



March 30, 2026

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-6098-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

RE: Request for Information Related to Comprehensive Regulations to Uncover Suspicious Health Care

Thank you for the opportunity to comment on the Comprehensive Regulations to Uncover Suspicious Health Care (CRUSH) request for information (RFI). CAQH supports efforts to protect the integrity of Medicare, Medicaid, the Children's Health Insurance Program, and the Marketplace, and offers the below input to help address fraud, waste, and abuse.

CAQH is the trusted data connector at the core of healthcare. For more than 25 years, the organization has powered the industry with the largest and most complete healthcare data foundation in the U.S., with more than 4.8 million provider data records sourced directly from providers and member data on 75% of covered lives supplied by health plans. By improving how essential information flows across the system, CAQH helps healthcare operate more efficiently and with greater confidence.

CAQH maintains provider data used by health plans for credentialing, directory management, and other administrative functions, including Primary Source Verification (PSV) and Sanctions Monitoring, which help identify potential fraud, waste, and abuse risks by checking provider information against 500+ authoritative sources; PSV provides point-in-time checks of sources such as the National Practitioner Data Bank, the Social Security Administration's Death Master File, OIG's List of Excluded Individuals and Entities (LEIE), GSA's System for Award Management (SAM), and state Medicaid sanction and exclusion lists, while Sanctions Monitoring provides ongoing updates to identify new actions taken against a provider.

For ten years CAQH has earned the National Committee for Quality Assurance's Credentialing Certification (formerly NCQA's Credential Verification Organization Certification). Our credentialing verification work provides participating Medicare Advantage plans, Qualified Health plans, Medicaid Managed Care Organizations, and Commercial Health Plans the vital information they need to make an informed decision about including providers in their networks who may present a future risk of fraud, waste, and/or abuse.

With our experience as a certified credentialing verification organization, we focus our response exclusively on question C-01 regarding the Medicare preclusion list which is equally in support of crushing fraud and burden reduction.

C-01: What changes could CMS make to better effectuate the preclusion list to prevent Traditional Medicare-revoked providers and suppliers from continuing to bill MA plans?

The Medicare Preclusion List is a critical mechanism for CMS to report providers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs. However, currently access to the

list is restricted. The Preclusion List's FAQ¹ document states it is accessible to "Only CMS approved healthcare plans, with a valid Health Plan ID" Additionally, the FAQ Document states:

Healthcare plans may allocate up to 5 users' access to the Preclusion List. If the healthcare plan delegates their claims adjudication and credentialing activities to a subcontractor, Pharmacy Benefit Managers (PBMs) or delegated claims/credentialing entity, the plan will need to share the Preclusion List with them or may approve the entity to use some of their allocated slots. The plan's compliance officer will be required to confirm the entity's association to the plan.

Notwithstanding CMS' allowance for health plans to share access, current practice is that health plans generally do not share access because of the limited number of users per plan. Additionally, CMS states in its FAQ, "the Preclusion List will not be made available publicly [sic] because it contains Medicare revocation data. Historically, CMS has not made this data public."

The current access restrictions to the Preclusion List create a barrier that prevents credentialing organizations like CAQH from incorporating the data into its services. This restriction results in credential verification organizations providing health plans an incomplete report on a provider's history. It also leads to duplication and administrative waste in the health care system because health plans cannot fully delegate their credentialing due diligence to a credential verification organization. Even if a health plan shares their access to the Preclusion List, the same access cannot be used to credential a provider for a different health plan, which inhibits true efficiency in accessing data that is intended to protect taxpayer dollars. This is a significant contrast with the OIG LEIE and SAM databases, which are publicly available and also help protect taxpayer dollars.

CAQH recommends CMS consider expanding access to the Preclusion List to certified credential verification organizations who carry out credential verification activities on behalf of health plans to increase data transparency and availability, improve efficiency, and more readily identify providers who have been precluded from billing traditional Medicare.

CAQH greatly appreciates the opportunity to provide feedback on the CRUSH RFI. Should you have any questions or would like additional information, please feel free to contact me at KBallantine@CAQH.org or 202-870-3288.

Sincerely,

Kristen Ballantine
Vice President, Government & Public Affairs, CAQH

¹ [CMS. Preclusion List Frequently Asked Questions. March 21, 2025.](#)