CMS Just Padlocked the Cookie Jar: What the CRUSH Initiative and DMEP(Moratorium Actually Mean for Health Tech Investors and Entrepreneurs

FEB 26, 2026 • PAID

Abstract

On Feb 25, 2026, the Trump administration announced a sweeping set of Medicare/Medicaid fraud enforcement actions including a 6-month nationwide DMEPOS enrollment moratorium, a $259.5M federal Medicaid funding deferral Minnesota, and the launch of the CRUSH (Comprehensive Regulations to Uncov Suspicious Healthcare) RFI. This essay unpacks the policy mechanics, data, and second-order implications for founders and investors in health tech.

Key facts up front:

- 80k+ DMEPOS suppliers enrolled; 6,000+ are medical supply cos (7.5% of total)

- 17% revocation rate for medical supply cos vs ~6% for other DMEPOS types

- CMS suspended $5.7B in suspected fraudulent Medicare payments in 2025

- $1.5B in suspected fraudulent DMEPOS billing stopped in 2025 alone

- CRUSH RFI comment deadline: March 20, 2026 (file code CMS-6098-NC)

- Minnesota deferral: $259.5M with possible $1B+ exposure over next year

- 7 specific medical supply company types covered by moratorium

- Moratorium applies nationwide, all states, territories, DC

- No judicial review of the moratorium decision itself

Table of Contents

What actually happened and why it matters

Feb 25, 2026 was a busy day at CMS. VP Vance, RFK Jr., and Dr. Oz held a Whit House press event to announce what amounts to the most aggressive coordinatec Medicare/Medicaid fraud enforcement posture in a decade. Three actions dropp simultaneously: a nationwide moratorium blocking new Medicare enrollment fo seven categories of medical supply company DMEPOS suppliers, a $259.5M fede Medicaid funding deferral in Minnesota, and the CRUSH RFI soliciting public i on a potential future rulemaking. These aren't isolated policy moves. They're a coordinated signal about where this administration wants to take program integ

enforcement, and the downstream effects on health tech companies, from compl infrastructure to AI vendors to DME-adjacent platforms, are significant.

The headline framing from CMS Administrator Oz was theatrical but directiona accurate: "CMS is done trying to catch fraudsters with their hands in the cookie instead, we're padlocking the jar and letting them starve." Secretary Kennedy fra it as replacing "pay and chase" with "detect and deploy." Whether or not you bu political branding, the underlying operational shift is real. CMS suspended $5.7 billion in suspected fraudulent Medicare payments in 2025, stopped $1.5 billion DMEPOS billing alone, revoked billing privileges from 5,586 providers, and sen fraud referrals covering $3.7 billion in billing to law enforcement. That's not rhe that's a functioning enforcement apparatus that got materially more aggressive c the past year.

The moratorium itself is the most immediately impactful piece for health tech operators. DMEPOS fraud has been on CMS and OIG radar for literally decades OIG reports flagging it since 1998. What's new is the bluntness of the tool being not additional screening requirements, not payment suspensions post-billing, bu hard stop on enrollment for an entire category of supplier. No new medical supp companies get in for at least 6 months, possibly longer if CMS extends. For the companies and investors playing in the DME supply chain, distribution, or adjac in software supporting these suppliers, this is a material market structure event.

The DMEPOS moratorium mechanics

The legal authority for this goes back to Section 6401(a) of the Affordable Care A which added Section 1866(j)(7) to the Social Security Act. That provision gave th Secretary authority to impose temporary enrollment moratoria on categories of providers and suppliers when there's "significant potential for fraud, waste, or a CMS implemented this via 42 CFR 424.570, and the regulations allow for both i 6-month moratoria and unlimited 6-month extensions. The original 2013 moratc on home health agencies and ambulance suppliers ran until January 2019 – six ye Worth keeping that precedent in mind.

The seven specific supplier types covered are: medical supply company, medical supply company with orthotics personnel, medical supply company with pedorth personnel, medical supply company with prosthetics personnel, medical supply company with prosthetic and orthotic personnel, medical supply company with registered pharmacist, and medical supply company with respiratory therapist. C is explicit that "medical supply company" for purposes of the moratorium means entity whose principal function is furnishing DMEPOS supplies directly to anot party, whether that's beneficiaries via mail order, medical providers, or both. Pharmacies, grocery stores, hospitals, and physician offices generally don't quali medical supply companies and are therefore not subject to the moratorium – the still open new locations and enroll.

