March 30, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244
Submitted electronically via regulations.gov

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

Dear Administrator Oz,

Thank you for the opportunity to submit feedback on the CRUSH RFI.

LeadingAge represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.

LeadingAge supports CMS' ongoing efforts to strengthen program integrity and believes that fraud, waste, and abuse can be effectively prevented and addressed while not overburdening legitimate providers furnishing critical services. As CMS continues to refine its oversight strategies, we encourage the agency to be as strategic as possible to adopt measures that are analytically rigorous, operationally feasible, and take a targeted risk-based approach consistent with CMS's statutory authorities. Our aging services provider members are deeply concerned about the instances of fraud in their communities. Our provider members are also deeply concerned about the reputational harm to services critically important to beneficiaries. CMS' program integrity efforts must simultaneously root out bad actors while protecting access to legitimate providers. We urge CMS to

balance the clear need for additional oversight with the impact of program integrity efforts, including messaging, on legitimate providers and those they serve.

A prime example relates to home and community based (HCBS) services in Medicaid. Categorizing HCBS services as "high risk" based solely on metrics like increased enrollment and increased billing is misleading. Increased enrollment in a particular program, increased spending on HCBS, or an increased number of direct care workers alone or in combination may be reflective of trends that have nothing to do with program integrity. HCBS spending has been increasing 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 residential care. Simply put, more people are enrolled in Medicaid HCBS and fewer people are relying on residential care; this is often the preference and choice of the person receiving services.

LeadingAge represents and strongly believes in the role of the full continuum of aging services. Residential care like nursing homes and assisted living are critical options alongside a robust HCBS program. We need more well-staffed and well-funded options across the continuum.

Please note, LeadingAge has recently sent two letters with partners, one in December 2025 and one in March 2026, on actions that CMS can take regarding fraud in Medicare hospice and home health. Our hospice and home health members understand that the fraud in their benefits is real and applaud CMS for its work to date. We once again emphasize the need for CMS' approach to balance targeting the true fraud that is occurring in some geographies in home health and hospice with the potential for burden on legitimate providers and the ongoing reputational harm of constant conversation about fraud.

Key Themes

No one solution is going to capture all bad actors. CMS needs to use a variety of tools and track both how they are working in terms of preventing fraud and abuse, but also the impact they are having on access and quality providers. A solution is not effective if it chills the interest of providers from entering a market where there is genuine need or if it causes existing quality providers in that space enough extra burden that they may cease operations. We also recommend that CMS consider carefully which tools should be permanent solutions versus which are temporary measures used to help stem the tide of bad behavior while more lasting solutions are developed.

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Transparency: LeadingAge asks that CMS and its contractors be as transparent as possible in their approach to combatting fraud, waste, and abuse. We highlight below examples with the current audit process, revalidation, and the current implementation of the provisional period of enhanced oversight (PPEO) for hospice organizations that lack transparency. Lack of transparency for providers who want to cooperate diminishes the effectiveness of interventions.

Involve providers in assessing risk: We recommend that CMS establish a Home Health and Hospice Program Integrity Workgroup, with involvement from the industry (including providers), CMS, and contractor staff, to establish a comprehensive set of indicators that paint a more complete picture of program risk. This workgroup could also help to identify new and emerging risk factors earlier, identify operational barriers to oversight, and help to align program integrity modernization efforts with provider capabilities. A more sophisticated risk-stratified framework would focus oversight on providers with objectively elevated risk while reducing unnecessary administrative burdens for compliant agencies. Ensuring that program integrity efforts are targeted is critically important. We applaud this Administration for focusing on regulatory burden reduction. We want to support you in achieving both your goals of crushing fraud and reducing burden so that good actors can continue to provide high-quality care and bad actors are prevented from entering the Medicare program or quickly removed.

This recommendation would also extend to Medicaid – if there is a focus on home and community based services (HCBS) in a certain state, CMS should form a program integrity working group with providers from that state along with federal and state representatives and advocates to ensure that access and oversight are balanced in a risk-stratified framework that leans on existing structures.

