

2027 Medicare Compliance Readiness: Ten Critical Questions Every Healthcare Leader Should Be Asking

From Regulatory Awareness to Organizational Accountability
LW Consulting, Inc. | November 2026

As healthcare organizations prepare for 2027, significant Medicare regulatory changes are creating new considerations for compliance officers, executive leaders, clinicians, and revenue cycle professionals.

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued several final rules affecting Medicare provider enrollment, physician reimbursement, clinical documentation, remote monitoring, hospital quality reporting, and behavioral health services *(CMS, 2026a, 2026b, 2026c).*

Although reimbursement changes often dominate the headlines, the broader compliance implications deserve equal attention.

As healthcare organizations prepare for 2027, LW Consulting, Inc. (LWCI) highlights ten important compliance questions leaders should consider to help strengthen their organizations' readiness for the year ahead.

The message connecting these questions is simple:
Understanding a regulatory change is important. Demonstrating how your organization responded to that change is essential.

As January 1, 2027, approaches, healthcare organizations should evaluate whether their compliance programs, internal controls, and operational processes are prepared to address applicable new requirements.

1. Is Your Organization Prepared for the 2027 Medicare Changes?

Regulatory readiness begins with understanding which requirements apply to your organization.

The 2027 Medicare final rules address multiple provider types and service settings, including hospitals, physician practices, home health agencies, ambulatory surgical centers, and behavioral health organizations *(CMS, 2026a, 2026b, 2026c).*

However, not every regulatory change applies equally to every provider. A compliance program should have a reliable process for identifying applicable requirements, evaluating their operational implications, assigning responsibility for implementation, and monitoring completion.

Organizations should avoid relying solely on regulatory announcements or general summaries. A structured regulatory review should assess how changes affect existing policies, processes, documentation requirements, and internal controls.

The compliance consideration: Has your organization performed a documented assessment of the 2027 regulatory changes that apply to its services and operations?

2. Could Medicare Enrollment Noncompliance Create Retroactive Financial Exposure?

One of the most consequential developments appears in the Calendar Year (CY) 2027 Home Health Prospective Payment System Final Rule (CMS-1844-F).

CMS finalized significant changes to Medicare provider enrollment requirements, including a policy making all enrollment revocation grounds retroactive to the date the underlying noncompliance began *(CMS, 2026b)*. Previously, certain enrollment revocations took effect prospectively, while others were already retroactive.

Under the revised approach, enrollment noncompliance could potentially expose organizations to Medicare payment recovery reaching back to the beginning of the applicable noncompliance period. CMS specifically identified strengthening its ability to recover improper payments from noncompliant providers as a central purpose of this policy *(CMS, 2026b)*.

Importantly, although these provisions were included in the home health final rule, most apply across Medicare provider and supplier types. This reinforces the importance of treating provider enrollment as an ongoing compliance responsibility rather than a one-time administrative process.

The compliance consideration: Does your organization have sufficient oversight to identify enrollment vulnerabilities before they result in regulatory action or financial exposure?



3. Are Ownership, Licensure, and Enrollment Changes Being Monitored?

CMS also finalized additional and expanded grounds for Medicare enrollment denial and revocation *(CMS, 2026b)*.

These include provisions involving certain ownership changes and suspensions or terminations of professional licenses or participation in government healthcare programs affecting providers, owners, or managing personnel.

For example, CMS expanded certain denial and revocation authorities involving license or program suspensions affecting owners and managing employees or organizations. The final rule also addresses existing reenrollment requirements following certain changes in majority ownership for home health agencies, hospices, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers *(CMS, 2026b)*.

Healthcare organizations frequently experience personnel changes, organizational restructuring, acquisitions, and changes in professional licensure. Each of these developments may carry regulatory implications.

An effective enrollment management process should establish clear responsibility for identifying reportable changes, maintaining accurate enrollment information, and ensuring required notifications are submitted appropriately.

Compliance leaders should also consider whether communication between human resources, credentialing, legal, finance, and operations is sufficient to identify potential enrollment concerns.