The operational carve-outs matter. Applications received by Medicare contracto before the moratorium's effective date are grandfathered. Changes in practice lo within an already-enrolled entity don't trigger the moratorium (unless moving fr outside to inside a moratorium area, which in this case is everywhere, so that car out doesn't really apply). Changes in ownership are generally excluded too, with major exception: if a DMEPOS supplier undergoes a non-exempt change in majo ownership within 36 months of initial enrollment or most recent CIMO, it has to enroll as a brand new supplier. That new enrollment is an initial enrollment, and moratorium therefore applies. This is not a loophole you want to stumble into.

CMS also made clear it will be screening all DMEPOS applications during the moratorium to ensure applicants aren't medical supply companies trying to enro under a different supplier type. The penalty for attempting to circumvent via misrepresentation is severe: up to a 10-year reapplication bar and potential crim referral to OIG. CMS has the authority under Section 424.530(a)(4) to deny enrol and impose bars for false or misleading information on applications. They're not subtle about the warning.

There's also no judicial review of the moratorium decision itself. Section 1866(j)(of the Social Security Act is explicit: no review under Sections 1869 and 1878 or otherwise. Applicants denied due to the moratorium can appeal, but the scope is

limited strictly to whether the moratorium applies to them, not whether the moratorium was a good idea.

The data CMS used to justify this

The Federal Register notice is unusually data-dense for a CMS moratorium announcement. CMS analyzed Medicare enrollment and claims data going back looking at more than 80 DMEPOS supplier types. The numbers on medical supp companies are genuinely striking. Roughly 85% of DMEPOS supplier payments f 2023 to present went to small DMEPOS suppliers. Within that small supplier category, medical supply companies account for the majority of Medicare FFS payments from 2023 through October 2025. So these entities are not marginal pl – they're the dominant billing channel for small-supplier DMEPOS.

But the fraud indicators are what drove the decision. Medical supply companies 17% revocation rate during the analysis period, meaning 17% of enrolled supplie eventually had their Medicare billing privileges revoked. That's roughly triple th for other DMEPOS supplier types. It doesn't stop there: all 7 medical supply cor types were in the top 20 out of 80+ DMEPOS supplier specialties for highest percentage revoked since 2023. Five of the 7 were in the top 10 for payment suspension rates. Six of the 7 were in the top 10 for law enforcement referrals. A were in the top 15 for benefit integrity unit complaints. That's not one bad data – that's a category consistently at the top of every adverse indicator CMS tracks.

The orthotic brace data is particularly interesting for anyone watching the prior and DME ordering workflows. CMS maintains a "Master List" of DMEPOS item identified as fraud/waste/abuse vulnerabilities. There are currently 32 prefabrica brace codes on that list, 9 of which are off-the-shelf braces. The OIG's May 2024 report flagged OTS braces as a major fraud risk, including beneficiaries receivin braces ordered by suppliers with no treating relationship, telemarketer solicitat and millions in fraudulent payments. The data CMS pulled for 2023 through lat October 2025 shows medical supply companies submitted more than 70% of the million claim lines for those 32 prefabricated brace codes. For the OTS brace su

specifically, medical supply companies submitted more than 80% of the 1.5 milli claim lines. That's a level of concentration that, when combined with the fraud indicators, makes the moratorium look less like a blunt instrument and more lik targeted intervention.

The criminal enforcement history in the notice is a roll call of fraud schemes: a $ power wheelchair fraud in California resulting in a 15-year prison sentence, a $2 brace fraud in California where a father and son ran sham marketing agreement $100M scheme in South Carolina where 10 DMEPOS companies operated throu offshore call centers and telemedicine prescriptions with no actual clinical relationship, and a Texas case involving $20M in DME claims built on weekly kickback payments for signed physician orders. The pattern across virtually all these is the same: a DMEPOS company, a marketing intermediary generating pa leads or physician orders, and telemedicine as the thin clinical veneer. It's a play that got industrialized.

The CRUSH RFI and what CMS is fishing for

The CRUSH initiative is the forward-looking piece. The RFI, filed under CMS-6 NC with a comment deadline of March 20, 2026, solicits input on a potential fut proposed rule. The breadth of topics is notable and worth reading carefully beca telegraphs where CMS is heading.

