Matters to be Considered: The agenda will include discussions on the following: Program updates; workgroup and subcommittee reports; update on the status of SEC petitions; and planning for an August 2026 Advisory Board meeting. Agenda items are subject to change as priorities dictate. For additional information, please contact Toll Free 1–800–232–4636.

The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6102–N]

Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the imposition of a 6-month nationwide moratorium on the Medicare enrollment of hospices.

DATES: This moratorium is effective on May 13, 2026.

FOR FURTHER INFORMATION CONTACT: Frank Whelan, (410) 786–1302.

SUPPLEMENTARY INFORMATION:

I. Background

A. CMS' Authority To Impose Temporary Enrollment Moratoria

1. Statutory and Regulatory Background

Under the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively known as the Affordable Care Act), Congress provided the Secretary with new tools and resources to combat fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). One of these was section 6401(a) of the Affordable Care Act, which added a new section 1866(j)(7) to the Social Security Act (the Act). It provided the Secretary with authority to impose a temporary moratorium on the enrollment of new fee-for-service (FFS) Medicare, Medicaid or CHIP providers and suppliers (including categories of providers and suppliers) if the Secretary determines that a moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs.

Section 6401(b) of the Affordable Care Act added specific moratorium language applicable to Medicaid at section 1902(kk)(4) of the Act, requiring States to comply with any moratorium imposed by the Secretary unless the state determines that the imposition of such moratorium would adversely impact Medicaid beneficiaries' access to care. Section 6401(c) of the Affordable Care Act amended section 2107(e)(1) of the Act to provide that all the Medicaid provisions in sections 1902(a)(77) and 1902(kk) also apply to CHIP.

In February 2011, in accordance with the aforementioned authority, CMS published a final rule with comment period titled, ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers'' (76 FR 5862). This final rule implemented section 1866(j)(7) of the Act by establishing new regulations at 42 CFR 424.570. Under § 424.570(a)(2)(i) and (iv), CMS—or CMS in consultation with the Department of Health and Human Services Office of Inspector General (HHS–OIG), the Department of Justice (DOJ), or both—may impose a temporary moratorium on newly enrolling Medicare providers and suppliers if CMS determines that there is a significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type, particular geographic areas, or both.

2. Particulars of a Moratorium as Outlined in § 424.570

a. Length

Per § 424.570(b), a temporary enrollment moratorium imposed by CMS remains in effect for 6 months. If CMS deems it necessary, the moratorium may be extended in 6-month increments. CMS evaluates whether to extend or lift the moratorium before the end of the initial 6-month period and, if applicable, before the expiration of any subsequent moratorium period. If the moratorium announced in this notice is extended, CMS will publish a document regarding such extension(s) in the **Federal Register**.

b. Cessation

As provided in § 424.570(d), CMS may lift a moratorium at any time if: (1) the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act; (2) circumstances warranting the imposition of a moratorium have abated or CMS has implemented program safeguards to address the program vulnerability; (3) the Secretary has declared a public health emergency; or (4) in the judgment of the Secretary, the moratorium is no longer needed. Once a moratorium is lifted, the provider or supplier types that were unable to enroll because of the moratorium will be assigned to the ''high'' screening level in accordance with §§ 424.518(c)(3)(iii) and 455.450(e)(2) if such provider or supplier applies for enrollment at any time within 6 months from the date the moratorium was lifted.

c. Circumstances in Which Moratorium Is Inapplicable

Under § 424.570(a)(1)(iii), a temporary moratorium does not apply to any of the following:

- Changes in practice location (except if the location is changing from a location outside the moratorium area to a location inside the moratorium area).
- Changes in provider or supplier information, such as phone numbers.
- Changes in ownership (except changes in ownership of home health agencies, hospices, or suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that would require an initial enrollment).

Also, in accordance with § 424.570(a)(1)(iv), a temporary moratorium does not apply to any enrollment application that has been received by the Medicare contractor prior to the date the moratorium is imposed.

3. Announcement of Moratorium

CMS states at § 424.570(a)(1)(ii) that it will announce a temporary moratorium in a **Federal Register** notice that includes the rationale for its imposition. This notice fulfills that requirement.

B. CMS' Previous Temporary Enrollment Moratoria

We first used our moratorium authority in a notice issued on July 31, 2013 (78 FR 46339). The moratorium prevented enrollment of: (1) new home health agencies (HHAs) in Miami-Dade County, Florida and Cook County, Illinois, as well as surrounding counties; and (2) Part B ambulance suppliers in Harris County, Texas and surrounding counties. We exercised our moratorium authority again in a notice published on February 4, 2014 (79 FR 6475). This involved—

- Extending our existing moratoria for an additional 6 months.
- Expanding it to include enrollment of—

++ HHAs in Broward County, Florida; Dallas County, Texas; Harris County, Texas; and Wayne County, Michigan and surrounding counties; and

++ Ground ambulance suppliers in Philadelphia, Pennsylvania and surrounding counties.

We extended these moratoria for additional 6-month periods on August 1, 2014 (79 FR 44702), February 2, 2015 (80 FR 5551), July 28, 2015 (80 FR 44967), and February 2, 2016 (81 FR 5444).

We again extended these moratoria for another 6 months on August 3, 2016 (81 FR 51120) and also expanded them statewide with respect to the enrollment of new HHAs in Florida, Illinois, Michigan, and Texas, and Part B non-emergency ambulance suppliers in New Jersey, Pennsylvania, and Texas. Yet in this same notice, we announced the lifting of temporary moratoria for all Part B emergency ambulance suppliers.

The original 2013 moratorium, after being extended and revised several times,[1] expired on January 30, 2019. However, in the February 27, 2026, **Federal Register** (91 FR 9855), we published a notice announcing a 6-month nationwide moratorium on medical supply companies enrolling as suppliers of DMEPOS.[2] This moratorium remains in effect.

