March 30, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Centers for Medicare & Medicaid Services Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098-NC)

Dear Dr. Oz:

For over 55 years, the National Health Law Program (NHeLP) has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations. We appreciate the opportunity to comment on the request for information regarding the Administration's "Comprehensive Regulations to Uncover Suspicious Healthcare" initiative.[1]

We encourage the Centers for Medicare & Medicaid Services (CMS) to work collaboratively with states, and it has done historically, and to rely on targeted oversight strategies that do not undermine access to care for Medicaid enrollees.

At this time, we are limiting our comments to Sections A, K and M.

Section A: Modifications to Program Integrity Requirements

Question: "Are there existing requirements or policies, including those issued through regulations,

memoranda, administrative orders, subregulatory guidance documents, or policy statements that could be altered to increase CMS' ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace®?"

Millions of consumers are dropping or downgrading coverage due to the expiration of enhanced premium tax credits and eligibility cuts under H.R. 1. Without access to affordable comprehensive coverage, many people may consider products like short-term, limited duration insurance (STLDI), despite its well-documented risks.[2] HHS should resume individual market enforcement of rules aimed at helping consumers to distinguish between STLDI and comprehensive coverage.[3] HHS should also finalize a five-year-old proposed rule related to the financial relationships between STLDI issuers and agents and brokers.[4] Insight into these compensation arrangements should be a necessary precursor to any future HHS action on STLDI.

Section K: Medicaid and CHIP

Question: "Is there any way that CMS should better leverage or expand its statutory or regulatory programs integrity oversight?"

Many of the Medicaid services that CMS is targeting in its actions in Minnesota, as well as many of the services that CMS has flagged for investigation in New York, Maine, California, and Florida, are Medicaid "Home- and Community-Based Services" (HCBS). HCBS is a program or group of services that is essential to the health and safety of low-income older adults and people with disabilities. HCBS programs vary by state, and may include services such as personal care assistance to help individuals with functional limitations perform daily activities like bathing, dressing, eating, and mobility; transition services to help people leave institutional settings and establish community-based living; employment supports;

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[1] 91 Fed. Reg. 9803–06 (Feb. 27, 2026).

[2] *See, e.g.,* Internal Revenue Service (IRS), Employee Benefits Security Administration (EBSA), and HHS, *Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage*, 89 Fed. Reg. 23338, 23396-23397 (April 3, 2024); National Association of Insurance Commissioners, *Short-Term Limited-Duration Health Plans* (Updated Feb. 1, 2023), https://content.naic.org/cipr-topics/short-term-limited-duration-health-plans.

[3] Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury Regarding Short-Term, Limited-Duration Insurance (Aug. 7, 2025), https://www.cms.gov/files/document/statement-regarding-short-term-limited-duration-insurance.pdf.

[4] Office of Personnel Management, IRS, EBSA, and HHS, *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement; Proposed Rules*, 86 Fed. Reg 51730, 51740-51744 (Sept. 16, 2021).

intensive community-based mental health services; transportation support; and habilitation services–just to name a few.

HCBS allow millions of people to live independently, avoid unnecessary and costly institutionalization, and remain connected to their families and communities. Today, 9.7 million people rely on Medicaid for Long-Term Services and Supports (LTSS), with approximately 8.4 million of those individuals receiving support outside of an institutional setting.[5] States have spent decades rebalancing their Medicaid LTSS programs to serve more people with HCBS to help people live independently, but also to save money. The 1.5 million people in institutional settings, or approximately 15% of the population receiving LTSS, is associated with 36% of total LTSS costs.[6] Most people with disabilities and older adults who need care do not have an alternative insurance option to access community-based supports, since Medicare has a very limited home care and skilled nursing facility benefit, most private health insurance options do not cover long-term care, and private long-term care insurance is prohibitively expensive with high denial rates. Thus, Medicaid plays an especially critical role in this landscape as the nation's largest, and often sole, payer of LTSS for low-income older adults and people with disabilities. As the aging population grows and disability needs remain high, strengthening HCBS is one of the most effective ways to promote autonomy and dignity while ensuring that long-term care remains both accessible and sustainable.