The compliance consideration: Who is accountable for ensuring that organizational changes are evaluated for potential Medicare enrollment implications?

4. Does Your Clinical Documentation Support Your Billing Practices?

The CY 2027 Medicare Physician Fee Schedule Final Rule (CMS-1848-F) includes changes affecting evaluation and management (E/M) services.



CMS finalized a payment adjustment for certain separately identifiable office or outpatient E/M visits furnished on the same day as procedures with a zero-day global period. Under the finalized policy, the most expensive applicable service is paid at 100%, while the other qualifying same-day services are paid at 80% *(CMS, 2026c)*.

The rule also transitions the existing E/M visit complexity add-on code G2211 to a new modifier structure, including modifier B1, and establishes modifier B2 for certain eligible accountable care organization practitioners *(CMS, 2026c)*. These changes present an opportunity to evaluate coding accuracy, charge capture procedures, and documentation practices.

Although reimbursement methodology and medical necessity are distinct considerations, organizations must ensure their claims accurately reflect services furnished and satisfy applicable Medicare billing requirements.

Regular auditing can help identify unsupported coding, inconsistent documentation, and potential billing errors.

The compliance consideration: When was the last time your organization evaluated whether its clinical documentation and billing practices adequately support one another?

5. Are Remote Monitoring Services Aligned With Finalized Medicare Requirements?

Remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) continue to evolve as healthcare organizations expand technology-supported care.

For 2027, CMS finalized additional requirements involving initiating visits and established-patient relationships for RTM, along with payment valuation changes *(CMS, 2026c)*. CMS also delayed implementation of a policy restricting payment to RPM or RTM services performed by clinical staff employed by the practice until January 1, 2029 *(CMS, 2026c)*.

The distinction between requirements effective in 2027 and those delayed until 2029 is important for organizations developing implementation plans.

Remote monitoring compliance requires more than acquiring technology. Organizations should evaluate applicable billing requirements, documentation practices, personnel responsibilities, vendor arrangements, and monitoring procedures. This includes ensuring that staff responsible for remote monitoring understand the regulatory requirements governing the services they provide.

The compliance consideration: Are your remote monitoring processes supported by clear policies, appropriate documentation, and an understanding of the applicable Medicare requirements?



6. Are Hospital Quality and Compliance Activities Working Together?

The CY 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Final Rule (CMS-1850-F) includes changes to hospital reimbursement and quality reporting.

Among these developments, CMS finalized revisions to the Overall Hospital Quality Star Rating methodology that place greater emphasis on the Safety of Care measure group *(CMS, 2026a)*. The rule also includes revisions affecting hospital outpatient quality reporting and related program requirements *(CMS, 2026a)*.

For hospital leadership, these changes reinforce the importance of reliable quality data, consistent clinical processes, and collaboration among departments. Quality improvement and regulatory compliance should not function as unrelated activities. Patient safety concerns, documentation weaknesses, inaccurate reporting, and ineffective corrective actions can create overlapping operational and compliance risks.

A coordinated approach allows organizations to identify trends, evaluate underlying causes, and implement sustainable improvements.

The compliance consideration: Do your compliance and quality improvement functions collaborate to identify and address organizational risks?

7. Are Behavioral Health Documentation and Billing Practices Prepared for 2027?

Behavioral health providers should also assess the implications of the finalized Medicare changes. The CY 2027 Hospital Outpatient Prospective Payment System Final Rule updates payment rates for intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs) furnished in hospital outpatient departments and community mental health centers *(CMS, 2026a)*.

The Physician Fee Schedule Final Rule also includes changes involving the Psychiatric Collaborative Care Model, including adjustments to work relative value units and clinical labor rates for behavioral health care managers *(CMS, 2026c)*.

For organizations delivering behavioral health services, documentation integrity remains a fundamental compliance consideration. Clinical records should accurately reflect the services provided and support applicable medical necessity, coding, and billing requirements.

