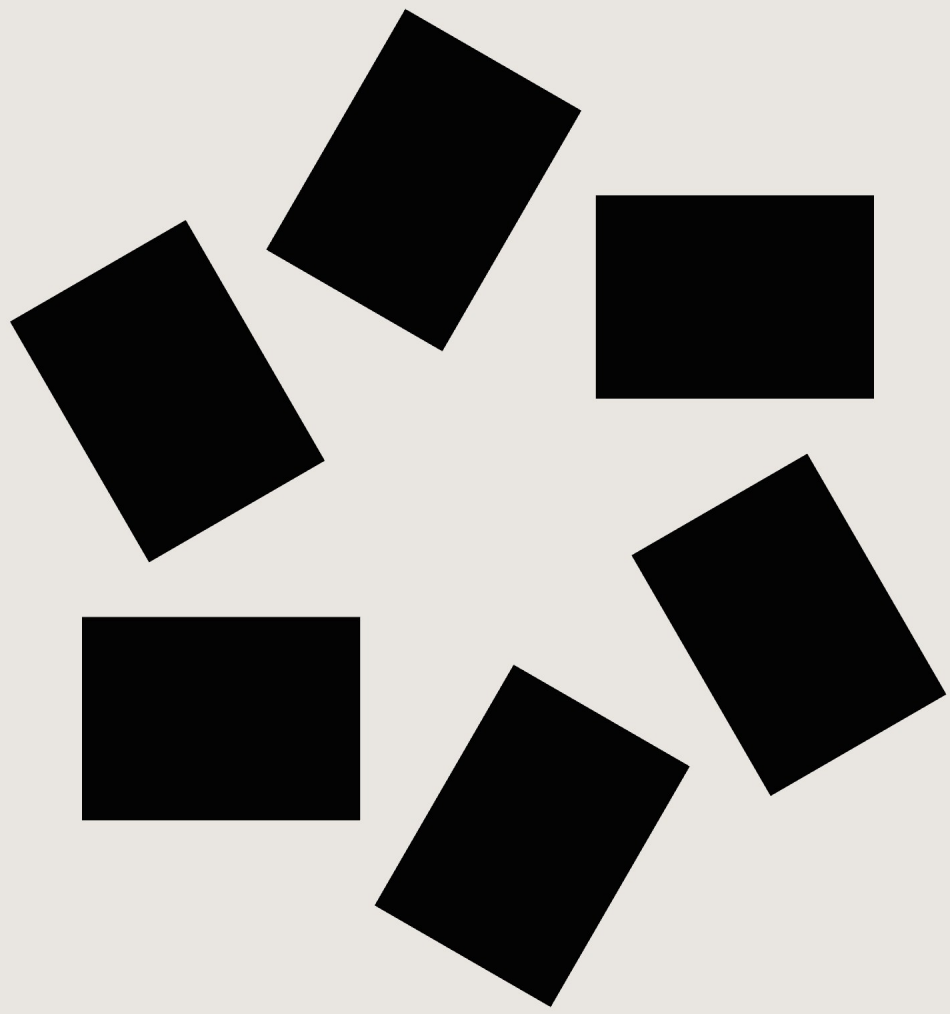
Proposed rule | CMS-6098-P



The CRUSH rule, illustrated

What CMS's proposed fraud, waste and abuse rule means for MA plans, Medicaid plans, D-SNPs and delegates.

~$9B a year in RADV recoveries, by CMS's estimate.

The impact as written is significant. Comments close Jan 19, 2027.

Readily

Source: CMS fact sheet on the CRUSH proposed rule, CMS-6098-P, Nov 16, 2026.
Not legal advice.

Index

Every provision at a glance

Grouped the way CMS presents them. ☆ **Key changes** are the ones most likely to hit plans and delegates.

