30 Years HCCA Report on MEDICARE COMPLIANCE

Volume 35, Number 42 • November 23, 2026

Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

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Publisher's Note
RMC will not be published next week. The next issue will be dated December 7, 2026. Happy Thanksgiving!

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CMS's Proposed CRUSH Rule Turbocharges Program Integrity; Suspension Is 'Toy of Choice'

CMS goes to town on payment suspensions in a sweeping new program integrity rule proposed Nov. 19.[1]

Fueled by credible allegations of fraud, payment suspensions will have a higher profile in policing major federal programs, according to the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

Anytime CMS suspects something is dodgy about a claim or enrollment application, it may be deemed a credible allegation of fraud. That tees up a potential payment suspension, which is a killer for providers and suppliers because CMS will shut off Medicare payments with little or no notice while it reviews the allegation.

"CMS seems really jazzed on payment suspensions, so they're applying it all through here," said attorney Judy Waltz, with Foley & Lardner LLP. "It's clear to me that payment suspensions will be their first-line enforcement choice."

A Grab Bag of Changes

CRUSH is a grab bag of proposed program-integrity measures for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Medicare Advantage (MA) and health insurance marketplace. The moat that helps keep bad actors out of Medicare—enrollment—would widen, with new reasons to deny or revoke enrollment, for example.

Medicaid figures prominently in the rule. For example, CMS fleshes out the Medicaid fee-for-service (FFS) version of the 60-day overpayment refund rule.

On the MA side of the house, CMS would fire up audits with extrapolation and require physicians in MA plans to enroll in Original Medicare.

There are many more changes in the proposed rule, which came on the heels of fiscal year (FY) 2026 improper payment rates for Medicare, Medicaid, MA and CHIP.[2] CMS said the rate was 7.32% in Original Medicare, up from 6.55% in FY 2025.

Will the Proposals Backfire?

Waltz said the rule is "well thought out," reflecting the many years CMS has had to build out authorities from the 2010 Affordable Care Act (ACA). But she worries the proposals will backfire. Some providers may opt out of Medicare or Medicaid altogether because the heat isn't worth staying in the kitchen.

"We may have beneficiary access problems resulting from provider departures, whether it's the provider or CMS initiating the exit," she said.

CMS has already backstopped its program integrity plans. The proposed rule has a severability provision, which basically said even if one or more provisions are struck down by a court, the rest will stand.

The 'Toy of Choice'

Payment suspension is their "toy of choice," Waltz said. Although CMS promises to tread carefully with a payment suspension based on credible allegations of fraud, "once it's applied, it's really hard for providers to get out from under it," she noted. "Even just six months without cash flow is really difficult for a lot of providers."

CRUSH would let states rely on CMS or any other federal agency's determination of credible allegations of fraud as the driver of Medicaid and CHIP

payment suspensions. That means the state may shut down payments "without conducting an independent redetermination of credibility," the rule states.

The rule also would crack down on the use of good-cause exceptions to payment suspensions. Medicaid payments to a provider under investigation for a credible allegation of fraud aren't eligible for federal matching funds unless they meet a good-cause exception.

But CMS said there's an overreliance on good-cause exceptions, which allow states to sidestep payment suspensions under certain circumstances (e.g., when law enforcement wants to avoid tipping the provider off to an investigation). If the rule is finalized, states must do more to validate the reasons for invoking a good-cause exception.

CRUSH also tinkers with payment-suspension reporting requirements for MA and Part D plans. The rule would "expand plan sponsor reporting of payment suspensions based on credible allegations of fraud by pharmacies to all provider and supplier types."

60-Day Rule for Medicaid: A Long Time Coming

CMS finally got around to officially spelling out the Medicaid version of the 60-day overpayment refund rule that debuted in the ACA. It mirrors the Medicare FFS version of the 60-day rule, which requires providers to report and return overpayments within 60 days of finding them.

In the proposed Medicaid FFS version, CMS requires a "person" (i.e., a provider or supplier) that has received an overpayment "to report and return it to, and in a form and manner specified by, the State, and include a written reason for the overpayment." The provider/supplier has identified an overpayment if they had actual knowledge of the existence of the overpayment or acted in reckless disregard or deliberate ignorance of the overpayment (consistent with the False Claims Act). CMS was mum, however, on the extra 180 days providers have under the Medicare FFS edition of the 60-day rule for a good-faith investigation of related overpayments.

