DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6101–N2]

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

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

ACTION: Notice of extension and modification of a temporary moratorium.

SUMMARY: This notice announces the extension and modification of the nationwide temporary moratorium on the enrollment of new Medicare Home Health Agencies.

DATES: The extension and modification of the moratorium is effective on November 12, 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 of the Department of Health and Human Services (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 current § 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 majority ownership (CIMOs) of home health agencies (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.

B. CMS' Previous Temporary Enrollment Moratoria

We first used our moratorium authority to prevent enrollment of new HHAs, subunits, and branch locations in Miami-Dade County, Florida and Cook County, Illinois, as well as surrounding counties, and Part B ambulance suppliers in Harris County, Texas and surrounding counties, in a notice issued on July 31, 2013 (78 FR 46339) in the **Federal Register**. We extended and expanded these moratoria several times, with the last in this series of moratoria expiring in 2019.

In the February 27, 2026, **Federal Register** (91 FR 9855), we published a notice announcing a 6-month nationwide enrollment moratorium on DMEPOS medical supply companies.[1] Said moratorium expired on August 27, 2026. It was not extended.

[1] ''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.

C. May 2026 HHA Moratorium

In weighing the need to establish an enrollment moratorium, CMS considers whether a significant 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. Having analyzed this risk with respect to HHAs, we published a notice in the **Federal Register** on May 15, 2026, announcing a 6-month nationwide temporary moratorium on the Medicare enrollment of new HHAs and HHA branches (91 FR 27954).[2] The moratorium took effect on May 13, 2026.

We detailed in that notice our specific reasons for the HHA moratorium. We stated that HHA fraud, waste, and abuse has been a severe problem for over two decades as noted by the OIG in numerous past reports and studies. In fact, HHAs have long been among the highest-risk Medicare provider/supplier types in terms of program integrity. We outlined in the notice various steps that CMS has taken over the years to address HHA program integrity. Along with certain HHAs being part of the first enrollment moratorium imposed in July 2013, these steps included:

- *Capitalization*—Under § 489.28(a), newly enrolling HHAs must have available sufficient funds at the time of application submission and at all times during the enrollment process up to the expiration of the 3-month period following enrollment. The purpose is to ensure that the HHA is a viable and financially stable business, for an underfunded entity could skimp on patient care to save money or engage in fraud to improve its finances. HHAs remain the only Medicare provider/supplier type that have minimum capitalization requirements as a condition of enrollment; this underscores the uniquely serious fraud, waste, and abuse threat HHAs pose.
- *Screening Designation*—HHAs are one of only six provider/supplier types subject to the highest and strictest level of enrollment application screening under § 424.518.[3] In fact, they were one of only two types originally assigned to this level in our initial screening category assignments in 2011.
- *CIMOs*—Further underscoring the program integrity threat they pose, HHAs in 2009 became the first provider type (and, until 2022, were the only one) to be required under § 424.550(b) to enroll in Medicare as a new provider and undergo a State survey or accreditation following a change in majority ownership—the purpose being to ensure that the HHA under its new ownership is fully compliant with Medicare requirements.
- *Provisional Period of Enhanced Oversight (PPEO)*—Section 1866(j)(3) of the Act permits the Secretary to establish a 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, we implemented a PPEO in 2019 under which new HHAs would not receive upfront payments prior to the provision of services stemming from their requests for anticipated payments (RAPs).[4] As with our capitalization and CIMO provisions—and in light of the longstanding HHA payment safeguard threats—HHAs were the first provider type to be subject to a PPEO.

We also emphasized in the May 15, 2026, notice, though, that despite the foregoing HHA program integrity initiatives, HHA fraud, waste, and abuse remains a significant problem. We cited a number of criminal cases in recent years involving HHAs, and pointed out the deeply disconcerting matter of clusters, whereby large groups of the same provider type suddenly locate themselves within a certain geographic area as part of a potential fraud scheme. Two such situations we noted were the following:

- The number of HHAs in Los Angeles County, California, between 2019 and 2023 rose more than 40 percent, and well over 1,000 new HHAs have enrolled in the county since 2019.
- In Ohio, we found numerous HHAs operating out of a single, common practice location. There were at least nine cases in Ohio where at least five HHAs have the same practice location address; four of these nine situations involve at least 9 HHAs in one location, with one location having 18 HHAs.

