COVER PAGE

Effective May 13, 2026 the Arkansas Health Services Permit Agency will no longer accept applications for Home Health Agencies per CMS Moratorium.

E 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. The subject notice fulfills that requirement.

B. CMS' Previous Temporary Enrollment Moratoria

We first used our moratorium authority to prevent enrollment of new HHAs, subunits, and branch locations (hereafter collectively referred to as HHAs) 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). We exercised the moratorium authority again in a notice published on February 4, 2014 (79 FR 6475), when we extended the existing moratoria for an additional 6 months and expanded it to include enrollment of HHAs in Broward County, Florida; Dallas County, Texas; Harris County, Texas; and Wayne County, Michigan and surrounding counties, and enrollment of ground ambulance suppliers in Philadelphia, Pennsylvania and surrounding counties. We extended these moratoria for another 6 months 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. In this same notice, though, 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

[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

published a notice announcing a 6-month nationwide enrollment moratorium on DMEPOS medical supply companies.[2] Said moratorium remains in effect.

C. Determination of the Need for Moratoria

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.

1. Law Enforcement

The HHS-OIG has long highlighted and documented the problem of HHA fraud, waste, and abuse. The OIG and DOJ have over the years encouraged and supported strong anti-fraud measures targeting HHAs, 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: (1) both current and historic Medicare enrollment data; and (2) indicators of fraud, waste, and abuse. Sections II.A. and B. of this notice discuss our review in more detail.

3. Access to Care

Beneficiary access to care in Medicare, Medicaid and CHIP is of critical importance to CMS and our State partners. In our moratorium determination, we carefully evaluated access to care for Medicare beneficiaries nationwide. We discuss our findings for Medicare beneficiaries in the Beneficiary Access to Care section later in this notice.

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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.

II. National HHA Moratorium

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

A. Longstanding HHA Program Integrity Risks and CMS Efforts to Alleviate Them

As previously alluded to, HHA fraud, waste, and abuse has been a severe problem for over two decades. Based on our experience, low start-up costs and the home-based nature of the services – with little direct supervision of the persons performing them – help make the HHA arena ripe for fraud. Indeed, HHAs have long been among the highest-risk Medicare provider/supplier types in terms of program integrity, with the OIG stating in 2018: "Home health has long been recognized by OIG and CMS as a program area vulnerable to fraud, waste, and abuse."[3] To help address this, CMS over the years has established a number of provider enrollment payment safeguards concerning HHAs.

One involves capitalization. Under § 489.28(a), newly enrolling HHAs must have available sufficient funds (known as "initial reserve operating 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 are 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.

Another involves risk designations. 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, they receive a site visit and must have their 5 percent or greater owners be

[3] https://oig.hhs.gov/documents/evaluation/2926/OEI-05-16-00510-Complete%20Report.pdf.

subject to fingerprinting for a criminal background check. HHAs are one of only six provider/supplier types in the "high" classification.[4] Especially telling, though, is that HHAs were one of only two types that were assigned to this level in our initial category assignments in 2011.

A third involves changes in majority ownership (CIMOs). 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 the survey or accreditation) with the specific intention of quickly selling it to another party. This allowed 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. To help halt such circumvention, we promulgated § 424.550 in 2009. It required an HHA undergoing a CIMO within 36 months of its initial enrollment (or within 36 months of its most recent CIMO) to – unless certain exceptions apply - initially enroll as a new HHA and undergo a State survey or accreditation.

An additional initiative concerned provisional periods 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 -- and in light of the HHA payment safeguard threats we have observed -- we implemented a PPEO in 2019 on new HHAs nationwide regarding their requests for anticipated payments (RAPs). Specifically, HHAs would not receive upfront payments prior to the provision of services stemming from their RAPs.[5] The PPEO expired in 2020, and there presently are no HHA-related PPEOs in effect.

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

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

Most pertinent to the current notice and as already mentioned, we also imposed and extended several HHA enrollment moratoria from 2013 through 2019. Although the particular circumstances involving each affected county and State varied somewhat, they all shared a common characteristic: a significant potential for HHA fraud, waste, and abuse. This was reflected in, for instance: (1) an abnormally high number of HHAs vis-à-vis the location's beneficiary population (that is, market oversaturation); and (2) heavy law enforcement activity as reflected in part by criminal convictions of HHA owners and operators.

We believe these and other provider enrollment measures have to some degree helped reduce the amount of HHA fraud, waste, and abuse. These measures also show our ongoing commitment to addressing this dilemma and our recognition of our obligation to do everything possible to protect Medicare beneficiaries, the Medicare Trust Funds, and the American taxpayers.

B. Continued Problems in the HHA Sphere

Despite all these initiatives, HHA program integrity risks are still among the highest of any provider/supplier type. Our actions might have lessened the degree of HHA fraud, waste, and abuse, but certainly not to the extent that CMS need no longer undertake additional initiatives. It should not be assumed that the expiration of the prior HHA moratoria and PPEO signified a massive reduction in the scope of the HHA risk. As the examples below demonstrate, hundreds of millions of taxpayer dollars remain under threat from fraudulent parties, and we must always consider further means of addressing this continuing problem, particularly as new threats arise.

One such threat involves the Los Angeles region, which has seen unusual and highly disturbing trends in HHA enrollment. CMS data indicates that the number of HHAs in Los Angeles County between 2019 and 2023 rose more than 40 percent. Well over 1,000new HHAs have enrolled in the county since 2019, and the county currently has roughly 12--15 percent of all HHAs nationwide – notwithstanding the fact that the county's Medicare beneficiary

population has not drastically changed over the past 7 years and represents roughly 3 percent of the total nationwide beneficiary community. There is no evidence of medical need or other justification for this sudden, overwhelming increase, and we believe this requires much closer scrutiny of potentially fraudulent HHA activity. Others share our concerns about this, including MedPAC, members of Congress, and even several national HHA organizations – with some having urged CMS to take additional measures to stem HHA fraud throughout Los Angeles County.[6] Concerning trends in HHA enrollment are not restricted to Los Angeles County. For instance, CMS has recently detected several situations in Ohio where numerous HHAs are operating out of a single, common practice location. In fact, we have uncovered 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 nine HHAs in one location, with one location having 18 HHAs. Similar situations have been seen in Texas, Michigan, North Carolina, and Nevada.

There have also been a considerable number of criminal convictions and other findings over the last several years involving home health fraud. These included, but were not limited to, the following:

- The owner of a Pennsylvania home care agency was sentenced to prison in June 2025 and ordered to pay over $235,000 in restitution. The provider had been reimbursed by Medicaid for services that were not provided and for claims containing false representations. The investigation revealed that some of the submitted claims pertained to: (1) patients who never signed up for or received care from the provider; or (2) employees who were not aware that the owner had submitted false claims for hours they allegedly worked.[7]

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[6] https://www.medpac.gov/wp-content/uploads/2025/12/Tab-H-HHA-update-Dec-2025.pdf; 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.

[7] https://www.attorneygeneral.gov/taking-action/owner-of-berks-county-home-care-agency-sentenced-to-prison-ordered-to-pay-more-than-235k-in-restitution-after-pleading-guilty-to-medicaid-fraud-scheme/

- Two Illinois home health care company owners were sentenced to prison in September 2022 and ordered to pay more than $8 million as part of a home health care fraud scheme. According to court documents, the two owned and operated three home health companies in Illinois and Indiana. From approximately January 2009 to June 2018, the pair secretly paid bribes and kickbacks to patient marketers in exchange for referring Medicare beneficiaries to the companies. One of the two maintained relationships with marketers and signed sham contracts with patient marketers on behalf of the companies, while the other facilitated kickback payments to marketers by writing checks to himself and agency employees; the latter would then convert the checks to cash that was used to pay kickbacks to marketers. Also, the former individual caused fraudulent claims to be submitted to Medicare for home health services that falsely represented that she, as a registered nurse, performed assessments of patients on dates when she was out of the country.[8] According to the Department of Justice: "[I]t was the practice of the [pair's] companies to admit, discharge, and re-certify certain patients repeatedly, regardless of their medical conditions."[9]

- A part-owner of a Massachusetts home health provider in January 2025 was sentenced in Federal court to 12 years in prison and ordered to pay almost $100 million in restitution for her role in a home health care fraud scheme. (A co-defendant, who was a nurse at the home health agency, had previously been sentenced to prison for her involvement in the scheme.) [10] According to the indictment for the co-defendant, the provider – through the part-owner, the nurse, and others -- billed for home health services that were (1) never provided; (2) not medically necessary; or (3) not authorized. The part-owner and others also developed employment relationships to pay kickbacks for patient referrals and disregarded medical necessity requirements. In addition, they allegedly entered sham employment relationships with

[8] https://www.justice.gov/archives/opa/pr/home-health-care-company-owners-sentenced-67-million-health-care-fraud.
[9] Ibid.
[10] https://www.justice.gov/usao-ma/pr/operator-home-health-care-company-sentenced-12-years-prison-multimillion-dollar-health; https://www.justice.gov/usao-ma/pr/lowell-nurse-pleads-guilty-100-million-home-health-care-fraud-and-kickback-scheme

patients' family members to provide home health aide services that were not medically necessary and routinely billed for fictitious visits that did not occur. As alleged in the civil complaint, the part-owner -- either directly or through the home health company --- "targeted particularly vulnerable patients who were low-income, on disability and/or suffering from depression and/or addiction."[11] The United States attorney for the case added that the part-owner, "used the stolen money to fund her lavish lifestyle, showing a callous disregard for those who were in dire need of care and assistance. Her actions not only defrauded taxpayers but also compromised the integrity of essential home health care services. The significant prison term imposed today reflects the seriousness of her crimes and the harm she caused to patients, providers, and the public."[12]

- A home health care owner was sentenced in April 2025 to 42 months in prison for committing Medicaid fraud and was ordered to pay $5.7 million in restitution to Medicaid. According to court documents and trial testimony, the defendant owned and operated three home health care businesses in Ohio. She lived in California for the majority of the time she owned the businesses, and despite not being involved in the businesses' daily operations, she did all the Medicaid billing for nursing services. In doing so, she: (1) inflated the hours of services provided; (2) billed for registered nurses when licensed practical nurses completed the care; and (3) billed for care for patients who were either deceased or ineligible to receive Medicaid.[13]

- The State of Massachusetts in December 2020 reached a $10 million settlement with a Massachusetts-based home health care company and its owner to resolve allegations that they falsely billed the State's Medicaid program for unauthorized services. According to the State's Attorney General, the State since 2016 had returned "more than $40 million to [the State's Medicaid program] by going after fraud in the home health industry."[14]

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[11] Ibid.
[12] Ibid.
[13] https://www.justice.gov/usao-sdoh/pr/home-health-care-companies-owner-sentenced-more-3-years-prison-57-million-medicaid.
[14] https://www.mass.gov/news/ag-healey-secures-10-million-from-home-health-care-company-that-falsely-billed-masshealth.

● A San Francisco Bay Area doctor was convicted in Federal court in November 2023 of charges that included: (1) accepting kickbacks for patient referrals to HHAs; (2) health care fraud; and (3) false statements relating to a health care matter. One of the schemes the physician engaged in involved referring patients to an HHA in exchange for illegal kickback payments. Regarding the HHA itself, employees thereof and the chief executive officer (CEO) conspired to pay the physician regular and recurring amounts to ensure that he referred Medicare patients to the HHA. The CEO pled guilty to charges of conspiracy to pay kickbacks for the referrals of Medicare beneficiaries on August 5, 2022.[15]

● In November 2024, a Michigan HHA owner and operator was sentenced to prison for his role in a health care fraud conspiracy that resulted in almost $7.9 million in false and fraudulent claims for home health care services paid by Medicare. According to court documents, the individual -- together with three doctors and two other home health care company owners -- offered kickbacks, bribes, and other inducements to beneficiary recruiters in exchange for Medicare beneficiary information. They then used this information to bill Medicare for services that were medically unnecessary and not provided.[16]

● A New Hampshire man pleaded guilty in July 2021 to two counts of Medicaid fraud. The individual owned a company licensed to provide in-home personal care services to Medicaid beneficiaries. He submitted claims for reimbursement for such services that: (1) were never actually provided; and (2) included periods when the company's patients were not at home but instead were in hospitals or nursing homes.[17]

● A Texas man in August 2025 was sentenced to 75 months in Federal prison for leading a Medicare fraud scheme. The individual owned and operated an HHA. He or others at his direction forged signatures of doctors and nurses; specifically, they cut out old signatures and

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[15] https://www.justice.gov/usao-ndca/pr/bay-area-doctor-convicted-health-care-fraud-and-kickback-scheme-referrals-medicare.
[16] https://www.justice.gov/archives/opa/pr/international-fugitive-home-health-care-owner-sentenced-fraudulently-billing-medicare.
[17] https://oig.hhs.gov/fraud/enforcement/home-care-company-owner-pleads-guilty-to-medicaid-fraud-agrees-to-pay-1000000-restitution/.

taped them onto newly created doctors' orders, nursing notes, and nursing assessments. The defendant submitted these falsified documents in response to a request for records from Medicare. He also: (1) continued using the signature of a nurse who had departed the HHA on nursing notes and assessments; (2) per witness testimony, bribed a doctor in exchange for approving home health services; and (3) billed Medicare for over $400,000 in HHA claims but did not maintain the documentation for many of them and later falsified records to support the claims.[18]

- A Michigan man was convicted in September 2023 for orchestrating a $2.8 million health care fraud and wire fraud conspiracy, and engaging in money laundering, aggravated identity theft, and witness tampering. Despite being excluded from billing Medicare, the individual purchased an HHA using the names, signatures, and personal identifying information of others to conceal his ownership of the company. In a 2-month period, he and his co-conspirators billed and were paid nearly $2.8 million by Medicare for services that were never provided. He then transferred these funds through bank accounts belonging to shell corporations and eventually into his accounts in another country. Too, on the eve of trial – and using a pseudonym -- he wrote false and malicious emails to various federal government agencies alleging a government witness had committed various crimes and should not be allowed to remain in the United States in an attempt to keep the witness from testifying.[19]

- An Oklahoma-based home health provider in January 2026 agreed to pay $34 million to resolve its civil liability under the False Claims Act for billing medically unnecessary home health claims to Medicare and providing financial benefits to physicians in exchange for referrals.[20]

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[18] https://www.justice.gov/usao-sdtx/pr/home-health-agency-owner-sentenced-more-six-years-medicare-fraud-and-identity-theft.
[19] https://www.justice.gov/archives/opa/pr/owner-home-health-company-convicted-28m-medicare-fraud-scheme.
[20] https://www.justice.gov/opa/pr/traditions-health-agrees-pay-34m-resolve-false-claims-act-liability-relating-home-health.

- In another Oklahoma case in October 2022, an Oklahoma-based home health provider, its affiliates, and their president and chief operations officer agreed to pay nearly $7.2 million to resolve allegations that they violated the False Claims Act by billing the Medicare program for medically unnecessary therapy provided to patients in Florida. Specifically, the home health provider allegedly billed the Medicare program knowingly and improperly for home healthcare to patients in Florida based on therapy provided without regard to medical necessity and overbilled for therapy by upcoding patients' diagnoses.[21]

C. Assessment of the Data

The foregoing information plainly shows a significant potential for fraud, waste or abuse with respect to HHAs nationwide. Several other observations can be made about this data.

First, while Los Angeles County has been the focus of much recent attention regarding HHA fraud, this does not mean an HHA enrollment moratorium should be limited to that area. HHA fraud can and does happen in numerous geographic regions -- even those that might not be traditionally considered very high risk, such as Massachusetts, Ohio, and Oklahoma. Indeed, quick and dramatic spikes in fraud can occur anywhere and at any time. Los Angeles County, for instance, had not been included in any of our previous HHA moratoria because the risk that existed there between 2013 and 2019 was deemed less than that posed by HHAs in other areas like Houston and the South Florida region. Yet a rapid, unexpected, and very substantial increase in the number of HHAs occurred in said county. Too, the aforementioned Ohio situation involving dozens of HHAs took place suddenly in the Columbus region, which had never before been a major hotspot for HHA fraud. The point is that the Los Angeles County situation -- rather than militating against a nationwide moratorium -- in our view bolsters the case for it, for fraud schemes can be highly migratory. As we stated in a previous HHA

[21] https://www.justice.gov/archives/opa/pr/carter-healthcare-affiliates-and-two-senior-managers-pay-7175-million-resolve-false-claims.

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."[22] With a nationwide HHA moratorium, though, prospective HHA enrollees seeking to defraud Medicare would have no new geographic area to which to migrate. Likewise, a national moratorium would prevent situations we saw during our prior HHA moratoria where HHAs – attempting to circumvent the moratorium – opened immediately outside the moratorium area and furnished services to beneficiaries within it.

Second, and in a similar vein, the fact that some of the home health fraud is occurring strictly in Medicaid (as shown in several of the previously noted cases) does not diminish the need for a Medicare moratorium. To the contrary, it shows that such fraud takes place across different Federal and State programs. It is the fraud activity itself and its widespread nature – not the specific health care program in which it happens – that is the critical consideration when establishing anti-fraud measures. This is particularly true given that many HHAs are enrolled in both Medicaid and Medicare, meaning behavior in one program could be repeated in another.

Third, we recognize that the overall nationwide number of non-California enrolled HHAs has decreased somewhat in recent years. On the surface at least, this might weigh against a moratorium, since the problem of large numbers of new enrollments is not present outside of Los Angeles County. However, we reiterate that the principal test under § 424.570 for a moratorium is whether a "significant potential for fraud, waste, or abuse" exists. Although a dramatic spike in enrollments is often indicative of potential fraud, it is not a prerequisite for it. Other data can also show this potential. For example, the aforementioned criminal and other cases and the clusters of co-located HHAs reveal that home health fraud is taking place even in areas that have

[22] "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).

seen reductions in the number of enrolled HHAs, such as Michigan and Texas.[23] Accordingly, we do not believe that the HHA decrease outside of California obviates the need for a moratorium.

CMS must be aggressive in halting fraud before it begins; proactivity is a far better anti-fraud approach than a reactive, "pay-and-chase" one. We found our previous HHA moratoria beneficial in this regard, which is largely why we extended and expanded them over a 5-year period. The HHA moratoria's lapse in 2019 did not signify a lack of their success but instead our view that it had achieved the desired goal of keeping potentially fraudulent parties in certain areas from enrolling in Medicare. However, given the serious problems in Los Angeles County and elsewhere, we believe that our current HHA anti-fraud measures have not by themselves dramatically reduced HHA fraud. HHA program integrity requires a holistic effort on our part. We cannot impose only one measure at a time and then wait indefinitely to see if it works before attempting another. Such has been the magnitude of HHA fraud for so long that more measures are needed to supplement our existing ones – and we believe that by applying an HHA moratorium nationwide, we could experience the success of our prior localized moratoria on a much broader geographic scale.

D. Moratorium Determination and Scope

In light of the foregoing concerns, and pursuant to our consultation with OIG, CMS has concluded that HHAs present significant potential for fraud, waste or abuse. To prevent potentially fraudulent HHAs from enrolling in Medicare, we have determined to impose a nationwide moratorium on the enrollment of all HHAs. Beginning on the effective date of this notice, no new HHAs or HHA branches or practice locations will be enrolled into Medicare unless the HHA's enrollment application was received by the applicable Medicare contractor prior to this notice's effective date. Geographically, the moratorium applies to HHAs seeking to

[23] Between 2019 and 2025, the number of enrolled HHAs in Michigan dropped from 485 to 361 (over 25 percent) and from 2,269 to 1,893 in Texas (roughly 17 percent).

enroll anywhere in the United States, including all States, territories, and the District of Columbia.