C. Determination of the Need for Moratoria

In determining whether to establish an enrollment moratorium, CMS considers whether a high risk of fraud, waste, or abuse exists. CMS also relies on its own and law enforcement's longstanding experience with ongoing and emerging fraud trends and activities gained through civil, criminal, and administrative investigations and prosecutions.

1. Law Enforcement

The HHS–OIG has highlighted the problem of hospice fraud, waste, and abuse. It recently stated: ''[T]here are significant problems with the (hospice) program. Our reports and investigations have revealed several concerning issues, including poor—sometimes harmful—quality of care, fraud schemes that involve enrolling beneficiaries without their consent, inappropriate billing practices, limited transparency for patients and their families, a payment system that creates incentives to minimize services, and a rapid growth in the number of new hospices, often to take advantage of these conditions.'' [3] The OIG in April 2025 also announced an upcoming audit titled ''Trends, Patterns, and Key Comparisons Related to New Medicare Hospice Provider Enrollments May Indicate the Need for Further Oversight'' (OAS–25–09–034), stating: ''Our objective is to identify trends, patterns, and key comparisons that indicate potential vulnerabilities related to new Medicare hospice provider enrollments. The data brief may help CMS evaluate the need for additional monitoring and program integrity efforts to ensure that hospices meet all the requirements.'' [4]

The OIG and DOJ have in the past encouraged CMS to undertake anti-fraud measures regarding hospices, and we believe the action announced by this notice is consistent therewith.

2. Data Analysis

In contemplating the present moratorium, we also used data analysis that included reviewing (i) both current and historic Medicare enrollment data and (ii) indicators of fraud, waste, and abuse. Sections II.A. and B. of this notice discuss our review in more detail.

3. Beneficiary Access to Care

Patient access to care in Medicare, Medicaid and CHIP is of critical importance to CMS and our state partners. CMS has carefully evaluated access to hospice care for Medicare beneficiaries nationwide. We discuss our findings later in this notice.

II. National Hospice Moratorium

Per our authority at § 424.570(a)(2)(i) and (a)(2)(iv), CMS is implementing a nationwide temporary moratorium on the Medicare enrollment of hospices. In this section of this notice, we explain the rationale for and scope of this moratorium.

A. Hospice Program Integrity Risks

1. The Increased Threat of Hospice Fraud, Waste, and Abuse

As previously indicated, hospice fraud, waste, and abuse has been a dilemma for some time. Although, on the surface, hospices traditionally had not appeared to pose the program integrity threat of certain other provider/supplier types like HHAs and DMEPOS suppliers, the elevated risk was still there. This risk has dramatically increased in the past 7 years to the point where hospices present no less of a payment safeguard threat than HHAs and DMEPOS suppliers. CMS outlined the rising problems in 2023, noting in part the following:

- Instances of hospices certifying patients for hospice care when they were not terminally ill and providing little to no services to beneficiaries.[5] This included telling patients that they were terminally ill when they were not. In such circumstances, beneficiaries who are inappropriately deemed terminally ill may be denied coverage for other care because they are receiving the hospice benefit.
- The rapid growth in potentially fraudulent hospices, particularly in

[1] On January 9, 2017, CMS issued another notice to extend the temporary moratoria for a period of 6 months (82 FR 2363). On January 9, 2017 (82 FR 2363) and July 28, 2017 (82 FR 35122), CMS again issued a notice to extend the temporary moratoria for a period of 6 months. On September 1, 2017, CMS lifted the Statewide temporary moratorium on the enrollment of new Medicare Part B non-emergency ground ambulance suppliers in Texas under the authority of § 424.570(d). This lifting of the moratorium also applied to Medicaid and CHIP in Texas. This decision was a result of the Presidential Disaster Declaration signed on August 25, 2017, for several counties in the State of Texas due to Hurricane Harvey. Upon declaration of the disaster, CMS carefully reviewed the potential impact of continued moratoria in Texas and decided to lift the temporary enrollment moratorium on non-emergency ground ambulance suppliers in Texas in order to aid in the disaster response. CMS published a formal announcement of this decision on November 3, 2017 (82 FR 51274). On January 30, 2018 (83 FR 4147), CMS announced the extension of the temporary moratoria for an additional 6 months. In August 2018, CMS announced the extension of the temporary moratoria for an additional 6 months. CMS allowed the temporary moratoria to expire on January 30, 2019.

[2] ''Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Medical Supply Companies'', 91 FR 9855.

[3] *https://oig.hhs.gov/reports/featured/hospice/.*

[4] *https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/trends-and-patterns-in-data-related-to-newly-enrolled-hospice-providers/.*

[5] *https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care#:~:text=Unfortunately%2C%20hospices%20are%20profiting%20from,beneficiaries%20in%20the%20Medicare%20program.*

Arizona, California, Nevada, and Texas, and that some of the addresses for these hospices appeared to be non-operational.[6]

• ''Churn and burn'' schemes whereby a new hospice opens and starts billing but once that hospice is audited or reaches its statutory yearly payment limit, it shuts down, keeps the money, and buys a new Medicare billing number; it then transfers its patients over to the new Medicare billing number, and starts billing again.[7]

Other problems we have seen included but were not limited to: (1) hospices paying recruiters to target beneficiaries who are not eligible for hospice care, sometimes without the beneficiary's knowledge; (2) hospices paying kickbacks to physicians for the latter to falsely certify a patient's terminal status (or falsely certifying even without receiving renumeration); and (3) parties establishing hospices for the exclusive purpose of selling them for a profit and/or after committing fraud but before they can be revoked from Medicare. Furnishing quality patient care was not a priority—or even a consideration—for these parties.

The tremendous growth in the number of hospices in certain states has been especially noteworthy and disturbing. In Arizona, California, Nevada, and Texas, the percentage increase has been far higher than that of hospice beneficiaries. Consider the following CMS data between calendar year (CY) 2019 and 2023:

TABLE 1—NUMBER OF ENROLLED HOSPICES IN CY 2019 AND CY 2023

State	CY 2019	CY 2023	Percentage increase
Arizona	152	311	105
California	1,130	2,559	126
Nevada	55	138	151
Texas	718	1,081	51

The problem has been particularly acute in places like Los Angeles County in California, where numerous hospices were simultaneously operating out of a single building or otherwise were massed in large numbers within a very small geographic area or neighborhood.