NHeLP is deeply concerned about CMS's recent actions. When funding for services is wholesale withheld or deferred, as it has been in Minnesota, Medicaid enrollees are ultimately harmed, not protected.[7] For many types of HCBS, finding a provider can be very difficult, time-consuming, and frustrating. The consequences of not having services are often devastating, leading to potential harm to health, loss of housing, institutionalization, or even death. Broad restrictions on funding services risk cutting off access to essential services for populations who already face significant barriers to care. CMS should instead rely on targeted, data-driven oversight strategies that identify misuse without undermining the health and stability of those who rely on Medicaid. When oversight efforts focus primarily on enrollees rather than on the complex financial practices of large corporate

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[5] Alexandra Carpenter *et al.*, Mathematica, *Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures*, 2023 (October 17, 2025) https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf.

[6] *Id.* at 3.

[7] See *Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act*, 91 Fed. Reg. 1539 (Jan. 14, 2026); See Letter from Dorothy Ferguson, Dir., Div. of Fin. Operations W., Ctr. for Medicaid & CHIP Servs., to John Connolly, State Medicaid Dir., Minn. Dep't of Hum. Servs., (Feb. 25, 2026), https://www.documentcloud.org/documents/27420090-cms-medicaiddeferral-letter-q4-2025/).

providers, enrollees bear the brunt of the harm. Even when enrollees are not the focus, care must be taken to ensure that enrollees are not collaterally harmed by enforcement actions, by ensuring enrollees can continue to receive needed services. Effective oversight must therefore prioritize corporate accountability and financial transparency to ensure that public funds are used to support the care and independence of older adults and people with disabilities, and that crucial programs like Medicaid HCBS remain available.

> **Question: "How can CMS better prevent, identify, and address Medicaid and CHIP fraud, waste, and abuse in the context of individuals who do not have satisfactory immigration status for full Medicaid or CHIP benefits who are accessing services inappropriately?"**

We do not believe that CMS needs to take additional steps to prevent, identify, or address fraud regarding individuals' immigration status. Per statute, citizenship and immigration status are already subject to stringent verification requirements, requiring that an individual's status is confirmed by the Department of Homeland Security – either through real-time verification via SAVE or through additional manual verification. There is no evidence to suggest that these existing procedures are inadequate or that fraud regarding immigration status is occurring on any meaningful scale. In our experience, the more common problem is that individuals who *do* have satisfactory immigration status are incorrectly found ineligible — because of data limitations in SAVE and/or the complexity of programming immigrant eligibility rules into state eligibility systems. CMS should focus its resources on ensuring that eligible individuals have access to the coverage to which they are entitled.

> **Question: "How can CMS help states to better prevent, identify, and address Medicaid and CHIP fraud, waste, and abuse related to service areas that have been identified has high risk for fraud in certain states, such as the following: housing stabilization services; behavioral health services; personal care assistance (PCA) services; nonemergency medical transportation?"**

Identifying any specific HCBS service as "high risk" can be complex. Increased enrollment in a particular program, increased spending on HCBS, or an increased number of direct care workers alone or in combination are not necessarily indicative of issues with program integrity. HCBS spending has increased across the country as a direct result of decades of work by families, people with disabilities, and older adults who want to live, work, and age with dignity in their own homes and communities, alongside bipartisan federal and state efforts to rebalance funding to HCBS from institutional care. Furthermore, these are services that we expect to grow, as the United States undergoes profound demographic changes. More than 10,000 people daily are turning 65 while an estimated one in four

adults have a disability.[8] Simply put, more people are enrolled in Medicaid HCBS and fewer people are relying on expensive institutional care.

To the extent any service in specific states and localities are identified as "high risk," the appropriate response is not to preemptively cut off federal funding, but rather to collaborate with stakeholders, protect access to services, and address individual issues surgically rather than take actions that destabilize the program at large.

Question: "What are the best practices for integrating artificial intelligence with existing technologies to maximize effectiveness?"

NHeLP has a long history of advocacy regarding the use of automated decision-making systems (ADS), including algorithms and other forms of artificial intelligence (AI) to determine health care eligibility and services.[9] We are particularly familiar with how the lack of transparency and accountability of many ADS impacts individuals' ability to understand and fight care denials or reductions. We have also seen how poor transparency in the ADS development and implementation process obscures opportunities for evaluation of errors or bias in these systems. And we have seen repeated instances of harm from ADS to individuals who do not understand that ADS has been used or how to seek remedy for that harm. In many ways, AI greatly increases the speed and scale of harm that can occur from errors, mistaken policies, or unintended bias that previously would have been caught and remedied before extensive harm occurred. Our long advocacy history with these systems supports our position that there must be protections for people throughout every step of the process that reflects the magnitude of potential harm.

