Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) Proposed Rule (CMS-6098-P)

Published November 19, 2026; *Federal Register*

CMS Fact Sheet

Executive **Summary**

On November 19, CMS published the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) proposed rule in the Federal Register. The regulation follows a Request for Information issued in February 2026, a June 2025 presidential memorandum on eliminating fraud in Medicaid, as well as CMS withholding federal matching funds from several state Medicaid programs based on allegations of fraud, waste, and abuse. The rule proposes to codify and expand fraud, waste, and abuse requirements across Medicare, Medicare Advantage, Medicaid, CHIP, and the Marketplace. Public comments on the rule are due to CMS no later than January 18, 2027.

Key Takeaways

- CMS expects to recover about $90B from Medicare Advantage plans, almost entirely by projecting audit errors across whole contracts.
- CMS proposes to replace state-run eligibility reviews, Medicaid Eligibility Quality Control (MEQC) Programs, with its own beneficiary eligibility audits and a stricter waiver test, making it harder for states to avoid federal payment recoveries.
- Several changes to how Medicaid improper payments are reported and returned to the federal government are proposed:
    - Fee-for-service (FFS) overpayments would carry a 60-day report-and-return duty.
    - Managed care capitation recovery would be clarified. States must return the federal share of capitation after an enrollee's death or out-of-state move to CMS, whether or not the state recovers the capitation from the plan.
    - Plans would have to report deaths and address changes within 30 days.
    - Payment suspensions would be easier to trigger. States could rely on CMS or other federal agencies' credible allegations of fraud determinations instead of re-verifying them.
- Unless otherwise specified, the effective date for all provisions is 60 days after publication of the final rule. However, CMS seeks public comment on the feasibility of these effective dates.

Medicaid and CHIP Program Integrity Proposals

Credible Allegations of Fraud and State Payment Suspensions

- Under current regulations, state Medicaid agencies must suspend Medicaid payment to a provider when it determines that there is a credible allegation of fraud for which there is an investigation pending, unless the state determines there is good cause not to do so. CMS proposes to add subparagraph § 455.23(a)(1)(i) to clarify that states may rely on a credible determination of fraud made by CMS or other federal agency in order to suspend payments pending an investigation. CMS proposes to revise the definition of "credible allegation of fraud" at § 455.2 to align with this new requirement.
- Current regulations require states to discontinue such payment suspensions if the state refers the case to a state or federal law enforcement agency and that agency declines the referral. CMS proposes to revise regulations at § 455.23(d)(4) to allow states to maintain a payment suspension due to a credible allegation of fraud, even if a federal or state law enforcement agency does not accept a referral, if the state documents that the provider is still under investigation.
- Current regulations at § 455.23(e) and (f) specify good cause exemptions for payment suspensions. CMS proposes to amend these sections to require additional verifications of whether a good cause exemption is appropriate, including documentation in writing, verification with law enforcement, and notification to CMS.

- Current regulations at § 455.23(g)(3) require states to report to CMS annually the summary information on payment suspensions. CMS proposes to revise this reporting to a quarterly cadence and to require states to report additional detail on payment suspensions.

Enhanced Electronic Visit Verification (EVV) Requirements

- Current regulations do not require states to use EVV data in preliminary fraud and abuse investigations. CMS proposes to amend § 455.14 to require state Medicaid agencies to incorporate a review of EVV records in preliminary fraud and abuse investigations for services subject to EVV requirements (e.g., personal care and home health services). CMS also proposes to amend § 447.45 to require that services subject to EVV requirements are supported by EVV records during the prepayment review process. CMS does not propose to condition federal financial participation (FFP) on compliance with the prepayment provision. CMS seeks public comment on the operational feasibility of the prepayment provision and whether states would need a transition period for compliance. CMS also seeks public comment on the feasibility of extending both the prepayment review requirement and the requirement to use EVV records in fraud and abuse investigations to managed care.

