PN SYSTEM | REGULATORY IMPACT GUIDE

CRUSH Rule Impact Guide

for Florida Home Health Agencies

CMS-6098-P • Comprehensive Regulations to Uncover Suspicious Healthcare with the CY 2027 Home Health PPS final rule enrollment changes

CRUSH: PROPOSED RULE, NOT YET EFFECTIVE

THIS GUIDE INCLUDES

- What is already law (effective January 1, 2027) and what is only proposed
- Key dates, including the January 19, 2027 comment deadline
- New applications, existing providers, branches and change of ownership
- Revalidation, Medicare Advantage and Florida Medicaid / EVV
- Fillable readiness checklist, 90-day plan and QAPI tracker
- Policies to review, public-comment topics and official sources

Prepared November 19, 2026 • Regulatory planning and survey-readiness resource

For owners, administrators, directors of nursing, enrollment coordinators and compliance staff

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HOW TO READ THIS GUIDE

Each requirement is labeled **Existing law**, **Proposed** (CRUSH, not yet in effect) or **PNS practice** (an internal recommendation, not a CMS or AHCA mandate). Act now on existing law; plan and comment on proposals; adopt PNS practices where they help your agency.

Existing law — In force now or on a fixed date already adopted in a final rule.

Proposed — In CMS-6098-P only. Could change or be dropped in the final rule.

PNS practice — Recommended internal target or practice from PN System.

1. Executive summary

Two federal actions this fall change the Medicare enrollment risk picture for Florida home health agencies (HHAs). They are easy to confuse, but only one of them is law today.

Existing law	**CY 2027 Home Health PPS final rule** (published November 9, 2026; enrollment changes effective January 1, 2027). Expands Medicare denial and revocation grounds, removes the factors CMS previously weighed before finding "abuse of billing privileges," and makes revocations retroactive to the date noncompliance began.
Proposed	**CRUSH proposed rule, CMS-6098-P** (announced November 16, 2026; comments due January 19, 2027). Would add further denial/revocation grounds, require **every** Medicare enrollment change to be reported within 30 days, require providers that bill Medicare Advantage to be enrolled in Original Medicare, and strengthen Medicaid EVV, overpayment and payment-suspension oversight.

Existing federal and Florida obligations continue to apply. CRUSH provisions apply only if and when a final rule adopts them; CMS estimates the proposal would save nearly $90 billion over 10 years.

> **PNS TIP**
> Because revocations are now retroactive, a late-reported change or an inaccurate PECOS record can reach back to the date the problem began. Clean, current enrollment records are the single most protective step an agency can take before January 1, 2027.

2. Key regulatory dates

Milestone	Date	Status
CY 2027 HH PPS final rule published	November 9, 2026	Existing law
HH PPS enrollment changes take effect	January 1, 2027	Existing law
CRUSH announced by CMS	November 16, 2026	Proposed
CRUSH published in the Federal Register (doc. 2026-23461)	November 19, 2026	Proposed
CRUSH comment deadline (docket CMS-2026-0826)	January 19, 2027	Proposed
MA/Part D plans report fraud-based payment suspensions	January 1, 2028 (as proposed)	Proposed
Providers billing MA must be enrolled in Original Medicare	January 1, 2030 (as proposed)	Proposed
General CRUSH effective date	60 days after a final rule, unless a provision states otherwise	Proposed
CRUSH final rule	Not published as of this guide	Proposed

3. New Medicare applications

Already in force (January 1, 2027): the HH PPS final rule's broader denial grounds apply to new applications. **Proposed in CRUSH:** CMS could also deny enrollment when it cannot identify or locate owners, managing employees or officers, or finds they pose an undue risk of fraud, waste or abuse; when the provider or its principals had a False Claims Act civil judgment within the prior 10 years; for excessive provider concentration in an area or sharing a suite with a denied or revoked provider; and for expanded "improper activity" tied to billing numbers and EFT arrangements.

- Reconcile legal business name, EIN, NPI, AHCA license, PECOS, NPPES and Florida corporate (Sunbiz) records.
- Verify every direct and indirect owner, officer, director and managing employee; document identity, address and ownership percentage, including any foreign parties.
- Screen all parties against the OIG exclusion list, SAM.gov and Florida Medicaid sanctions; review prior enrollment actions and civil judgments.
- Confirm the physical location, posted hours, signage and phone, and that the office is ready for an unannounced site visit. Avoid suites shared with other enrolled providers where possible.
- Keep a signed pre-submission review and answer contractor development requests within the stated deadline.

> **PNS TIP**
> Florida's Medicare home health moratorium status should be checked before investing in a new application; CRUSH does not create a moratorium exception.

4. Existing Medicare-certified providers

Today, reporting deadlines depend on the type of change: generally **30 days** for changes of ownership or control (and certain other changes) and **90 days** for most other changes, under 42 CFR 424.516. **CRUSH proposes 30 days for every change.** Under the HH PPS final rule, revocation for failure to report can now be retroactive to the date the change should have been reported.

