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HHS Sets Its Sights on $50B in Cost Savings: Medicare Payments to Nonhospice Providers Potentially Under Fire

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In May 2025, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) published a review, titled "Potential Cost Savings HHS Programs – HHS Actions," which provided some insight into the OIG's direction to accomplish the Trump administration's stated goal of cutting federal spending. This review spans 35 reports, adding up to $50 billion in potential cost savings — including a reported $6.6 billion in potential savings by preventing Medicare payments for nonhospice items or services furnished to active hospice beneficiaries (nonhospice payments).

Hospice is palliative end-of-life care for individuals with incurable illnesses and can be provided in an individual's home, at a nursing facility, hospital, or in an inpatient hospice facility. When a beneficiary qualifies for and elects hospice benefits, the beneficiary signs a statement choosing hospice care over other Medicare-covered treatments for their terminal illness, and the hospice provider is paid a daily, per diem rate to provide these comprehensive services.

With nonhospice payments accounting for a significant portion of HHS's potential savings, providers across the health care industry — including nursing and long-term care facilities, hospice and home health agencies, hospitals, individual providers, pharmacies, and medical equipment distributors — will need to be ready for the OIG's possible next steps.

Overview of the OIG's Report

In February 2022, the OIG issued its report, "Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight." The report concluded there was an increase in nonhospice providers billing for items or services that should otherwise be provided and covered by the hospice benefit, with the majority of these payments occurring for Part B items or services.

Medicare Part A accounted for 35% of the nonhospice payments, with the majority resulting from inpatient hospital stays. Part A — otherwise known as hospital insurance — covers inpatient hospital stays, skilled nursing facility services, and home health services. Payments are generally based on a prospective payment system (PPS), and payment covers all services related to the beneficiary's treatment during a stay. However, when a beneficiary qualifies for hospice, the hospice provider takes over responsibility for providing necessary items and services for the beneficiary and is paid the daily, per diem rate (once again, under Part A). Inappropriate payments most often

occurred due to provider's billing for inpatient services that were already covered by the per diem.

Medicare Part B accounted for the vast majority of nonhospice payments, at 65%. Part B generally covers items and services, including physician services, outpatient services, and durable medical equipment (DME). The largest category of improper payments under Part B was reported for items and services, including evaluation and management visits, ambulance services, and collection of blood samples.

The OIG specifically highlighted the use of the GW modifier for the majority of these Part B nonhospice payments. Providers use the GW modifier to identify services provided to a hospice patient that are unrelated to the terminal illness and fall outside the hospice benefit. Despite the prevalent use of the modifier, the Centers for Medicare and Medicaid Services (CMS) "has long taken the position that services provided to a hospice beneficiary that are unrelated to the beneficiary's terminal illness and related conditions should be exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit."[1] This suggests that CMS believes providers should use the GW modifier sparingly, if at all.

Part C (Medicare Advantage) and Part D (covering prescription drugs and some DME) were not included within the scope of the report. However, the OIG acknowledged that it believes duplicative payments are also occurring under Part D based on its prior work.

Key Takeaways

1. **There will likely be an increase in CMS and OIG audits/investigations regarding payments to nonhospice providers for items and services.** CMS and OIG will likely increase their auditing and investigating efforts to determine whether providers have submitted improper nonhospice claims. There is likely to be significant focus on billings under Medicare Part A and Part B in particular. In anticipation of increased enforcement, providers should consider proactively conducting self-audits of their billing policies and practices, including developing mechanisms to identify when a patient is currently a Medicare hospice beneficiary and/or eligible for nonhospice items or services.

2. **Providers should exercise caution when using the GW modifier and/or billing for nonhospice services to hospice beneficiaries.** Nonhospice services should only be billed when the items or services are unrelated to a beneficiary's terminal illness or related conditions. The OIG has reiterated its position that only rare circumstances would call for a hospice patient to receive services outside the hospice benefit. If a provider decides that certain services are unrelated to the beneficiary's terminal illness, they should be sure that this determination is supported by relevant medical records and preserve all such documentation.

3. **While not included in the report, the OIG is aware that similar nonhospice billing practices are occurring under Part D, which could likewise result in scrutiny.** Pharmacies and other Part D providers and suppliers should not consider themselves exempt from the OIG's scrutiny of nonhospice billing practices. While the OIG is likely to focus its cost-saving efforts on providers billing under Part A and Part B, providers should also take this opportunity to reevaluate their Part D billing practices with respect to Medicare hospice patients before the OIG potentially shifts focus to Part D.

[1] OIG Final Data Brief: Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight, A-09-20-03015; *see also* 84 Fed. Reg. 38484, 38506 (Aug. 6, 2019) ("In the FY 2020 hospice proposed rule, we reiterated our long-standing position that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit as articulated upon the implementation of the benefit.").

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