Requiring National Provider Identifiers (NPIs) for Eligible Medicaid and CHIP Provider Types

- Current regulations require states to collect and retain a provider's NPI on claims for ordering and referring providers. CMS proposes to amend § 455.440 to add sections (b) through (d), requiring states to collect, maintain, and use NPIs as part of Medicaid and CHIP provider enrollment, revalidation, claims processing, managed care oversight, program integrity, and reporting. This will apply across Medicaid FFS, managed care, and CHIP. CMS notes that not all provider types are eligible to obtain an NPI and encourages states to collect another unique identifier for such providers. CMS seeks public comment on the feasibility of these NPI collection requirements and states' anticipated timeframes to come into compliance.

Updating State Program Integrity Reporting Requirements

- CMS states that current Medicaid program integrity reporting is not sufficient to provide the level of detail necessary to support national oversight and accountability. The agency is therefore unable to conduct national trend analysis, identify emerging fraudulent schemes, or coordinate oversight activities.

As a result, the agency proposes to update Medicaid fraud and abuse reporting requirements at § 455.17 to improve the usefulness of information reported to the agency. These changes would only apply to suspected provider fraud and abuse cases and do not extend to beneficiary fraud and abuse cases. States would report additional information beyond the number of fraud and abuse complaints that warranted a full investigation. More granular data on the provider suspected of fraud would need to be reported to CMS, such as their name, NPI, provider and service type, relevant claim dates, payors, time periods, and estimated overpayment amount. The agency is seeking comment on whether these proposed data elements are feasible, if additional elements should be included, and the timeframe in which states would need to come into compliance.

Deregulation of the Medicaid Eligibility Quality Control (MEQC) Program

- CMS proposes to deregulate the state-led MEQC program at §§ 431.800 through 431.820 and codify a new audit and disallowance strategy described in the following sections with the goals of reducing administrative burden, enhancing federal oversight, and lowering eligibility improper payment rates.
- The agency describes its perceived limitations of the MEQC program; that it is administratively burdensome with little effectiveness in reducing Payment Error Rate Measurements (PERM). (The PERM program measures improper payments in Medicaid and CHIP and produces improper payment rates for each program.) Notably, CMS describes how participation in and compliance with the MEQC program enables states to qualify for a good faith waiver of the disallowance if their eligibility improper payment rate exceeds the 3% statutory threshold. The agency describes this as "a relatively low bar that allows States to easily avoid disallowances, even if their improper payment rate for eligibility errors is well above 3 percent."
- CMS proposes to phase out the MEQC program over 3 years following the publication of the final rule and ensure that there is no overlap between PERM and beneficiary eligibility audits for the purposes of disallowances in a given year.
- Starting on July 1, 2027, section 1903(u) disallowance authority would be applicable under the beneficiary eligibility audit program instead of PERM. The MEQC payment review process for improper payments will continue to operate under § 431.812 (e) until the program is phased out for each review cycle. Current good faith effort regulatory criteria would be applied until the proposed changes at § 455.804 become effective.

Effective Date: Three years after the publication of the final rule.

Medicaid and CHIP Beneficiary Eligibility Audit Program

- CMS proposes codifying existing Medicaid and CHIP beneficiary eligibility audits, §§ 455.700 through 455.712, to improve federal oversight of eligibility determinations and authorize the agency to effect payment recoveries where appropriate. As described above, the proposed regulatory structure for beneficiary eligibility audits would allow CMS to pursue potential disallowances of Federal Financial Participation (FFP) from states for identified overpayments.
- The audits would prioritize high-risk states using a risk formula and ensure that each state would undergo an eligibility audit at least once every five years. Improper payment rates reported under the Payment Integrity Information Act of 2019 would continue to be determined exclusively through PERM reviews on its regular triennial cycle.

Effective Date: After the completion of the PERM review period that is underway as of the effective date of the final rule.

