CMS Healthcare Enforcement Initiatives May Cause Disruption

By **Gregory Etzel and Jonathan York** (March 17, 2026)

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On Feb. 25, the Centers for Medicare & Medicaid Services **announced** sweeping new enforcement actions intended to combat healthcare fraud, with a particular focus on personal care, home- and community-based services in Minnesota, and suppliers of durable medical equipment, prosthetics, orthotics and supplies, or DMEPOS.

The measures, which include a nationwide DMEPOS enrollment moratorium and new transparency requirements around billing revocations, mark a significant escalation in CMS' efforts toward its stated goal of combating and preemptively heading off potential fraud by immediately stopping payments in close to real time.

CMS' continued emphasis on a revoke-and-stop-payments-first, ask-questions-later approach, however, has significant potential to disrupt the operations of unsuspecting and compliant providers and suppliers. The agency's approach mirrors its prior escalation in other industry sectors — specifically, hospice.

This concern is heightened when CMS is deploying previously unutilized authorities and relying on potentially incomplete and imperfect data to make decisions with such potentially devastating consequences. Stakeholders should be prepared to quickly respond to adverse and potentially unfounded agency actions based on the sweeping dragnet.

CMS' Newest Anti-Fraud Initiatives

The announcement highlighted three new initiatives through which CMS intends to continue demonstrating its revised approach to combating fraud, waste and abuse.

CMS will be deferring $259.5 million in federal funds based on Minnesota Medicaid's spending from the fourth quarter of fiscal year 2025. The announcement suggests that approximately $244 million of that figure was for unsupported or potentially fraudulent Medicaid claims.

Specifically, the announcement provides that CMS' analysis identified unusually high spending for services related to personal care, home- and community-based services, and other practitioner services.

CMS has also imposed a six-month, nationwide moratorium on new Medicare enrollment for certain DMEPOS suppliers. The moratorium is a follow-on measure from a purported $1.5 billion in suspected fraudulent DMEPOS billings that CMS claims it stopped last year. The moratorium applies to all applications for initial enrollment and changes in majority ownership for suppliers.

The announcement also solicits input from industry stakeholders on CMS' Comprehensive Regulations to Uncover Suspicious Healthcare initiative. CRUSH has been shorthand for CMS' efforts under the second Trump administration to preemptively guard against potential fraud in government healthcare programs.

One accomplishments bulletin, for example, provides that the CRUSH initiative deployed automated edits to prevent improper payments to providers and suppliers.[1] The request for information on CRUSH spans the gamut of providers, suppliers and Medicare/Medicaid programs, all with an eye toward "strengthening CMS' ability to prevent, detect, and respond to fraud."

For interested stakeholders, comments are due by March 30.[2]

In a corresponding transparency measure, CMS will begin publishing information on providers and suppliers whose Medicare participation has been revoked, including national provider identifiers and the reasons for revocation.

"Detect and Deploy" Versus "Pay and Chase"

In the announcement, U.S. Department of Health and Human Services Secretary Robert F. Kennedy Jr. described these initiatives as a decisive shift from retrospective "pay and chase" tactics to a real-time "detect and deploy" model to prevent fraud before it occurs.

The announcement emphasizes how these efforts will be data-driven, and that the agency will leverage advanced AI tools. To hit home the emphasis on proactive, rather than reactive, fraud prevention measures, CMS Administrator Dr. Mehmet Oz noted that "CMS is done trying to catch fraudsters with their hands in the cookie jar — instead, we're padlocking the jar and letting them starve."

Akin to prior initiatives invoking earlier forms of data analytics, HHS and CMS are now advancing with a full embrace of AI tools to try to cut off funding to purportedly fraudulent actors through adverse actions like billing revocations and claim denials.

But this emphasis on prevention raises questions: What information and data is CMS considering in order to make appropriate determinations on such adverse actions? And, what authorities is the agency relying upon as the legal basis to move forward with these adverse actions?

While CMS has not announced the methodology underlying the detect-and-deploy approach, nor would stakeholders necessarily expect the agency to provide such a glimpse behind the anti-fraud curtain, its similar anti-fraud initiatives directed toward the hospice industry may offer other providers and suppliers a potential road map of what is to come.