On the ownership and identity side, CMS is asking about requiring U.S. citizens legal permanent residency for anyone with 5%+ ownership in a Medicare-enrolle entity. It's also asking about expanding fingerprinting and background checks be the current high-risk category requirement to include managing employees, sub owners, and other affiliated individuals. The framing here is around "internatio fraud schemes characterized by opacity of ownership structures" and owners operating outside U.S. law enforcement reach. This is not a hypothetical concern CMS data has shown enrollment structures using nominee owners and shell companies as a recurring fraud pattern.

The preclusion list questions are operationally significant for Medicare Advanta plans and the vendors that serve them. CMS identifies a specific gap: providers revoked from Traditional Medicare for reasons not classified as "detrimental to best interests of the Medicare program" don't end up on the preclusion list. Thc providers then pivot to billing MA plans, where they can keep collecting. CMS i asking whether all providers and suppliers should be required to enroll in Tradi Medicare as a condition of billing MA plans. If that becomes a requirement, the compliance and credentialing infrastructure across MA would need substantial retooling.

The lab testing section is a significant signal for the diagnostics and genomics st Medicare Part B spending on clinical lab tests hit $8.4B in 2024, up 5% year ove Genetic tests are only 5% of lab test volume but 43% of Part B lab spending at $3 The OIG and DOJ have been actively pursuing genetic testing fraud – the 2019 enforcement action resulted in charges against 35 individuals for over $2.1 billic losses. CMS is asking about expanding the MolDX program, requiring registrati it as a condition of payment, and bringing MA plans into alignment with traditi Medicare on lab oversight requirements.

The beneficiary solicitation section is directly relevant for any company touchin patient acquisition in the DMEPOS space. CMS wants to expand the existing prohibition on unsolicited telephone contact by DMEPOS suppliers to include e text, and social media. It's also asking about explicitly prohibiting DMEPOS sup from collaborating with marketing agencies or third parties for beneficiary solicitation. This would functionally eliminate the lead-gen intermediary model appears in almost every major DMEPOS fraud prosecution.

The surety bond questions are worth flagging for anyone in the insurance infrastructure space. DMEPOS suppliers currently must maintain at least a $50, surety bond. CMS is asking about increasing the required amount, expanding su bond requirements to other provider types, and taking tougher action against bc companies not meeting obligations. An increase in required bond amounts or expansion to home health would be a material change to the insurance market fc these provider types.

Minnesota as a canary

The Minnesota deferral is worth separate treatment because it illustrates how C using financial pressure as a program integrity tool in ways that go beyond just Medicare. CMS deferred $259.5M in federal Medicaid matching funds covering fourth quarter of FY2025. Of that, $243.8M is for unsupported or potentially fraudulent claims and $15.4M relates to claims involving individuals lacking satisfactory immigration status. The specific service categories flagged are perso care services, home and community-based services, and other practitioner servic

CMS is explicit that failure to address program integrity vulnerabilities could re in deferral of more than $1 billion over the next year. That's not a small number a substantial portion of Minnesota's federal Medicaid matching funds. For healt companies operating in HCBS, personal care, or adjacent waiver program spaces signals that CMS is willing to treat state-level fraud as a federal funding probler act accordingly. Medicaid managed care organizations, HCBS technology platfor and companies doing utilization management in these benefit categories should paying very close attention.

The CRUSH RFI's Medicaid section reinforces this. CMS is asking states about revalidation frequency (currently up to every 5 years for high-risk providers – C questioning whether that's sufficient), about tools for fraud detection in manage care, and specifically about high-risk service areas including housing stabilizatic services, behavioral health, personal care assistant services, and non-emergency medical transportation. If you're a venture-backed company in any of those cate understanding how your state Medicaid partner is going to respond to this press environment is not optional.

What this means for founders

The immediate effect for founders is straightforward: if you are building a new medical supply company and planned to enroll in Medicare, you can't for at leas next 6 months, and probably longer. If your business model depends on being a r new Medicare-enrolled DMEPOS supplier in one of the seven covered categorie

have a hard problem. The workarounds CMS has flagged – attempting to enroll
a different supplier type – carry a 10-year ban risk. That's not a risk worth takin

For founders in adjacent spaces, the implications are more nuanced but still significant. Companies building software for DMEPOS suppliers, whether that's billing platforms, compliance tools, order management, or patient-facing interfa are going to see their market go through a contraction of new entrants while exi suppliers face higher scrutiny. The 6,000+ currently enrolled medical supply companies aren't going anywhere immediately, but their compliance burden is a to increase. Tools that help existing enrolled suppliers demonstrate compliance documentation management, order verification, proof of delivery, prior authoriz workflow – are going to be in higher demand.

