



April 2, 2026

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

**Re: Hospice Program Integrity — Concerns Regarding a Nationwide
Moratorium on New Hospice Enrollments and Its Impact on
Telehealth Recertification**

Dear Administrator Oz:

We write on behalf of the Association for Home and Hospice Care of North Carolina, the Florida Hospice & Palliative Care Association, and the South Carolina Home Care & Hospice Association. Our organizations collectively represent hundreds of hospice providers across three states, all of whom are committed to delivering compassionate, high-quality care to Medicare beneficiaries and their families. We share fully the Administration's commitment to protecting Medicare beneficiaries and rooting out fraud, waste, and abuse in the hospice and home health programs.

We write to follow up on two recent letters submitted to CMS on March 25, 2026: (1) the joint letter from the National Alliance for Care at Home, LeadingAge, LeadingAge California, and the California Association for Health Services at Home (the "Joint Letter"), and (2) the letter from the National Partnership for Healthcare and Hospice Innovation ("NPHI") calling for a temporary, nationwide moratorium on new hospice provider enrollments. Although we appreciate and support the goals expressed in both letters, we write to urge CMS to exercise caution before imposing a nationwide moratorium for hospice—as recommended in NPHI's letter—which we believe would constitute an overly broad response that carries significant unintended

consequences for Medicare beneficiaries' access to needed end-of-life care.

A Limited Problem Warrants a Tailored Solution.

As the Joint Letter persuasively details, Medicare home health and hospice fraud has historically been concentrated in geographic hot spots. In the hospice space, Arizona, California, Nevada, and Texas have emerged as fraud hot spots. In late 2021, California enacted a general moratorium on licensing new hospice agencies beginning January 1, 2022, lasting until at least January 1, 2027.

The data confirms the geographic concentration of this problem. As documented in the Joint Letter, the extraordinary surge in new hospice enrollments during the COVID-19 Public Health Emergency was disproportionately concentrated in Los Angeles County and the surrounding Southern California region. The March 2026 Medicare Payment Advisory Commission Report to Congress echoed these findings through independent research.

Given this well-documented geographic concentration, a nationwide moratorium as NPHI recommends would be overkill. Although we respect NPHI and share its concern about fraudulent operators, applying a blanket moratorium across the entire country would punish communities that have not experienced the same explosive, fraud-driven growth as southern California and a handful of other hot spots. In states like North Carolina, Florida, and South Carolina, where established hospice providers are working diligently to serve their communities, a nationwide moratorium would impede the development of new, legitimate hospice programs in areas where additional capacity is genuinely needed to serve aging populations.

For example, in North Carolina, there is a demonstrated need for three new hospices through a thoughtful methodology and after significant public input. In Florida, at least twenty additional hospices are in the process of being licensed to keep pace with demographic and utilization trends in the state (some awarded in 2025 and in the initial survey and licensure process; more will be awarded this year). Florida's planning process projects future needs, and a national moratorium would disrupt the system of meeting future needs and undermine the state's excellent regulatory system which assures residents of the state have hospice services where they need them, when they need them. Our states have no indicators of hospice fraud or abuse. In the states we represent, each hospice program is well known by the state regulatory agency due to the vetting process, subsequent surveys, and oversight.

We therefore agree with the Joint Letter's admonition that CMS should

approach any moratorium decision with a careful analysis of likely effectiveness, potential unintended consequences for access to care, and the availability of other tools that may be better calibrated to the problem.

A Nationwide Moratorium Would Eliminate Telehealth Flexibility for Hospice Recertification.

Perhaps the most serious unintended consequence of a nationwide moratorium is its impact on telehealth flexibilities for hospice recertification. Both the Joint Letter and NPHI's letter acknowledge this concern, but we believe it warrants more detailed attention than either letter provided.

Section 6209(f) of the Consolidated Appropriations Act, 2026 extends Medicare's flexibility that allows hospice face-to-face recertification encounters to be performed via telehealth through December 31, 2027. This extension, however, includes important exceptions. The legislative language provides that telehealth may not be used for the required hospice recertification encounter if any of the following three conditions apply:

1. The patient is in a region under a moratorium on new hospice enrollments (SSA §1866(j)(7)).
2. The hospice program is under enhanced oversight by Medicare (SSA §1866(j)(3)) (which provides for a provisional period (30 days - 1 year) of enhanced oversight for new providers of services and suppliers), **or**
3. The recertifying physician or nurse practitioner is not enrolled in Medicare or has not officially opted-out of Medicare pursuant to 1802(b)(6)(D).

Section 1866(j)(7) of the Social Security Act authorizes HHS to impose temporary moratoria on new provider enrollments in Medicare, Medicaid, and CHIP to combat fraud, waste, and abuse. This authority permits CMS to freeze the enrollment of new hospices in certain geographic areas, or to impose a moratorium nationwide. Because of the first statutory exception described above, however, if HHS or CMS declares a moratorium on enrollment of new hospices—whether in a certain region or nationwide—the face-to-face encounter for hospice recertification for every Medicare beneficiary in the affected area would have to be conducted in person rather than via telehealth.

The practical consequences of this restriction are severe and far-reaching. As the Joint Letter notes, hospice providers across the country, in both urban and rural settings, are depending on telehealth flexibility for completing the required hospice face-to-face encounter. This is especially critical given physician and nurse practitioner shortages and in areas with extensive drive times that make in-person visits difficult to accomplish within the short regulatory timeframes for recertification. As NPHI itself acknowledged, requiring clinicians to travel long distances to complete what is largely an administrative requirement would be particularly challenging in rural communities, despite no demonstrated decline in quality since these telehealth flexibilities were introduced.

A nationwide moratorium would thus undermine the very telehealth flexibility that Congress extended through the end of 2027 for the benefit of Medicare hospice beneficiaries everywhere, not just in fraud hot spots. Patients who are receiving legitimate, high-quality hospice care in North Carolina, Florida, South Carolina, and every other state would be forced to receive in-person recertification visits even when telehealth encounters are clinically appropriate, logistically necessary, and fully authorized by statute. This would impose unnecessary burdens on terminally ill patients and their families at some of the most vulnerable moments of their lives.

Targeted Enforcement Is the Appropriate Response.

We strongly support the program integrity actions CMS has already taken, including enhanced site visits, the Provisional Period of Enhanced Oversight, enhanced prepayment reviews, new hospice physician enrollment requirements, heightened screening for newly enrolling hospices, and beneficiary notification and rapid disenrollment protections. We also support the Joint Letter's recommendation that CMS focus its resources using a risk-based approach centered on new providers and recent entrants, aberrant billing patterns, referral relationships, ownership structures, and other fraud indicators. These tools have proven effective: CMS reports that through December 2025, 817 hospices have been subject to medical review and CMS revoked Medicare enrollment for 181 of those hospices.

If CMS determines that a moratorium is warranted, we urge the agency to use its authority to impose geographically targeted moratoria in the specific regions where the data demonstrate the highest risk of fraud, rather than implementing a nationwide freeze. Additionally, should CMS pursue a moratorium in any form, we urge the agency to work with Congress in advance of implementation of any moratorium to address the statutory interaction between a moratorium and the telehealth recertification flexibility so that legitimate hospice patients are not

deprived of the benefits of telehealth simply because they reside in a region where CMS has imposed an enrollment freeze.

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We are grateful for your leadership and the Administration's commitment to bringing a whole-of-government approach to combating fraud in Medicare's home health and hospice programs. Our organizations stand ready to support these efforts and to collaborate with CMS on solutions that protect program integrity without compromising access to compassionate, high-quality end-of-life care.

Sincerely,



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