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President and CEO

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Via electronic submission at http://www.regulations.gov

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information Related to Comprehensive Regulations to Uncover Suspicious Health Care (CRUSH) (CMS-6098-NC)

Dear Administrator Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to provide input on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding potential regulatory and programmatic changes to strengthen program integrity across Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Marketplace coverage. Strong oversight is essential to maintaining public trust in these programs and ensuring that federal resources are directed toward beneficiaries who depend on them.

Tax-paying hospitals share CMS's commitment to protecting the integrity of federal health care programs and ensuring that taxpayer resources are used appropriately to support patient care. Criminal actors who commit fraud and intentionally game these programs for their own financial benefit divert needed support away from consumers and the providers who serve them. Eliminating criminal actors from the Medicare and Medicaid programs is critical to supporting an efficient and durable health care system. Each year, policymakers make difficult decisions on allocation of increasingly sparse resources for those programs. Keeping those dollars in the health care system, and out of the coffers of fraudulent actors, is imperative.

Separate from intentional fraud, provider practices that are inconsistent with sound fiscal, business or medical practice may constitute abuse and waste in the system.[1] While hospitals are among the most regulated bodies in the United States, other health care suppliers are not subject to the same levels of careful oversight. FAH commends CMS for its focus on targeting programs with minimal barriers to entry and decentralized oversight.

Policies designed to address fraud, waste and abuse must be carefully targeted to ensure that enforcement efforts focus on the bad actors without creating unnecessary administrative burdens for legitimate providers or unintended barriers to patient access to care. Hospitals operate under extensive compliance and oversight requirements and play a central role in caring for Medicare, Medicaid and Marketplace beneficiaries. As CMS considers potential regulatory changes under the CRUSH initiative, it is important that program integrity policies reflect the operational realities of the health care delivery system.

FAH offers several overarching perspectives that we believe should guide CMS as it evaluates potential regulatory changes. FAH supports CMS's continued efforts to strengthen its ability to identify and prevent fraud across federal health care programs. Effective program integrity efforts are essential to protecting taxpayer dollars and maintaining the long-term sustainability of the Medicare, Medicaid, CHIP and Marketplace programs.

I. Program integrity efforts should focus on targeted, data-driven oversight

Hospitals operate within a robust oversight framework that includes provider enrollment screening, medical review, audits and extensive compliance obligations. As CMS evaluates potential regulatory changes, the Federation encourages the agency to prioritize targeted, data-driven approaches that focus oversight on areas of demonstrated risk while maintaining efficient and predictable program administration for providers that comply with program rules.

Program integrity policies are most effective when they leverage the agency's vast institutional knowledge of payment policy, coupled with advanced analytics, coordinated enforcement activities and modern data tools to identify high-risk billing patterns. These approaches allow CMS to focus enforcement resources on fraudulent actors while avoiding duplicative oversight requirements for providers delivering care in good faith.

Building on this approach, CMS should prioritize policies that improve payment accuracy across the program in a manner that lifts all providers, rather than targeting discrete areas in isolation. Leveraging its institutional expertise in payment policy, CMS should advance strategies that reduce administrative burden, enhance revenue cycle predictability and strengthen overall program integrity, while supporting timely access to care for patients.

II. Program integrity policies must reflect the operational realities of the health care delivery system

Hospitals operate in complex regulatory environments and frequently participate in multiple federal health care programs simultaneously. Policies designed to address fraud must therefore be implemented in ways that recognize the operational realities of hospital systems and the importance of maintaining stable health care delivery infrastructure.

FAH encourages CMS to ensure that new program integrity requirements do not inadvertently disrupt legitimate provider operations or discourage participation in federal health care programs. Hospitals serve diverse patient populations and often rely on integrated clinical and financial structures that support patient access to care.

For example, hospitals may participate in a variety of ownership structures, joint ventures and investment arrangements that support innovation, infrastructure development and expanded patient services. This diversity helps maintain patient access to critical hospital care by facilitating solutions that keep hospitals and hospital service lines open despite difficult market circumstances. Policies affecting ownership disclosure, identity verification or enrollment processes should therefore be carefully evaluated to avoid unintended consequences for legitimate provider organizations, including by tailoring requirements for those select provider types where evidence demonstrates particularized risks.