2. Criminal and Other Improper Hospice Activity

In the CY 2024 Home Health Prospective Payment System (HH PPS) final rule (88 FR 77676) and the Fiscal Year (FY) 2024 Hospice Wage Index final rule (88 FR 51164), we outlined a number of improper hospice activities we had seen.[8] This included criminal cases involving hospices. We unfortunately continue to see criminal or other inappropriate activity in the hospice sphere, with some court cases involving the behavior cited in section II.A. of this notice. Recent cases include, but are not limited to, the following:

• A former Louisiana resident in June 2024 was sentenced to 6 years in prison for conspiracy to commit health care fraud and three counts of health care fraud. Evidence presented at trial demonstrated that over 24 patients were placed on hospice by the defendant's hospice without meeting the criteria required by Medicare. During the time period that the patients were under the care and supervision of the hospice, none of them had been diagnosed with a terminal condition and, in fact, many of the patients and their families never even knew they had been placed on hospice. One patient testified at trial that Medicare refused to cover a procedure he needed to have because, unbeknownst to him, he was listed as a hospice patient. Many of these patients thought they were receiving some type of home health or free services, rather than being placed on hospice.[9]

• A Utah health care company in March 2023 agreed to pay over $1 million to resolve allegations they violated the False Claims Act by submitting false claims to Medicare and Medicaid for hospice services that were not medically necessary; the patients' records lacked documentation of a terminal illness to qualify for services.[10]

• Several California residents were sentenced to prison in 2025 for their roles in defrauding Medicare of nearly $16 million through sham hospice companies and laundering the fraudulent proceeds. According to court documents, the individuals—who operated several sham hospices—schemed to bill Medicare for hospice services that were medically unnecessary and never provided. They concealed the scheme by using foreign nationals' names and personally identifiable information to act as straw owners for the hospices and to open bank accounts, submit information to Medicare, and sign property leases. They also controlled and used cell phones in the names of the foreign nationals in furtherance of the scheme. After defrauding Medicare, the individuals moved the funds between various assets and accounts—including bank accounts in the names of shell companies—to further conceal their actions.[11]

• Two California residents were found guilty in December 2024 of paying and receiving hundreds of thousands of dollars in illegal kickbacks for patient referrals that resulted in the submission of approximately $3.2 million in fraudulent claims to Medicare for purported hospice care. One of the individuals had been excluded from Medicare because of prior federal convictions for receiving illegal kickbacks. While excluded, she purchased a hospice through her daughter and concealed her ownership interest in the hospice from Medicare. She (the owner) then paid ''marketers'' (including her co-defendant) hundreds of thousands of dollars in illegal kickbacks for patient referrals that she could bill to Medicare for purported hospice care.

Also, and consistent with the owner's instructions, the co-defendant falsely

[6] Ibid.

[7] Ibid.

[8] ''Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements'', November 13, 2023 (88 FR 77676); ''Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements'', August 2, 2023 (88 FR 51164).

[9] *https://www.justice.gov/usao-wdla/pr/hospice-care-company-owner-sentenced-health-care-fraud-charges.*

[10] *https://www.justice.gov/usao-ut/pr/summit-hospice-pay-over-1m-settle-false-claims-liability.*

[11] *https://www.justice.gov/opa/pr/four-california-residents-sentenced-prison-connection-16m-hospice-fraud-and-money-laundering.*

represented to prospective patients that they did not need to be dying to be on hospice. After collecting personal identifying information from prospective patients who were not dying, the co-defendant sent the information to the owner so the latter could bill Medicare for purported hospice care. Many of the patients that were billed to the hospice did not know they were signed up for hospice, and some patients only found out after they were denied medical coverage for services they needed. In addition:

++ When Medicare requested additional documentation from the hospice to support the purported hospice claims, the owner and her husband directed employees to create fake patient charts and had said charts submitted to Medicare.

++ Court documents alleged that while awaiting trial in this matter, the owner took control of three other hospices and caused the submission of approximately $4.8 million in claims for purported hospice care.[12]

• A successor to a hospice chain agreed in July 2024 to pay over $19 million to resolve allegations that the chain knowingly submitted false claims and knowingly retained overpayments for hospice services provided to patients who were ineligible to receive hospice benefits. The hospice locations included sites in Rhode Island, Texas, Missouri, Alabama, Indiana, and Ohio. The specific allegations included the following:

++ The defendants knowingly submitted or caused to be submitted false claims for hospice services provided to hospice patients who were ineligible for the Medicare or Medicaid hospice benefit because they were not terminally ill.

++ Some locations knowingly and improperly concealed or avoided obligations to repay the foregoing hospice claims.

++ One location allegedly violated the Anti-Kickback Statute by willfully paying renumeration to a consulting physician to induce hospice referrals.[13]

• A Georgia hospice and its owners and managers in June 2024 agreed to pay $1.4 million to resolve allegations that they violated the False Claims Act by entering into kickback arrangements with medical directors in exchange for referrals of hospice patients to the hospice. The alleged kickbacks included monthly stipends and a signing bonus paid to the medical directors. The compensation allegedly increased when the medical director referred more patients and decreased when the medical director failed to make referrals. The Special Agent in Charge of the Federal Bureau of Investigation's Atlanta office stated: ''The False Claims Act settlement in this case will hopefully be a deterrent to those who selfishly evade our federal healthcare programs for their own benefit.'' The Georgia Attorney General added: ''Decisions regarding end-of-life care are incredibly difficult and personal, and families must be able to trust the intentions of their chosen providers. Those who instead take advantage of the system for their own personal gain will be held accountable.'' [14]