Similar situations have been seen in Texas, Michigan, North Carolina, and Nevada. We explained that these situations occurring across various States—rather than being limited to one geographic region—highlighted the national nature of this problem, and that such clusters can pop up at any time and in any place.

Above all, we stressed that CMS must be aggressive in halting fraud before it begins; proactivity is a much better anti-fraud approach than a reactive, ''pay-and-chase'' model. We found our previous HHA moratoria beneficial in this regard, which is largely why we extended and expanded them over a 5-year period.

D. Continued Problems in the HHA Sphere and Consequent Need for Moratorium Extension

We believe there remains a significant potential for fraud, waste, and abuse in the HHA sphere. The payment safeguard threats from HHAs remain high, and the Department of Justice (DOJ) in an August 13, 2026, memorandum noted the DOJ's emphasis on halting home health misconduct. It stated in part that: ''The [DOJ's] Fraud Division will use cutting-edge data analysis to target exploitative health care fraud schemes,'' including with respect to home health.[5] Too, home health criminal and other cases continue to occur (including in Medicaid, which shows that the problem is wide-ranging), such as the following:

- In May 2026, a Michigan nurse and home health care agency owner was convicted for operating a $1.6 million scheme to defraud Medicare. According to court documents and evidence presented at trial, the defendant:

++ Bribed a discharge nurse at a Detroit hospital to identify Medicare patients and fax their confidential records to the home health agency unbeknownst to the patients.

++ Developed the kickback relationship with the hospital discharge nurse at a home health company she had previously co-owned, but she offered the nurse an additional $100 per patient to induce her to refer patients to her new company, paying the discharge nurse over $130,000.

++ Used these stolen profiles to bill Medicare for home health services, exploiting the diagnostic and personal information of patients who were unaware their data had been compromised.

++ In billing claims for patients who were obtained through kickbacks, falsely represented to Medicare that a doctor had certified patients as meeting the Medicare requirements to receive home health services (including being homebound) when evidence proved no doctor had ever evaluated these patients for home health services.

++ In many instances, used the identities of real doctors to fabricate the

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

[3] The others are DMEPOS suppliers, hospices, Medicare diabetes prevention programs, skilled nursing facilities, and opioid treatment programs.

[4] CMS eliminated the use of RAPs for HHAs; beginning January 1, 2022, CMS replaced RAP submissions with a Notice of Admission.

[5] *https://www.justice.gov/opa/pr/assistant-attorney-general-colin-m-mcdonald-issues-memorandum-national-fraud-enforcement.*

existence of these evaluations when, in reality, these doctors had never even met the patients and did not know that the defendant was using their information to fraudulently bill Medicare.[6]

• A Missouri woman pleaded guilty in March 2026 to one count of health care fraud. The defendant admitted submitting fraudulent documents to enroll her home health care company with Missouri Medicaid; the paperwork falsely claimed that someone else owned the company, concealing her ownership and role due to a 2012 criminal conviction. She also admitted submitting fraudulent claims to Missouri Medicaid seeking reimbursement for home healthcare services that were never provided. On numerous occasions, clients were in the hospital and could not have received any health care services at home; on other occasions, the defendant submitted claims when the company did not have any timesheet records or documentation of the services.[7]

• Two Florida home health providers in January 2026 agreed to pay over $700,000 to resolve allegations that they violated the Physician Self-Referral Law (commonly known as the Stark Law (section 1877 of the Act)) by making bonus payments to an employee based on the number of patient referrals made by the employee's spouse, a physician.[8]

• In July 2026, a California man was convicted of conspiracy to commit health care fraud. According to evidence presented at the trial:

++ The defendant conspired with his wife, the former CEO of a California home health agency, and two former agency employees to commit health care fraud. The defendant and his wife agreed to defraud Medicare by: (1) having unqualified medical professionals provide care for home health patients outside their authorized scope of practice; (2) billing Medicare for services never provided; (3) submitting false documents to California Department of Public Health inspectors to maintain the ability to bill Medicare; and (4) instructing former employees to lie to the FBI and Federal law enforcement to conceal their fraudulent activity.