Hospice Crackdown

Similar to its recently announced initiatives, CMS has taken steps to heighten the agency's scrutiny of hospice providers to combat fraud and abuse.

At the end of December, CMS posted a revised Medicare Learning Network fact sheet announcing the geographic expansion of its provisional period of enhanced oversight for newly enrolling hospices and those hospices that had a change of ownership from the initial four states of Arizona, California, Nevada and Texas to now include Georgia and Ohio.

During the provisional period of enhanced oversight, CMS is authorized to conduct medical reviews of claims — such as prepayment reviews — of the newly enrolled hospices, and the period may last from 30 days up to one year.

The expansion of CMS' provisional period of enhanced oversight for newly enrolling hospices was accompanied by a public push to crack down on purported hospice fraud, with Oz conducting several press events in states like California and Nevada, which he has referred to as the epicenter of hospice fraud.

This push has resulted in a steady number of Medicare billing revocation actions by CMS and its hospice Medicare administrative contractors arising from a provisional period of enhanced oversight audits, where Medicare administrative contractors found the hospices had engaged in abusive billing practices.

However, these findings are often based on limited sample claim review and errors involving clinical judgment and documentation sufficiency, not outright fraud. Regardless, the focus on hospice and the low threshold CMS and the Medicare administrative contractors are using to trigger extreme remedies should put other providers and suppliers on notice.

New Authorities, Who's This?

The increased audit activity in the hospice sector has also shed light on the "new," or, more precisely, "old but previously underutilized" authorities that CMS has begun to deploy to cut off payments to providers and suppliers.

In 2019, CMS finalized its rule on disclosure of affiliations.[3] The purpose of the rule was to provide CMS with information from providers and suppliers about current and previous affiliations with other providers and suppliers that have had disclosable events, e.g., were subject to a payment suspension under a federal healthcare program, in order to identify and assess affiliations that could pose a risk of fraud and abuse.[4]

At the time of the rulemaking, CMS noted that the agency was frustrated by the whack-a-mole scenario in which repeat players were involved in fraud, waste and abuse — a not unfamiliar tone now over six years later. The disclosure-of-affiliations rule was supposed to allow CMS to better identify, track, and assess providers and suppliers that may remain risks to the Medicare program.

Under the rule, CMS can revoke Medicare billing privileges and Medicare enrollment based on a provider's or supplier's affiliation, e.g., an individual or entity with 5% or greater direct or indirect ownership, or an individual or entity that exercises operational or managerial control, with another provider or supplier it determines to pose an undue risk of fraud, waste or abuse.[5]

The intent of the affiliations rule was for CMS to ask providers or suppliers to disclose information on such affiliations during enrollment or revalidation, such as the duration of the affiliation and the nature of the affiliated provider or supplier's disclosable event, in order to have sufficient information to determine whether the affiliation actually posed an undue risk to the Medicare program.

But, seemingly unbeknownst at the time, the affiliations rule also included a little-known

discretionary provision that also gave CMS the authority to revoke a provider or supplier's enrollment if the agency unilaterally determines that an undisclosed affiliation poses undue risk of fraud, waste or abuse.[6]

While CMS had not utilized this provision to any material degree since the final rulemaking in 2019, there are signs that CMS is applying this provision more frequently — particularly with respect to hospice medical directors who were affiliated with hospices that had billing privileges revoked on account of a provisional period of enhanced oversight audit with negative findings.

Broader Implications for Providers and Suppliers

If hospice serves as a template for the anti-fraud initiatives outlined in CMS' recent announcement, there could be serious operational uncertainty on the horizon for providers and suppliers more broadly.

Preemptive efforts based on data and AI tools will ultimately sweep compliant providers and suppliers operating in good faith into the mix of the broad enforcement initiative.

Indeed, the announcement touts that CMS' CRUSH initiative has already led to CMS revoking the ability of 5,586 providers and suppliers to bill Medicare because of inappropriate behavior.

However, the announcement does not illuminate what constitutes sufficiently inappropriate behavior to warrant a revocation, let alone what regulatory authority CMS has used to make those determinations.