Technology: Technology, including artificial intelligence (AI), is undoubtedly a tool that can help better target efforts to reduce fraud, waste and abuse. LeadingAge emphasizes through this RFI that technology still needs knowledgeable human oversight, including boots on the ground activity, and transparency into the role that AI is playing in these efforts.

State-Federal Partnership: CMS must work closely with states on program integrity. In some areas, this partnership already exists -- Medicaid fraud programs involve a coordinated effort between federal and state agencies, primarily the Department of Health and Human Services (HHS), its Office of Inspector General (OIG), the Department of Justice (DOJ), and

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state-level Medicaid Fraud Control Units (MFCUs). In other areas, CMS will have to build out a more robust relationship with states on oversight. For example, CMS should provide guidance to states on what trends or red flags they should look for in their licensure processes to mirror some of the actions CMS is taking at the federal level.

Thank you again for the opportunity to comment on the CRUSH initiative and you will find specific answers to questions posed in the RFI below.

A1: Are there ways in which CMS could better use existing statutory authorities to expeditiously prevent bad actors from engaging in fraud, waste, and abuse?

Transparency

- CMS should build on its successful nursing home ownership tracking initiative and extend it across all certified provider types. In 2022, CMS began tracking and publishing nursing home ownership data on cms.data.gov, later sharing it to the Nursing Home Care Compare website in 2023. CMS identified "affiliated entities" — Medicare-certified nursing homes that shared common owners and/or operators across different locations — and posted aggregate performance data including star ratings, enforcement remedies, and for-profit/not-for-profit status. CMS also began using this information to evaluate prospective owners and operators prior to certification and during change of ownership requests.
- CMS should extend this model to all provider types by integrating verified ownership data with Medicare Care Compare, validating the ownership information that providers report, and making co-ownership relationships visible to the public.
- For hospice specifically, CMS should eliminate the "other" ownership category from publicly available data. No other Medicare provider type includes this designation, and it obscures the governing nature of the hospice from the public.
- CMS should also consider creating and maintaining a publicly searchable Hospice Owner Registry and Home Health Owner Registry with verified ownership information for every Medicare-enrolled hospice and home health agency based on the current information submitted on the 855A similar to the data already available for skilled nursing.

SSA §1866(j)(3) — Provisional Period of Enhanced Oversight (PPEO):

We support the Department's current use of the Provisional Period of Enhanced Oversight (PPEO) and Enhanced Prepayment Reviews (EPR) for hospice as targeted tools to identify and address fraudulent billing before funds are improperly paid and the expansion of those efforts to home health agencies in the Los Angeles area and elsewhere for both

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home health and hospice when warranted. CMS reports that through December 2025, 817 hospices have been subject to medical review and CMS revoked Medicare enrollment for 181 of these hospices.[1] CMS feels confident enough in this tool's effectiveness that they have expanded the PPEO to Georgia and Ohio.

We do, however, wish to note several important refinements that would improve the effectiveness and fairness of these programs. The goal of these tools must be clearly and consistently framed around catching fraud, not reducing the number of providers, whether fraudulent or not. Compliant providers, often longstanding participants in the Medicare program, who undergo a change of ownership should not face enhanced burdens designed for bad actors. We encourage CMS to better target these tools using a risk-based approach focused on new providers and recent entrants, billing patterns, referral relationships, ownership structures, and other fraud indicators that would allow CMS to focus its resources where they are most needed and reduce the burden on compliant providers.

We have received reports of a lack of transparency, timely information, and issues with due process from at least one Medicare Administrative Contractor (MAC) involved in these reviews, National Government Services (NGS), to be called Wellpoint Federal as of 4/1/2026, which operates in California, Nevada and Arizona. Providers subject to enhanced oversight deserve clear communication, a way to ask questions or get accurate information about their PPEO status, including the basis for review, timelines, and pathways to resolution, and appropriate due process. We urge CMS to establish consistent, transparent standards for all contractors conducting PPEO and EPR activities.