The CRUSH RFI signals several specific product opportunities. CMS is explicitl asking about AI and ML tools for fraud detection, real-time claims analytics, ide proofing infrastructure, and beneficiary contact verification. The administration stood up a Fraud Defense Operations Center that it credits with $1.8 billion in taxpayer savings in 2025, including over $100 million related to suspect labs. CM actively looking for commercial technology it can buy, partner with, or regulate existence. If you're building in any of these categories, the comment period is ac worth participating in. CMS will use responses to inform both the potential CRU rule and internal procurement decisions.

The lab testing signal deserves specific attention for genomics and diagnostics founders. $3.6B in Medicare Part B genetic test spending and a history of billion dollar fraud prosecutions means this category is going to get materially more regulated. The MolDX expansion question in the RFI is particularly important: i CMS requires all labs to register in MolDX as a condition of Medicare payment, outside the existing 28-state footprint, that changes the reimbursement access p for any lab billing Medicare. For early-stage genomics companies designing thei to-market around Medicare reimbursement, this is a scenario worth modeling.

For founders in the MA space specifically, the preclusion list and MA enrollmen questions in the CRUSH RFI are worth watching closely. The requirement to en

Traditional Medicare as a condition of billing MA plans, if it becomes a rule, wo force a significant reconfiguration of how MA-only billing entities operate. Companies building provider-facing tools, network management platforms, or credentialing infrastructure for MA plans should be tracking this closely.

What this means for investors

At the portfolio level, this announcement is a reminder that regulatory environm isn't a static variable in health tech. The DMEPOS moratorium affects a specific category directly, but the CRUSH initiative's scope – MA, lab, Medicaid manage care, exchanges, HCBS – is broad enough to touch a substantial portion of the d health investment landscape.

For investors with DMEPOS-adjacent positions, the first question is market stru The moratorium blocks new entrants in medical supply categories, which in the should be a stabilizing factor for currently enrolled suppliers. But the 17% revoc rate and the aggressive revocation posture CMS has demonstrated (5,586 revocat in 2025 alone) means that the existing enrolled base is under more scrutiny, not l Portfolio companies that are Medicare-enrolled DMEPOS suppliers or that cour such suppliers as their primary customer need to be doing a careful risk assessm their compliance posture right now.

For investors evaluating new opportunities in the DMEPOS space, the 6-month moratorium (and potential multi-year extension history as precedent) is a materi factor in any go-to-market that requires new Medicare enrollment. That doesn't the market is closed – it means the path to Medicare billing for new entrants in covered categories is blocked, and the business model needs to work around tha wait it out.

The compliance and program integrity technology category looks like a genuine tailwind from all of this. CMS is publicly signaling it wants to buy technology fo real-time fraud detection, AI-assisted claims review, identity proofing, and provi monitoring. The FDOC, which CMS credits with $1.8B in savings, is a real operational entity that will need technology partners. Companies building in thi

space have a policy environment that is explicitly favorable, and there's a comme period mechanism that can create direct dialogue with the buyer.

For investors in the genomics and diagnostics space, the $3.6B genetic test spen figure and the regulatory attention it's attracting is a double-edged signal. The n is large and growing. The fraud history has been severe enough to produce billio dollar enforcement actions. The likely result is a compliance-intensive reimburs environment that favors companies with the infrastructure to navigate it and disadvantages pure-play lab operators without strong documentation and medic necessity workflows. Cap table construction and management team composition this category should reflect that.

For HCBS and personal care technology investors, the Minnesota situation and t Medicaid questions in the CRUSH RFI are worth treating as forward indicators. deferring $260M in state funds for personal care and HCBS-related fraud is a di shot across the bow at states and their managed care partners. Technology comp helping states or MCOs detect fraud in these categories are in a favorable regula environment. Companies whose revenue depends on beneficiaries in these progr at states with weak compliance postures have a risk that wasn't fully visible befo this announcement.

The AI angle

There's a specific AI subplot here worth pulling out separately because it's getti real budget behind it. Secretary Kennedy's "detect and deploy" framing is explic about AI-driven real-time fraud detection replacing the traditional post-paymen audit model. The FDOC, stood up in 2025, is described as a "high-tech unit" usi cross-functional teams for real-time fraud targeting. $1.8B in 2025 savings is the headline number CMS is attributing to this approach.