Control	Agency action
Ownership / management	Reconcile PECOS disclosures to current corporate, AHCA licensing and accreditation records.
Change reporting	Keep an event log; record the date each change occurred, its current deadline and the date it was reported.
Adverse actions	Review reportability of any license action, exclusion, conviction or civil judgment and resolve inconsistencies promptly.
Contractor requests	Keep evidence of each Palmetto GBA request, the response and the resolution.

> **PNS PRACTICE: 30-DAY CALENDAR NOW**
> Require every department to notify the enrollment coordinator within **five business days** of learning of a change, and report **every** change to CMS within 30 days now, even where 90 days is still allowed. That meets today's rules and the CRUSH proposal at once. This is an internal target, not a CMS mandate.

5. Medicare branch offices

CRUSH is not a branch rule. Existing HHA branch requirements, including 42 CFR 484.105 and Florida AHCA approval procedures, remain separate. A branch operates as part of its parent HHA under parent supervision and administrative control, not as an independently certified provider using the parent's CCN.

- Document one integrated governing body and administrative structure, with parent clinical supervision.
- Maintain shared policies, QAPI, infection control and HIPAA oversight, with personnel and clinical records accessible to the parent.
- Document staffing coverage, realistic travel times, backup routes, missed-visit escalation and parent intervention.
- Obtain AHCA branch approval and report the practice location to Medicare (an existing 30-day change).
- Analyze any HHA enrollment moratorium separately; CRUSH does not grant a moratorium exception.

6. Change of ownership (CHOW)

A transaction's Medicare treatment depends on its legal structure; a stock transfer, asset sale and restructuring can have different consequences. **Proposed in CRUSH:** CMS could deny or revoke enrollment after a change of more than 50% direct ownership when a party failed to comply with requirements or the transaction poses an undue risk of fraud, waste or abuse.

Due diligence	Evidence
Seller status	PECOS, CCN, AHCA license, accreditation, unresolved audits, overpayments and enrollment actions
Buyer / owners	Identity, beneficial ownership, exclusions, adverse actions and civil judgments
Operations	Claims, overpayments, QAPI, complaints and patient continuity
Transaction	Legal structure, Medicare and AHCA notices/approvals, deal terms covering enrollment risk, counsel review

PNS TIP

Check the HHA **36-month rule** (42 CFR 424.550(b)) before any majority ownership change: a change within 36 months of initial enrollment or the last majority change can require new enrollment and a new survey or accreditation, with limited exceptions.

File the AHCA change-of-ownership application at least 60 days before the effective date, and never assume Medicare billing privileges transfer automatically with a purchase.

7. Medicare revalidation

- Confirm the PECOS record, NPI, CCN, revalidation due date (generally every five years) and any pending requests.
- Reconcile owners, officers, managing employees, addresses and practice locations.
- Review reportable adverse legal actions and exclusion records for every listed party.
- Watch for Palmetto GBA revalidation and development letters and respond by the stated deadline.
- Keep evidence of verification and the authorized official's sign-off.

CRUSH does not create a new HHA revalidation cycle. Correct reportable inaccuracies under current rules now rather than waiting for revalidation; with retroactive revocation, waiting is the riskier choice.

8. Medicare Advantage

Proposed: beginning January 1, 2030, providers and suppliers that bill Medicare Advantage plans would have to be enrolled in Original Medicare, which brings CMS's full screening (identity verification, licensure review, site visits and, where applicable, fingerprint-based background checks) to MA participants.

- Inventory MA contracts and confirm the agency's Original Medicare enrollment status.
- Identify any MA-only service lines or entities and ask each plan how it will apply the requirement.
- Review claims support, clinical records and fraud-referral escalation for MA members.
- Do not assume the proposal overrides an active Medicare enrollment moratorium.

> **PNS TIP**
> An MA-only agency in a moratorium area could be blocked from the Original Medicare enrollment it would later need. Raise this in public comments if it applies to you.

9. Florida Medicaid and managed care

Proposed: states would have to verify during prepayment review that billed in-home Medicaid services subject to EVV are supported by an EVV record (new 42 CFR 447.45(f)(1)(vi)) and use EVV data in preliminary fraud investigations for personal care and home health; self-identified Medicaid fee-for-service overpayments would have to be reported and returned within **60 days**; and states could rely on CMS fraud determinations and a broader "credible allegation of fraud" standard to suspend payments.

EVV element	Cross-check against the claim
Patient and eligibility	Medicaid eligibility and service authorization
Date and time	Actual visit record and billed units
Staff and service	Assigned worker, service code and scope
Location	Applicable EVV location rules
Corrections	Exception reason, review and approval

Florida Medicaid managed-care plans may impose their own contract requirements. Keep the proposed Medicaid FFS 60-day rule separate from the existing Medicare 60-day overpayment rule and from plan contract terms.

> **PNS TIP**
> Run a monthly EVV-to-claims match now and fix exceptions before billing. If states must match EVV before payment, unmatched visits would simply not be paid.

