

March 30, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6098-NC
P.O. Box 8013
Baltimore, MD 21244

Re: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH), CMS-6098-NC

Dear Administrator Oz:

I write on behalf of the Council for Affordable Health Coverage ([CAHC](#)) in response to the Centers for Medicare & Medicaid Services' Request for Information (RFI) regarding potential regulatory and programmatic changes that could strengthen federal health program integrity under the agency's Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative.¹

CAHC is a broad-based advocacy alliance dedicated to a singular mission: bringing down the cost of health care for all Americans. CAHC promotes policies that lower health costs through competition, transparency, informed consumers, and expanded choice. Because fraud, waste, and abuse increase public spending and ultimately raise costs for families, employers, and taxpayers, strengthening federal health program integrity is an essential component of improving affordability.

CMS is correct to pursue a more modern fraud prevention framework. As fraud schemes evolve - particularly those involving identity theft, automated application attacks, and sophisticated billing patterns - program integrity must shift from a reactive "pay-and-chase" model to a prevention-oriented system that stops improper payments before they occur.

CAHC believes CMS can achieve this goal through a strategy built on five pillars:

1. Preventing fraud at the front door of federal health programs
2. Strengthening Provider Enrollment Oversight and Use of Existing Authorities
3. Strengthening Managed Care Integrity and Outcomes-Based Oversight
4. Improving Data Analytics and Payment Accuracy
5. Addressing Structural Sources of Waste and Improving Payment Design

1. Centers for Medicare & Medicaid Services, *Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)*, Federal Register Document 2026-03968 (Feb. 27, 2026).

The recommendations below align with the CRUSH RFI's request for input regarding regulatory tools, program integrity authorities, and analytic capabilities that could strengthen CMS oversight.

Executive Summary

In 2024, federal health care programs spent more than \$1.9 trillion, with Medicaid alone accounting for roughly \$931 billion in combined federal and state spending.² Even relatively small improvements in program integrity can generate substantial taxpayer savings.

CAHC recommends that CMS adopt a prevention-focused framework aligned with five complementary pillars.

- First, strengthen front-door safeguards by enhancing identity verification, multi-factor authentication, protections against automated enrollment activity, and cross-state duplicate enrollment detection.
- Second, strengthen provider enrollment oversight and more fully use existing authorities - including moratoria, affiliation screening, payment suspensions, and risk-based revalidation - to prevent high-risk providers from entering or remaining in federal programs.
- Third, strengthen managed care integrity and program oversight by establishing clear plan-level expectations, standardizing referral processes, and improving encounter data validation and accountability.
- Fourth, modernize data analytics and payment accuracy by integrating identity, enrollment, ownership, encounter, and payment data, and by advancing clinically grounded payment approaches and oversight of risk-adjusted models.
- Fifth, address structural sources of waste and improve payment design by expanding value-based approaches, improving plan auto-assignment, aligning Medicaid financing incentives, and refining inpatient and outpatient payment systems.

Estimated Fiscal Impact of Key Program Integrity Reforms

While precise savings estimates depend on regulatory design and implementation, available evidence suggests that the reforms described in this letter could generate \$10 to 20 billion in annual savings for federal and state taxpayers. These estimates are directional but illustrate the substantial fiscal benefits of strengthening prevention-focused program integrity policies.

² Centers for Medicare & Medicaid Services, National Health Expenditure Data. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>

I. Preventing Fraud at the Front Door of Federal Health Programs

Strengthening enrollment safeguards represents one of the most effective opportunities to reduce fraud.

Public benefit programs increasingly rely on digital enrollment platforms. While these systems improve access and efficiency, they also create opportunities for fraudsters to exploit identity verification weaknesses using stolen or synthetic identities. Bad actors may use compromised personal information to enroll individuals who are not eligible for coverage or to establish accounts used to submit improper claims.

1. *Identity Verification:* CMS can reduce these risks by establishing clear expectations for identity verification within Medicaid eligibility systems. States should implement modern identity proofing standards and multi-factor authentication protections for enrollment systems and beneficiary portals. These safeguards should apply during both initial enrollment and high-risk account transactions such as address changes, financial account updates, or authorized representative changes.
2. *Bot Attacks:* Another emerging vulnerability involves automated attacks on eligibility systems. Fraudsters increasingly deploy bot networks to submit thousands of fraudulent applications simultaneously. Federal testimony has highlighted the growing scale of such attacks and the need to incorporate automated defenses into eligibility systems.