• The owner and operator of a Louisiana hospice with multiple offices was sentenced to 20 years in prison in May 2024 for orchestrating an extensive health care fraud scheme. The hospice billed Medicare approximately $84 million in fraudulent claims and was paid approximately $42 million relating to these claims. The scheme involved: (1) overbilling for hospice patients for expensive general inpatient services; and (2) manipulating Medicare billing codes despite such services being medically unnecessary or despite their inclusion in the daily hospice benefit the hospice already received for its patients. The Special Agent in Charge at HHS–OIG said the defendant, ''showed no regard for quality end-of-life hospice care. Instead, [his] motivation centered around multiple fraud schemes to maximize profit and steal from American taxpayers.'' The Special Agent in Charge of the FBI New Orleans Division stated: ''Each fraudulent claim filed by [the defendant] potentially deprived another deserving and suffering individual from the emotional and physical comfort of end-of-life care.'' [15]

• Several companies in May 2024 agreed to pay $4.2 million to resolve allegations that they violated the False Claims Act by knowingly submitting false claims and knowingly retaining overpayments for the care of hospice patients in Texas; the patients were ineligible for the Medicare hospice benefit because they were not terminally ill.[16]

• The owner of two California-based hospice companies, along with his biller/consultant, were sentenced to prison in March 2024 for their roles in a scheme that resulted in obtaining over $9 million from Medicare in false and fraudulent claims for hospice services. According to court documents, the owner concealed his ownership and control over the hospice entities from Medicare, inserted nominee owners, paid kickbacks to patient recruiters, and profited from the scheme. The biller/consultant, meanwhile, submitted false and fraudulent Medicare enrollment forms, falsely identifying a straw owner as the sole owner and manager and concealing the actual owners and managers.[17]

• In February 2024, a California man was convicted for his role in a scheme to defraud Medicare by billing $2.8 million for hospice services that patients did not need. According to court documents and evidence presented at trial, the individual was the medical director of several hospice companies. He fraudulently certified Medicare patients of one hospice as having terminal illnesses that the patients did not have so the hospice could bill Medicare for hospice services. The individual in 2015 was listed as the attending provider for more hospice claims paid by Medicare than any other provider in the nation.[18]

• A Texas man in September 2023 was sentenced to prison for his role in a scheme that involved the submission of over $150 million in false and fraudulent claims to Medicare for hospice and other health care services. According to court documents, the person was the medical director of a large health care company that operated dozens of locations throughout Texas. Evidence at the trial of his co-defendants showed that the company marketed their hospice programs through a group of companies. They enrolled patients with long-term incurable diseases, such as Alzheimer's and dementia, as well as patients with limited mental capacity who lived at group homes, nursing homes, and in housing projects. In some instances, the company marketers falsely told patients they had less than six months to live. They also sent chaplains to the patients based on the false pretense they were near death. The group hired the defendant and other medical directors but made payment of their medical director fees contingent upon an

[12] *https://www.justice.gov/usao-cdca/pr/glendale-woman-and-lakewood-man-found-guilty-32-million-hospice-fraud-scheme-involving.*

[13] *https://www.justice.gov/usao-wdky/pr/kindred-and-related-entities-agree-pay-19428m-settle-federal-and-state-false-claims.*

[14] *https://www.justice.gov/usao-ndga/pr/tapestry-hospice-settles-healthcare-kickback-claims-14-million.*

[15] *https://www.justice.gov/usao-edla/pr/hospice-owner-sentenced-240-months-imprisonment-and-ordered-repay-42000000-defrauding.*

[16] *https://www.justice.gov/archives/opa/pr/elara-caring-agrees-pay-42-million-settle-false-claims-act-allegations-it-billed-medicare.*

[17] *https://www.justice.gov/archives/opa/pr/two-men-sentenced-role-9m-hospice-fraud-scheme.*

[18] *https://www.justice.gov/archives/opa/pr/doctor-convicted-28m-medicare-fraud-scheme.*

agreement to certify unqualified patients for hospice. In addition to regular medical director payments, the defendant received luxury trips, bottle service at exclusive nightclubs, and other perks in exchange for his certification of unnecessary hospice patients. He himself certified over $18 million in unnecessary hospice services as part of the over $150 million conspiracy.[19]

- An Oklahoma hospice company agreed to pay over $48,000 to resolve allegations that it violated the False Claims Act by knowingly submitting false claims to Medicare for hospice care provided to beneficiaries who did not qualify for the services (they were not terminally ill) and for services that were not medically necessary.[20]
- A health care company in February 2025 agreed to pay $3 million to resolve allegations that it violated the False Claims Act by knowingly submitting false claims for the care of hospice patients in Alabama who were ineligible for the Medicare hospice benefit because they were not terminally ill.[21]
- A California physician who worked for two hospices was sentenced to Federal prison in December 2024. He and his co-defendant schemed to defraud Medicare by submitting nearly $4 million in false and fraudulent claims for hospice services submitted by two hospice companies, which the co-defendant controlled. The physician falsely stated on claim forms that patients had terminal illnesses to make them eligible for hospice services covered by Medicare, typically adopting diagnoses provided to him by hospice employees whether or not they were true. He did so even though he was not the patients' primary care physician and had not spoken to those primary care physicians about the patients' conditions. Medicare paid on the claims supported by the defendant's false evaluations and certifications and recertifications of patients.[22]

3. CMS Measures Regarding Hospice Fraud

To address several of the foregoing issues, CMS has taken a number of regulatory and operational initiatives.

First, all providers/suppliers are assigned to an application screening level under § 424.518 of ''limited,'' ''moderate,'' or ''high.'' Those in the ''high'' category receive the strictest scrutiny. When initially enrolling in Medicare or undergoing an ownership change ''high'' level providers/suppliers must undergo a site visit and have their 5 percent or greater owners be subject to fingerprinting for a criminal background check. Hospices in 2011 were originally assigned to the ''moderate'' category. Given the increase in hospice fraud, waste, abuse—which includes the consequent need to exercise closer scrutiny of hospice owners, such as through criminal background reviews—we moved hospices to the ''high'' classification beginning in 2024. Hospices are one of only six provider/supplier types in the ''high'' category, which reflects their uniquely elevated risk.