CMS seeks comment on the proposed five-year audit cadence, feasibility for state Medicaid agency personnel to meet the timelines, and inclusion of CHIP cases.

Medicaid and CHIP Beneficiary Eligibility-Related Disallowances

- CMS proposes implementing disallowances that meet the requirements of section 1903(u) of the Act pursuant to the newly proposed Medicaid and CHIP beneficiary eligibility audits (42 CFR part 455, subpart H) instead of the PERM program by removing the current PERM disallowance provision at § 431.1010 and establishing comprehensive disallowance regulations at § 455.800, et seq. that only apply to the proposed beneficiary eligibility audits.
- Accordingly, the agency proposes to replace the existing good faith waiver framework with new criteria in new § 455.804 that would establish the process and standards by which CMS could reduce, either fully or partially, eligibility-related disallowances based on a state's demonstration of a good faith effort to meet the 3% allowable threshold while preserving CMS' discretion to deny such a waiver in cases of systemic or persistent program integrity failures.
    - *Examples of Good Faith Efforts*
        - Under proposed § 455.804(b)(3), CMS would evaluate whether the state undertook additional reasonable actions to prevent, identify, or mitigate eligibility determination errors based on the totality of the circumstances. Relevant considerations could include, but would not be limited to, whether the state maintained reasonable pre-existing eligibility controls; whether the same errors had been identified in previous audits or reviews; the timeliness and substance of the state's response after error identification; any corrective actions already taken; and the state's cooperation and transparency during CMS audits and reviews.
    - *Examples of Circumstances that May Not Meet Good Faith Efforts*
        - Proposed § 455.804(e) specifies examples of circumstances that CMS may consider in determining that a State had not demonstrated the good faith effort necessary to qualify for a full or partial waiver under section 1903(u)(1)(B) of the Act. These examples are intended to be illustrative of circumstances that may indicate systemic or persistent program integrity deficiencies but are not meant to constitute an exhaustive list or establish automatic disqualifying criteria. Circumstances could include, but would not be limited to: repeated Medicaid and CHIP beneficiary eligibility audit or PERM findings involving the same or substantially similar errors; failure to address or implement prior CMS audit recommendations related to eligibility determination errors; known system defects, operational deficiencies, or policy weaknesses affecting eligibility determinations that remained unaddressed by the State during the audit period; or patterns of eligibility-related noncompliance identified through other Federal oversight activities, including audits, investigations, or findings by the HHS-OIG or other Federal agencies.

Effective Date: July 1, 2027, after the completion of the PERM review period that is underway as of the effective date of the final rule.

Payment Error Rate Measurement (PERM) Corrective Action Plans (CAPs)

- CMS proposes to amend § 431.992(a) to require States to submit a combined PERM CAP that would address, as applicable, Medicaid and CHIP PERM errors and deficiencies to streamline administrative operations. This does not merge, reduce, or otherwise modify the distinct statutory and regulatory obligations for Medicaid and CHIP.
- CMS also proposes two amendments at § 431.992(b)(3)(ii) to clarify that the monitoring plan required for each corrective action must be designed to assess the progress of its implementation and to add a new paragraph which details what must be included in the evaluation plan for the Corrective Action Plan.
- Finally, CMS proposes to revise § 431.992(c) to establish a uniform approval and revision process that would set a minimum floor for the completeness and sufficiency of PERM CAP submissions while preserving state flexibility to develop and implement corrective actions that are appropriate to their unique circumstances. CMS seeks to implement a biannual (every 6 months) reporting requirement at § 431.992(e) for states with a Medicaid and/or CHIP eligibility improper payment rate over the 3% allowable threshold for consecutive PERM years, which would begin 2 months after the agency formally approves a state's PERM CAP.