Organizations should evaluate whether existing documentation templates, clinical workflows, and internal auditing practices remain appropriate for the services delivered.

The compliance consideration: Can your organization consistently demonstrate that billed behavioral health services meet applicable coverage, documentation, and billing requirements?

8. Do Your Policies and Procedures Reflect Current Regulatory Requirements?

Regulatory changes often create a need to reassess existing organizational policies and procedures. However, effective policy management is not simply a matter of adding new language to an existing document. Organizations should determine which changes are applicable, which processes are affected, and whether current practices adequately address the revised requirements.

For example, CMS finalized certain 2027 remote monitoring requirements while delaying another provision until 2029, demonstrating why organizations must distinguish between finalized requirements and different implementation dates *(CMS, 2026c).*

A documented regulatory implementation process can help ensure that policy changes are evaluated, approved, communicated, and incorporated into operations. Unnecessary or inaccurate policy revisions can create confusion and introduce additional compliance risks.

The compliance consideration: Does your organization have a structured process for translating regulatory changes into operational expectations?

9. How Will You Know Whether Employees Are Prepared?

An updated policy does not automatically result in compliant practices. Employees must understand the requirements relevant to their roles and how those requirements affect their responsibilities.

For example, the education needed by a revenue cycle professional may differ significantly from that needed by a credentialing specialist, clinician, compliance officer, or department leader. Training should therefore be targeted and practical.

The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), in its *General Compliance Program Guidance*, identifies compliance education and training as a fundamental component of an effective compliance program. The guidance also emphasizes evaluating program effectiveness through appropriate auditing and monitoring *(OIG, 2023).*

Organizations should consider how they will assess whether education has been effective. Methods may include knowledge assessments, documentation reviews, workflow observations, targeted audits, or monitoring of relevant performance indicators.

An employee's attendance at a training session demonstrates participation, but it does not necessarily establish understanding or consistent application.

The compliance consideration: How does your organization determine whether education has translated into appropriate daily practices?

10. Can Your Organization Demonstrate Compliance?

Perhaps the most important question for healthcare leaders is whether they can demonstrate that regulatory requirements have been appropriately evaluated and implemented.

Compliance is not established simply because an organization maintains written policies, provides annual education, or conducts occasional audits.

HHS-OIG's *General Compliance Program Guidance* emphasizes the importance of established compliance policies, effective education, ongoing auditing and monitoring, corrective action, and leadership oversight as components of a comprehensive compliance program *(OIG, 2023).*

When evaluating readiness for 2027, organizations should consider whether they can demonstrate:

- Identification of applicable regulatory changes.
- Documented assessment of organizational impact.
- Assignment of implementation responsibilities.
- Appropriate policy and procedure revisions.
- Education for affected personnel.
- Monitoring and auditing of high-risk activities.
- Documentation of identified deficiencies and corrective actions.
- Leadership oversight and follow-up.

These activities support a defensible, risk-based approach to regulatory compliance.

The compliance consideration: If asked to demonstrate your organization's response to the 2027 Medicare changes, what documentation could you provide?



Compliance Is Not a One-Time Event

The transition into a new regulatory year should not represent the conclusion of an organization's compliance activities. Instead, it should serve as an opportunity to evaluate the effectiveness of existing processes and establish priorities for the year ahead.

The strongest compliance programs do more than react to changes after problems arise. They establish processes for identifying emerging risks, communicating expectations, monitoring performance, and making necessary improvements.

As 2027 approaches, organizations have an opportunity to reinforce these practices and strengthen accountability throughout their operations.

Regulatory awareness tells an organization what has changed. Compliance readiness demonstrates what the organization has done about it.

How LW Consulting, Inc. Can Help

LW Consulting, Inc. assists healthcare organizations in identifying compliance vulnerabilities, evaluating internal processes, and strengthening regulatory compliance practices. Our services include compliance program assessments, documentation and coding audits, regulatory risk assessments, policy and procedure reviews, and targeted education.