CRUSH would require states to create a mechanism for a person to report the overpayments, and states are obliged to return the federal share of the overpayment to CMS. That's where the action really is, Waltz said.

"This is setting up a federal framework that must be adopted by the state to continue its federal Medicaid payments," Waltz said. "It's not like the provider will send in a check to CMS." The provider's check would go to the state, which repays the federal program. But ratcheting up the pressure on states will do the same to providers.

Thirty Days to Report All Enrollment Changes

Enrollment and billing revocations take center stage in CRUSH. It requires providers and suppliers to report all changes to Medicare enrollment in 30 days, said Claire Ernst, director of government relations and public policy with Hooper, Lundy & Bookman. The deadline is currently 90 days for some changes, although others are 30.

CMS also would require all physicians participating in MA plans to enroll in FFS Medicare.

"While many MA organizations require providers to be enrolled in Original Medicare as a condition of contracting, well over 100,000 in-network providers remain unenrolled. In certain cases, a particular MA organization's credentialing process may not be as comprehensive as Original Medicare enrollment screening," the rule noted. "Original Medicare enrollment is the front line of Medicare program integrity. It enables us to detect and stop non-compliant and potentially fraudulent parties from billing MA at the start, rather than after they begin doing so."

CMS flirted with this requirement a few years ago but instead created the Medicare Advantage Preclusion List, which contains providers and suppliers who are forbidden to receive payments from MA or Part D plans. The preclusion list will be the go-to until this enrollment requirement takes effect Jan. 1, 2030.

RADV Extrapolation, Take Two

CRUSH has more to say about MA plans. CMS took another swing at using extrapolation in risk

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6462 City West Parkway, Eden Prairie, MN 55344. 888.580.8373, hcca-info.org.

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adjustment data validation (RADV) audits, which are its "main corrective action for overpayments made to MA organizations when there is a lack of documentation in the medical record to support the diagnoses reported for risk adjustment."

Its first stab was in a 2023 regulation, which said RADV audit findings would be extrapolated starting with payment year (PY) 2018. CMS also said it wouldn't apply an FFS adjuster, which accounts for differences in how diagnosis codes are validated in FFS vs. MA.

But a federal court shot down the rule for procedural reasons. CMS is at the drawing board again in CRUSH, saying nothing in the Social Security Act stands in its way. "Given the volume of diagnosis data submitted by MA organizations, amount of improper payments identified under the MA program, interest in determining an accurate recovery amount for each audited MA plan, and importance of protecting the overall integrity of the program, we believe that it is in the public interest for CMS to apply extrapolation to PY 2018 and all subsequent years," the rule stated.

And CMS again wouldn't apply an FFS adjuster, which it said is "neither required nor appropriate to reduce a RADV audit overpayment."

Provider Ownership Changes Are 'Pretty Harsh'

The rule amplifies CMS's focus on hospices and durable medical equipment (DME), which it considers a fraud magnet. One of the proposals targets turnover in hospice administrators.

"Among the hospice fraud schemes we have seen involves administrators opening clusters of hospices within a small geographic area—sometimes even in the same building—without any corresponding need for such an increase in hospice services. The administrator inappropriately bills Medicare through these hospices, departs the hospices, and then repeats the pattern as administrator of other hospices the individual opens," the rule said.

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Brief Summary of Key Provisions in New HIPAA Privacy Rule

Here's a summary from the new HHS Office for Civil Rights' regulation (see story, p. 5).[1]

