CMS Finalizes Medicare Enrollment Changes Affecting All Providers & Suppliers: Retroactive Revocations and New Denial and Revocation Grounds

November 23, 2026

At a Glance

- The CY 2027 Home Health Prospective Payment System (HH PPS) final rule (CMS-1844-F, 91 FR 72022), published November 9, 2026, contains Medicare provider enrollment changes. Most of them apply to all Medicare-enrolled provider and supplier types, not just home health agencies (HHAs).
- Every revocation ground will now have a retroactive effective date. For most grounds, this is the date the noncompliance began, allowing CMS to recover payments made from that date forward; however, certain grounds use a different effective date, as described in further detail below.
- Revoked providers and suppliers will have 15 days from the date of the revocation letter, rather than 60 days from the revocation effective date, to submit outstanding claims.
- CMS added and expanded grounds for denying or revoking enrollment. These include certain misdemeanor convictions and an excessive concentration of providers and suppliers in a limited geographic area.
- CMS can now impose a reapplication bar of up to 10 years after any enrollment denial.

Effective Date

All provisions, other than the HH PPS and HH QRP provisions and the changes to 42 CFR 484.245, are effective 60 days after November 4, 2026 (i.e., the date of filing for public inspection at the Federal Register).

Summary of the Final Rule

1. Retroactive revocations

- **Abuse of billing privilege.** Currently, CMS considers four factors to determine whether a provider or supplier is engaging in a pattern or practice of abusive billing. Under the final rule, CMS will no longer be constrained to these factors when making that determination.

- **False or misleading information.** Currently, CMS may revoke a provider's or supplier's Medicare billing privileges if the provider or supplier certified as "true" false or misleading information on the enrollment application. Under the final rule, this ground expands beyond the enrollment application to include enrollment-related forms, documents furnished with enrollment-related forms, letters from a provider demonstrating that a particular provider official qualifies as an authorized or delegated official, and any other required or requested enrollment-related document.

- **Retroactive revocation effective dates.** Currently, a revocation generally takes effect 30 days after CMS or its contractor mails the revocation notice, unless it falls within one of the existing retroactive grounds, such as

those based on exclusion or debarment, felony convictions, license suspensions or revocations, non-operational practice locations, lapses in IDTF liability insurance, DMEPOS supplier standard violations, and abusive billing. Under the final rule, every revocation ground in § 424.535(a) will have a retroactive effective date. For most grounds, this is the date the noncompliance began, but certain grounds use a different date, for example:

  - Application fee noncompliance: the date CMS or its contractor determines that revocation is warranted.
  - Failure to report enrollment changes: the day after the reporting deadline.
  - Re-enrolling under a different name or identity: the effective date of the current enrollment.
  - Undue risk of fraud, waste, or abuse to the Medicare program: the date CMS or its contractor determines that revocation is warranted.

- **Claims submission after revocation.** Under the current rule, a revoked provider or supplier has 60 calendar days after the revocation effective date to submit claims for items and services furnished before the date of the revocation letter. HHAs have 60 days after the later of the revocation effective date or the date their last payable episode ends. That approach worked when most revocations were prospective, because the effective date fell after the letter was sent. Now that revocations are retroactive, the effective date may fall months before the letter, so the 60-day window could close before the provider even learns of the revocation. To address this, the final rule ties the deadline to the letter rather than the effective date: providers and suppliers must submit all claims for items and services furnished before the revocation effective date within 15 calendar days of the date of the revocation letter.

- **Practical effect.** Medicare payments made between the start of the noncompliance and the revocation notice may be subject to recovery, and the window to submit outstanding claims is significantly shorter. Because the exposure now accrues from the start of the noncompliance, how long an issue goes undetected or uncorrected matters much more financially.

2. New grounds for denial or revocation

- **Certain misdemeanor convictions.** Currently, conviction-based denials and revocations under 42 CFR 424.530(a)(3) and 424.535(a)(3) are generally limited to felony convictions. Under the final rule, new grounds also include certain misdemeanor convictions related to sexual assault or financial misconduct. The revocation effective date will be retroactive to the date of conviction.