Program Integrity CAPs

- CMS seeks to add a new subpart G to 42 CFR 455, titled Requirements for Program Integrity Corrective Action Plans. The section would establish standardized requirements for program integrity CAPs, including when a CAP is required, the information it must contain, CMS review and approval procedures, and state implementation and monitoring responsibilities.
- The agency would be responsible for identifying the findings, if any, during a program integrity audit for which the state would be required to develop a program integrity CAP. The state would be required to submit the CAP to CMS no later than 30 days after the date of the final audit report delivered by the agency.

Medicaid Fee-for-Service (FFS) Overpayment Reporting (60-Day Rule)

- CMS proposes to implement the overpayment reporting and return requirements at section 1128J(d) of the Act to Medicaid FFS programs by creating a new part 455 subpart J (§ 455.900, et seq.). This is not applicable to CHIP.
- As with 1128J(d), Medicaid beneficiaries are excluded from the definition of "person" for the purposes of overpayments. The proposed regulations are in line with Original Medicare for timeframes for remittance, recordkeeping, and lookback periods.

Medicaid and CHIP Managed Care Oversight Policies

- CMS proposes to add § 438.3(c)(2)(i) such that, following the provision of notice of action with fair hearing rights in accordance with §§ 435.917 and 435.918 and part 431 subpart E, a state must recover capitation payments from MCOs, PIHPs, or PAHPs for any payment periods following the death of an enrollee when verified through the DMF, and may recover capitation payments from MCOs, PIHPs, or PAHPs for any payment periods following the date of out-of-State relocation of an individual.
- Likewise, the states would be required to reimburse CMS an amount equal to the Federal share of all capitation payments subject to recovery as described above. This is required regardless of whether the state elects to recover or require the plan to return the capitation payment following the enrollee's death or date of relocation.
- CMS also proposes to define "prompt" reporting of changes in beneficiaries' circumstances from the 2016 Managed Care final rule to mean within 30 calendar days of when a plan receives information about a change that may affect the individual's ability for or access to covered services.

Effective Date: The first rating period beginning on or after January 1, 2027.

Request for Information on Payment Deductions under 42 CFR 447.10(i)

- To gain public input on policies to strengthen consent, documentation, and recordkeeping requirements as they relate to payment deductions under 42 CFR 447.10(i), CMS issued a request for information within the proposed rule.
- Specifically, CMS is concerned that some states may not have sufficient safeguards in place to protect Medicaid providers' First Amendment rights when deductions are made from Medicaid provider payments to pay third parties, including labor unions, on behalf of the practitioner. Namely, that states might automatically deduct union dues from a practitioner's Medicaid payment without that person's affirmative consent. In June 2026, CMS sent letters to nine state Medicaid agencies to remind them of the statutory requirement at § 447.10(i) and of the Supreme Court's holding in *Janus v. American Federation of State, County, & Municipal Employees, Council 31, 585 U.S. 878 (2018)* and requested that they review their Medicaid payment arrangements.
- The agency also hopes to use the public comment garnered from this RFI to inform the implementation of section 71121 of H.R. 1, which establishes the new HCBS waiver option but mandates that no payments may be used by a state to make payments to a third party on behalf of an individual practitioner for benefits like health insurance, skills training, etc.

Medicare Advantage and Medicare Part D Proposals

Mandatory Reporting of Fraud, Waste, and Abuse

- Regulations currently encourage, but do not explicitly require, Medicare Advantage plans and Part D plan sponsors to report referrals of suspected or substantiated fraud, waste, and abuse to CMS. To align with OIG recommendations, CMS proposes to require Medicare Advantage plans and Part D plan sponsors to report all referrals of suspected or substantiated fraud, waste, and abuse to CMS through the Health Plan Management System (HPMS) fraud, waste, and abuse (FWA) Reporting Module.
- Current regulations require plan sponsors to report payment suspensions based on credible allegations of fraud by pharmacies; CMS proposes to expand this requirement to all provider types.