1 Medicare provider enrollment 2

☆ 1 **Enrollment changes reported in 30 days**
2 **New denial and revocation ground**

2 Medicare Advantage and Part D 4

☆ 3 **Mandatory fraud reporting to CMS**
☆ 4 **MA providers in Original Medicare**
☆ 5 **RADV extrapolation, no FFS adjuster**
6 **RADV hardship exception process**

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24 Limits on who can participate
25 Suspension for abusive conduct
26 Termination-for-cause process
27 No system access from outside the US

Spotlight: the biggest financial change for MA plans

RADV errors would cost plans far more

Today, a plan pays back only the overpayments CMS finds in the members it audits.
Under the proposal, the plan would pay as if everyone in the pool CMS sampled from had the same average error. This applies to every audited year since 2018.

A worked example: what the plan repays

Illustrative figures.
Bars drawn to scale.

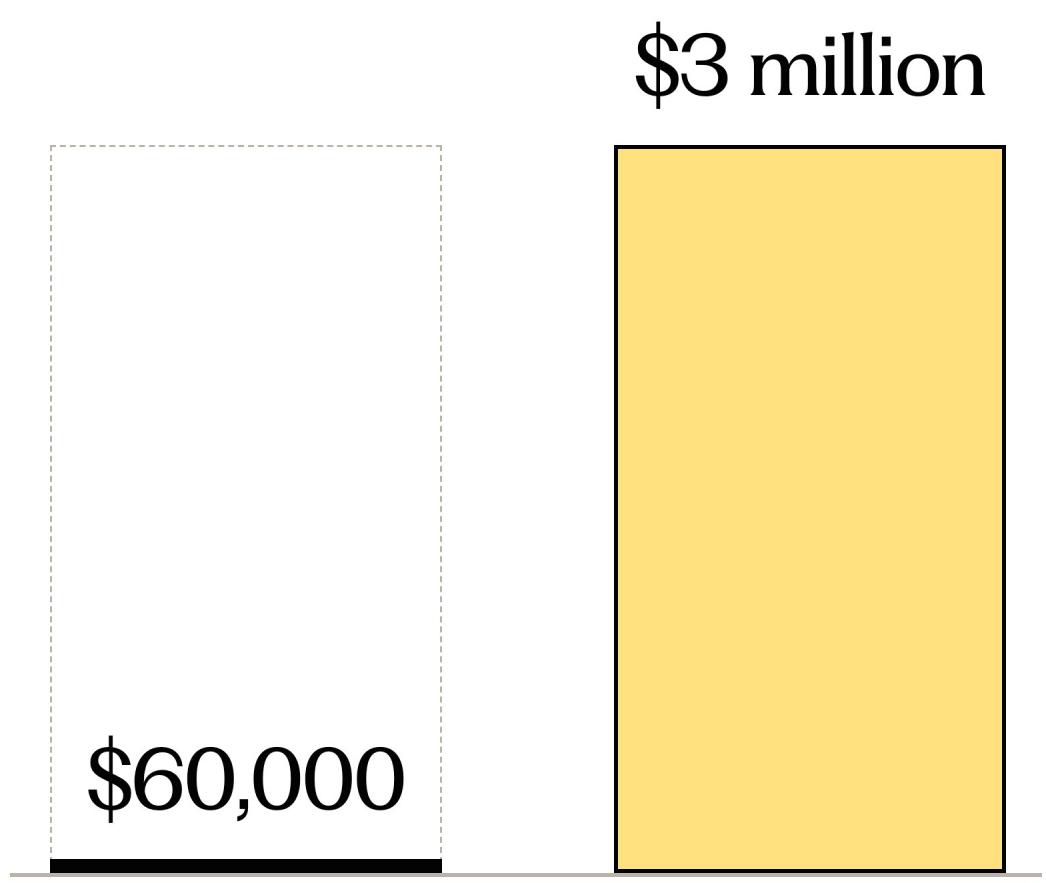
20,000
members in the contract

2,500
in the higher-risk pool
CMS samples from

50
drawn at random from the
pool and audited

$1,200
average overpayment per
audited member

The proposed figure applies only if the sample result is statistically reliable.