Table 4—Non-Quantified Costs/Benefits for Covered Entities and Individuals

Regulatory Changes	Costs	Benefits
Modifying definition of health care operations and clarifying disclosures permitted to social services agencies for certain purposes	Potential increase in requests for disclosures for certain care coordination and case management purposes	Improved health outcomes because of better care coordination and case management
Modifying requirements for identity verification		Improved access for individuals to their PHI
Adding permission to disclose PHI to Telecommunications Relay Services (TRS) and excluding TRS providers from the definition of business associate		Improved employment conditions and opportunities for workforce members who are deaf, hard of hearing, or deaf-blind, or who have a speech disability; compliance with non-discrimination laws
Adding right for individuals to discuss covered entity's privacy practices, eliminating requirement to acknowledge receipt of NPP, modifying NPP content requirements, and requiring provision of NPP to incarcerated individuals		Greater understanding of individuals' rights and covered entities' privacy practices; enhanced trust in the health care system
Strengthening right of access (free access using an internet-based method, decreased wait times for access, and information about access fees)		Improved access to PHI for individuals—receiving PHI more quickly; fewer disputes about access fees; increased certainty about allowable fees; expanded ability to use health IT
Restricting the right of access to direct a covered entity to transmit PHI in an electronic health record to a person designated by the individual ("right of access to direct")	Increased burden on individuals to submit two forms—an access request and an authorization—when seeking to send a complete designated record set (electronic and nonelectronic) to a person they designate	Improved clarity and certainty for covered entities about the scope of the right of access to direct

Endnotes

1 Nina Youngstrom, "Access Looms Large in Final HIPAA Privacy Rule; Fees Are in the Mix," *Report on Medicare Compliance* 35, no. 42 (November 23, 2026).

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In response, CMS would give itself the authority to deny or revoke a hospice's enrollment if the administrator changes within 36 months—even though CMS acknowledges it may be legitimate (e.g., an administrator retires).

"That's pretty harsh," Waltz said. Frequent management turnover isn't necessarily shady and may reflect "limited staffing options and low profit margins," she said. "It will get really hard for hospices to continue operating."

CMS also would be able to deny or revoke the enrollment of any provider or supplier if they're associated with a change in minority ownership (CIMO) where the seller, buyer or any involved provider or supplier didn't comply with Medicare enrollment requirements or the CIMO "poses an undue risk of fraud, waste, and abuse" to Medicare.

A CIMO occurs "when a party acquires more than a 50 percent direct ownership interest in a provider," CMS said. That isn't hard to do because it "would include the cumulative effect of asset sales, stock transfers, consolidations or mergers, and would apply whether the CIMO occurred within 36 months of initial enrollment or 36 months of the most recent CIMO, or whether the change requires a new enrollment," Waltz explained.

HHA Rule Had Its Own Crackdown

CMS reiterates in CRUSH that it also has new Medicare revocation and enrollment provisions for all providers and suppliers in the 2027 final home health prospective payment system rule.[3]

Among other things, CMS added reasons for revoking or denying enrollment. For example, CMS could require hospices, home health agencies and DME suppliers to re-enroll in Medicare as a new provider if there are certain changes in ownership. CMS also could deny or revoke enrollment if a provider's owners or managing employees/organizations have been suspended or revoked.

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Endnotes

1 Medicare, Medicaid, and Marketplace Programs; Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 74,680 (Nov. 19, 2026), https://bit.ly/4930uhJ.

2 Centers for Medicare & Medicaid Services, "Fiscal Year 2026 Improper Payments," fact sheet, November 16, 2026, https://bit.ly/4zraigb.

3 Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies, 91 Fed. Reg. 72,022 (Nov. 9, 2026), https://bit.ly/4j0CO2a.

Chart of Fees for Various Patient Access Requests Under New Privacy Rule

The chart summarizes "how different types of disclosures and recipients of the PHI [protected health information] affect the fees that the Privacy Rule permits covered entities to charge for copies of PHI," according to the new HIPAA Privacy Rule (see story, p. 5).[1]

Relevant Provision of the Privacy Rule	Type of Disclosure	Recipient of PHI	Allowable Fee
Right to inspect 45 CFR 164.524(a)	In-person inspection	Individual (or personal representative)	Free
Right of access 45 CFR 164.524(a)	Internet-based method of receiving copies of PHI (e.g., using VDT, or a personal health app connection via a secure, standards-based API)	Individual (or personal representative)	Free
Right of access 45 CFR 164.524(a)	Non-internet-based method of receiving an electronic copy of PHI, in response to an access request (e.g., by sending PHI copied onto electronic media through the U.S. Mail or via certified export functionality)	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of labor for: (1) making copies
Right of access 45 CFR 164.524(a)	Non-electronic copy of PHI	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of: (1) labor for making copies; (2) supplies for copying; and (3) actual postage and shipping
Right of access 45 CFR 164.524(a)	Summary or explanation agreed to by the individual	Individual (or personal representative)	Reasonable, cost-based fee, limited to costs of: (1) labor for making copies; (2) supplies for copying; and (3) actual postage and shipping; and (4) preparing the summary or explanation as agreed to by the individual