Would, for example, the inappropriate behavior catchall include undue risk determinations under the affiliations rule? Take the hypothetical example of a hospice medical director who was affiliated with a hospice that had its billing privileges revoked on account of a provisional period of enhanced oversight audit with negative findings.

Is that affiliation sufficiently problematic for CMS to revoke the medical director's Medicare billing privileges? What about affiliations that the medical director may have with other, nonhospice-related providers or suppliers?

Based on the current detect-and-deploy model, the answer to all these questions is likely yes.

And, while Title 42 of the Code of Federal Regulations, Section 424.435(e), allows for reversal of revocation where the business relationship with the problem affiliate is terminated within 15 days of the notice of revocation, such reversal is expressly made discretionary, with Medicare Manual guidance prohibiting CMS contractors from issuing such reversals without directly forwarding them to CMS.[7]

At bottom, it may be easy for CMS to deploy AI tools to connect such affiliation-related dots, but such a connection between providers and suppliers does not itself prove an actual risk of fraud, waste or abuse.

Moreover, revoking a provider or supplier's billing privileges with Medicare is a serious remedy that invariably cascades to other government payors like state Medicaid programs and even commercial payors.

It is not hyperbole to state that a Medicare revocation could be the first step toward a provider or supplier no longer being able to effectively operate and service its patients.

While CMS and HHS may direct providers and suppliers that have been on the receiving end of such preemptive actions to appropriate administrative appeal mechanisms, that process is challenging and time-consuming. There are serious questions about CMS' ability to handle a potential onslaught of appeals in a timely manner, given the reduction in agency staffing that has occurred over the past year.

Ultimately, while providers and suppliers attempt to navigate the regulatory requirements to try and reverse CMS' determinations, their patients are at risk of not receiving necessary services or supplies.

What Stakeholders Can Do

CMS' proactive approach leaves little visibility for stakeholders to, in turn, take proactive steps to get ahead of CMS' anti-fraud initiatives. But there are some takeaways stakeholders can keep in mind as CMS' approach continues to develop.

Prioritize enrollment and credentialing.

Stakeholders should be hypervigilant for any communications from CMS or their Medicare administrative contractor with respect to their enrollment status and all relevant

submission deadlines. Failure to keep track of regular deadlines may result in unwanted attention that could quickly result in an adverse action like a billing revocation.

Communicate with surveyors.

Prepare for and be prepared to inform CMS-contracted surveyors regarding the details of the provider's operations and compliance with applicable conditions of participation.

Consider tracking potential affiliations.

Stakeholders should consider taking steps to stay informed of their managing employees' affiliation with other providers or suppliers, particularly new hospices or those undergoing an ownership change that may be subject to a provisional period of enhanced oversight review, in order to assess the affiliation's potential to lead to an adverse action.

Strengthen and pressure test audit functions.

With CMS and Medicare administrative contractors' aggressive posture, a poor audit finding may be a ticket to a billing revocation rather than more typical education and training on billing requirements.

Conclusion

CMS' latest initiatives demonstrate a concerted effort to proactively identify and stop program funds from flowing to potentially fraudulent actors. The announcement aligns with the agency's similar emphasis on the hospice sector, and stakeholders can look to those efforts as a road map of what is likely to come.

CMS is proactively looking for ways to stop program funds from being improperly dispersed, which will undoubtedly produce potential collateral damage. Providers and suppliers will need to be equally proactive to adjust to the new normal. It may be the difference between the ability to continue serving patients and having to shut down operations.

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[1] https://www.cms.gov/files/document/cpi-data-dashboard-january-update.pdf.

[2] https://www.federalregister.gov/documents/2026/02/27/2026-03968/request-for-information-rfi-related-to-comprehensive-regulations-to-uncover-suspicious-healthcare.

[3] See generally 42 C.F.R. § 424.519.

[4] 42 C.F.R. § 424.519(a-b).

[5] 42 C.F.R. § 424.519(f-g).

[6] 42 C.F.R. § 424.519(i).

[7] See CMS Pub 100-08, Ch. 10, § 10.6.18.