Medicare Advantage Risk Adjustment Data Validation (RADV) Reforms

- CMS currently uses risk adjustment methodologies to ensure appropriate and accurate payments based on the differences in cost between types of Medicare Advantage enrollees, largely based on diagnosis code. CMS then conducts post-payment, contract-specific audits to identify improper risk adjustment payments. Currently, CMS makes recoveries from these audits only based on the cases actually sampled. CMS proposes to extrapolate contract-specific RADV findings by using statistically valid random sampling techniques, beginning with PY 2018; and require plans to remit extrapolated recovery amounts from audit findings to CMS. CMS also proposes to *not* apply a fee-for-service (FFS) adjuster to RADV audits. Finally, CMS proposes to codify regulatory requirements on how plans can qualify for and request a hardship exemption for records retention requirements during an RADV audit.

Provider Enrollment Proposals

DMEPOS Supplier Provisions

- CMS proposes to strengthen surety bond requirements under 42 CFR § 424.57(d) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers to improve the recovery of Medicare overpayments, civil monetary penalties, and assessments. Under the proposed changes § 424.57(d)(5)(ii)(B) and (C), surety companies cannot dispute CMS' debt calculations or delay payment because a supplier has pending administrative appeals. CMS could also refuse future bonds from sureties that fail to pay within 30 calendar days after receiving written notice from CMS containing sufficient evidence of liability, subject to notice and rebuttal procedures (§ 424.57(d)(16)).
- Under proposed 42 CFR § 424.57(i), DMEPOS suppliers must disclose domestic and foreign individuals and entities involved in marketing, fulfillment, and wholesale activities through their Medicare enrollment applications. They must also provide supporting documentation upon request, giving CMS additional information to assess business relationships that may pose program integrity risks. Enrollment may be denied or revoked under proposed §§ 424.530(a)(26) and 424.535(a)(31) if CMS determines that these arrangements present an undue risk of fraud, waste, abuse, or beneficiary harm.
- Under the new supplier standard, 42 CFR § 424.57(c)(32) requires obtaining affirmative beneficiary consent before shipping initially ordered equipment or supplies. Before delivery, they must confirm that the beneficiary is aware of the order, needs the item, and agrees to receive it. Suppliers must also document these communications, including contact information and confirmation of consent, although the requirement does not extend to refills.
- Survey requirements under 42 CFR § 424.58(e)(8)(i)(A) expand for DMEPOS suppliers undergoing changes in majority ownership or practice location. A survey is required when an individual or organization acquires more than 50% direct ownership, regardless of when the transaction occurs or whether it qualifies for an exemption under existing ownership change requirements. Suppliers changing practice locations are also subject to surveys to verify continued compliance with Medicare quality standards.
- Physicians and practitioners who order DMEPOS items or services that are not reasonable or necessary may face Medicare enrollment revocation. Under the proposed 42 CFR § 424.535(a)(29), CMS would not need to establish a repeated pattern of improper ordering before taking action. Revocation remains discretionary, allowing the agency to consider the circumstances of each case.

Factors for Consideration for Denial and Revocation Decisions

- CMS proposes to remove all specified factors it is currently required to consider when determining whether to deny or revoke Medicare provider or supplier enrollment through revisions to 42 CFR §§ 424.530(a) and 424.535(a) and the reenrollment bar factors in § 424.535(c)(3). These include whether an enrollment change was reported, how late it was reported, the materiality of the information, and a provider's history of final adverse actions. CMS states that these considerations can limit its ability to take enforcement action against noncompliant providers, even when denial or revocation is warranted.

Faster Enrollment Change Reporting for Medicare Providers

- CMS proposes a 30-day reporting deadline for all changes to Medicare provider and supplier enrollment information (revising 42 CFR § 424.516(d) and (e), with conforming changes to §§ 410.33(g)(2) and 424.205(c)(5)), replacing the existing 90-day reporting period for certain updates. The requirement covers changes involving ownership, management, practice locations, banking information, billing agencies, and other enrollment details. CMS notes that late reporting does not automatically result in revocation, as the agency may also address noncompliance through enrollment stays or deactivations.