CMS should therefore encourage states to deploy automated fraud detection tools capable of identifying bot activity, monitoring suspicious device behavior, and preventing large-scale automated application attacks.

Recommendation: Consistent with existing authority, CMS can also increase reliance on electronic verification systems under 42 C.F.R. §§ 435.945 and 435.948 and Exchange verification requirements at 45 C.F.R. § 155.315. CMS should reduce reliance on self-attestation where electronic data is available, shorten inconsistency resolution timeframes for high-risk cases, and require escalation protocols when verification discrepancies persist.

By strengthening front-door safeguards, CMS can prevent fraudulent activity before improper payments occur, reducing program costs and protecting taxpayer resources.

II. Strengthening Provider Enrollment & Use of Existing Authorities

Provider enrollment is the gateway through which individuals and entities gain access to federal health programs. Once a fraudulent provider enters the system, improper billing can occur rapidly and at large scale.

Risk Based Screening: CMS should expand risk-based screening requirements for provider types historically associated with higher fraud risk. Enhanced screening tools including site visits, fingerprint-based background checks, and improved ownership disclosure can help

ensure that individuals with histories of fraud cannot re-enter federal health programs under new entities.

In Medicaid, CMS already requires states to screen providers by categorical risk level under 42 C.F.R. § 455.450, to conduct federal database checks under 42 C.F.R. § 455.436, and to revalidate enrollment at least every five years under 42 C.F.R. § 455.414. In Medicare, CMS also reserves the right to conduct onsite reviews under 42 C.F.R. § 424.517.

The HHS Office of Inspector General has repeatedly identified provider enrollment oversight as a critical component of Medicaid program integrity. Strengthening screening safeguards would therefore reduce the likelihood that fraudulent providers gain access to federal health programs.

Recommendation: CMS has authority to impose temporary enrollment moratoria under 42 C.F.R. § 424.570 (Medicare) and 42 C.F.R. § 455.470 (Medicaid/CHIP), consistent with section 1866(j)(7) of the Social Security Act. CMS should use these authorities more dynamically by conducting recurring, data-driven hotspot analyses by provider type and geography and applying time-limited moratoria where risk indicators are elevated.

Managed Care: CMS should also ensure that providers delivering services through Medicaid managed care plans are subject to the same enrollment and screening requirements as fee-for-service providers. Because most Medicaid beneficiaries receive services through managed care, consistent screening safeguards are essential.

Managed care plans often have the best visibility into suspicious provider billing patterns. However, OIG has found that some plans have made few or no referrals of suspected provider fraud. Establishing baseline expectations for investigative capabilities and referral protocols would strengthen fraud detection across managed care networks.

Recommendation: CMS also has authority to address undue-risk affiliations under 42 C.F.R. § 424.519, with enforcement through denial (42 C.F.R. § 424.530(a)(13)) or revocation (42 C.F.R. § 424.535(a)(19)). CMS should more routinely screen disclosed affiliations for links to excluded entities, prior payment suspensions, revoked billing privileges, or patterns of serial ownership changes.

III. Strengthening Managed Care Integrity and Outcomes-Based Oversight

Modern fraud detection increasingly depends on advanced data analytics that can identify suspicious billing patterns and utilization anomalies. Analytics are only as effective as the underlying data.

Managed Care Analytics: OIG has found that Medicaid managed care payment data reported to CMS are frequently incomplete or inaccurate, limiting oversight of managed care payments.

Clinical Context: Payment systems should better reflect the clinical context to reduce incentives for miscoding or fragmented billing. Clinically structured payment methodologies—particularly for outpatient services—can improve transparency, align reimbursement with resource use, and support more effective detection of anomalous billing patterns.

Greater use of clinically grounded validation approaches and comparative population analysis could improve oversight of coding practices and payment accuracy. As care continues to shift toward outpatient settings, payment systems should better account for visit-level complexity and relationships across services to improve both payment accuracy and program integrity.

AI: CMS should also encourage the use of advanced technologies, including artificial intelligence and machine learning, to support real-time monitoring of billing patterns, improve claim accuracy, and reduce avoidable administrative burden associated with denials and rework.

