CMS Unveils “CRUSH” Proposed Rule Targeting Fraud, Waste, and Abuse Across Federal Health Programs

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On November 16, 2026, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule titled Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098-P). Unlike CMS’s annual payment rules, CRUSH is a stand-alone program integrity package that reaches nearly every federal health care program—Medicare fee-for-service, Medicare Advantage (MA), Part D, Medicaid, CHIP, and the ACA Marketplace. CMS projects roughly $90 billion in federal savings over 2027–2036 and has signaled that it expects to issue a similar program integrity rule every year.

Although CRUSH is not yet final, physicians, hospitals, home health agencies, hospices, DME suppliers, therapists, chiropractors, and other providers should begin assessing its impact now. Key provisions include:

Medicare Enrollment: Shorter Deadlines and Closer Scrutiny of Ownership

- **Uniform 30-day reporting window.** Today, certain changes (such as ownership, practice location, and final adverse actions) must be reported within 30 days, while others may be reported within 90 days. CMS would eliminate the 90-day category, so that every change to enrollment data—for example, a new managing employee, officer, bank account, billing agent, or mailing address—would be due within 30 days.
- **Unverifiable or high-risk owners.** CMS could deny or revoke enrollment when it cannot confirm the identity of an owner, partner, officer, director, or managing employee (domestic or foreign), or concludes that such a person presents an undue program integrity risk. Organizations with layered or investor-backed ownership should confirm their disclosures are complete.
- **Original Medicare enrollment as a condition of MA billing.** Other than in PACE, providers and suppliers that bill MA plans would need an approved Original Medicare enrollment, subjecting them to full fee-for-service screening. This requirement would begin with the plan year starting two years after the final rule is published.

Medicare Advantage and Part D: More Plan Reporting, More Provider Audits

MA organizations and Part D sponsors would be required—rather than merely encouraged—to refer suspected or substantiated fraud, waste, and abuse to CMS, and to report credible-allegation payment suspensions involving any provider type, not only pharmacies. The proposal would also codify Risk Adjustment Data Validation (RADV) audit policies, including extrapolation beginning with payment year 2018, that a federal court previously vacated. Network providers should expect more plan record requests, coding reviews, and payment holds.

Medicaid: New Provider-Level Obligations

- **60-day overpayment rule.** Medicaid fee-for-service providers would have to report and return identified overpayments to the state within 60 days, mirroring the Medicare standard. An

overpayment is treated as identified when the provider knows of it or acts in reckless disregard or deliberate ignorance of it, and funds kept past the deadline may give rise to False Claims Act liability.

- **Quicker payment suspensions.** States could base a Medicaid payment suspension on a credible allegation of fraud found by CMS or another federal agency, and the "good cause" exception to suspension would be narrowed.
- **Broader enrollment grounds and disclosures.** Medicaid and CHIP denial and termination grounds would be aligned with Medicare's (for example, felony convictions and abusive billing or prescribing), and providers would have to disclose more about their owners, managing employees, and adverse legal actions.
- **Electronic visit verification (EVV).** States would have to use EVV data in prepayment claim review and preliminary fraud investigations for home health and personal care services, making accurate visit documentation essential for home-based providers.

DME Suppliers

DMEPOS suppliers would have to list on Form CMS-855S related businesses that provide marketing, fulfillment, wholesale, or manufacturing services. The current restriction on unsolicited telephone contact with beneficiaries would be extended to text messages, social media direct messages, emails lacking an opt-out, and door-to-door solicitation.

Practical Steps

Providers should consider: (1) moving all Medicare enrollment updates to a 30-day timeline; (2) confirming that all owners, officers, directors, and managing employees are accurately reported; (3) identifying clinicians or sites billing MA without Original Medicare enrollment; (4) extending Medicare overpayment policies to Medicaid fee-for-service; (5) auditing EVV data (home health and personal care); and (6) reviewing vendor relationships and outreach practices (DME).

Comments are due 60 days after Federal Register publication (scheduled for November 19, 2026) under file code CMS-6098-P. We are available to help you evaluate how CRUSH may affect your organization and to prepare comments to CMS.

This article is general in nature and does not constitute legal advice. Readers with questions should contact Mark Opara (mopara@sb-kc.com), Lori Beam (lorib@sb-kc.com), John Neyens (johnn@sb-kc.com) or their regular Seigfreid Bingham contact at 816.421.4460.