Second, and to further increase our oversight of hospices, we expanded the change in majority ownership (CIMO) ''36-month rule'' in § 424.550(b) to include hospices. We found in the mid-2000s that some HHAs were attempting to enter Medicare without undergoing the required State survey or accreditation. Brokers would enroll an HHA (after being surveyed or accredited) with the specific intention of quickly selling it—or ''flipping'' it—to another party. This enabled the buyer to participate in Medicare with no survey or accreditation of the HHA under its new ownership—hence increasing the possibility of an illegitimate HHA furnishing (and billing for) poor or otherwise non-compliant services to beneficiaries. We thus promulgated § 424.550 in 2009, which required an HHA undergoing a CIMO within 36 months of its initial enrollment (or within 36 months of its most recent CIMO) to initially enroll as a new HHA and undergo a State survey or accreditation (unless certain exceptions apply). As already noted, we have seen similar situations in the hospice realm, whereby promptly selling the business—rather than furnishing good patient care—is the hospice's owner's principal motivation. We believed that expanding the 36-month rule to hospices would help stem the practice by, in part, facilitating a thorough vetting of the new owner and the hospice in question via a survey or accreditation.

Third, 42 CFR 418.22(c) states that (1) the hospice medical director, the physician designee (as defined in § 418.3), or the physician member of the hospice interdisciplinary group (hereafter the ''hospice physician'') and (2) the attending physician (if the beneficiary has one) must initially certify the patient's terminal condition. (For subsequent periods, only the hospice physician must do so). We revised 42 CFR 424.507 in 2023 to require these two categories of physicians to be enrolled in or opted-out of Medicare in order for the hospice service to be paid. We concluded that requiring enrollment or opt-out would allow us to screen the certifying physician to ensure they are qualified (for example, licensed) to certify the terminal condition and do not pose program integrity risks such as past final adverse actions (as that term is defined in § 424.502). This is a particularly important consideration given the aforementioned issue of improper certifications.

Fourth, section 1866(j)(3) of the Act permits the Secretary to establish a provisional period of enhanced oversight (PPEO) of between 30 days and 1 year during which new providers or suppliers (including categories thereof) would be subject to enhanced oversight, such as prepayment review and payment caps. Consistent therewith, and in light of the payment safeguard threats that hospices posed, we implemented a PPEO in 2023 on new hospices enrolling in Arizona, California, Nevada, and Texas. Under this initiative, as of June 2025 approximately 670 hospices were subject to medical review with 122 of them revoked from Medicare. This 18 percent revocation rate is far more than the average revocation rate of about 1 to 3 percent. (That is—and though it varies depending on, for example, the provider/supplier type in question and the geographic region involved—1 to 3 percent of providers/suppliers are revoked at least once during their enrollment). The much higher percentage of hospices revoked during this initiative compared to general provider/supplier revocation rates helps demonstrate the extent of the hospice program integrity problem.

Fifth, we revised our provider enrollment regulations to clarify that hospice medical directors and administrators qualify as ''managing employees'' under § 424.502. They must therefore be reported on the hospice's Form CMS–855A application (Medicare Enrollment Application—Institutional Providers; OMB Control No. 0938–0685). This would foster greater transparency regarding the operators of hospices. It would also permit us to ascertain whether certain medical directors and administrators hold such roles at multiple hospices, which could be an indicator of a broader scheme if

[19] *https://www.justice.gov/archives/opa/pr/hospice-medical-director-sentenced-150m-hospice-fraud-scheme.*

[20] *https://www.justice.gov/usao-ndok/pr/united-states-settles-false-claims-allegations-against-evergreen-hospice-llc-48830.*

[21] *https://www.justice.gov/opa/pr/saad-healthcare-agrees-pay-3m-settle-false-claims-act-allegations-it-billed-medicare.*

[22] *https://www.justice.gov/usao-cdca/pr/santa-paula-doctor-sentenced-2-years-federal-prison-role-hospice-fraud-bilked-medicare.*

the hospices in question otherwise pose program integrity risks.

It should be noted, some of these initiatives mirrored recommendations made by national hospice organizations that expressed deep concerns about fraud within the hospice community—concerns that various members of Congress share.[23]

B. Ongoing Problems in the Hospice Arena

1. Background and Need for Action

CMS is aggressively continuing its efforts to crush hospice fraud, waste, and abuse via the previous and other measures. Closer examination of hospices via the ''36-month rule'' and the elevation of hospices to the ''high'' risk category may well have resulted in some problematic hospice owners being unable to enter Medicare. CMS' PPEO measures have, as stated, resulted in a number of revocations. Yet we are concerned that vulnerabilities remain. Notwithstanding our tighter screening, hospices can still enroll in large numbers if all Medicare requirements are initially met. This is precisely what occurred in Los Angeles County and elsewhere. The dilemma is that some of these providers later engaged in fraudulent activity. Put otherwise, we have indeed established more stringent requirements for hospices to initially enroll, but they cannot in every case prevent a potentially problematic hospice from entering Medicare. Hospice anti-fraud measures require a comprehensive, wide-ranging approach that impact a variety of hospice activities. They cannot be limited to post-enrollment scrutiny (such as medical review), greater screening of new owners, or even both. All facets of hospice enrollment must likewise be addressed. Given the continued severity of hospice program integrity problems, we believe that addressing the very front end of the enrollment process—before the Medicare contractor even starts reviewing the hospice's initial enrollment application, screening the hospice's owners, etc.—is a program integrity gap that must be filled. Preventive action—specifically, halting fraud before it has a chance to begin—is a far better anti-fraud approach than the traditional ''pay-and-chase'' model of waiting for the fraud to happen before taking remedial steps.