III. Program integrity efforts should preserve beneficiary access to care

Hospitals serve as the backbone of the nation's health care delivery system and play a critical role in ensuring access to care for Medicare, Medicaid, CHIP and Marketplace beneficiaries. Program integrity policies should therefore be designed in ways that maintain patient access while addressing fraudulent behavior.

Policies that inadvertently restrict provider participation in federal programs or impose operational barriers to care delivery may ultimately harm beneficiaries. As CMS evaluates potential program integrity enhancements, it is important to consider how regulatory changes may affect patient access, care coordination and provider participation. Several issues raised in the RFI highlight the need to carefully balance program integrity objectives with access to care considerations.

Maintaining Established Medicare Claims Filing Timelines Supports Accurate Billing and Program Integrity

Timely claims submission is an important objective for both payers and providers, and CMS has long established clear expectations for claims filing in federal health care programs. In accordance with the statutory claims deadlines established by Congress, providers must submit claims within one calendar year of the date of service,[2] except where CMS has recognized an exception lengthening the timely filing period (e.g., in cases of error or misrepresentation by a MAC). CMS guidance further explains that this one-year filing limit is intended to ensure that claims are submitted within a reasonable period while recognizing the time necessary for providers to complete documentation, coding, and billing processes.

As described in the Medicare Claims Processing Manual, Chapter 1, §70, the one-year timely filing requirement balances the need for program integrity and efficient claims administration with the operational realities of health care billing. This framework is particularly important for hospital claims, which often involve complex services, multiple

departments, and extensive medical record documentation requirements that must be completed before claims can be accurately submitted. In addition, hospitals' billing practices may require extra time to accommodate coordination of benefits and to navigate multiple payor enrollment databases that often do not provide accurate and up-to-date eligibility information. **Maintaining clear and consistent federal timelines for claims submission helps ensure that hospitals are able to submit complete and accurate claims while supporting the efficient administration of the Medicare program.** Congress has struck the appropriate balance when adopting a timely filing deadline of one calendar year for Part A and Part B claims while permitting CMS to address exceptional circumstances that necessitate a later claim submission deadline.

Fraud Enforcement Authority Should Remain with CMS, with MA Plans Continuing a Referral Role

CMS should retain primary authority for fraud enforcement actions, with MA plans continuing to serve an important referral role. As discussed earlier in this letter, federal law draws important distinctions between fraud, waste and abuse and reserves the most significant enforcement authorities—such as payment suspension—for circumstances involving credible allegations of fraud. These authorities have historically been exercised by CMS and its designated program integrity contractors under clearly defined regulatory safeguards, reflecting a deliberate policy structure in which determinations involving potential fraud are evaluated within a consistent federal framework.

MA organizations already play a meaningful role in supporting program integrity. Plans are required to maintain compliance programs, monitor claims activity and report suspected fraud, waste and abuse to CMS and appropriate authorities. These responsibilities appropriately position MA plans as partners in identifying potential concerns while preserving CMS's responsibility for evaluating allegations and determining whether enforcement actions are warranted.

Granting MA plans independent authority to identify providers for payment suspension or similar fraud-related actions would represent a significant shift in the existing framework. Unlike CMS or its program integrity contractors, MA plans operate within negotiated contractual relationships with providers and administer claims through a range of commercial payment management tools, including utilization management, claims review, downcoding of claims and payment denial processes. Providers have increasingly reported that these mechanisms, as well as continuously changing rules in Provider Manuals, can result in delays, denials and significant administrative burden. Expanding MA authority into areas traditionally reserved for federal fraud enforcement risks further blurring the line between government program integrity determinations and commercial claims management practices.

Maintaining CMS's central role in determining when fraud-related enforcement actions are appropriate also helps ensure that these decisions remain independent of the contractual dynamics that can exist between plans and providers. MA plans may simultaneously be engaged in network negotiations, payment disputes or other contractual matters with providers while administering claims and utilization management processes. Preserving CMS's role as the entity responsible for evaluating allegations and determining appropriate enforcement actions helps ensure consistency in program integrity oversight and avoids introducing potential conflicts into the fraud determination process.