++ The defendant took steps to thwart the law enforcement investigation into the home health agency. He and his wife met with one of the home health agency's former employees, who informed them that FBI agents had questioned her regarding the home health agency's billing practices and patient medical assessments. The defendant instructed the employee to lie to the FBI and falsely state that the employee had been trained and supervised by a registered nurse in the course of conducting patient assessments.[9]

The United States Attorney stated that the defendant and his wife ''defrauded Medicare by altering medical records and forging doctor signatures, and in the process stole millions from the hardworking American taxpayer.'' The Special-Agent-in-Charge added: ''[The defendant] and his conspirators orchestrated a deliberate scheme that put vulnerable patients at risk and stole from Medicare.'' [10]

• A Missouri woman in February 2026 pleaded guilty to one count of wire fraud. She admitted that while owner of a home health care agency, she submitted hundreds of fraudulent reimbursement claims to the Missouri Medicaid Program and the Department of Veterans Affairs. She admitted submitting claims for services on dates when the veteran patients were in the hospital and could not possibly have received home healthcare services. She also submitted claims knowing both that the services were not provided and that she did not have any necessary documentation of the services.[11]

The circumstances warranting the imposition of the HHA moratorium, in short, have not yet abated. CMS has accordingly determined that the moratorium on new HHA enrollments is still needed as we: (1) monitor the indicators; and (2) continue with administrative actions to combat fraud and abuse, such as payment suspensions and revocations of providers.[12] We note that we consulted with the HHS–OIG regarding the extension of this moratorium; OIG agreed there remains a significant potential for fraud, waste or abuse in the Medicare program with respect to HHAs. Based in part on said consultation, we believe our moratorium extension is justified.

We are, though, scaling back the moratorium's scope during the 6-month extension period. The moratorium extension will only apply to initially enrolling HHAs (including those initially enrolling pursuant to a non-exempt CIMO under § 424.550(b)). The extension will not apply to additions of HHA branches, and the moratorium on the addition of branches by currently enrolled HHAs will end as of the effective date of this notice. This modification is primarily due to our greater concern at this current time about new HHAs—with whom we may have no experience—than with HHAs that are already enrolled but are merely seeking to add a branch to their current enrollment (though the latter are still of concern to us).

2. Medicaid and CHIP

We stated in our May 15, 2026, notice that, in our view, it is in Medicaid and CHIP beneficiaries' best interests to allow each State to decide whether some form of HHA 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 pool of HHAs—including the requirements for each type of HHA—than CMS. Nevertheless, we encouraged each State to, as appropriate, implement an HHA moratorium tailored to the specifics of their beneficiary population as well as any geographic considerations (in accordance with 42 CFR 455.470(b)). We also offered each State and territory the opportunity to consult with CMS on the prospect of implementing a Medicaid- or CHIP-based moratorium in their jurisdictions.

Two States—Ohio and Rhode Island—have implemented home health moratoria in response to our May 15, 2026, notice. Our extension notice is not intended to impact these existing moratoria. As we stated in the May 15, 2026, notice, the decision still lies with the State or territory.

3. Access to Care

We have not seen evidence that the May 15, 2026, HHA moratorium has materially reduced Medicare beneficiary access to HHA services on a nationwide or even a State level. In addition, States and territories have not indicated to CMS that the HHA moratorium has led to access to care problems for Medicaid or CHIP beneficiaries in their jurisdictions. Nonetheless, we will continue to monitor this important issue—particularly in rural areas—to

[6] *https://www.justice.gov/opa/pr/michigan-home-health-care-agency-owner-convicted-16m-medicare-fraud-scheme-and-kickback.*

[7] *https://www.justice.gov/usao-edmo/pr/home-health-care-operator-admits-defrauding-missouri-medicaid.*

[8] *https://www.justice.gov/usao-sdfl/pr/two-home-health-providers-agree-pay-702541-resolve-self-referral-allegations.*

[9] *https://www.justice.gov/usao-ndca/pr/ceo-bay-area-home-health-agency-convicted-health-care-fraud-conspiracy-targeting.*

[10] Ibid.

[11] *https://www.justice.gov/usao-edmo/pr/local-home-healthcare-company-owner-admits-over-200000-fraud.*

[12] For more information regarding the monitored indicators, see the February 4, 2014, and July 28, 2017, moratoria document (79 FR 6475) and 82 FR 35127, respectively).

ensure that such problems do not arise with our moratorium extension.

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 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.

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 requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. Regulatory Impact Statement

A. Statement of Need

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

B. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 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). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the Executive Order itself.