2. The Historical Benefits of an Enrollment Moratorium

Our previously mentioned HHA and ground ambulance moratoria were intended to address fraud, waste, and abuse among these two provider/supplier types in general and, in particular, the rapid increase in the number of HHAs and ground ambulance suppliers in the affected localities. The two concepts are related. A sudden rise in new enrollments within a particular area that is not tied to a similar increase in the number of Medicare beneficiaries has long been a strong indicator of fraud, waste, and abuse. Consider Nevada in Table 1 of this notice. There was no medical justification for a 151 percent increase in enrolled hospices over a 4-year period, especially since the State's beneficiary population increased by no more than 10 percent during that timeframe; likewise, having dozens of newly enrolled hospices within a fairly small area of Los Angeles County strongly suggests improper behavior.

The previous moratoria were, in our view, successful in stemming similar activity regarding HHAs and ground ambulance suppliers. Since there were no new enrollments of these provider/supplier types in the impacted high-fraud regions, new providers/suppliers that would or might otherwise have engaged in fraud, waste, and abuse in these areas were blocked from doing so. Too, with no new provider/suppliers coming in, we were able focus our program integrity efforts and resources on post-enrollment activities—that is, on enrolled HHAs and ground ambulance suppliers. Through our very close scrutiny of their activities and, in some cases, revocations, the overall number of enrolled HHAs and ground ambulance suppliers in said localities fell to a level more commensurate with the number of beneficiaries therein—and with this, an ostensible reduction in fraud, waste, and abuse.

With the aforementioned program integrity gap at the beginning of the hospice enrollment process, the ongoing hospice payment safeguard issues, and the success of our previous moratoria, we believe that temporarily closing the enrollment door at the very start via a moratorium is required.

C. Nationwide Application

Aside from the need to halt hospice fraud at the beginning, there is another consideration behind our planned moratorium and why we believe it should be nationwide: the transitory nature of fraud schemes.

The main impetus for the enrollment measures discussed in section II.A. of this notice were the problems seen in Arizona, California, Nevada, and Texas—mostly involving the quick, sharp increase in new enrollments (described in Table 1). Since CY 2023, the number of new enrollments in Arizona, California, and Texas have fallen substantially, as shown in Table 2:

TABLE 2—NUMBER OF NEWLY ENROLLING HOSPICES IN CY 2023 AND CY 2025

State	CY 2023	CY 2025
Arizona	53	3
California	362	29
Texas	164	67

Encouraging though this is, difficulties remain—and are spreading. The number of newly enrolling hospices in Nevada has changed little since CY 2022 despite our hospice program integrity efforts. Whereas there were five new hospice enrollments in Nevada in CY 2019, between 35 and 39 hospices have enrolled in each of the last 4 calendar years. The total number of enrolled Nevada hospices continues to rise at a rate well beyond that of the beneficiary population—from 138 in CY 2023 to 188 in CY 2025, or 36 percent. This potentially reflects a shifting of some fraudulent hospice activity from California and Arizona to Nevada given the sharp decrease in new enrollments

[23] Letter from United States House Representatives Brett Guthrie, John Joyce, M.D., Morgan Griffith, Jason Smith, David Schweikert, and Vern Buchanan to T. March Bell, Inspector General, HHS–OIG, January 9, 2026, *https://energycommerce.house.gov/posts/chairmen-guthrie-joyce-griffith-smith-schweikert-and-buchanan-ask-hhs-oig-about-ongoing-hha-and-hospice-fraud-in-los-angeles-county-1;* Letter from LeadingAge and the National Alliance for Care at Home Letter to Dr. Mehmet Oz, CMS Administrator, December 22, 2025, *https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf.*

in the former two States. Equally concerning is the increase in hospice payment safeguard problems in States like Ohio and Georgia, neither of which have historically been among the highest risk States for Medicare fraud. Though the number of newly enrolling hospices in Ohio has remained fairly steady over the years, we have recently seen, for example, instances of numerous hospices operating out of a single location. In Georgia, there have been sharp increases in the number of hospices there—from 221 in CY 2019 to 273 in CY 2025, or a 24 percent rise; in this same timeframe, the number of Medicare beneficiaries increased only 6 percent. Again, highly disproportionate and otherwise unwarranted increases in hospice enrollments are often indicative of fraudulent behavior. The Ohio and Georgia situations were so alarming that in 2025 we expanded our four-State PPEO to include these two States. With this spread in hospice fraud—combined with the previously noted fraud cases in typically lower-risk States such as Oklahoma, Utah, and Louisiana—fraudulent hospice activity is clearly a nationwide problem, not a regional or local one. It is not limited to long-standing hotspots of provider and supplier fraud, waste, and abuse such as south Florida. Indeed—like Ohio and Georgia—Nevada, Arizona, and even Los Angeles County were never previously deemed as posing excessively high hospice fraud risks. All of this shows that hospice fraud can (and does) arise anywhere at any time—and can spread to any location regardless of that area's perceived historical risk. As we stated in a previous HHA moratorium notice: ''The HHS–OIG and CMS have learned that some fraud schemes are viral, meaning they replicate rapidly within communities, and that health care fraud also migrates—as law enforcement cracks down on a particular scheme, the criminals may redesign the scheme or relocate to a new geographic area.'' [24] We saw instances of this in our prior HHA and non-emergency ambulance supplier moratoria. Providers would leave the initial counties that were subject to the moratoria and move to other locations to circumvent the enrollment ban. While our consequent expansion to State-based moratoria alleviated this problem on a county-level, we still saw isolated circumvention efforts whereby providers would leave the impacted States and enroll new locations elsewhere. With a nationwide hospice moratorium, though, prospective hospice enrollees seeking to defraud Medicare would have no new geographic area to go to.[25]

D. Moratorium Determination and Scope

Considering the foregoing concerns, and after consultation with the OIG, CMS has concluded that hospices have a significant potential for fraud, waste or abuse. With the need to prevent potential fraud before it begins rather than after the fact, we have determined to impose a nationwide moratorium on the enrollment of all hospices and hospice practice locations. Beginning on the effective date of this notice, no new hospices or hospice practice locations will be enrolled in Medicare unless the hospice's enrollment application was received by the applicable Medicare contractor prior to this notice's effective date. Geographically, the moratorium applies to hospices seeking to enroll anywhere in the United States, including all States, territories, and the District of Columbia.