10. Readiness checklist

Check each item when complete and note who did it and when.

Done	Item	Completed by	Date
☐	Verify owners, officers, directors and managing employees		
☐	Reconcile PECOS, NPPES, AHCA, accreditation and Sunbiz records		
☐	Screen sanctions, exclusions and enrollment histories		
☐	Create the enrollment change log and 30-day reporting workflow		
☐	Audit parent/branch administrative control		
☐	Review pending CHOW transactions and the 36-month rule		
☐	Check revalidation dates and open MAC requests		
☐	Inventory MA-only participation		
☐	Reconcile Medicaid EVV to billing		
☐	Review Medicare and Medicaid overpayment procedures		
☐	Add enrollment integrity to QAPI		
☐	Train administrators, enrollment and billing staff		
☐	Decide on public comments before January 19, 2027		

11. 90-day preparation schedule

Window	Focus	Owner	Completed
Days 1–15	Ownership, management and enrollment reconciliation	Administrator	
Days 16–30	Branches, CHOW and revalidation files	Compliance/enrollment	
Days 31–45	EVV, claims and overpayment controls	Billing/clinical	
Days 46–60	Draft policy revisions and management education	Administrator/DON	
Days 61–75	Internal compliance review and corrective action	QAPI	
Days 76–90	Close gaps; monitor the final rule and guidance	Governing body	

Correct existing-law problems immediately, especially before January 1, 2027; do not hold them for this optional timeline. Start day 1 now so days 1–45 finish before the comment deadline.

12. QAPI monitoring

Internal indicator	PNS target	Q1	Q2	Q3	Q4
Ownership/management disclosures verified	100%				
Enrollment changes reported within 30 days	100%				
Branch oversight evidence complete	100%				
EVV discrepancies investigated	100%				
Overpayments evaluated and resolved	100%				
Relevant staff trained	100%				

Targets are PNS recommendations, not CMS performance standards. Report findings quarterly to the Clinical Record Review Committee and the governing body, incorporate trends into QAPI, and escalate serious issues promptly.

13. Policies to review

Done	Policy	Date
☐	Medicare Enrollment, Change Reporting and Revalidation	
☐	Ownership and Management Disclosures	
☐	Change of Ownership Due Diligence (including the 36-month rule)	
☐	Parent/Branch Oversight	
☐	Medicaid EVV and Billing Integrity	
☐	Fraud, Waste, Abuse and Overpayment Response (Medicare and Medicaid)	
☐	Medicare Advantage Participation	
☐	QAPI and Compliance Monitoring	

Update policies now for the HH PPS final rule (effective January 1, 2027). Draft CRUSH-related revisions, but do not describe proposed obligations as effective requirements.

14. CMS public comments

Comments are due **January 19, 2027**. Submit electronically at Regulations.gov, docket CMS-2026-0826, file code CMS-6098-P. Useful topics for Florida HHAs:

- Administrative feasibility of reporting every enrollment change within 30 days.
- Clarity, notice and appeal rights under the “undue risk” standard.
- Safeguards for legitimate majority-ownership changes and buyers acting in good faith.
- Medicare Advantage enrollment for agencies in moratorium areas.
- Prepayment EVV matching: exception handling, rural connectivity and caregiver errors.

PNS TIP

Cite the specific proposed section and give a concrete operational example with numbers, such as how many changes your agency reports a year. Specific, data-backed comments carry more weight than general objections.

15. Final recommendations and official sources

Prioritize accurate enrollment and licensing records before January 1, 2027, documented parent oversight, ownership due diligence, revalidation readiness, EVV reconciliation and internal escalation. Watch for the CRUSH final rule before adopting any new mandatory deadline or enforcement standard.

Official references
CMS CRUSH fact sheet (CMS-6098-P) cms.gov/newsroom/fact-sheets/comprehensive-regulations-uncover-suspicious-healthcare-crush-proposed-rule-cms-6098-p
CRUSH proposed rule, Federal Register doc. 2026-23461 federalregister.gov/d/2026-23461
Regulations.gov docket regulations.gov/docket/CMS-2026-0826
CY 2027 Home Health PPS final rule, Federal Register doc. 2026-22750 federalregister.gov/d/2026-22750
42 CFR 424.516 (reporting enrollment changes) ecfr.gov/current/title-42/section-424.516
42 CFR 424.535 (revocation) and 424.530 (denial) ecfr.gov/current/title-42/section-424.535
42 CFR 424.550 (HHA 36-month rule) ecfr.gov/current/title-42/section-424.550
42 CFR 484.105 (HHA organization and administration) ecfr.gov/current/title-42/section-484.105
AHCA Medicare branch office approval process ahca.myflorida.com/content/download/9677/file/Medicare_Branch_HHA_Office_approval_process-web.doc

Educational compliance planning guide; not legal advice. Verify final text, effective dates, agency-specific facts and current CMS, AHCA and Palmetto GBA guidance before acting. Obtain transaction-specific legal advice for ownership changes.