- **2018 means 2017 records.** A payment year 2018 audit checks diagnoses from 2017 visits.
- **Each year counts.** Every year since 2018 can be audited and extrapolated. Payment year 2024 records are due Feb 5, 2027.
- **Not settled.** CMS's RADV final rule of Feb 1, 2023 set this same policy. A court struck it down in 2025 (Humana v. Becerra), and CMS has appealed. Comments close Jan 19, 2027.
- **Hardship exception.** Today it exists only in guidance. The rule would set out in regulation the extraordinary circumstances that qualify a plan for an exception.

Readily

Method from CMS's payment year 2024 RADV audit instructions (Aug 2026). The proposal has no adjuster for errors in traditional Medicare data. Sources: CMS RADV audit methods; CRUSH proposed rule, CMS-6098-P.

For Medicare Advantage and Part D plans

Reporting fraud to CMS stops being optional

Beyond RADV, three changes land on MA and Part D plans. The third reaches into your provider network.

Fraud referrals to CMS become mandatory

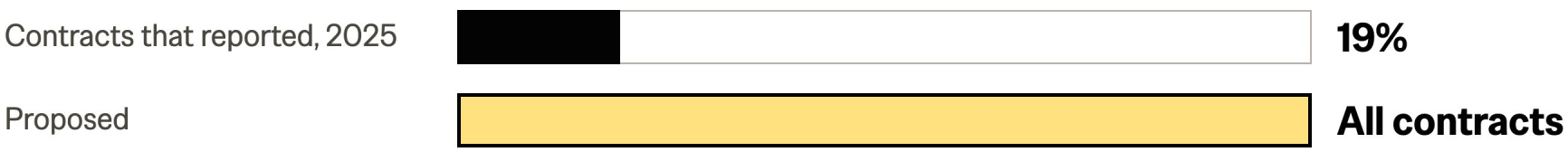
Today CMS only encourages plans to refer substantiated or suspicious fraud, waste and abuse.



CMS burden estimate: about 26 referrals a year per plan, at roughly 30 minutes each, or about 13 staff hours a year.

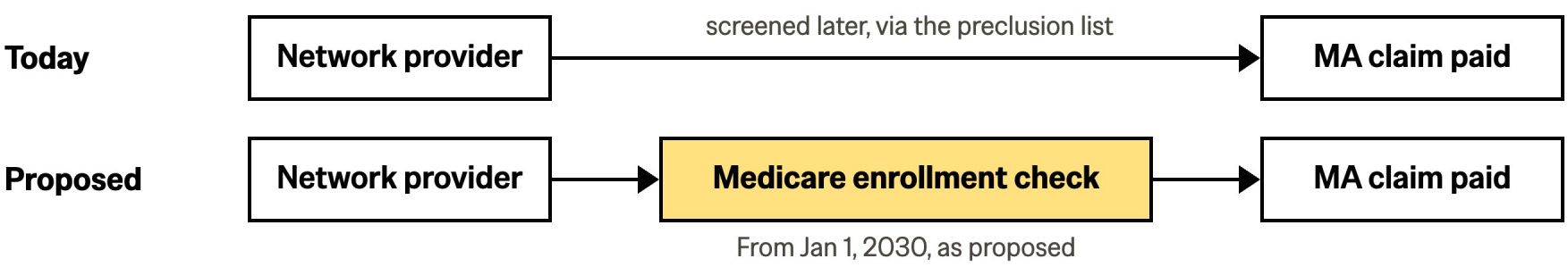
Payment suspensions reported for every provider type

Today plans must report suspensions for credible allegations of fraud only for pharmacies.



Network providers must be enrolled in Original Medicare

Providers would need to pass Medicare's full screening, including fingerprints and a site visit, before billing MA. PACE is exempt.