42 CFR 424.515 — Revalidation

LeadingAge believes that more frequent revalidations could be an important tool for high risk settings, e.g., home health and hospice currently. We offer the following feedback on how it has worked to date across settings:

- **Revalidation should not just be an overly expansive paperwork exercise.** In skilled nursing facilities, our members experienced challenges with the off-cycle revalidation process because of new and extensive reporting requirements. Prior to the delay, SNF members were telling us that they were having to gather thousands of pieces of documentation in order to attempt to complete the requirement. It was

[1] Testimony of Kim Brandt, CMS Deputy Administrator and COO, on March 17th to House Committee on Energy and Commerce, Subcommittee on Oversights and Investigations.

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not clear how this documentation would be utilized or how CMS would verify its accuracy. It was also unclear, given the sheer volume, how the information would be helpful to the public—since a key goal was transparency. The off-cycle revalidation process used for SNFs should not be extended to other provider types including home health and hospice.

- **On site-visits are a critical component of revalidation, but transparency is key**. For on-site visits, both associated with revalidation and regarding our recommendation on site visits prior to hospice and home health enrollment applications in section A2, we have also heard complaints about the site visitors themselves. During both the recent off-cycle revalidation process for SNFs and site visit project for hospices in 2023, members told us that the contractor behavior made them suspicious of the process. They did not show identification, they did not come with documentation or language that made the hospice agencies or nursing homes feel comfortable letting the contractor into the office or nursing home. They couldn't clearly state why they were on site, but made threats like "if you do not let me take pictures, if you don't let me in, you will lose your Medicare funding." While CMS did ultimately improve their transparency, we would want to be sure that any future site visit contractors are clear as to their identities and purpose. LeadingAge strongly supports on site visits – both associated with revalidation and in other circumstances – because boots on the ground is one of the most effective tools against fraud and abuse**.** However, we recommend that CMS provide better training, documentation and oversight to the contractors charged with the visits.

With regards to more frequent revalidations, we recommend:

- Annually for newly-enrolling hospice and home health agencies for the first three years in areas at high risk for fraud, waste, and abuse.
- CMS could also conduct targeted off-cycle revalidations for agencies that exhibit billing patterns associated with elevated program integrity risk.

SSA §1866(j)(7) — Enrollment Moratoria

CMS could consider a targeted, strategic use of enrollment moratoria, where data demonstrates concentrated fraud activity (e.g., home health agencies in Los Angeles County). Targeted moratoria would have to be utilized in conjunction with other tools, like PPEOs and enhanced site visits in surrounding areas to be effective. Ultimately, the goal should be that stronger enrollment controls are put in place such that future newly enrolling providers can be screened more appropriately for participation in the Medicare and Medicaid programs. Therefore, we ask that:

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- Any moratoria put in place should be accompanied by what criteria CMS is using to evaluate when the moratoria would end.
- CMS also needs to be clear and transparent about what actions and policies need to exist to preserve gains made during the time period in which a moratorium were in place.
- CMS should coordinate with states around recommendations for or feedback on changes to licensure policy that could help support appropriate scrutiny.
- Currently, moratoria should be used on a short-term basis. CMS should encourage Congress to pass language, such as is drafted in the *Hospice CARE Act of 2026* that would give CMS direct authority to create exemptions to moratoria. One challenge with the use of moratoria right now is that CMS has limited ability to do exemptions – it could be a longer-term solution if exemptions could be more easily designed and granted.
- We also want to express concern about the impact of potential moratoria on the ability of hospices to complete required hospice face-to-face encounters via telehealth. The ability to do the face to face encounter via telehealth helps maintain access to hospice services.

Social Security Amendments of 1967 §402

In home health and hospice, the data points to outsized growth of new providers in certain markets.