AI is only effective if there is recognition in the implementation process of its limits and biases and transparency around those limits and biases to all relevant stakeholders. There must also be strict adherence to existing protections and guardrails regarding the rights of those affected by the use of AI. This includes ensuring that people know when AI is being used and are provided with the option and a clear process to request an exception or individual review of determinations related to benefits and coverage that are made by AI. Including a "human in the loop" is an insufficient protection against bias and harm.[10] Last, key to maximizing the effectiveness of AI is close monitoring and timely public reporting.

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[8] Centers for Disease Control and Prevention, *Disability Impacts All of Us Infographic*, https://www.cdc.gov/disability-and-health/articles-documents/disability-impacts-all-of-us-infographic.html (last visited Mar. 24, 2026).

[9] *See generally* Nat'l Health Law Program, *Fairness in Automated Decision-Making Systems*, https://healthlaw.org/algorithms/; Elizabeth Edwards & David Machledt, Nat'l Health Law Program, *Principles for Fairer, More Responsive Automated Decision-Making Systems* (May 15, 2023), https://healthlaw.org/resource/principles-for-fairer-more-responsive-automated-decision-making-systems/.

[10] Hannah Quay-de la Vallee & Kevin De Liban, Ctr. for Democracy & Tech. & Benefits Tech Advocacy Hub, *Rethinking the Loop: Encircling Public Benefits AI with Human Oversight*

Section M: Federally Facilitated Exchange (FFE) and Sate-Based Exchanges

Question: "How could CMS strengthen program integrity, including fraud prevention and consumer protection, in both the FFE and SBEs by—(1) better leveraging existing regulatory oversight authority; and (2) identifying areas where additional regulatory authority may be needed?"

HHS should withdraw recent proposals that would impose onerous pre-verification requirements on individuals without evidence that such barriers improve program integrity.[11] Research shows that this kind of red tape reduces enrollment, weakens the individual market risk pool, and increases costs for consumers, regulators, and providers.[12] Instead of targeting individuals, HHS should strengthen its oversight of agents and brokers, including adopting policies that have proven successful in State Based Exchanges (SBEs) and withdrawing a proposal to allow private web-brokers to take over consumer-facing enrollment.[13] Finally, HHS should restore Navigator funding to ensure that consumers have access to qualified, unbiased enrollment assistance.[14]

(Sept. 25, 2025), https://cdt.org/insights/rethinking-the-loop-encircling-public-benefits-ai-with-human-oversight-cdt-btah/.

[11] HHS, Patient Protection and Affordable Care Act, *HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*, 91 Fed. Reg. 6292, 6343-6349 (Feb. 11, 2026) (hereinafter "2027 NBPP"); note that policies related to income pre-verification are similar to those already stayed by a federal court in *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123 (D. Md. 2025).

[12] HHS estimates that current income verification proposals would trigger 3.3 million new data matching incidents (DMIs) and 488,000 disenrollments, with annual costs of over $83 million to consumers, $75 million to SBEs, and $122 million to the Federally Facilitated Exchange (FFE). *See* 2027 NBPP at 6451. An independent analysis found that the same proposals would trigger 4.7 million DMIs and over 3 million disenrollments. *See* Zachary Sherman *et al.*, Health Management Associates, *2027 Proposed NBPP: Analyzing State and Consumer Impacts New and Returned Trump Administration Policy Priorities* at 14 https://www.healthmanagement.com/wp-content/uploads/2027-Proposed-NBPP-Analyzing-State-and-Consumer-Impacts.pdf.

[13] For example, while the FFE allows brokers to enroll consumers directly through Enhanced Direct Enrollment, most SBEs require agents and brokers to use centralized enrollment platforms and Massachusetts Health Connection prohibits broker-assisted individual enrollment entirely, while the FFE allows web-brokers to enroll consumers directly through Enhanced Direct Enrollment. Covered California requires consumers to affirmatively delegate authority to enrollment partners before any application changes, preventing unauthorized plan switching. *See* 2027 NBPP at 6330-6332

[14] Kaya Pestaina, KFF, A 90% Cut to the ACA Navigator Program (Feb. 14, 2025), https://www.kff.org/quick-take/a-90-cut-to-the-aca-navigator-program.

Conclusion

Thank you for the opportunity to provide a response to this Request for Information. If you have any questions or concerns, please feel free to contact Jennifer Lav at lav@healthlaw.org.

Sincerely,

Jennifer Lav
Director, Disability Practice Area