Recommendations: CMS should prioritize a layered analytical approach that connects identity, enrollment, ownership, encounter, and payment data. Key components include:

- Cross-program entity resolution to identify shared ownership, addresses, or control relationships;
- Network and graph analytics to detect clusters of related providers or billing entities;
- Predictive anomaly detection using peer comparisons and utilization shifts; and
- Cross-state identity and enrollment analytics leveraging existing verification data sources.

These approaches align with CMS's authority under the Medicare Integrity Program (42 U.S.C. § 1395ddd) and can be implemented across programs and contractors.

CMS should also continue to strengthen encounter data quality under 42 C.F.R. § 438.242, as analytics are only as reliable as the underlying data.

IV. Improving Data Analytics and Payment Accuracy

Because most Medicaid beneficiaries receive services through managed care, program integrity efforts must extend fully into plan operations. CMS already has significant authority under:

- 42 C.F.R. § 438.608 (fraud, waste, and abuse programs),
- 42 C.F.R. § 438.604 (ownership and overpayment reporting), and
- 42 C.F.R. § 438.242 (encounter data validation).

CMS should use these authorities to establish clearer operational expectations, including:

- Standardized fraud referral timelines and data requirements;
- Minimum investigative capabilities for plan special investigation units;
- Consistent reporting of overpayment recoveries; and
- Structured encounter-data anomaly review protocols tied to corrective actions.

CMS should also continue to evaluate risk-adjusted payment models, including Medicare Advantage, to ensure that coding intensity reflects clinically supported conditions and does not result in systematic overpayments.

The Medicare Advantage (MA) Star Ratings program could be strengthened by incorporating more outcomes-based measures—such as potentially avoidable hospital admissions, emergency department visits, complications, and readmissions. These measures provide a direct, claims-based view of quality and cost, enabling CMS to better identify waste and care gaps while aligning incentives with value-based care and overall program efficiency.

Expanding these approaches across Medicaid managed care, Medicare Advantage, and Marketplace programs would better align incentives with the total cost of care while reducing reliance on process-heavy reporting. State experience demonstrates that outcome-based approaches can reduce avoidable events and improve program efficiency when paired with appropriate financial incentives.

V. Addressing Structural Sources of Waste in Medicaid

Program integrity efforts should also address structural incentives that contribute to inefficient spending within Medicaid programs. Another opportunity involves improving incentives within Medicaid financing structures. Under the current federal matching system, federal payments increase as state spending rises. Evaluating alternative approaches that reward efficiency and value could strengthen fiscal accountability while preserving flexibility for states.

Auto-assignment: CMS should consider policies that improve the allocation of beneficiaries across managed care plans. A substantial share of Medicaid beneficiaries are automatically assigned to plans without considering plan performance. Research suggests that directing these beneficiaries toward higher-performing plans could reduce Medicaid spending by approximately one percent annually.³

Clinical Risk Groups: CMS should continue to evaluate payment design across inpatient and outpatient settings. Expanding the use of prospective, clinically grounded payment systems and improving how outpatient services are grouped and reimbursed could reduce administrative burden, improve transparency, and limit incentives for fragmented billing.

These structural reforms would complement traditional fraud prevention efforts by addressing incentives that contribute to wasteful spending.

Conclusion

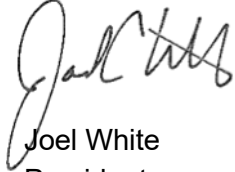
The CRUSH initiative represents an important opportunity to modernize program integrity policies across federal health programs. By strengthening front-end safeguards, improving provider enrollment oversight, enhancing managed care and program oversight, modernizing

³ One Percent Steps, *Improving Auto-Assignment in Medicaid Managed Care* (estimating that “smarter defaults would lower spending in Medicaid by approximately 1%,” equivalent to roughly \$3.7–\$9.2 billion annually), available at: <https://onepercentsteps.com/policy-briefs/improving-auto-assignment-in-medicaid-managed-care/>

analytics and payment accuracy, and addressing structural drivers of waste, CMS can significantly enhance its ability to protect taxpayer resources.

CAHC appreciates the opportunity to provide input on this RFI and looks forward to working with CMS to advance policies that improve program integrity, lower health care costs, and expand access to affordable coverage.

Sincerely,

A handwritten signature in black ink, appearing to read "Joel White". The signature is written in a cursive, flowing style with a large initial "J".

Joel White
President