For these reasons, FAH encourages CMS to continue leveraging MA plans as partners in identifying and reporting potential fraud, waste and abuse while maintaining CMS's responsibility for evaluating allegations and determining whether enforcement actions, which may include a provider's placement on the preclusion list, are appropriate. FAH appreciates the tremendous effort taken to publish the most recent Revoked Medicare Providers and Suppliers data set in its transparency efforts.[3]

IV. Technology and advanced analytics can strengthen program integrity efforts

FAH appreciates CMS's interest in exploring the use of advanced technologies, including artificial intelligence, to improve program integrity oversight and administrative efficiency. Taxpaying hospitals are embracing emerging technologies to support coding accuracy, compliance monitoring and medical record review. These tools have the potential to improve efficiency and help identify potential billing issues earlier in the claims process.

At the same time, it is important that any technology-driven oversight tools used by CMS are implemented thoughtfully and incorporate appropriate safeguards to ensure accuracy, transparency and accountability. Oversight systems that rely on automated technologies should maintain appropriate "human in the loop" review and clearly communicate expectations to providers. We also note the critical importance of a federal regulatory framework for AI that would preempt an increasingly difficult to navigate patchwork of state regulations, and we urge the Administration's leadership in ensuring such a federal framework. FAH recommendations to address these AI principles and achieve these critical

goals are detailed in our comments to HHS in response to its *Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care Request for Information* issued on December 23, 2025.

Experience with earlier program integrity initiatives illustrates the importance of careful program design and oversight. For example, the implementation of the Medicare Recovery Audit Contractor (RAC) program in the early 2000s relied on contingency-based contractors charged with identifying improper payments. At the time, many were using algorithms to identify what were believed to be improper payments. While improving payment accuracy was an appropriate goal, early program experience demonstrated challenges when audit activities were not sufficiently grounded in the complexities of Medicare payment and coverage policy. This resulted in large volumes of recoupments that were frequently overturned on appeal, creating significant administrative burden and financial uncertainty for hospitals and other providers, including inpatient rehabilitation facilities.

The volume of appeals associated with these reviews also contributed to substantial case backlogs for the Office of Medicare Hearings and Appeals, placing additional strain on the Medicare appeals system. CMS subsequently implemented a number of reforms to strengthen program oversight, including reducing reliance on contingency-based payment structures, limiting the number of medical records contractors may request, requiring clinical reviewers with appropriate specialty expertise, and requiring CMS review and public posting of approved audit target areas before contractors may proceed. These refinements illustrate the importance of ensuring that program integrity initiatives incorporate appropriate safeguards and policy expertise to avoid unintended disruptions to providers delivering care in good faith.

More recently, experience with the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration further illustrates the importance of ensuring that program integrity initiatives are appropriately targeted and proportionate to the risks identified. The demonstration requires IRFs in participating states to undergo extensive medical review processes, including review of 100 percent of claims through pre-claim or post-payment review options. Available data from the program has shown very high affirmation and compliance rates, while providing limited evidence of widespread fraud or abuse within the IRF benefit. At the same time, providers have reported substantial operational burden associated with repeated documentation submissions, communications with contractors and related appeals processes, diverting clinical and administrative resources away from patient care. This experience underscores the importance of focusing program integrity initiatives on areas of demonstrated program risk and ensuring that oversight approaches do not impose broad administrative requirements where compliance rates are already high.

V. Federal and state collaboration is essential to strengthening Medicaid program integrity

Medicaid operates as a federal-state partnership and hospitals play an essential role in delivering care to Medicaid beneficiaries across the country. FAH supports strong program integrity efforts in Medicaid and CHIP and recognizes the importance of ensuring that federal and state resources are used appropriately.

At the same time, program integrity policies affecting Medicaid must recognize the complexity of state program structures and financing mechanisms. States properly forge tailored solutions to local issues and innovate in program design using Medicaid program flexibilities and waivers, allowing Medicaid programs to evolve and maintain stability within the framework of the federal-state partnership. Hospitals frequently work closely with states to deliver care to vulnerable populations and rely on stable program financing structures to maintain access to services. Medicaid program integrity initiatives, therefore, need to be flexible enough to respect the “cooperative federalism” and shared responsibility that is the foundation of the Medicaid program. Such initiatives should prioritize consistency and stability in the program so that hospital and other essential services remain available and accessible to Medicaid beneficiaries.