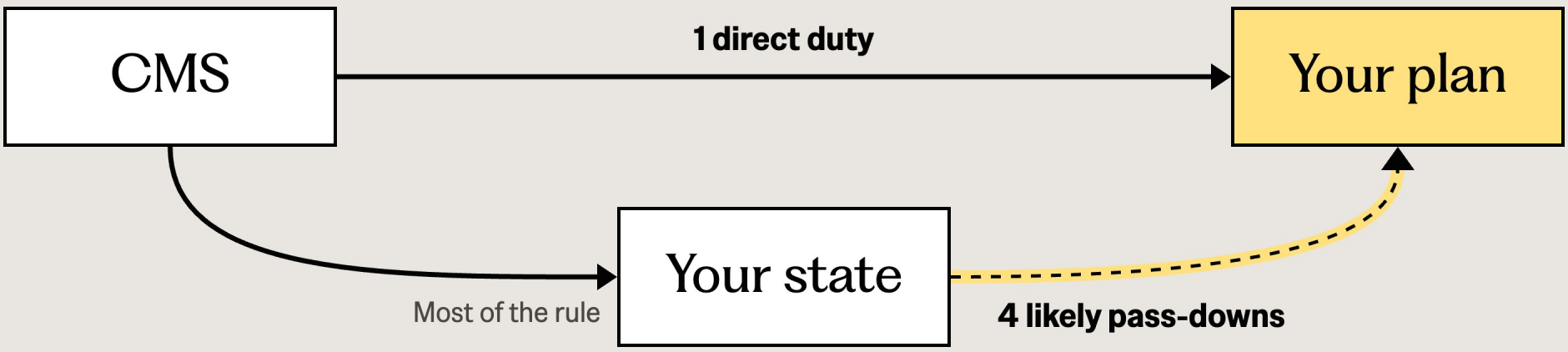
CMS burden estimate: about 174,000 provider hours a year in the first three years, across all of the rule's enrollment changes. No separate figure for plans.

The Jan 1, 2030 start date and the burden figures are from the proposed rule text.
Source: CRUSH proposed rule (CMS-6098-P), Federal Register, Nov 19, 2026.

For Medicaid managed care plans

One new duty from CMS, more through your state

The rule names Medicaid plans directly only once. Most of it lands on states, and states pass requirements down through your contract.



30 days

to report a death or a move

Return payments for members who died or moved

Report deaths and address changes within 30 days, and return overpayments for members who died or moved out of state.

LIKELY TO REACH YOU THROUGH YOUR STATE CONTRACT

More payment suspensions

States could suspend providers on a federal fraud finding, with fewer good-cause exceptions. Plans usually follow.

More providers removed

New denial and termination grounds mirror Medicare's, so more providers could leave your network.

Stricter provider data

NPIs required across claims and managed care oversight. Home care visits checked against visit-verification data before payment.

Membership churn

Federal eligibility audits, with penalties above a 3% error rate, push states to tighten eligibility checks.