The CRUSH RFI section on AI in Medicare Advantage coding oversight asks specifically about commercial off-the-shelf AI solutions for record abstraction, features needed to incorporate coder feedback and prevent hallucinations, how recommendations should be displayed to human reviewers, compliance risk

considerations, pricing structures, and cloud deployment environments. This is abstract policy question – it reads like a procurement spec. CMS is trying to understand the vendor landscape before it commits to a technology approach.

The question about AI for hospital billing efficiency is also in there, which is br than just fraud detection. Hospital billing accuracy has downstream effects on b MA risk adjustment and Traditional Medicare fee-for-service payments, and CM signaling it wants AI in the loop on both sides.

For AI health tech founders and their investors, the specific framing around hallucination prevention and human reviewer integration is important. CMS is r going to buy a black-box fraud detection system. The regulatory and liability environment for false positives in provider credentialing or claims adjudication severe enough that any AI tool in this space needs to have defensible human-in-t loop workflows, explainability, and audit trails. Companies that have built for th from day one are better positioned than those retrofitting explainability onto mo designed for pure accuracy optimization.

The RFI also asks what analytics methodologies and data sources would most effectively detect fraud. This is an invitation. Companies with novel data assets - pharmacy transaction networks, lab ordering patterns, telehealth prescription d claims data outside Medicare – should think carefully about whether there's a partnership or licensing angle here with CMS or its contractors. The MAC infrastructure and the FDOC are active buyers of analytical capability, and the F the mechanism to get in front of that procurement process.

How to think about the comment perio

The CRUSH RFI comment deadline is March 20, 2026. That's tight. Comments g CMS-6098-NC via regulations.gov or by mail to CMS in Baltimore. CMS is expli that it will use responses for program planning and potentially to inform a futur proposed rule. It's also explicit that comments become government property, wil posted publicly, and should not contain proprietary or confidential information.

For health tech companies, the calculus on whether to comment is straightforwa any of the 13 topic areas in the RFI (program integrity authorities, identity proo preclusion list, lab testing, non-participating DMEPOS in MA, claim filing dead AI in coding, beneficiary solicitation, beneficiary contact, surety bonds, Medicaid/CHIP, state-specific Medicaid, and FFE/SBE exchanges) materially affe your business, you should comment. CMS uses RFI responses to understand mar structure and operational feasibility before proposing rules. A comment that exp the operational impact of, say, a 90-day claim filing deadline for DMEPOS suppl or the practical challenges of MolDX registration for labs in non-MolDX states, actually informs the rulemaking process in ways that can matter.

Industry associations will file comments, and their positions will reflect the broa member interests. That doesn't mean individual company perspectives are irrele CMS specifically invites feedback that includes "supporting facts, research, and evidence" and encourages citations and documentation. A data-driven comment a technology company with actual operational evidence about fraud detection ef identity verification costs, or claims filing workflow impacts is more useful to C than a general advocacy position.

For investors, it's worth encouraging portfolio companies in the affected categor engage. The 30-day comment window on an RFI that could result in a major rulemaking is not the time to be passive. The companies that will have the most difficulty with whatever CRUSH rule eventually emerges are the ones that didn't engage when there was an explicit invitation to do so. The ones that will find the navigable are the ones that helped shape them.

The DMEPOS moratorium itself has no comment period and no judicial review. ship has sailed. What's still open is the CRUSH RFI, the shape of a potential futu rule, and the specific regulatory approaches CMS adopts for each of the 13 topic areas. That's where the policy window is.

Stepping back, what Feb 25, 2026 represents is a pretty significant acceleration o trend that's been building for years. CMS has more enforcement tools, more data infrastructure, and a clear political mandate from this administration to use bot

aggressively. The DMEPOS moratorium is the bluntest tool in that kit – a hard enrollment stop for a category with a documented 17% revocation rate. The CRU initiative is the more systematic effort to upgrade the regulatory architecture acr the full program integrity stack. For health tech entrepreneurs and investors, th question isn't whether this is good or bad for the industry in the abstract. It's wh you're building something that helps the legitimate system work better, or some that depends on the gaps the system is about to close.

> The cookie jar is getting padlocked. Plan accordingly.

2 Likes • 1 Restack

Previous

Nex

Discussion about this post

Comments Restacks

Write a comment...