Federal and state policymakers have taken meaningful steps in recent years to strengthen oversight, transparency, and accountability across Medicaid supplemental payments and financing arrangements, including provider taxes, intergovernmental transfers, Disproportionate Share Hospital (DSH) payments, state directed payments, upper payment limits (UPLs), and section 1115 waiver program payments. These financing tools are critically important and longstanding features of the Medicaid program and allow states to address gaps between base Medicaid payment rates and the cost of delivering care to beneficiaries. Importantly, Congress and the Centers for Medicare & Medicaid Services (CMS) have implemented several reforms designed to increase federal visibility into these arrangements while preserving the flexibility states rely upon to support access to care. Policies that inadvertently disrupt established Medicaid financing structures risk destabilizing hospital funding and, in turn, access to care, particularly in rural and underserved communities.

Congress has reinforced transparency through the Consolidated Appropriations Act, 2021, which added section 1903(bb) to the Social Security Act and requires CMS to establish a reporting system for states to submit detailed annual information on Medicaid supplemental payments. Under this provision, states must report supplemental payment expenditures and provide narrative descriptions explaining the purpose of the payments, the providers eligible to receive them, and the methodology used to calculate and distribute funds. The statute also requires states to describe how these payments promote efficiency, economy, quality of care, and access to services for Medicaid beneficiaries consistent with section 1902(a)(30)(A) of the Social Security Act.[4]

CMS has implemented these statutory requirements through expanded reporting systems, including the Medicaid Budget and Expenditure System (MBES) which collects supplemental payment data and narrative information from states. These reporting processes significantly expand federal visibility into supplemental payment arrangements across states and supplement existing oversight mechanisms such as state plan amendment review, upper payment limit demonstrations, and demonstration waiver oversight. As CMS continues to expand reporting requirements, it should also consider opportunities to streamline and align existing data collection processes to avoid duplicative reporting and unnecessary administrative burden on states and providers.

Similarly, Medicaid DSH payments operate under detailed statutory and regulatory limits designed to ensure accountability and appropriate targeting of payments. Section 1923 of the Social Security Act establishes hospital-specific limits that restrict DSH payments to each hospital's uncompensated care costs and requires states to develop CMS-approved DSH methodologies. Federal law also requires annual independent DSH audits and reporting, which states must submit to CMS to verify compliance with hospital-specific limits and other statutory requirements.[5]

CMS has strengthened oversight of supplemental payments and state directed payments through structured review processes and expanded reporting requirements. State directed payments in Medicaid managed care must undergo federal review and approval under 42 C.F.R. §438.6(c), which requires states to submit detailed preprints describing the payment methodology, financing sources, and program goals associated with each arrangement. As part of this process, CMS conducts extensive review prior to approval and has taken additional steps to improve transparency by publicly posting approved state directed payment preprints on its website, allowing policymakers and stakeholders to review these arrangements and CMS approvals.[6] **CMS should consider further actions to deepen oversight and transparency of supplemental payments by posting the additional supporting materials (including state directed payment financial models and any provider tax broad-based and uniform waivers) associated with preprint approvals. Further, many states, including Arizona and Texas, have provided all of their relevant information on websites for the public to review, and we would encourage CMS to encourage other states to do the same.**

In addition, CMS finalized in the 2024 Managed Care Final Rule a Biden Administration policy requiring states to phase out the use of separate payment terms for state directed payments beginning in 2027. This approach conflicts with the Trump Administration's stated goals of strengthening transparency, accountability, and program integrity in Medicaid financing.

Separate payment terms have long served as a clear and effective mechanism to track SDP funding, ensure payments are directed to providers serving vulnerable populations, and provide transparent documentation of how funds are structured and delivered. Actuaries have long recommended that states use separate payment terms to ensure that SDPs are being used for their intended purpose, and as a result, 87% of SDP spending was made through separate payment terms in 2024.[7] Eliminating this tool will reduce visibility, weaken traceability and auditability of payment flows, increase administrative complexity, and undermine oversight at a time when enhanced program integrity is a priority. In addition to restoring the option to use separate payment terms, CMS should require that SDPs made through capitation rate adjustments or other methods be separately identified on the electronic remittance advice (ERA), *i.e.*, the Medicaid 835 file, to allow for more accurate and concurrent tracking of SDP amounts during the rate period by providers. Similarly, CMS should clarify that when actuarially sound capitated rates are established by state agencies that initially comply with the applicable OBBBA state-directed payment ceiling amount, such rates will not be subject to a non-compliance determination based on actual utilization for the applicable rate period. **FAH encourages CMS to revisit this policy and preserve—or at a minimum delay—the phase-out to better align with broader program integrity objectives.**