Endnotes

1 Nina Youngstrom, "Access Looms Large in Final HIPAA Privacy Rule; Fees Are in the Mix," *Report on Medicare Compliance* 35, no. 42 (November 23, 2026).

Access Looms Large in Final HIPAA Privacy Rule; Fees Are in the Mix

A new HIPAA Privacy Rule settles the matter of when covered entities (CEs) may charge patients for access to their protected health information (PHI) and electronic PHI (ePHI). To the extent fees hamper access, CEs may think twice about them because access looms large in the final rule, which was published in the Nov. 19 *Federal Register*.[1]

"HHS's position is, if at all possible, don't charge," said attorney Debra Geroux, with Butzel. "Having someone pay for their records is one of those issues that may prevent them from getting timely access. It's easier to say, 'we don't charge for records or we don't charge for the first one.'"

Access is a theme of the new HIPAA rule, *Changes to Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens*, which comes from the HHS Office for Civil Rights (OCR). The rule requires CEs to comply with patient access requests faster and allows CEs to disclose PHI for care coordination and case management without patient authorization, among other things.

The tenor of the rule is different from the 2021 proposed version, which looked through a deregulatory lens, said attorney Andrea Frey, with Hooper, Lundy & Bookman. Although OCR reduced a few burdens—for example, it ditched the acknowledgement that patients received the Notice of Privacy Practices (NPP)— burden reduction plays a minimal part in the final rule.

"HHS is trying to adapt the Privacy Rule to this new healthcare environment in which patients are expected to have access to their health information electronically" and in mobile apps that are outside the CE/business associate (BA) ecosystem, Frey noted.

Compliance 'Is No Small Feat'

CEs have time to get their HIPAA house in order. While the rule takes effect 60 days after the publication date, the compliance deadline is 180 days later.

"There's no shortage of follow-up items for regulated entities to take actionable steps on," Frey said. "The final rule seems clear on the face of it in terms of the new requirements, but once you get into the workflows of a CE," compliance challenges mount in part because patient records often don't fit within one electronic health record portal. "Figuring that system out and working with your vendors and making sure everyone is in compliance is no small feat," Frey said.

A workflow biggie: OCR reduced the deadline for responding to a patient's request for access to their PHI from 30 days to 15 days, with the possibility of a 30-day extension.

"Any discussion between the CE and the patient regarding how they want those records sent doesn't stay the 15 days," Geroux noted. "It doesn't buy you additional time." She added that "CEs need to make sure they're not questioning why a patient wants the information. That's irrelevant."

The rule also spells out the allowable charges for patient access or inspection (see box, p. 4).[2] For example, CEs aren't permitted to charge patients to inspect PHI in person or access it via the internet (e.g., through portals or apps). But reasonable, cost-based fees are OK for paper copies and non-internet electronic copies of PHI.

"The final rule prohibits fees when individuals obtain electronic copies of PHI through automated internet-based methods that do not require workforce labor to make the copy," said Claire Ernst, director of government relations and public policy at Hooper, Lundy & Bookman.

If CEs charge patients for PHI, they must post what they're charging on their website.

Some of the provisions in the rule are a direct response to a federal court ruling in *Ciox Health, LLC v. Azar,* a lawsuit against HHS over its then-limitations on fees for transmitting ePHI.[3]

Care Coordination, Case Management Is TPO

OCR also has added care coordination and case management to treatment, payment and operations. That means CEs may share PHI with social services agencies, community-based organizations and other third parties to facilitate care coordination and case management without patient authorization.

For example, providers could disclose PHI to an Agency on Aging that's helping a diabetic person with their diet. "If the services are treatment adjacent, that would be considered part of treatment," Geroux explained.