New Medicare-Certified Home Health Agencies and Hospices, 2018-2025

Initial Certification Year	**Los Angeles County**		**California**		**United States**	
	Hospices	*HHAs*	*Hospices*	*HHAs*	*Hospices*	*HHAs*
2018	78	83	126	119	290	293
2019	85	72	140	185	317	340
2020	208	120	292	265	491	482
2021	430	136	609	344	910	618
2022	447	144	546	303	941	610
2023	100	302	142	381	449	631
2024	29	127	44	295	278	585
2025	7	42	18	307	161	527

Source: CMS Provider of Services File, Q4 of 2025, Accessed on March 23, 2026 at: https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-internet-quality-improvement-and-evaluation-system

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California is not the only area with problematic growth trends. CMS has seen these patterns themselves and acted by using PPEO authority in Arizona, Texas, and Nevada since 2023 and recently added Ohio and Georgia in December of 2025. Given that a large increase in new entrants to Medicare programs are at, a minimum, a suspicious trend, CMS could act to increase oversight on these particular agencies. CMS could require that home health agencies and hospices in high-risk areas to be surveyed once per year for the first three years. New entrants in high-risk areas should also be required to complete training from MACs each year for the first three years, including coverage basics and billing for the new provider. This would not be a Targeted Probe and Educate program, but would require the participating providers to test their knowledge on a pass/fail basis. These proposals also have the benefit of potentially helping legitimate new entrants likely improving their quality of care.

These changes could be made via a demonstration under Section 402 demonstration authority under the Social Security Amendments of 1967 or via future rulemaking.

A2: Are there ways to modify provider enrollment, medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility?

Enrollment Documentation Requirements

Both for Medicare and Medicaid enrollment and revalidation, CMS should require the submission of additional documentation during initial enrollment and revalidation. These documents should not extend beyond standard documentation that quality providers would already have on hand. CMS and states should require providers to submit:

1. Proof that the provider has a comprehensive liability insurance policy.
2. A copy of lease/deed for the provider's office location.
3. A legitimate business email address that is HIPAA compliant, a public-facing website, and an active phone number.
4. Proof that the provider employs staff, especially any required clinical and direct care worker staff (e.g., payroll tax records).
5. Disclosure of any managing employees (e.g., Administrator, Medical Director) that are employed or contracted with another Medicaid-enrolled and/or Medicare-certified entity.
6. Copies of tax returns and/or audited financial statements (for changes of ownership, revalidation, or reactivation).
7. Credit reports (for changes of ownership, revalidation, or reactivation).

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Note: Items 1–5 apply broadly to all provider enrollments. Items 6–7 are particularly relevant for changes of ownership and revalidation/reactivation scenarios, where additional financial scrutiny is warranted.

Site Visits

We applaud CMS's expansion and enhancement of site visits, which put more federal presence on the ground in high-risk areas and create meaningful accountability at the point of enrollment and afterwards. Increased boots-on-the-ground oversight is one of the most effective deterrents to fraudulent enrollment, and we encourage CMS to continue and expand these efforts in high-risk markets for home health and hospice. According to CMS, the enhanced site visits have had tremendous success in the hospice space – helping to shut down fraud, while ensuring legitimate hospices can continue to do the right thing.[2] As a result of enhanced site visits, 48 hospices have had their Medicare enrollment revoked, 478 hospices have had their billing privileges deactivated, and 318 hospices update their practice locations to reflect address changes.[3] We encourage CMS to apply similar enhanced site visit protocols to home health agencies in the Los Angeles area and other areas where the data demonstrate comparable fraud risk. CMS should also conduct enhanced site visits prior to approving enrollment applications. More checks should be conducted during the site visit, similar to DME supplier site visits. The national site visit contractor should run a report prior to a visit to determine if other certified home health agencies or hospices are associated with the same address. Please refer to our comments under revalidation in A1 regarding the need for transparency from the site contractors once on site.

Physical Office Space

CMS should define minimum office standards for home health and hospice providers similar to regulations for DME at 424.57(c)(7), including visible signage, prohibition on certification of hospices operating exclusively from virtual offices, residential addresses without operational capacity, or shared shell office spaces.