Whether your organization is evaluating new Medicare requirements, reviewing existing compliance controls, or preparing its 2027 auditing and monitoring priorities, an independent assessment can provide valuable insight into potential areas of risk.



Is your organization ready to demonstrate its compliance preparedness for 2027? Contact LW Consulting, Inc. to discuss how our healthcare compliance consulting and auditing services can support your organization's regulatory readiness.

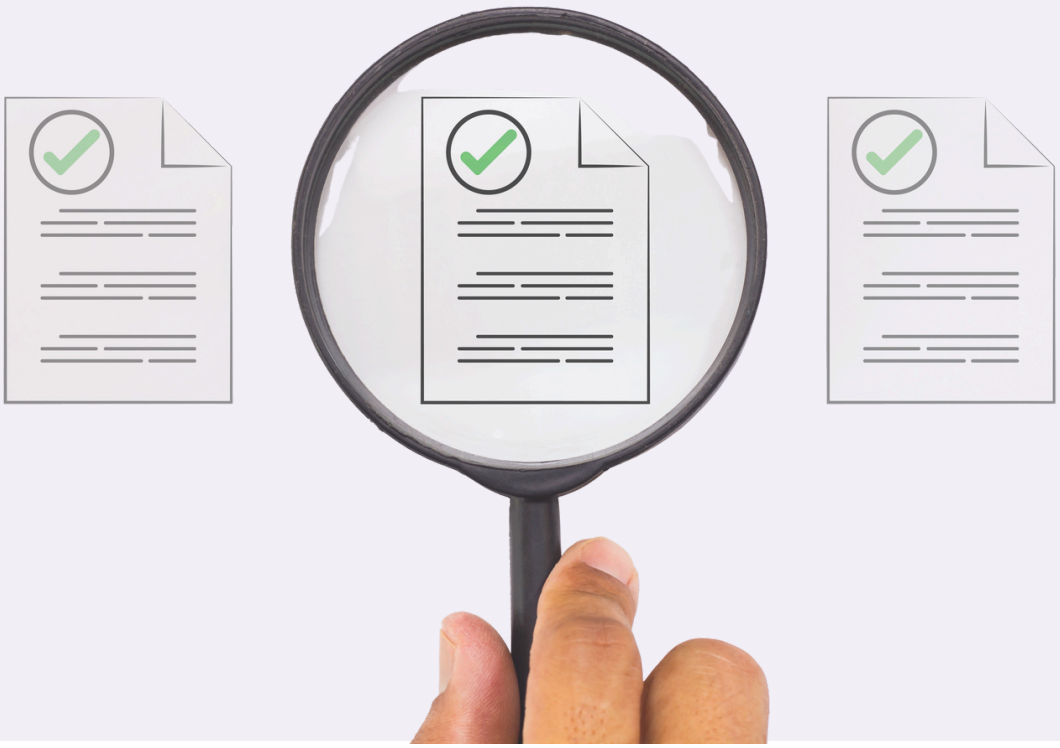
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About LW Consulting, Inc.

LW Consulting, Inc. (LWCI) is a recognized leader in providing reimbursement, operational, compliance, and clinical consulting solutions across the healthcare continuum. For more than two decades, we have partnered with healthcare organizations to navigate complex regulatory requirements, strengthen compliance programs, mitigate risk, and improve organizational performance.

Our multidisciplinary team includes clinicians, compliance professionals, certified coders, auditors, reimbursement specialists, and operational experts with extensive experience across post-acute care, physician services, behavioral health, hospitals, and other healthcare settings. We assist organizations with compliance program assessments, coding and documentation audits, investigations, regulatory readiness, education and training, reimbursement support, and independent review services.

LWCI is an experienced Independent Review Organization (IRO) and Independent Monitor, supporting organizations with Corporate Integrity Agreement (CIA) obligations, corrective action plans, and ongoing compliance oversight. We also serve as a trusted resource to healthcare providers, attorneys, government agencies, and industry stakeholders seeking expert guidance in today's increasingly complex regulatory environment.

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