A new term, "personal health application," was added to the rule to support a person's right of access to PHI through a personal health app. "It's no different than providing PHI to the individual themselves," she said. A business associate agreement (BAA) isn't required with the app vendor.

OCR also said no written authorization is needed to share PHI with telecommunication relay service (TRS) providers. "It's kind of a no-brainer because when you're sharing PHI with a TRS provider, it's because the patient is right there, and the patient has implicitly consented to sharing PHI by virtue of the fact they need this communication provider to assist them with the discussion," Geroux said.

Speaking of BAs, OCR gave CEs until Jan. 18, 2028, to update existing BAAs vis-à-vis the new rule, she noted.

Directing Records to Another Person

The rule clarifies the right to direct ePHI to a third party (e.g., a family member or health app) in the wake of the *Ciox Health* decision. "It's making it explicit in the final rule that individuals have the right to direct their records to another person or company but limited it to the electronic version of their PHI," Trey said.

OCR also tweaked NPP requirements. CEs won't have to get acknowledgments from existing patients that they received the NPP. However, providers must include the name of a contact person who can answer a patient's questions about the NPP.

And providers are required to add a header to the NPP that sums it up, including how patients can access their health information and file a HIPAA complaint.

Contact Geroux at geroux@butzel.com, Frey at afrey@hooperlundy.com and Ernst at cernst@hooperlundy.com. ✧

Endnotes

1 HIPAA Privacy Rule: Changes To Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens, 91 Fed. Reg. 74,848 (November 19, 2026), https://bit.ly/4ABl1oe.

2 Nina Youngstrom, "Brief Summary of Key Provisions in New HIPAA Privacy Rule," *Report on Medicare Compliance* 35, no. 42 (November 23, 2026).

3 *Ciox Health, LLC v. Azar, et al.*, No. 18-cv-0040 (D.D.C. January 23, 2020).

CMS Drops Some Recent CoP Additions, Adds One on Birth Products

Certain 2025 additions to the Medicare conditions of participation (CoP) are subtracted in a proposed rule published in the Nov. 10 *Federal Register*.[1]

If the rule is finalized, CMS would ditch certain requirements for obstetric care, discharge planning and emergency readiness. For example, the OB-specific standards in the quality assurance and performance improvement (QAPI) CoP will be history. Only one requirement—on informed consent related to birth products—was added to the CoP.

Although the rule generally reduces administrative burden, it's not a pass on oversight of maternal care, said Mary Ellen Palowitch, president of MEP Healthcare Consulting LLC. Hospitals would still be required to apply QAPI, which is a data-driven system to improve quality of care, patient safety and outcomes, to all their departments, including OB. But CMS would remove OB as a separate feature of QAPI.

"Other services are not specifically highlighted under QAPI, so this was a bit of an outlier," Palowitch noted. Hospitals will have more flexibility in satisfying the requirements and training people on them if the rule is finalized, she said. But the basics remain. "If you're being recertified or have an accreditation survey, the expectation is you're in compliance with QAPI."

The proposed rule also tinkers with CoPs for other facilities, such as critical access hospitals (CAHs), rural emergency hospitals and long-term care facilities. CMS has done burden reduction before, but it seems to emphasize the impact of CoPs on rural hospitals and CAHs, "which are really struggling," Palowitch noted.

Hospitals and other facilities are required to satisfy CoPs to keep their Medicare certification. State and accreditation organization surveyors review compliance with CoPs, and hospitals must address deficiencies or they risk falling out of Medicare's good graces.

Brand-New Requirement on Birth Tissue

Although the rule mostly subtracts requirements, CMS added one for informed consent for the collection of birth tissue (e.g., cord blood, placenta) at hospitals that provide OB services. It's designed to support families that ask for their birth tissues for cultural, religious or personal reasons, CMS explained. The informed-consent requirement is under the CoP for OB services (independent of QAPI).

"We would require that the hospital ensure that it obtains informed consent from the patient or the patient's representative prior to the collection, storage, donation, transfer, banking, or release to patients of birth tissues, consistent with the hospital's scope of services and role in those activities," according to the proposed rule.

Hospitals will need new policies and procedures around this requirement, if it's finalized. "As much burden as they're taking away, this adds another step back in, but it's giving the patient the right to decide what happens with the products," Palowitch said.