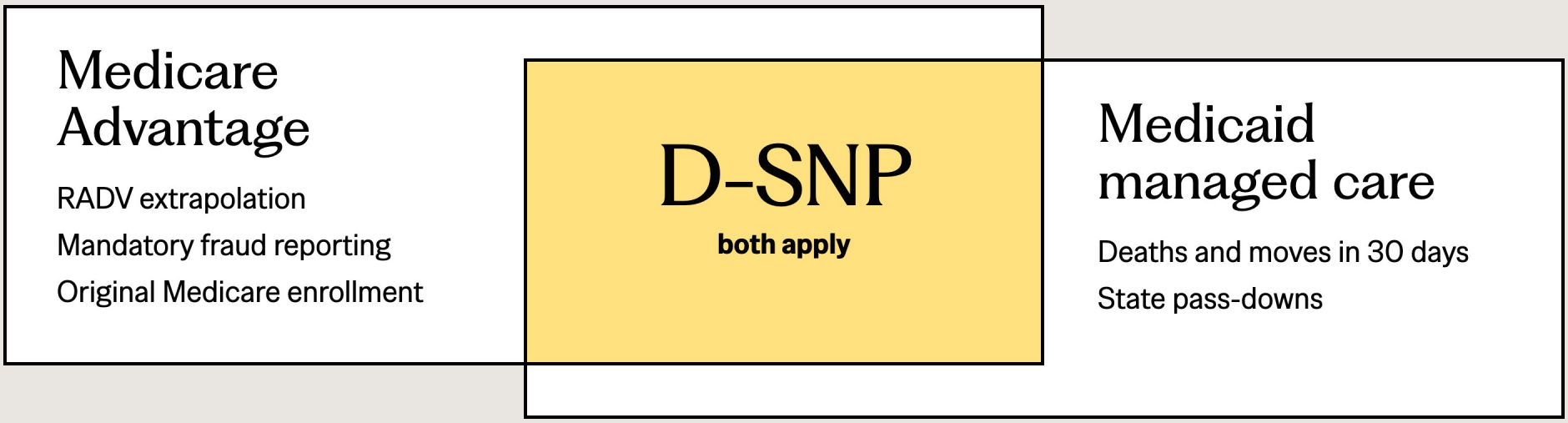
Readily

Pass-downs are Readily's assessment of how state requirements usually reach plans. Check your contract. Source: CMS fact sheet, CRUSH proposed rule (CMS-6098-P), Nov 16, 2026.

For D-SNPs

D-SNPs carry both sets of changes at once

A D-SNP gets everything on the MA card. If it is integrated with Medicaid, it gets the Medicaid card too.



Where they compound

1 RADV hits harder *

Duals carry high risk scores, so more payment rides on diagnoses, and CMS samples from members its models flag as higher risk.

2 Two overpayment duties

RADV and Medicare overpayment rules on one side. Reporting deaths and moves in 30 days on the Medicaid side, for integrated plans.

3 A mixed network to sort

D-SNP networks mix providers who can enroll in Medicare, like home health agencies, with home and community-based providers who can't. Plans would need to know which must enroll by Jan 1, 2030.

4 Members who lose Medicaid *

Tighter state eligibility checks mean more duals losing Medicaid, and with it D-SNP eligibility.

Readily

* Readily's assessment. Item 3 is from the proposed regulation text: the requirement applies to provider types eligible to enroll in Medicare. Source: CMS fact sheet, CRUSH proposed rule (CMS-6098-P), Nov 16, 2026.

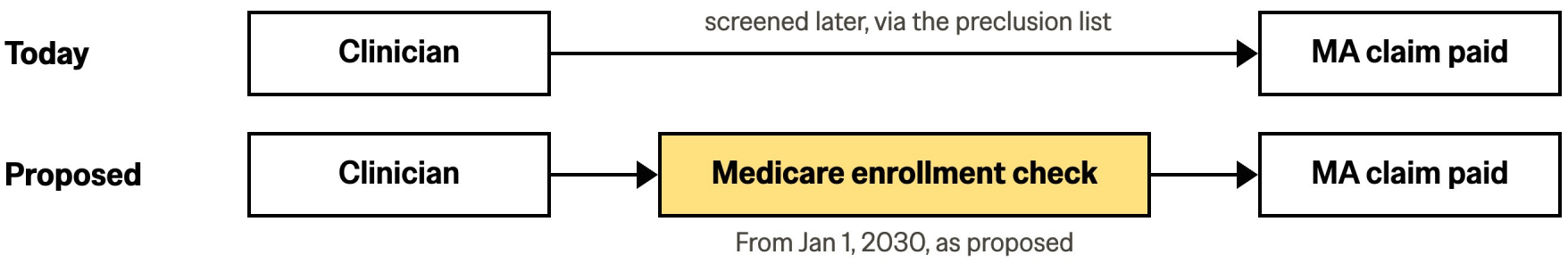
For MSOs, IPAs and other delegated entities

Your clinicians would need Medicare enrollment to bill MA

Delegates aren't named in the rule, but its provider enrollment and plan oversight changes run straight through them.