New Bases for Medicare Provider Enrollment Denial/Revocation

- CMS proposes additional authority 42 CFR § 424.530(a)(23) to deny or revoke enrollment for providers located in small geographic areas with excessive concentrations of providers that present a high risk of fraud, waste, or abuse. The changes also address providers sharing office space with another provider whose Medicare enrollment has been denied or revoked (§§ 424.530(a)(19) and 424.535(a)(26)). Additional grounds apply to hospices whose medical directors or administrators oversee multiple facilities, operate too far from the hospice to fulfill their responsibilities, or, in the case of medical directors, lack an active physician license in the state where they practice (§§ 424.530(a)(20) and 424.535(a)(27)). These provisions supplement enrollment enforcement grounds introduced in the CY2027 Home Health Prospective Payment System proposed rule. Hospice enrollment could be denied or revoked under new 42 CFR §§ 424.530(a)(24) and 424.535(a)(28) when an administrator changes within 36 months of the hospice's initial enrollment or its most recent administrator change. CMS identifies frequent administrator turnover as a concern in certain hospice fraud schemes involving individuals who repeatedly establish, operate, and leave facilities. The agency acknowledges that administrator changes may occur for legitimate reasons and is not proposing to prohibit all changes within the 36-month period. New 42 CFR § 424.536 would subject changes involving more than 50% direct ownership of a Medicare provider or supplier to expanded denial and revocation authority. The provisions apply across provider types, regardless of when the transaction occurs or whether the ownership change requires a new enrollment application. CMS could deny or revoke enrollment if the seller, buyer, or another involved provider fails to comply with Medicare enrollment requirements or if the transaction or involved parties present an undue risk of fraud, waste, or abuse. Revised revocation authority 42 CFR § 424.535(a)(7) would expand beyond the misuse of Medicare billing numbers to address other improper activities involving Medicare enrollment, billing identifiers, and electronic funds transfer arrangements. CMS identifies inappropriate disclosure or sale of Medicare beneficiary identifiers as an example of conduct that may not be explicitly covered under existing revocation provisions. CMS states that it expects to use this expanded authority in exceptional circumstances.

Verification of Identity and Risk Posed by Foreign and Domestic Owners and Managing Employees

- Under the proposed rule, identity verification requirements for Medicare providers, suppliers, owners, managing employees, partners, and corporate officers or directors would be strengthened. Additional documentation, including passports, driver's licenses, Social Security cards, or birth

certificates, may be requested through new 42 CFR § 424.510(d)(2)(ii) when conventional verification methods are unsuccessful or identity theft is suspected. Enrollment could also be denied or revoked, per proposed §§ 424.530(a)(25) and 424.535(a)(30), when domestic or foreign owners or managing personnel cannot be verified or present an undue risk of fraud, waste, or abuse. The provisions do not prohibit foreign ownership or management of Medicare providers.