Rolling Back OB, Emergency Training

CMS is rolling back changes that were in the 2025 outpatient prospective payment system rule with staggered effective dates. Some went live this year, while others have a Jan. 1, 2027, effective date, giving the Trump administration a narrow window to cancel them in time.

For one thing, CMS would scrap the requirement that the hospital/CAH governing body identify and document the types of staff members who are required to complete annual training on best practices and areas ripe for advanced training that have been identified by the QAPI program.

Then Again, Maybe I Won't

CMS also would ditch the CoP staff training requirements on emergency services readiness for hospitals and CAHs, with or without OB services, and discharge planning related to transfers, but only for hospitals. In terms of the latter, CMS said freeing hospitals from the training "may allow clinicians to spend more time with patients and prioritize high-quality patient care" while giving them flexibility and lessening the compliance burden.

The big-picture expectations for training remain, but hospitals have more leeway to decide when and how often to provide training and what it covers, Palowitch said.

"Only two years ago, they were saying how important it was to put these requirements in the CoP, while now they're saying in hindsight, many of the requirements are duplicative."

Contact Palowitch at maryellen@mephealthcare.com. ✧

Endnotes

1 Medicare and Medicaid Programs; Cutting Administrative Requirements for Excellence in Patient Care, 91 Fed. Reg. 72,634 (Nov. 10, 2026), https://bit.ly/4CbIGyj.

OIG: Use of 'Older, Broader' Sepsis Definition Is Costing Medicare

Medicare's use of an "older, broader" sepsis definition is costing billions of dollars, the HHS Office of Inspector General (OIG) said in a data brief posted Nov. 19.[1] Some hospitals may apply the older definition to maximize their Medicare reimbursement.

CMS could have put $2.2 billion "to better use" if hospitals applied the 2016 definition of sepsis instead of the 1991 version, OIG said.

Although OIG recommended adjusting payments to reduce the financial incentive to bill sepsis and increasing oversight, CMS didn't bite. CMS asked OIG to remove the recommendations, but OIG stuck to its guns.

Medicare pays more for hospital stays when sepsis, the body's extreme response to an infection, is billed as a principal or secondary diagnosis. One in 10 inpatient stays has a sepsis diagnosis, and Medicare shelled out $12 billion for them in 2024.

Under the older definition, Systemic Inflammatory Response Syndrome with a documented infection, "a fever and elevated heart rate with an infection can be considered sepsis," OIG noted. The more precise 2016 definition, known as Sepsis-3, is a life-threatening organ dysfunction caused by a dysregulated host response to infection.

In its data brief, OIG focused on hospital stays for sepsis, not severe sepsis or septic shock. OIG created a model to figure out whether claims for sepsis stays would have landed in a different MS-DRG (e.g., for underlying infection) if the hospital used the 2016

CMS Transmittals and *Federal Register* Regulations, Nov. 13-19, 2026

Transmittals

Pub. 100-04, Medicare Claims Processing

- Transcatheter Aortic Valve Replacement (TAVR), Trans. 14047 (Nov. 19, 2026)
- Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2027 and Productivity Adjustment, Trans. 13986 (Nov. 13, 2026)

Federal Register

Final Rules

- HIPAA Privacy Rule: Changes To Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens, 91 Fed. Reg. 74,848 (Nov. 19, 2026)

Proposed Rules

- Medicare, Medicaid, and Marketplace Programs; Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 74,680 (Nov. 19, 2026)

Notices

- Medicare Program; CY 2027 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement, 91 Fed. Reg. 74,556 (Nov. 19, 2026)
- Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible Beginning January 1, 2027, 91 Fed. Reg. 74,570 (Nov. 19, 2026)
- Medicare Program; CY 2027 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts, 91 Fed. Reg. 74,582 (Nov. 19, 2026)
- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—July Through September 2026, 91 Fed. Reg. 74,559 (Nov. 19, 2026)

Notice of Extension and Modification of a Temporary Moratorium

- Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of the Extension and Modification of the Nationwide Temporary Moratorium on Enrollment of Hospices, 91 Fed. Reg. 73,597 (Nov. 16, 2026)
- Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of the Extension and Modification of the Nationwide Temporary Moratorium on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 73,603 (Nov. 16, 2026)

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definition. "We also assessed billing variation among hospitals for these stays that met the broad definition but would not have been consistent with the updated definition," OIG said.

