National Alliance for Care at Home

October 7, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: National Home Health and Hospice Enrollment Moratoria and Targeted Program Integrity Approaches

Dear Administrator Oz:

On behalf of the National Alliance for Care at Home (the Alliance), the nation's largest organization representing home health agencies, hospices, and home care organizations, I write to follow up on our September 4, 2026 letter regarding the nationwide enrollment moratoria on home health agencies and hospices. We commend your leadership in safeguarding the integrity of the Medicare home health and hospice benefits, and we remain committed partners in protecting Medicare beneficiaries and the Trust Funds. As CMS determines how to carry that work forward after November 13, we urge the agency to rely on targeted enforcement rather than nationwide enrollment moratoria.

As we expressed previously, we respectfully request that CMS allow the moratoria to expire at the end of the initial six-month term on November 13, 2026. As our prior letter described, the moratoria are preventing long-standing providers with proven quality records from extending services to rural and underserved communities, delaying or ending health system affiliations, leaving struggling providers that would have been acquired facing closure, and keeping newly built and renovated hospice inpatient units from serving patients. Likewise, recent studies indicate a worsening of access to home health and hospice services nationwide, particularly in rural areas. Further extension of the moratoria may compound the challenges associated with access to these important in-home services.[1] None of these situations adds a new operator to Medicare. At the same time, the nationwide enrollment moratoria do nothing to stop bad actors already enrolled in the program.

CMS already has effective tools to reach those actors, including the provisional period of enhanced oversight, survey, pre-payment review, audits, high-risk screening, revocation, the Review Choice Demonstration, and, where warranted, referral to law enforcement. Fraud continues to be

[1] *See, e.g.*, U.S. Gov't Accountability Off., GAO-24-106442, Medicare Hospice: CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys, GAO-24-106442, at 30 (May 2024). *See also* S. M. Vergez et al., *Disparities in Timely Receipt of Home Healthcare: Neighborhood Disadvantage and Delayed Start-of-Care Visits in New York City*, 73 J. Am. Geriatrics Soc'y 73 (2025).

concentrated in certain hotspots rather than spread evenly across the country, and these tools allow CMS to act where that risk is evident.

If CMS determines that some form of the moratoria must continue, we urge the agency to narrow the scope to concentrate on the areas of greatest risk and limit the effect on beneficiary access. Specifically, in such a case we urge CMS to limit the moratoria to the highest-risk states and exclude certificate-of-need (CON) states, which already have rigid licensure criteria and adjudicative processes. Indeed, never before has CMS implemented moratoria on a nationwide scale, and to continue doing so risks serious access consequences for the beneficiaries the Medicare program serves.

Further, section 1866(j)(7)(A) of the Social Security Act authorizes a temporary moratorium on enrollment of "*new providers of services and suppliers*" when necessary to prevent or combat fraud, waste, or abuse. An additional practice location established by an already enrolled provider is not the same as a new provider entering Medicare. 42 C.F.R. § 424.570(a)(1) recognizes the distinction and provides that CMS *"may"* impose a moratorium on new provider enrollment or on the establishment of new practice locations. It does not require CMS to prohibit both. Accordingly, if CMS extends these moratoria, we urge you to exercise that discretion to permit established providers with strong compliance records to open new practice locations in growing and rural communities.

Similarly, a gold-carding approach would give CMS a practical way to identify providers who qualify for this status. CMS has recently used gold carding as a concept to exempt providers with demonstrated compliance records from review requirements, including in the Wasteful and Inappropriate Service Reduction (WISeR) Model. A similar standard here would permit enrolled home health agencies and hospices that meet reasonable criteria to establish new practice locations while the moratoria remain in effect for new entrants. It would also keep CMS focused where risk is greatest and free screening and oversight resources for higher-risk entities. To support this work, the Alliance is convening a work group of large national nonprofit and for-profit providers, together with rural and regional providers, to develop gold-carding recommendations, which we would welcome the opportunity to share with you and your team.

We welcome the opportunity to meet with you and your team in support of this important work to safeguard the Medicare program and preserve access to care for the beneficiaries it serves. Thank you for your leadership on program integrity and your continued engagement with the home health and hospice communities.

Respectfully,

Jennifer Sheets

Jennifer Sheets
Chief Executive Officer

cc: Kimberly Brandt, Deputy Administrator and Chief Operating Officer
Jeneen Iwugo, Acting Director, Center for Program Integrity