Auditor Accountability and Transparency

At the March 17, 2026, hearing in the House Committee on Energy and Commerce, Subcommittee on Oversights and Investigations, CMS Deputy Administrator and Chief Operating Officer Kim Brandt said that CMS is focusing "audits to high-risk areas rather

[2] https://insidehealthpolicy.com/daily-news/lawmakers-cms-aim-mitigate-medicare-hospice-fraud?utm_medium=ihpbn

[3] Testimony of Kim Brandt, CMS Deputy Administrator and COO, on March 17th to House Committee on Energy and Commerce, Subcommittee on Oversights and Investigations.

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than burdening all providers with unnecessary oversight. A risk-based strategy improves efficiency and reduces administrative burden on compliant providers and enables CMS to intervene earlier, providing stronger protection for beneficiaries and taxpayer dollars."[4] We could not agree more with this statement.

Audits could be a tool of great effect for targeting fraud, waste, and abuse if they are targeted and risk-based. To date, our members' collective experience with audits has not been that. Members report continual audits across a variety of CMS audit contractors – the Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractors (SMRCs), Unified Program Integrity Contractors (UPICs), Comprehensive Error Rate Testing (CERT) Contractors, Recovery Audit Contractors (RACs), and the HHS Office of the Inspector General (OIG). Members experience the following issues with audits across the continuum of contractors[5]:

- Being subject to more than one audit simultaneously;
- Under audit for an extensive period of time to meet the claims minimum threshold (18-24 months);
- Short turnaround times (45 days in the case of a SMRC audit) with a huge volume of requested records that are not always accepted electronically;
- Delays by auditors in completing their audits and not remaining in communication regarding timeframes or status;
- Auditors being uneducated about the service they are auditing resulting in misapplication of Medicare program rules, overlooked documentation, and patterns of denials inconsistent with full chart review (e.g. every 8th chart denied);
- "Automatic-fail" triggers that cause a provider to fail an audit with no further investigation and no recourse.
- Target, probe, and educate (TPE) guidance that is inadequate, incorrect, and/or inconsistent.
- Higher claim denial overturn rates on appeal (this is anecdotal in part because of a lack of transparency in the process).

CMS's focus on program integrity would be served by pursuing stronger contractor accountability and education. CMS spends significant funds on audit contractors and it is mission critical to the focus of the CRUSH initiative that their work focus on the truly bad actors. CMS should also improve provider due process and transparency which would

[4] Testimony of Kim Brandt, CMS Deputy Administrator and COO, on March 17th to House Committee on Energy and Commerce, Subcommittee on Oversights and Investigations.
[5] LeadingAge and National Partners Hospice Audit Report from 2023

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improve efficiency and targeting as well as improve compliant provider morale. Finally, having a more open and transparent process would ultimately improve payment accuracy since providers would have better understanding and sightline into where errors occur and why. CMS should:

- Not only focus on initial claims error rates, but the final error rate after claims adjudication and the appeal process is exhausted, and implement solutions to address areas of vulnerability where auditors are too aggressively and improperly targeting certain providers within a provider group.
- Conduct an evaluation of audit frequency and targeting, as our members report frequent audits on areas untethered to areas of vulnerability.
- Increase transparency of audit contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, and top denial reasons.
- Emphasize the education of providers rather than recovery of payments and ensuring there are clear definitions and standards communicated effectively to providers and that are applied uniformly in the audit process.
- Require substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies.
- Modify the audit, recovery, and appeals processes to reduce the need for lengthy adjudication and reduce the burden for typically compliant providers. This should include a procedure for centrally monitoring audits across all contractors to ensure a high bar before a provider goes through multiple audits simultaneously.
- Require each audit contractor to designate a specific contact to respond to provider inquiries.
- Implement a questions and issues resolution team for providers to access regarding complaints or questions arising from the audit process.
- Conduct comprehensive review of claims reason and denial codes to determine where greater specificity would be helpful: 1) to inform providers as to the reasons for a claim denial, and 2) to ensure providers receive appropriate notice for any denied claim (which is a requirement for a claim reopening and payment denial).
- Implement policies to prohibit the same Medicare claims from being subjected to multiple reviews by audit contractors, as a claim can only be denied and recouped once.
- Limit denial review reasons strictly to initial audit review findings during the appeal process. Additional denial reasons should not be added later.
- Implement an informal mechanism to enable MACs and providers to resolve technical claims denials prior to engaging in the formal appeal process.

