
HOSPICE AND END-OF-LIFE LITIGATION

Comfort Promised

Hospice Care Failures and the Federal Crackdown

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Families usually meet hospice at the worst moment of their lives. When it works, it's one of the best things medicine does. When it doesn't, they're left remembering a parent in pain, calls nobody answered, and visits that never came.

Hospice is also under more federal pressure right now than at any point in recent memory. On May 13, 2026, CMS announced a six-month nationwide moratorium on new Medicare enrollments for hospices and home health agencies. It said it had suspended payments to roughly 800 hospices and home health agencies in the Los Angeles area suspected of fraud, revoked or deactivated hundreds more, and put heightened oversight on Arizona, California, Georgia, Nevada, Ohio, and Texas. It also announced a public hospice scoring system. The hospice Special Focus Program, meant to add oversight for the worst performers, has been paused since February 2025 while CMS reevaluates it.

Fraud and poor care aren't the same thing, but they travel together. A hospice that enrolls people who aren't dying, or bills for visits that never happen, is often the same hospice that fails its real patients.

WHAT HOSPICES HAVE TO DO

Medicare hospices must meet the Conditions of Participation at 42 C.F.R. Part 418. For litigation, a few matter most. The hospice must complete an initial assessment within 48 hours of election and a comprehensive assessment within five days (§ 418.54). The interdisciplinary group must write a plan of care and review it at least every 15 days (§ 418.56). A registered nurse must supervise aide services with an on-site visit at least every 14 days (§ 418.76). Nursing must be available around the clock. And patients have a right to effective pain management and symptom control (§ 418.52).

A physician must certify a terminal illness, meaning a prognosis of six months or less if the disease runs its normal course, and a face-to-face encounter is required before recertification for longer stays. Since October 1, 2025, hospices have also had to complete the Hospice Outcomes and Patient Evaluation (HOPE), a standardized assessment of symptoms and needs at set points in the stay. It's a new record type, and it may be very useful in a case.

A FICTIONAL CASE

An 86-year-old man with advanced lung cancer elects hospice at home. His daughter is his caregiver. The plan calls for nurse visits twice a week, aide visits three times a week, and morphine for pain and breathlessness. Over three weeks, the daughter calls the after-hours line several times about severe pain and trouble breathing. Some calls go to voicemail. A Friday nurse visit doesn't happen. His morphine runs out over a weekend and the pharmacy delivery is late. He dies Sunday night. His daughter says he spent his last two days in agony.

WHAT WAS PROMISED VERSUS WHAT WAS DELIVERED

Put the plan of care next to the visit record. Twice-weekly nurse visits were planned. How many are documented, on what dates, for how long, and what was done? Hospice visit notes are usually entered on tablets, and many systems record when a note was started and finished and sometimes where. That metadata can confirm a visit happened when the note says, or reveal notes written days later.

Then the phone calls. Hospices keep after-hours call logs, and many use outside answering services with their own records. When did she call? Who answered? What was she told? Was a nurse sent, and when did the nurse arrive?

Then the medications. When was morphine ordered and delivered, and how much? When did it run out? Who was supposed to reorder it, and was the request made in time? Contracted hospice pharmacies keep delivery records that can show exactly when medication arrived.

WAS THE PAIN MANAGED?

This is the heart of the case. Hospice nurses are expected to assess pain with validated tools, and observational scales exist for patients who can't self-report. When symptoms get worse, the plan should change: higher doses, breakthrough medication, anxiolytics, a call to the physician or NP. Did that happen?

If the chart says "patient comfortable" on days the daughter says he was screaming, reconcile it with everything else: call logs, pharmacy records, texts and voicemails, and her account.

WHAT WAS THE FAMILY TAUGHT?

Home hospice leans hard on family. Was the daughter taught how to give breakthrough doses, recognize distress, and when to call? Was she told what to do if medications ran low? Caregiver education should show up in the record. If she was left to manage without it, that's part of the story.

OTHER HOSPICE CASES

Some cases involve falls and pressure injuries, especially when hospice patients live in nursing homes and there's confusion about who was responsible for what. Those facilities must have a written agreement with the hospice spelling out responsibilities; get it, along with both sets of records. Some involve live discharges, sometimes appropriate and sometimes hard to justify. And some involve the reverse problem, the one regulators are chasing now: a patient who wasn't terminally ill was enrolled and gave up curative treatment she needed. There the review looks at the certifying diagnosis, the evidence behind the six-month prognosis, whether the patient declined over time, and whether recertifications were supported. A dementia patient on hospice for three years with stable weight and no decline raises obvious questions. So does a patient who thought hospice was just "extra help at home."

DAMAGES WHEN THE PATIENT WAS ALREADY DYING

It's a mistake to assume there's no case because the patient was terminal. The harm in hospice cases is often the suffering itself: days of uncontrolled pain, fear, and breathlessness that proper care would have relieved. Those damages are real and documented. Whether the family's own experience is compensable depends on state law, but the clinical record is what proves what happened.

RECORDS WORTH REQUESTING

- The election statement and all certifications and recertifications, including face-to-face notes
- Initial and comprehensive assessments and HOPE assessments
- Every version of the plan of care and interdisciplinary group notes
- All visit notes with electronic metadata (start and end times, location)
- After-hours call logs and answering service records
- Medication orders and hospice pharmacy delivery records
- Aide assignments and RN supervision records
- Caregiver education records
- Any facility-hospice agreement, if the patient lived in a facility
- The hospice's survey history, and family texts, voicemails, and notes

SOURCES

- CMS, “CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice and Home Health Agency Enrollment Moratoria” (May 13, 2026)
- CMS, Hospice Special Focus Program (implementation paused Feb. 14, 2025)
- 42 C.F.R. Part 418, including §§ 418.22, 418.52, 418.54, 418.56, 418.76
- CMS, Hospice Outcomes and Patient Evaluation (HOPE), effective Oct. 1, 2025

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a hospice case and want the promised plan of care measured against the visits, calls, and deliveries that actually happened, we'd welcome the conversation.

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