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Under Pressure: CMS's CRUSH Rule Takes Aim at Fraud, Waste, and Abuse

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On November 16, 2026, the Centers for Medicare & Medicaid Services ("CMS") issued the proposed Comprehensive Regulations to Uncover Suspicious Healthcare" ("CRUSH") proposed rule, a package of program-integrity reforms affecting Medicare, Medicare Advantage ("MA"), Medicare Part D, Medicaid, the Children's Health Insurance Program ("CHIP"), with additional focus on durable medical equipment suppliers, and the Health Insurance Marketplace. CMS describes CRUSH as a shift from after-the-fact recovery (sometimes called "pay and chase") toward fraud prevention and early detection. Certain provisions of the proposed rule that are likely to affect providers, plans, and states are summarized below.

Medicare Advantage Risk-Adjustment Data Validation Reforms

Characterizing MA as "a program responsible for $21 billion per year in overpayments due to the improper inflation of beneficiary risk scores," CMS proposes to extrapolate risk-adjustment data validation ("RADV") audit findings to "the universe of enrollees from which the sample is selected." Under this proposal, CMS may use contract-specific extrapolation methodologies to extrapolate findings from a statistically significant sample, regardless of error rate. CRUSH also includes provisions that would require MA organizations to remit extrapolated recovery amounts from RADV audit findings as offsets to the MA plans' monthly capitation payments. These proposed changes underscore CMS's (and DOJ's) emphasis on anti-fraud initiatives for MA plans.

Expanded Medicare Reporting Requirements and Revocation Grounds

CRUSH would shorten the deadline for reporting changes to Medicare enrollment information. Currently, providers and suppliers generally must report changes in ownership or control, practice location, and adverse legal actions, within 30 days, and most other changes may be reported within 90 days. *See* 42 C.F.R. § 424.516(d)-(e). Under CRUSH, all changes of information would have to be reported within 30 calendar days, regardless of the type of change or provider involved. Providers should therefore

be prepared to identify and report, within 30 days, changes that previously fell within the longer window.

CMS also proposes new grounds for denying or revoking Medicare enrollment. CMS, and states in consultation with CMS, could take action when CMS cannot confirm the identity of a provider's or supplier's domestic or foreign owner, managing employee, organization, partner, officer, or director, or determines that such a person or entity presents an "undue risk" of fraud, waste, or abuse. CRUSH would give CMS and states broad discretion to consider risks associated with individuals and entities behind an enrolled provider or supplier, rather than focusing exclusively on the enrolled entity itself.

Mandatory Reporting by MA and Part D Organizations

CMS currently encourages, but generally does not require, MA organizations and Part D plan sponsors to refer substantiated or suspicious fraud, waste, and abuse to CMS. CRUSH would make those referrals mandatory. It would also expand requirements for reporting payment suspensions based on credible allegations of fraud, which currently focus on pharmacies, to payment suspensions involving all provider and supplier types.

CMS reports that, during calendar year 2025, only 46 percent of Part C and Part D contracts voluntarily reported referrals of suspected or substantiated fraud, waste, and abuse, and only 19 percent reported payment suspensions based on credible allegations of fraud. The proposal would convert what is now largely a voluntary reporting framework into an affirmative compliance obligation.

Expanded DMEPOS Disclosure and Marketing Restrictions

CRUSH would expand the information that durable medical equipment, prosthetics, orthotics, and supplies ("DMEPOS") suppliers must disclose. In addition to existing ownership and management disclosures, suppliers would have to report certain associated entities, including companies furnishing marketing, fulfillment, wholesale, or device-manufacturing services. CMS believes these disclosures would help identify coordinated or interrelated supplier networks.

The proposed rule would also broaden restrictions on unsolicited beneficiary contact. Existing regulations generally prohibit unsolicited telephone contact by DMEPOS suppliers, subject to specified exceptions. CRUSH would extend those restrictions to text messages, social-media direct messages, emails without an opt-out mechanism, and door-to-door solicitations, generally subject to the exceptions applicable to telephone contacts.

Medicaid and CHIP Enrollment and Payment Suspensions

Under existing regulations, a state Medicaid agency generally must suspend payments when it determines that a credible allegation of fraud ("CAF") exists, unless good cause supports an exception. CRUSH would allow a state to adopt a CAF determination made by CMS or another federal agency without independently redetermining credibility.

Although reliance would not be mandatory, the proposal could enable faster coordination of payment suspensions across federal and state programs. CMS also proposes to narrow and more closely scrutinize the use of good-cause exceptions to payment suspensions. Because administrative recourse is limited, a federal determination adopted by a state could have a significantly greater immediate financial impact, particularly for providers with substantial or multi-state Medicaid billings.

CRUSH would also add grounds for Medicaid and CHIP enrollment denial or termination that parallel certain existing Medicare grounds, including specified felony convictions and revocations involving abusive billing or prescribing. CMS intends this alignment to reduce the risk that a provider removed from Medicare could continue billing Medicaid or CHIP. In addition, providers would have to disclose more information about owners, managing employees, and adverse legal actions, giving states additional visibility into the persons and entities controlling provider operations.

Medicaid Corrective Action Plans and the 60-Day Rule

The proposal would establish a formal framework governing state program-integrity corrective action plans following CMS audits, including requirements for CMS approval, implementation monitoring, and corrective-action oversight. CMS also proposes enhancements to Payment Error Rate Measurement corrective action plans, including a single combined Medicaid and CHIP plan and increased monitoring of implementation.

Finally, CRUSH would implement a Medicaid fee-for-service overpayment rule requiring providers to report and return self-identified overpayments within 60 calendar days of the later of identification of the overpayment or the date a related cost report is due. CMS characterizes the proposal as implementing statutory requirements and bringing Medicaid fee-for-service into closer alignment with the overpayment-reporting frameworks applicable to Medicare and Medicaid managed care. If finalized, providers would need reliable procedures for investigating potential overpayments, determining when an overpayment has been identified, and completing repayment within the regulatory period.

Health care organizations should evaluate their reporting and compliance practices to ensure they are prepared to incorporate changes required by CRUSH in the event the regulations are finalized.

Dorsey & Whitney LLP continues to monitor developments involving the proposed rule. Please contact the authors or your regular Dorsey attorney with questions regarding the proposed rule, submitting a comment, or its application to your organization.