- **Geographic concentration.** This is a new authority with no counterpart in the current regulations. CMS may revoke an enrollment that it deems to present a high risk of fraud, waste, or abuse due to the provider's or supplier's location within a limited geographic area that has an excessive number of providers and suppliers. CMS states that it will apply this authority only in exceptional cases after considering the facts and circumstances. The revocation is effective on the date CMS or its contractor determines that revocation is warranted.

- **Same suite or office.** This is a new denial ground. CMS may deny enrollment if the provider's or supplier's practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied.

- **Hospice medical directors and administrators.** This new denial ground applies only to hospices. CMS may deny a hospice's enrollment application if its medical director or administrator serves in that role for multiple other hospices, or is located so far from the enrolling hospice that they cannot realistically perform their

required functions under 42 CFR part 418. CMS may also deny enrollment if the medical director does not hold an active physician license in the state in which they practice.

- **Misuse of identity.** This is a new denial ground. CMS may deny enrollment if the prospective provider or supplier is attempting to enroll under another party's identity, such as where one party uses a physician's credentials and identifiers to enroll and bill Medicare without that physician's knowledge.

- **Reapplication bar.** Currently, CMS may impose a reapplication bar of up to 10 years after denying enrollment only when the denial was based on the submission of false or misleading information on or with the enrollment application. Under the final rule, CMS may impose a reapplication bar of up to 10 years regardless of the reason for the denial. This change applies to denials only; CMS already may impose a reenrollment bar of 1 to 10 years following any revocation under 42 CFR 424.535(c), and that authority is unchanged.

3. Hospice, HHA, and DMEPOS ownership changes

- The 36-month rule requiring hospices, HHAs, and DMEPOS suppliers to re-enroll in Medicare as a new provider and undergo a state survey or accreditation after certain changes in majority ownership is not new. However, the final rule adds new authority at 42 CFR 424.530(a)(22) and 424.535(a)(25) to deny or revoke enrollment for noncompliance with it, including attempts to circumvent the rule through unreported sales or management agreements. CMS declined to limit these grounds to intentional conduct, and the revocation is effective on the date CMS determines revocation is warranted.

4. Proposals CMS did not finalize or narrowed

- **Revocation of other enrollments.** Currently, when a triggering enrollment is revoked under 42 CFR 424.535(a), CMS may revoke any and all of the provider's or supplier's other enrollments. CMS proposed to expand this authority so that a denial of the triggering enrollment under 42 CFR 424.530(a) could also lead to revocation of the provider's or supplier's other enrollments. CMS is not finalizing this change, so the current rule, which is limited to revocations under 424.535(a), remains in place.

- CMS withdrew the proposed expansions of its debt-based and payment-suspension denial authorities that would have reached additional associated parties and business or financial relationships.

- CMS removed beneficiary relationships from the expanded affiliation definition and clarified that providers are not required to continuously investigate or monitor their affiliations.

- CMS confirmed that the documentation provision applies only to records already covered by existing enrollment requirements and does not create a new condition of payment.

- CMS codified corrective action plans for certain enrollment denials and established a process for rebutting reactivation effective dates. It declined many other requested safeguards, including materiality and reasonable due diligence standards.

What Providers Should Do Now

These provisions take effect early in 2027 and apply to existing enrollments, not just new applications. Providers and suppliers should consider the following steps:

1. **Audit PECOS enrollment records.** Confirm that ownership, managing employee, practice location, and other enrollment information is accurate and current. Retroactive revocation raises the cost of any undetected reporting failure.

2. **Report changes on time.** Review internal processes for reporting changes of ownership, control, practice location, and managing employees within the regulatory deadlines.

3. **Correct noncompliance promptly.** Once an issue is identified, document the corrective action and its timing. Because revocations can now reach back to the date noncompliance began, a prompt correction may limit the recovery period.

4. **Assess geographic concentration risk.** Providers and suppliers in areas CMS has identified as high-risk should anticipate closer scrutiny of new enrollments and revalidations.

Prepare for appeals. Make sure staff know the corrective action plan and reconsideration processes and the deadlines that apply to them.

Contact Us

If you have any questions or need further guidance regarding this matter, please contact Licensure, Certification and Enrollment team.

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