An RIA must be prepared for a regulatory action that is significant under section 3(f)(1) of Executive Order 12866. 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. Accordingly, we have not prepared a regulatory impact analysis. 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 an RIA 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 HHAs, 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 continue to expect savings for the Medicare program from the reduction in the number of newly enrolling HHAs. However, we do not yet 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 organizations, 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. For reasons stated in the May 15, 2026, notice, we do not believe that our HHA moratorium has a significant economic impact on a substantial number of small businesses. Even conceding the impact on newly enrolling HHA, we believe that the risk that HHA 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 contemplated allowing the May 15, 2026, moratorium to expire without extension. Yet as already mentioned, fraud schemes remain a significant problem. We believe that permitting new HHAs—some of which may, after enrollment, engage in fraud, waste, or abuse—to begin enrolling again without limitation would only exacerbate the dilemma. Second, we contemplated extending the moratorium but limiting it to southern California, which is a recognized area of HHA fraud, waste, and abuse. We believe, though, that the problems the moratorium seeks to address are nationwide, rather than restricted to particular geographic areas.

D. Unfunded Mandates Reform Act (UMRA)

Section 202 of the UMRA of 1995 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.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2026–23241 Filed 11–12–26; 4:15 pm]

BILLING CODE 4169–69–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; Information Collection Request Title: Rural Maternity and Obstetrics Management Strategies Program Data Collection, OMB No. 0915–0394—Revision

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30-day comment period for this notice has closed.

DATES: Comments on this ICR should be received no later than December 16, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, the HRSA Information Collection Clearance Officer, at *paperwork@hrsa.gov* or call (301) 443–9094.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: Rural Maternity and Obstetrics Management Strategies Program Data Collection, OMB No. 0915–0394—Revision.

Abstract: HRSA administers the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program, which is authorized by section 330A–2(d) of the Public Health Service Act. The RMOMS Program grants support networks that improve access to, and continuity of, maternal and obstetrics care in rural communities. The goals of the RMOMS Program are to: (1) improve maternal and neonatal outcomes within a rural region; (2) develop a sustainable network approach to increase the delivery and access of preconception, prenatal, pregnancy, labor and delivery, and postpartum services; (3) develop a safe delivery environment with the support and access to specialty care for perinatal patients and infants; and (4) develop sustainable financing models for the provision of maternal and obstetrics care in rural hospitals and communities. HRSA currently collects information about RMOMS grants using an OMB-approved set of performance measures and seeks to revise that approved collection. The proposed changes are a result of keeping this instrument relevant, responsive to the RMOMS Program needs, and to improve clarity of reporting for respondents.

A 60-day notice published in the **Federal Register** on August 19, 2026, vol. 91, No. 159; pp. 53622–53623. There were no public comments.

Need and Proposed Use of the Information: The purpose of the revised data collection is to assess RMOMS awardees' progress in meeting the program goals and how well each awardee meets their community needs. Additionally, HRSA will be able to monitor and assess the impact of the RMOMS Program and ensure that funds are effectively used to provide services that meet the target population's needs.

The proposed changes to this data collection include:

- Changing the frequency of data reporting from an annual basis to a biannual basis (twice a year).
- Changing from aggregate data reporting to patient level data reporting.
- Reducing the number of measures from 34 to approximately 25 data elements.
- Removing Forms/Sections 1 (Consortium/Network) and 2 (Sustainability).
- Form/Section 3: Demographics will be changed to Section 1: Demographic Information.
- Form/Section 4: Project Specific Domain will be separated into the following: Section 2: Prenatal Care and Pregnancy Characteristics; Section 3: Labor and Delivery; Section 4: Postpartum Care; Section 5: Health Behaviors and High-Risk Conditions; and Section 6: Program and Support Services.

HRSA also estimates an increase in the estimated total burden hours compared to the currently approved ICR package. The increase in burden is to account for additional RMOMS respondents, changes to the instrument and frequency of data reporting, and the time it takes for awardees to refine their existing processes to coordinate and collect data from their partner organizations. Awardee organizations vary in data collection and reporting capacity as well as in the number of member organizations each must coordinate with to report this data to HRSA. The amount of time it takes to build processes to coordinate and collect data from network partners will vary. Larger networks with multiple partners across different organizations are likely to report higher burdens due to the wait time in between coordinating data requests. Networks that already have established working relationships with member organizations may have existing processes in place to effectively collect data for this program.

Likely Respondents: Respondents will be the RMOMS award recipients.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose