

CMS Imposes Nationwide Enrollment Moratoria for Home Health Agencies and Hospices

Insights

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Executive Summary

On May 13, 2026, the Centers for Medicare & Medicaid Services (CMS) simultaneously imposed six-month nationwide temporary enrollment moratoria on Home Health Agencies (“HHAs”) and hospices under its authority at 42 CFR § 424.570. Medicare, Medicaid, and Children’s Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 27,954 (May 15, 2026); Medicare, Medicaid, and Children’s Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices, 91 Fed. Reg. 27,946 (May 15, 2026). These are the first-ever nationwide moratoria for both provider types, dramatically expanding CMS’s prior moratoria, which had been limited to specific geographic areas.

Both moratoria were effective as of May 13, 2026, and will remain in force for an initial six-month period, with the possibility of six-month extensions if CMS determines they are necessary. CMS imposed these moratoria after consultation with the HHS Office of Inspector General (HHS OIG), citing a significant potential for fraud, waste, or abuse and pointing to dramatic enrollment spikes, extensive criminal prosecutions, co-located providers, and migratory fraud patterns.

For provider operators, these moratoria create immediate transactional and operational risks, particularly with respect to changes in majority ownership (“CIMOs”), application of the 36-month rule, branch or practice-location expansion, and M&A activity during the moratorium period.

Particulars of the HHA and Hospice Moratoria and CMS’s Rationale for them

The HHA moratorium applies to all HHAs, HHA branches, and HHA practice locations seeking to enroll anywhere in the United States. CMS expressly includes HHA branch offices within the moratorium, treating branches as “practice locations” under 42 CFR § 424.570(a)(1)(i). The hospice moratorium applies nationwide to all hospices and hospice practice locations.

CMS has extensive prior experience with HHA moratoria. CMS first imposed HHA moratoria in 2013, expanded and extended them multiple times, and allowed them to expire in January 2019. CMS now cites the Los Angeles County enrollment surge—well over 1,000 new HHAs since 2019, representing 12–15 percent of all U.S. HHAs despite the county accounting for approximately three percent of

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Medicare beneficiaries—as a principal justification for reinstating a moratorium on a nationwide basis.

By contrast, CMS has never before imposed a hospice-specific enrollment moratorium. CMS characterizes the hospice moratorium as a response to a recent and dramatic escalation in hospice fraud risks nationwide.

For HHAs, CMS emphasizes market oversaturation and co-location, including findings of multiple HHAs operating from a single address, sometimes in unusually large numbers, as a basis for the moratorium. CMS also documents extensive criminal prosecutions and civil settlements involving HHA owners and operators across multiple states.

For hospices, CMS highlights explosive enrollment growth in Arizona, California, Nevada, and Texas, as well as dense clustering of hospice locations in Los Angeles County. CMS also describes hospice-specific fraud schemes, including “churn-and-burn” schemes, inappropriate terminal certifications, enrollment of beneficiaries without their knowledge, and kickback arrangements involving physicians and medical directors. Criminal cases cited by CMS involve losses in the tens or hundreds of millions of dollars.

Program Integrity Context

HHAs have been classified as high-risk providers since CMS first established screening tiers in 2011 and remain one of only six provider types subject to the highest level of enrollment screening. HHAs are also the only Medicare provider type subject to capitalization requirements as a condition of enrollment. The 36-month rule has applied to HHAs since 2009 to prevent rapid “flipping” of newly enrolled agencies seen in the past. CMS also previously imposed a nationwide provisional period of enhanced oversight (“PPEO”) on new HHAs in 2019, which expired in 2020.

Hospices historically were classified as moderate-risk providers, but CMS elevated hospices to the high-risk category beginning in 2024 due to escalating fraud concerns. CMS has expanded the 36-month rule to hospices, required enrollment or opt-out for certifying physicians, and clarified that hospice medical directors and administrators are managing employees subject to disclosure. CMS implemented a multi-state hospice PPEO beginning in 2023 and expanded it in 2025, resulting in revocation rates far exceeding historical norms.

Circumstances Where Moratoria Are Inapplicable and Other Pertinent Details

Under 42 CFR § 424.570(a)(1)(iii), the moratoria do not apply to routine changes in practice location, provider contact information, or ownership changes—except for ownership changes involving HHAs or hospices that would require an initial enrollment. A non-exempt CMO within the applicable 36-month lookback period would mean that a new purchaser could not assume assignment of the existing provider agreement and would be forced to file an initial enrollment as a new provider, which the moratoria prohibit.

Enrollment applications received by the Medicare contractor before May 13, 2026, are expressly excluded from both moratoria.

CMS’s decision to impose the moratoria is not subject to judicial review, although providers may pursue limited administrative appeals solely on the question of whether the moratoria apply. Application fees will be refunded if an application is denied due to the moratoria.

With respect to Medicaid and CHIP, CMS did not impose a federal moratorium. Instead, CMS permits—and expressly encourages—states to determine whether to adopt parallel moratoria and offers consultation to states considering such action. CMS reasons that states have greater expertise with their home health providers and beneficiary populations. CMS, however, offers to consult with the states in crafting their own moratoria.

CMS concluded that the moratoria will not threaten beneficiary access to care and are committed to ongoing monitoring.

Why CMS Acted Now

CMS repeatedly emphasizes that health care fraud schemes are migratory and “viral,” replicating rapidly and relocating as enforcement pressure increases. CMS cites prior experience demonstrating that geographic moratoria allowed fraudulent providers to relocate outside restricted areas. CMS points to regions such as Los Angeles County for HHAs and Ohio and Georgia for hospices as evidence that fraud can arise quickly in previously lower risk jurisdictions.

Across both notices, CMS frames the moratoria as preventive measures, concluding that halting fraud before enrollment is preferable to traditional “pay-and-chase” enforcement.

Deal and Compliance Implications for Provider Operators

The most significant operational risk created by the moratoria is their interaction with the 36-month rule. A non-exempt CMO within the 36-month lookback period requires an HHA or hospice to initially enroll as a new provider, rather than filing a standard change-of-ownership application whereby the purchaser would accept assignment of the existing Medicare provider agreement. Because initial enrollment is prohibited during the moratorium, such transactions are effectively blocked.

Transactions may inadvertently trigger the 36-month rule through miscalculation of the lookback period, mistaken assumptions regarding exceptions, failure to identify prior ownership changes, or misunderstanding indirect ownership and control concepts under 42 CFR § 424.502. Provider operators contemplating ownership changes, restructurings, or multi-provider transactions during the moratorium period should obtain regulatory counsel review before proceeding.

Conclusion

The May 13, 2026 nationwide moratoria on HHA and hospice enrollment represent an unprecedented escalation in CMS's program-integrity enforcement. By imposing simultaneous nationwide enrollment freezes, CMS has eliminated geographic workarounds and significantly constrained ownership transactions and growth strategies.

Operators should assume that CMOs triggering the 36-month rule are effectively frozen for the duration of the moratoria, that post-May 13, 2026 enrollment applications are barred, and that state Medicaid moratoria may follow. Early regulatory analysis is essential before proceeding with any ownership change or restructuring during this period.

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