OIG's findings: Medicare paid about $5,000 more for hospital stays with a diagnosis of sepsis, not severe sepsis or septic shock, which means patients probably didn't have organ dysfunction consistent with the 2016 definition. Without a sepsis diagnosis, the stays would have landed in a different base DRG or a lower severity level and yielded less reimbursement.

"Most often, these different base DRGs would be related to diagnoses of pneumonia and metabolic encephalopathy," OIG said.

The older definition makes it easier to diagnose sepsis. Nationally, one in 10 hospital stays is billed with sepsis, but "some hospitals billed more than one in five of their Medicare inpatient stays with sepsis while other hospitals billed no sepsis stays at all," OIG noted.

To reduce the financial incentive for hospitals to bill sepsis stays, CMS could require a diagnosis of severe sepsis or septic shock for payment under the MS-DRGs 870-872 so all sepsis stays mesh with the updated definition. Other stays could be billed to infection-related MS-DRGs or to a new group of MS-DRGs developed by CMS.

CMS also should do more to monitor hospital billing for sepsis, OIG said. While the Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a valuable first step, CMS could use PEPPER "or new monitoring to determine appropriate follow-up actions—such as targeted medical record reviews or education—for hospitals that are billing for sepsis stays at higher volumes than expected and may be using the broad definition of sepsis to maximize payments."

CMS isn't interested at the moment. It noted it can't propose revisions to "MS-DRG GROUPER logic until the diagnosis code changes are made through the established consensus-based process." If that happens, CMS could adjust the MS-DRGs through rulemaking.

CMS already has a "robust program integrity strategy" and has greenlit MS-DRG coding validation by recovery audit contractors. ✧

Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, *Medicare Could Put Billions of Dollars To Better Use by Adjusting Hospital Payments To Be Consistent with the Updated Definition of Sepsis*, data brief, OEI-02-24-00230, November 2026, https://bit.ly/3V7Aa2y.

NEWS BRIEFS

◆ **CMS released fiscal year (FY) 2026 improper payment rates Nov. 16.**[1] Original Medicare's rate was 7.32%, up from 6.55% in FY 2025. Medicare Advantage's improper payment rate was 5.68% in FY 2026, down from 6.09%. Medicare Part D's was 3.85%, down from 4%, and Medicaid's was 7.08%, up from 6.12%. There was a bigger jump in the Children's Health Insurance Program improper payment rate, from 7.05% in 2025 to 9.81% in 2026. "An improper payment is a payment that does not meet CMS program requirements," CMS noted. "Improper payment rates do not measure fraud."

◆ **The HHS Office of Inspector General (OIG) has updated its Work Plan.**[2] Among the items are an audit of separate Medicare payments for outpatient drugs that providers billed for with codes associated with drugs not separately payable and an audit of nonhospice claims paid by Medicare contractors for items and services provided to hospice enrollees.

◆ **In a Medicare compliance review posted Nov. 19, the HHS OIG said Wellstar Cobb Hospital in Austell, Georgia, received overpayments of at least $1 million** for hospital inpatient and inpatient rehabilitation facility claims in 2020 and 2021.[3] OIG reviewed a stratified random sample of 104 claims and determined the hospital didn't comply with Medicare billing requirements for 15 of them. The actual overpayment was $404,074, which was extrapolated. OIG recommended the hospital repay the $1 million. The hospital rebutted the findings and the use of extrapolation, and disagrees that a refund is warranted.

Endnotes

1 Centers for Medicare & Medicaid Services, "Fiscal Year 2026 Improper Payments," fact sheet, November 16, 2026, https://bit.ly/4zraigb.

2 U.S. Department of Health and Human Services, Office of Inspector General, "Work Plan," accessed November 20, 2026, https://bit.ly/3V76seg.

3 U.S. Department of Health and Human Services, Office of Inspector General, *Wellstar Cobb Hospital Received At Least $1 Million in Medicare Overpayments*, A-07-21-05134, November 19, 2026, https://bit.ly/4A0LkWn.