As previously mentioned, our prior HHA moratoria included the establishment of HHA subunits and branches. In 2013, a "subunit' of an HHA, like the HHA itself, was required under 42 CFR part 484 to independently meet the HHA conditions of participation (CoPs) in 42 CFR part 484, sign a separate provider agreement, and separately enroll in Medicare; the only material distinction between an independent HHA and a subunit was that they could share the same governing body, administrator, and group of professional personnel.[24] Considering CMS' conclusion that the requirement for a subunit to independently meet the CoPs rendered said distinction moot, CMS ended the "subunit" designation in 2018.[25] Subunits are accordingly not part of the present moratorium. An HHA "branch office," meanwhile, is defined in 42 CFR 484.2 as an approved location or site from which an HHA provides services within a portion of the total geographic area served by the parent HHA – the parent providing supervision and administrative control of the branch. The branch need not independently meet the HHA CoPs. For purposes of provider enrollment, CMS has always considered an HHA branch to be a practice location of the HHA. It is therefore an integral part of the HHA and its operations, which is partly why we included branches within the previous moratoria and do so in the present one. More basically, § 424.570(a)(1)(i) is clear that a moratorium can apply to "the establishment of new practice locations," which, again, new HHA branches are.

We also note § 424.550(b), which, as already mentioned, requires an HHA 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 HHA and undergo a State survey or accreditation. The HHA's current enrollment and provider agreement are terminated in these situations. This means that the HHA's new enrollment is an initial enrollment no less than if the

[24] See the proposed rule titled "Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies", published in the **Federal Register** on October 9, 2014 (79 FR 61164 and 61167).
[25] Ibid.

HHA had never enrolled in Medicare before. Hence, our moratorium would prohibit an HHA undergoing a non-exempt CIMO from reenrolling in Medicare because, again, it would constitute an initial enrollment; the HHA is "new".

E. Applicability to Medicaid and CHIP

As already mentioned, 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. The Secretary is not required to impose a particular moratorium on all three programs but may do so 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 interests to allow each State to decide whether some form of a home health provider moratorium is appropriate for their respective Medicaid and CHIP programs, and the scope of any such moratorium. Each State has greater expertise and experience with their pool of home health provider types -- including the requirements for each type of home health provider --- than CMS. Nevertheless, CMS encourages each State to, as appropriate, implement a home health provider moratorium tailored to the specifics of their beneficiary population as well as any geographic considerations (in accordance with 42 CFR 455.470(b)). Additionally, CMS is offering every State and territory the opportunity to consult with CMS on the prospect of implementing a Medicaid- or CHIP-based (or both) home health moratorium in their jurisdictions.

F. Beneficiary Access to Care

[26] The 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.

Although there has been a slight decline in the number of Medicare-enrolled non-California HHAs since 2019, there remain over 11,500 HHAs nationwide. We have not seen evidence of a present nationwide shortage of HHAs or of access-to-care issues for beneficiaries in Medicare either nationally, in particular geographic areas, or rural regions. We are also not aware of similar concerns in Medicaid or CHIP. We therefore do not believe that a national moratorium will threaten beneficiaries' ability to receive home health services in any of these programs. However, we will monitor this matter for any access issues – including in rural areas -- that arise.

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 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 HHAs.

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"; and 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. 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). Accordingly, we have not prepared a regulatory impact analysis.

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 suppliers, 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 note that we expect savings to the Medicare program from the reduction in the number of newly enrolling HHAs. 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 HHA moratorium notice will have a significant economic impact on a substantial number of small businesses. Between 2023 and today in States other than California, the combined annual number of newly enrolling HHA has generally been less than 400 (or an average of roughly 150 to 200 over a 6-month period). If we assumed that a roughly similar number would seek to enroll during the moratorium but 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 HHA branches could not be added as practice locations during the moratorium. Moreover – and excluding their ability to add branches to their enrollments – the moratorium would not impact the roughly 11,500 currently enrolled HHAs, which could continue furnishing services (assuming they remain compliant with all Medicare requirements). Accordingly, we expect few small businesses to be affected by the moratorium. Even conceding the impact on newly enrolling HHAs and prospective HHA branches, 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 considered forgoing a moratorium entirely. Yet as already mentioned, the longstanding fraud, waste, and abuse problems require fraud, waste, and abuse prevention measures beyond those described earlier in this notice, such as capitalization requirements. Helpful though the latter have been, more is needed. Second, we contemplated limiting the moratorium to southern California. We believe, though, that the problems the moratorium seeks to address are nationwide rather than 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 HHAs in Los Angeles County and the tens of HHAs in Ohio operating out of single site – require nationwide (rather than localized) proactivity to prevent these schemes from developing in the first place. Third, we contemplated requiring States to implement an HHA 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.

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 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.
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