Medicaid and CHIP Provider Enrollment Reforms

- CMS proposes to update Medicaid and Children's Health Insurance Program (CHIP) provider enrollment definitions at 42 CFR §§ 455.2 and 455.101 to align more closely with Medicare requirements. The revisions clarify which criminal convictions are included in enrollment disclosures and expand the definitions of managing organizations and ownership or control interests. These changes also account for business structures such as limited liability companies and partnerships.
- Revised 42 CFR §§ 455.104(b) and 455.106(a) expand disclosure requirements for Medicaid and CHIP providers, covering ownership, management, and adverse actions. Required information includes certain felony and misdemeanor convictions, revocation, termination, or suspension from Medicaid, CHIP, Medicare, or other Federal health care programs, payment suspensions, and adverse licensing actions. Providers must also disclose relevant information associated with previous names or business identities.
- Revised 42 CFR § 455.416 adds grounds for denying or terminating Medicaid and CHIP provider enrollment, including certain criminal convictions, program exclusions, affiliations posing an undue risk of fraud, waste, or abuse, false enrollment information, and abusive prescribing or ordering practices at new § 455.416(j) and (k). Most of these actions are mandatory under the proposed framework, although States can apply specified exceptions when denial or termination does not serve their programs' best interests. Certain grounds, including exclusions or debarments at § 455.416(a) and qualifying program terminations at § 455.416(c), do not permit these exceptions.
- CMS proposes to revise provider screening requirements (42 CFR § 455.450) to require States to assign Medicaid and CHIP providers risk categories at least as stringent as those used for corresponding Medicare provider types. The categories include limited, moderate, and high risk, with States retaining authority to conduct additional screening. The rule also updates references in § 455.436(b) and (c) to the former Excluded Parties List System to reflect its current name, the System for Award Management.
- 42 CFR § 455.460 clarifies application fee requirements to include Medicaid and CHIP institutional providers undergoing enrollment revalidation. States may also collect additional fees when conducting enhanced screening beyond what Medicare or another State has already completed. These charges are limited to the costs of the additional screening, and States must document the reasons for requiring it.
- State Medicaid and CHIP agencies are required to report specified provider enrollment denials and terminations to CMS monthly (42 CFR § 455.418). Reports include provider identifiers, the regulatory basis for each action, and supporting facts explaining the decision. States must also report instances in which they decline an otherwise mandatory denial or termination based on a best-interests determination, including the reasons for that decision.

Medicare Advantage Original Medicare Provider Enrollment Requirements

- Beginning January 1, 2030, CMS proposes 42 CFR § 422.223, to require providers and suppliers furnishing services to Medicare Advantage (MA) beneficiaries to maintain approved enrollment in Original Medicare. The requirement covers eligible in-network and out-of-network providers, including applicable first-tier, downstream, and related entities, locum tenens (i.e., substitute) providers, and providers furnishing incident-to services. These providers become subject to Original Medicare enrollment screening, including reviews of licensure, ownership, management practice locations, and adverse legal histories. Approved enrollment status excludes providers whose enrollment has been revoked or deactivated.
- The existing MA provider preclusion-list framework is scheduled for replacement under 42 CFR §§ 422.2 and 422.222. Current MA preclusion-list requirements remain applicable before January 1, 2030, when mandatory Original Medicare enrollment takes effect. The separate Medicare Part D prescriber preclusion-list requirements remain in place.
- Under 42 CFR § 422.204(c)(2) MA organizations would be responsible for maintaining documented procedures to verify that providers and suppliers meet the Original Medicare enrollment requirements. Beginning January 1, 2030, payments to providers who fail to satisfy these requirements are prohibited, including those whose Medicare enrollment has been revoked or deactivated. The proposal maintains with restrictions involving excluded providers and applicable precluded Part D prescribers. MA organizations that fail to comply may face sanctions or contract termination.

Marketplace Proposals

Expand Authority to Deny and Terminate Agents, Brokers, and Web-brokers' Exchange Participation

- Under the proposed rule 45 CFR § 155.220(g)(3)(iii), CMS could deny registration or immediately terminate Exchange participation agreements for agents, brokers, and web-brokers who have been suspended, terminated, revoked, debarred, or excluded from a federal program. The authority also extends to individuals whose State licenses have been suspended or revoked for conduct that may harm consumers or program integrity, including in a State other than where they are enrolling consumers. These actions could be taken even when an appeal is pending.
- Registration and immediate terminations could also apply to agents, brokers, and web-brokers convicted of certain Federal or State misdemeanors or felonies that HHS determines are detrimental to the Exchanges or consumers (§ 155.220(g)(3)(iv)). Covered offenses include financial crimes, identity theft, insurance fraud, and certain crimes against individuals. Affected individuals would receive notice of the decision and have an opportunity to request reconsideration.

