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Moratorium on New Medicare Enrollment

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CMS is imposing a six-month nationwide moratorium on new Medicare enrollment for hospices and home health agencies in a sweeping effort to combat fraud.

Effective immediately, CMS will not process new Medicare enrollment applications or certain changes in majority ownership for hospices and home health agencies across the country for the next six months. This action is designed to prevent fraudulent providers from entering the Medicare program and to disrupt schemes that exploit vulnerable beneficiaries and taxpayer funds. Existing providers are not affected and may continue to serve Medicare patients as usual.

During the moratorium, CMS has announced that it will intensify investigations, use advanced data analytics, and accelerate removal of providers suspected of fraud. The moratorium also aims to close loopholes that have allowed bad actors to evade detection by shifting operations across state lines. CMS has highlighted that this is one of its most significant fraud prevention actions to date, building on recent payment suspensions and provider revocations in high-risk areas.

Hospice and home health agencies considering new Medicare enrollment or ownership changes should anticipate delays and increased scrutiny. Compliance teams should review current operations and be prepared for potential site visits or additional oversight measures.

Existing providers should also be aware that the same announcement likely signals accelerated revocations of Medicare billing privileges and an expanded use of payment suspensions. Providers facing a revocation, deactivation, or denial of enrollment or certification have appeal rights but the deadlines are short.

A request for reconsideration must generally be filed within sixty (60) days of the initial determination, followed, if necessary, by an Administrative Law Judge hearing before the HHS Departmental Appeals Board, review by the Departmental Appeals Board (DAB) Appellate Division, and ultimately federal court review. For revocations predicated on noncompliance with enrollment requirements, a Corrective Action Plan may be available in parallel. Because revocations also trigger re-enrollment bars of up to ten years with longer bars for repeat revocations, the consequences extend well beyond the current billing privileges and warrant immediate counsel involvement upon receipt of any adverse CMS or Medicare Administrative Contractor (MAC) determination.

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