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- Require audit contractor medical reviewers to have an equivalent level of expertise and training in the area which they are auditing (e.g. in hospice, the same level as the hospice medical director who certified a patient's terminal illness).
- Evaluate whether it can leverage the RAC Data Warehouse and other data-sharing tools to coordinate contractor activity. By limiting multiple contractors from conducting audits simultaneously in the same geographic areas or on the same providers, CMS can reduce redundancy and administrative strain on compliant agencies.

Ensure Transparency in Enforcement Actions

CMS should require that any enforcement action regarding the closure against a Medicare provider be accompanied by a concurrent transition-of-care plan ensuring continuity of services for patients. CMS should also establish an expedited appeal pathway for Medicare providers if applicable, so that erroneous actions can be corrected within days rather than weeks, months or years. Finally, CMS should create a real-time notification system to inform patients and families when their Medicare provider is subject to an enforcement action that will remove the provider's billing privileges.

A3: Are there existing requirements or policies that could be altered to increase CMS' ability to promote payment accuracy and efficiency?

Medicare Advantage

CMS should issue guidance to Medicare Advantage (MA) plans that they must update their claims systems with correct rate schedules no later than the date the rates are effective and non-complying MA plans should be assessed daily fines for every day they are out of compliance. Inaccurate payments to providers under MA increase administrative burden, threaten cashflow, add unnecessary costs, and can jeopardize access to care for all Medicare beneficiaries.

Our skilled nursing facilities and home health agency members have reported several MA plans are not updating their rate schedules to correspond with their contracts in their claim systems. Plans will inaccurately pay provider claims based upon the previous schedule, then take the money back and require providers to resubmit claims. In some cases, the plan will even deny payment for the resubmitted claim, stating the claim did not meet timely filing deadlines.

Recently, when CMS ran into a similar situation with PACE providers where it underpaid in January and February 2026, it issued a memo notifying providers that CMS would simply pay the missing amount as part of the next month's payments. No extra burden on the provider. MA plans should follow CMS's lead.

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Now that MA covers more than 50% of Medicare beneficiaries, CMS should have greater authority to hold MA plans accountable. However, the noninterference clause ties CMS's hands. CMS should ask Congress to broaden its oversight authority by limiting the application of the noninterference clause.

Review Choice Demonstration (RCD)

Today, RCD operates in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas for home health agencies. CMS should evaluate whether RCD has been successful in reducing fraud, waste, and abuse through a formal evaluation that is made public. If RCD is successful, CMS should consider whether it could be expanded geographically to other areas at high-risk of fraud, waste, and abuse, and potentially apply to other provider types in high-risk geographies. If CMS does consider applying RCD to new settings, it must carefully consider nuances between provider types. If CMS considers expanding RCD to new provider types, there should be consultation with stakeholders and opportunity for public comment. For example, if CMS considered RCD for hospice services it would have to minimize burden for hospices that are acting in good faith and acknowledge issues that result from very short lengths of stay.

As part of any effort to expand RCD to new provider types, CMS should ensure that the medical review staff have the necessary experience and training to accurately review relevant claims, RCD should be targeted to only the highest-risk areas of the country, and compliant providers need to be quickly identified and exempted from the RCD process. Agencies undergoing a change in ownership should be required to return to RCD. The highest-risk areas for fraud, waste and abuse may not be entire states but could be specific metropolitan areas within states. CMS should also share criteria that would trigger RCD as well as what criteria they would use to end it in a given geography.