Section 424.550(b), as already mentioned, requires a hospice undergoing a non-exempt CIMO within 36 months of its initial enrollment (or within 36 months of its most recent CIMO) to enroll in Medicare as a brand-new hospice and undergo a State survey or accreditation. The hospice's current enrollment and provider agreement are terminated. This means the hospice's new enrollment is an initial enrollment no less than if the hospice had never enrolled in Medicare before. Hence, our moratorium will prevent a hospice undergoing a non-exempt CIMO from reenrolling in Medicare because, again, it would constitute an initial enrollment; the hospice is ''new.''

E. Application to Medicaid and CHIP

Section 1866(j)(7) of the Act authorizes imposition of a temporary enrollment moratorium for Medicare, Medicaid or CHIP if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either program. The Secretary is not required to impose a particular moratorium on all three programs. This statutory discretion enables the Secretary to impose a moratorium on any combination of the three programs or one program alone.[26]

At this time, we believe it is in Medicaid and CHIP beneficiaries' best interest to allow each State to decide whether some form of a hospice moratorium is appropriate for their respective Medicaid programs and CHIPs, and the scope of any such moratorium. Each State has greater expertise and experience with their hospice provider types—including the requirements for each type of hospice—than CMS. Nevertheless, CMS encourages each State to, as appropriate, implement a hospice moratorium tailored to the specifics of their beneficiary population as well as any geographic considerations, (in accordance with 42 CFR 455.470(b)). CMS is also offering every State and territory the opportunity to consult with CMS on the prospect of implementing a Medicaid- or CHIP-based (or both) hospice moratorium in their jurisdictions.

F. Beneficiary Access to Care

In general, and excluding the recent increases in Arizona, California, Georgia, Nevada, and Texas, the number of enrolled hospices nationwide has remained reasonably stable over the past 7 years. During this period, we saw little evidence of nationwide, across-the-board hospice access-to-care issues for beneficiaries in Medicare—or, for that matter, in Medicaid or CHIP. Therefore, we do not believe that a national moratorium will threaten beneficiaries' ability to receive hospice services in any of these programs. However, we will monitor for any access to care issues.

III. No Judicial Review of CMS's Decision To Impose an Enrollment Moratorium

In accordance with section 1866(j)(7)(B) of the Act, there is no judicial review under sections 1869 and 1878 of the Act, or otherwise, of the

[24] ''Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Temporary Moratoria on Enrollment of Ambulances Suppliers and Providers and Home Health Agencies in Designated Geographic Areas'', July 31, 2013 (78 FR 46339).

[25] California enacted legislation in 2021 (SB–664, Health & Safety Code Article 2.3) that placed a moratorium on the issuance of new hospice licenses in the State; the moratorium remains in effect. Although it has helped to significantly reduce the number of new HHAs in California (see Table 2), it cannot prevent hospice enrollment in other States, a problem that a nationwide enrollment moratorium could resolve.

[26] The aforementioned February 2, 2011, final rule also established new Medicaid regulations at 42 CFR part 455, subpart E, including § 455.470, which implements the moratoria authority under section 1902(kk)(4) of the Act. Likewise, that final rule implemented § 457.990, providing that part 455, subpart E applies to CHIP in the same manner as it applies to Medicaid. Under § 455.470(a)(1) through (3), the Secretary may impose a temporary moratorium, in accordance with § 424.570, on the enrollment of new providers or provider types after consulting with any affected State Medicaid agencies. The State Medicaid agency will impose a temporary moratorium on the enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State determines that the imposition of a moratorium would adversely affect Medicaid beneficiaries' access to medical assistance and so notifies the Secretary in writing.

decision to impose a temporary enrollment moratorium. Under §§ 424.530(a)(10) and 424.570(c), CMS denies the enrollment application of a provider or supplier if the provider or supplier is subject to a moratorium. In addition, § 424.514(d)(2)(v)(C) states that if the provider or supplier was required to pay an application fee, the application fee will be refunded if the application was denied because of the imposition of a temporary moratorium. However, a provider or supplier that is impacted by a moratorium may use the existing appeal procedures at 42 CFR part 498 to administratively appeal a denial of billing privileges based on the imposition of a temporary moratorium; the scope of any such appeal, though, would be limited solely to assessing whether the temporary moratorium applies to the provider or supplier appealing the denial. (See 42 CFR 498.5(*l*)(4)).

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

V. Regulatory Impact Statement

A. Statement of Need

This notice is necessary to help reduce the prevalence of Medicare fraud, waste, and abuse among hospices.

B. Overall Impact

We have examined the impacts of this notice as required by E.O. 12866, ''Regulatory Planning and Review''; E.O. 13132, ''Federalism; E. O. 13563, ''Improving Regulation and Regulatory Review''; E.O. 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA), 5 U.S.C. 601 through 612; section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995.

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts). Based on our analysis, the Office of Information and Regulatory Affairs (OIRA) has determined that this notice is not significant pursuant to section 3(f)(1) of Executive Order 12866. In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget. In accordance with Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this notice does not meet the criteria for a major rule as defined in 5 U.S.C. 804(2).

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the RFA provisions at 5 U.S.C. 604. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This notice is primarily applicable to hospices, not rural hospitals. Therefore, the Secretary has certified that this notice will not have a significant economic impact on the operations of small rural hospitals.

We expect savings to the Medicare program from the reduction in the number of newly enrolling hospices. However, we do not have data upon which to base an estimate of the amount of savings.