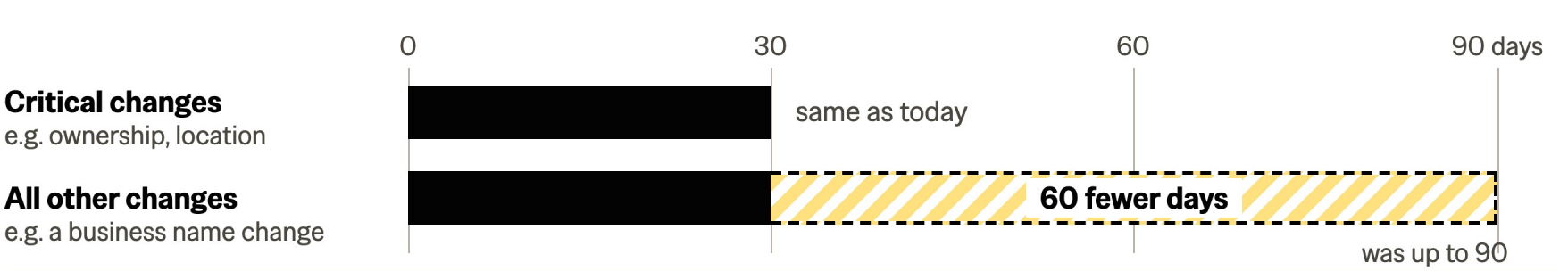
Original Medicare enrollment for everyone billing MA

CMS counts about 150,000 providers who bill MA without Medicare enrollment. Each would need full screening, including fingerprints and a site visit.



Every enrollment change due in 30 days

All other changes would get the same 30 days as critical ones, down from up to 90.

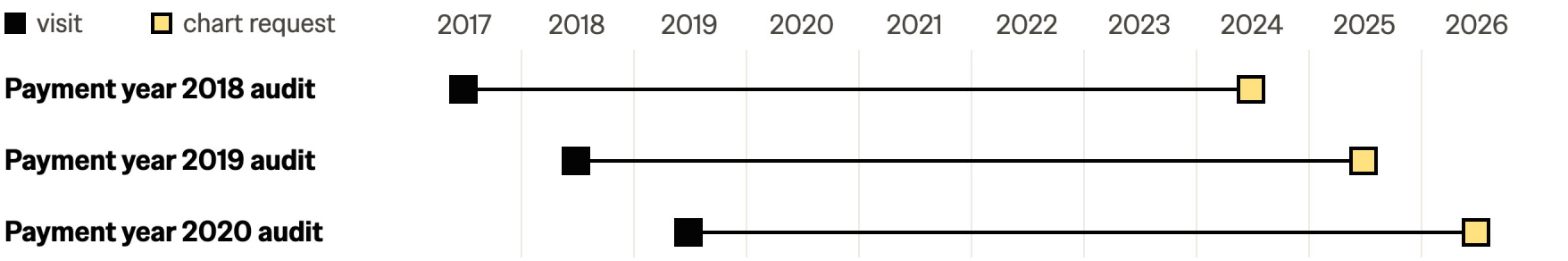


Owners and managers screened

CMS could deny or revoke enrollment over an owner or manager it can't verify or sees as a fraud risk.

RADV record requests reach back about seven years *

Plans will need your charts to defend diagnoses, and risk contracts may pass recoveries down.



Readily

* Pass-down depends on each delegation or risk contract (Readily's assessment). Audit years as reported from CMS announcements. Provider count and start date from the proposed rule. Source: CRUSH proposed rule (CMS-6098-P).

What to do now

Where to start

The rule is proposed, not final. These steps make sense either way.

MA and Part D plans

- ☐ Re-check a sample of 2018 to 2020 charts to estimate your RADV exposure
- ☐ Find network providers not enrolled in Original Medicare
- ☐ Have your SIU rework fraud referral and suspension reporting for CMS
- ☐ Update delegation agreements to pass these duties down

Medicaid plans

- ☐ Speed up how you learn about member deaths and moves
- ☐ Check your state contract for suspension, NPI and visit-verification terms

D-SNPs

- ☐ Sort which network providers must enroll in Original Medicare by 2030
- ☐ Plan for members who lose Medicaid

MSOs, IPAs and delegates

- ☐ Confirm every clinician is enrolled in Original Medicare
- ☐ Check how your risk contracts pass down RADV repayments
- ☐ Be ready to pull charts from years back
- ☐ If you bill Medicaid fee-for-service, set up a 60-day overpayment return

The impact as written is significant.

We strongly encourage you to comment by Jan 19, 2027.