certification ResourceS

Axxess Training and Certification directs your team for training, updates and industry knowledge.

The Maxim Memo

Serving up the freshest, most impactful industry news in the homecare and hospice world. Stay in the know with industry insights you can use.

Read Now

Resources

Engage with in-depth digital resources that can set you up for success.

Learn More

Blogs

Learn from industry thought leaders about a variety of care at home topics.

Learn More

Product Updates

Explore new and upcoming software features and product updates:

Home Health
Home Care
Hospice
Palliative

Help Center

HOPE

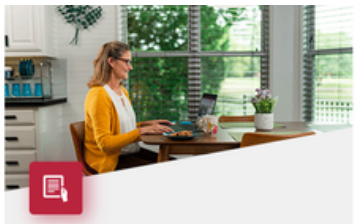
The Hospice Outcomes and Patient Evaluation (HOPE) goes into effect on October 1, 2025. Learn imperative strategies to ensure organizational success.

Learn More

Regulatory Tools and Resources

Stay up to date with the regulatory changes that may affect the care at home industry.

Learn More



Blogs

Learn from industry thought leaders about a variety of home care topics.

Learn More

References

- Centers for Medicare & Medicaid Services
- American Hospital Association