C. Regulatory Flexibility Analysis (RFA)

1. Small Business Impact

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organization, and small governmental jurisdictions. Most entities and most other providers and suppliers are small entities, either by nonprofit status or by having revenues less than $19 million to $41 million in any 1 year. Individuals and States are not included in the definition of a small entity. We do not believe that this hospice moratorium notice will have a significant economic impact on a substantial number of small businesses. Excluding the aforementioned outliers in Arizona, California, Georgia, Nevada, and Texas, between CY 2023 and CY 2025 the combined nationwide number of new enrollments was roughly 500 (166 per year). If we assumed that a similar number would seek to enroll during the moratorium would be prohibited from doing so, this is a miniscule percentage when compared to the well over 2 million providers and suppliers currently enrolled in Medicare; the same would hold true if several hundred hospice practice locations (aside from the main provider) could not be added by hospice providers. Furthermore—aside from their ability to add new practice locations to their enrollments—the moratorium would not impact the approximately 7,000 currently enrolled hospices, which could continue furnishing services (assuming they remain complaint with all Medicare requirements). Accordingly, very few small businesses will be affected by the moratorium. Even conceding the impact on newly enrolling hospices and prospective hospice practice locations, we believe that the risk that hospice fraud, waste, and abuse poses to the Trust Funds, Medicare beneficiaries, and the taxpayers far exceeds this and thus justifies our measure.

2. Alternatives Considered

There are two principal alternatives we considered in preparing this notice. First, we considered forgoing a moratorium entirely. Yet as already noted, the longstanding fraud, waste, and abuse problems require remedial measures beyond those we presently utilize. Helpful though the latter have been, more is needed. Second, we contemplated limiting the moratorium to the six States currently subject to the previously-mentioned hospice PPEO. However, we reiterate that the problems the moratorium seeks to address are nationwide instead of restricted to particular geographic areas. As we also stated earlier, the transient nature of fraud schemes—as shown in, for instance, the sudden upswing in new hospices in States like Nevada and Georgia—require nationwide proactivity to prevent these schemes from developing in the first place. Third, we contemplated requiring States to implement a hospice moratorium, but, as noted, we believe States are in the best position to determine whether a moratorium is appropriate for their jurisdictions and beneficiary populations.

D. Unfunded Mandates Reform Act (UMRA)

Section 202 of UMRA of 1995 UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This notice will not impose a mandate that will result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year. UMRA only applies in situations where an agency

engages in notice-and-comment rulemaking. It does not apply to this notice.

E. State and Local Costs

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed regulatory action (and subsequent final action) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this notice does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Dr. Mehmet Oz, having reviewed and approved this document, authorizes Chyana Woodyard, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Chyana Woodyard,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2026–09718 Filed 5–13–26; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6101–N]

Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the imposition of a 6-month nationwide moratorium on the Medicare enrollment of home health agencies (HHAs).

DATES: This moratorium is effective May 13, 2026.

FOR FURTHER INFORMATION CONTACT: Frank Whelan, (410) 786–1302.

SUPPLEMENTARY INFORMATION:

I. Background

A. CMS' Authority To Impose Temporary Enrollment Moratoria

1. Statutory and Regulatory Background

Under the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively known as the Affordable Care Act), Congress provided the Secretary with new tools and resources to combat fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). One of these was section 6401(a) of the Affordable Care Act, which added a new section 1866(j)(7) to the Social Security Act (the Act). It provided the Secretary with authority to impose a temporary moratorium on the enrollment of new fee for service (FFS) Medicare, Medicaid or CHIP providers and suppliers—including categories of providers and suppliers—if the Secretary determines that a moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs.

Section 6401(b) of the Affordable Care Act added specific moratorium language applicable to Medicaid at section 1902(kk)(4) of the Act, requiring States to comply with any moratorium imposed by the Secretary unless the State determines that the imposition of such moratorium would adversely impact Medicaid beneficiaries' access to care. Section 6401(c) of the Affordable Care Act amended section 2107(e)(1) of the Act to provide that all the Medicaid provisions in sections 1902(a)(77) and 1902(kk) are also applicable to CHIP.

In February 2011, in accordance with the aforementioned authority, CMS published a final rule with comment period titled, ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers'' (76 FR 5862). This final rule implemented section 1866(j)(7) of the Act by establishing new regulations at 42 CFR 424.570. Under § 424.570(a)(2)(i) and (iv), CMS—or CMS in consultation with the Department of Health and Human Services Office of Inspector General (HHS–OIG) or the Department of Justice (DOJ) or both—may impose a temporary moratorium on newly enrolling Medicare providers and suppliers if CMS determines that there is a significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type or particular geographic areas or both.

2. Particulars of a Moratorium as Outlined in § 424.570

a. Length

In accordance with § 424.570(b), a temporary enrollment moratorium imposed by CMS remains in effect for 6 months. If CMS deems it necessary, the moratorium may be extended in 6-month increments. CMS evaluates whether to extend or lift the moratorium before the end of the initial 6-month period and, if applicable, before the expiration of any subsequent moratorium periods. If the moratorium announced in this notice is extended, CMS will publish a document regarding such extension(s) in the **Federal Register**.

b. Cessation

As provided in § 424.570(d), CMS may lift a moratorium at any time if: (1) the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act; (2) circumstances warranting the imposition of a moratorium have abated or CMS has implemented program safeguards to address the program vulnerability; (3) the Secretary has declared a public health emergency; or (4) in the judgment of the Secretary, the moratorium is no longer needed. Once a moratorium is lifted, the provider or supplier types that were unable to enroll because of the moratorium will be assigned to the ''high'' screening level in accordance with §§ 424.518(c)(3)(iii) and 455.450(e)(2) if such provider or supplier applies for enrollment at any time within 6 months from the date the moratorium was lifted.

c. Circumstances Where Moratorium Is Inapplicable

Under § 424.570(a)(1)(iii), a temporary moratorium does not apply to any of the following:

- Changes in practice location (except if the location is changing from a location outside the moratorium area to a location inside the moratorium area).
- Changes in provider or supplier information, such as phone number or address.
- Changes in ownership (except changes in ownership of HHAs, hospices, and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that would require an initial enrollment).

Also, in accordance with § 424.570(a)(1)(iv), a temporary moratorium does not apply to any enrollment application that has been received by the Medicare contractor prior to the date the moratorium is imposed.

3. Announcement of Moratorium

CMS states at § 424.570(a)(1)(ii) that it will announce a temporary moratorium in a **Federal Register** notice that includes the rationale for its imposition.