Taken together, these statutory requirements, enhanced reporting systems, and CMS transparency initiatives reflect a sustained effort by Congress and CMS to strengthen oversight of Medicaid financing arrangements and supplemental payments. Public reporting of state directed payment approvals, expanded supplemental payment reporting under the Consolidated Appropriations Act, and longstanding statutory guardrails governing provider taxes and DSH payments

collectively provide policymakers with substantial visibility into these programs while maintaining the flexibility states rely upon to ensure Medicaid beneficiaries maintain access to hospital care and other essential health care services. Collectively, these mechanisms already provide CMS with substantial oversight and transparency into Medicaid financing arrangements. Any additional policy changes should build on this framework and be narrowly targeted to identified risks.

As CMS evaluates potential regulatory changes, FAH encourages the agency to pursue collaborative approaches that strengthen program integrity while preserving the stability of Medicaid programs and ensuring continued patient access to care.

VI. Program Integrity Standards of Conduct and Consumer Protection in the Marketplaces Will Help Ensure Appropriate Enrollments

FAH supports decisive action with respect to agents, brokers, and web-brokers that improperly enroll consumers through the Marketplaces and appreciates HHS' commitment to holding non-compliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers. Noncompliant agents, brokers, and web-brokers earn commissions through improper and fraudulent enrollments at the cost of surprise tax liabilities for consumers and inflated federal health care spending. FAH believes that robust enforcement of program integrity rules and requirements with respect to agents, brokers, and web-brokers is the single most important measure that HHS can take to address its concerns with respect to improper enrollments and fraud without unwittingly creating barriers to proper enrollments that are critical to maintaining the stability of the Marketplace risk pool.

We support measures that focus on: requirements related to consumer consent documentation; prohibitions on certain potentially misleading marketing activities; imposing civil monetary penalties on non-compliant agents and brokers while taking appropriate action to suspend and terminate non-compliant brokers and agents. In addition, program integrity measures also could include rigorous vetting requirements for those agents or brokers authorized to handle Marketplace enrollments.

FAH continues to support the adoption of program integrity measures focused on agents, brokers and web-brokers as the most effective way to address the root cause of improper enrollments without the need for Marketplace verification requirements and their attendant administrative costs, access barriers, and adverse risk pool impacts. FAH continues to encourage implementation of these measures before determining whether additional Marketplace-wide verification measures are necessary or appropriate.

VII. Conclusion

FAH appreciates CMS's continued commitment to protecting the integrity of federal health care programs and welcomes the opportunity to provide input as the agency evaluates potential regulatory changes under the CRUSH initiative. Hospitals share CMS's goal of ensuring that fraud, waste and abuse are effectively identified and addressed.

As CMS considers future regulatory proposals, FAH encourages the agency to focus on targeted, evidence-based policies that strengthen program integrity while preserving access to care and minimizing unnecessary administrative burden for legitimate providers. FAH looks forward to continued engagement with CMS on these important issues. If you have any questions, please contact Alyssa Keefe, SVP, Head of Policy at akeefe@fah.org.

Sincerely,
/s/
Charlene MacDonald
President and CEO

Endnotes

[1] 42 C.F.R. § 455.2
[2] Sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act; 42 C.F.R. §424.44
[3] https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/revoked-medicare-providers-and-suppliers, Accessed March 24, 2026.
[4] See Consolidated Appropriations Act, 2021, § 202, Pub. L. 116-260, adding SSA §1903(bb); see also CMS, Medicaid Supplemental Payment Reporting, available at: https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes/medicaid-supplemental-payment-expenditure-reporting.
[5] 42 U.S.C. §1396r-4; 42 C.F.R. §447.299
[6] See CMS, Approved State Directed Payment Preprints, available at: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.
[7] Medicaid and CHIP Payment and Access Commission (MACPAC). Directed Payments in Medicaid Managed Care. October 2024. https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/. Accessed March 24, 2026