Strengthening CMS' Authority to Terminate an Agent, Broker, or Web-Broker for Cause

- CMS proposes to replace 45 CFR § 155.220(g)(3)(i), the existing 30-day opportunity to resolve noncompliance, with a 30-day period to submit evidence refuting CMS's determination. Taking corrective action would not automatically prevent termination if the evidence establishes that noncompliance occurred. Enforcement decisions would consider relevant factors, including the severity and duration of violations, prior non-compliance, and the number of consumers affected (§ 155.220(g)(1)(i)).
- CMS proposes to revise 45 CFR § 155.220(g)(5), to expand its authority to suspend or terminate agents, brokers, and web-brokers for abusive conduct that causes or is likely to cause harm to consumers or the Exchanges. Examples include unauthorized enrollments, misleading websites, inaccurate application information involving income, household composition, coverage, or residential addresses, and enrollment of deceased consumers. Suspensions could be based on credible allegations of abusive conduct, a term newly defined in § 155.20, while termination requires determination by a preponderance of the evidence that abusive conduct occurred.
- Suspended agents, brokers, and web-brokers retain an opportunity to submit evidence rebutting allegations of abusive conduct. Revised § 155.220(g)(5)(ii)(B) provides that when evidence is submitted within 30 calendar days of suspension, CMS must determine whether to lift the suspension within 90 calendar days of the suspension. The proposal also clarifies reconsideration rights (§ 155.220(h)(1)) for Exchange agreement terminations, registration denials, and certain penalties.

Restriction on Access to the FFEs and SBE-FPs and Exchange Data from Outside the United States

- CMS proposes 45 CFR § 155.220(j)(2)(ix), to codify existing restrictions on accessing Federally-facilitated Exchanges (FFEs), State-based Exchanges on the Federal Platform (SBE-FPs), and associated data from outside the United States into Federal regulations. Agents, brokers, and web-brokers would need to maintain reasonable administrative, technical, and contractual safeguards preventing unauthorized foreign access by employees, contractors, subcontractors, and other entities acting on their behalf. These protections also apply to virtual private networks (VPNs) and other technologies that route Exchange traffic through foreign infrastructure. CMS would not consider an entity noncompliant if prohibited access occurred despite reasonable safeguards and could not reasonably have been known about or prevented.

Clarifying Existing Requirement and Adding a New Unsolicited Beneficiary Contact Prohibition

Proposed Revisions to Supplier Standards Pertaining to Beneficiary Solicitation

- Under current Medicare requirements, DMEPOS suppliers are generally prohibited from making unsolicited telephone calls to beneficiaries. Exceptions apply when a beneficiary provides written permission, the supplier is coordinating delivery, or the supplier furnished a covered item within the previous 15 months. Failure to comply may result in revocation of Medicare billing privileges. CMS may also review related claims for medically unnecessary items and refer suspected fraud to law enforcement. In February 2026, CMS announced a nationwide temporary enrollment moratorium for new Medicare DMEPOS medical supply companies, citing significant program integrity concerns. Between March 31, 2025, and March 31, 2026, its Fraud Defense Operations Center suspended payments to 138 suspected DMEPOS suppliers. As of August 2026, these suspensions were holding $1.9B.
- The proposed rule clarifies existing restrictions under 42 CFR § 424.57(c)(11) to explicitly cover text messages and third-party agents acting on behalf of DMEPOS suppliers. A new supplier standard § 424.57(c)(31) also prohibits unsolicited social media direct messages, emails without opt-out provisions, and door-to-door solicitation. Exceptions apply when beneficiaries provide written permission, suppliers are coordinating delivery, or suppliers furnished a covered item within the previous 15 months.
- The restrictions apply to DMEPOS suppliers regardless of whether they or another qualified party furnishes the equipment or supplies. CMS clarifies that general advertising through television, radio, print, and digital platforms remains permissible. If finalized, the changes take effect 60 days after publication of the final rule.