A4: What changes could CMS or its contractors make to existing processes to more expeditiously gather actionable information and effectively deter fraud, waste, and abuse?

National Provider Directory and Data Infrastructure

CMS should centralize provider data into a single national provider directory and create a national all-payer claims database. Together, these tools would make it easier to identify fraudulent providers and payments. With a full list of providers participating in federal and state programs and the associated claims for services, CMS would be able to use artificial intelligence to identify high-risk claims that share beneficiary, provider, and date of service information. Provider claims volume could also be monitored along with patterns and

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trends. It would make it easier to determine if multiple payers are being billed for the same service for the same patient by one or more providers.

A national provider directory would also serve a secondary benefit: streamlining the MA credentialing process. We would encourage CMS to consider ways to exempt providers enrolled in traditional Medicare from the redundant MA credentialing process. Instead, there could be a provider authentication process tied to the national provider directory where a provider TIN is entered and a multi-step authentication process is used for the provider to verify their contractual relationship with an MA plan.

Home Health and Hospice Surveys

CMS should revise interpretive guidance in Appendix M to require accrediting organizations (AOs) and state agency surveyors to scrutinize whether a hospice is truly able to provide all four levels of hospice care. They should also require the AOs and State Survey Agencies to track the patients that each home health agency or hospice uses to obtain its initial Medicare certification so that fraudulent providers are not recycling the same patients. CMS should consider implementing similar AO oversight policies for AOs with deeming authority for home health and hospice as those for DME providers.

Nursing Home Surveys

CMS has been piloting a risk-based survey approach in nursing homes for the past few years that will effectively cut survey resource waste. The risk-based survey utilizes data from past surveys, quality measures, and payroll-based journal to identify nursing home providers that consistently deliver higher quality care. A portion of these providers are then selected to receive a more focused survey that takes less time and surveyor resources than a traditional standard recertification survey. The survey resources saved from the risk-based surveys can then be more appropriately and efficiently allotted to nursing home providers most in need of oversight and enforcement. We urge HHS to fully implement this approach into the long-term care survey process to efficiently improve quality and safety of nursing home care.

Program for Evaluating Payment Patterns Electronic Report (PEPPER)/Comparative Billing Reports

CMS should continue its work to reestablish PEPPER reports and work with providers to revise and improve the target areas. CMS should also review these reports and use them as part of a risk-based approach for targeted medical review activities.

Provider Enrollment Chain and Ownership System (PECOS) Enrollment Reviews

CMS should conduct regular reviews of PECOS enrollments to check the credentials of key provider personnel. CMS should determine a threshold for the number of providers a

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managing employee can be associated with before it triggers mandatory audits through PPEO.

A6: How can CMS improve its transparency about its oversight and enforcement activities?

In addition to our responses to previous questions regarding transparency, we offer the following other suggestions regarding transparency which we believe should be a core principle in the partnership between CMS, states, plans, providers, and beneficiaries.

Public Education

CMS should provide primers and tools that aid the public interpretation of survey and deficiency reports. CMS should publish a user guide that explains how to read and evaluate survey data. CMS should summarize and publicly report survey enforcement actions by state and by accrediting organization/State Survey Agency.

Certification and Survey Provider Enhanced Reports (CASPER) Transition

CMS should prioritize the transition of home health and hospice survey data from the CASPER system to the QCOR and correct current data errors and delays. Home Health Agency Provider Reports are currently only accurate through May 19, 2021.

CMS Market Saturation Dataset

CMS should ensure the integrity of this data set and work to update the data on a more timely basis (the current tool only has data through 2024). CMS should use the Market Saturation metrics to identify areas at risk of oversaturation.

MAC-Specific Dashboards

CMS should develop MAC-specific public dashboards that report the volume and status of pending provider enrollment applications by provider type and state, including information on whether certification will be conducted by an AO or the State Survey Agency.

Section C — Medicare Advantage Preclusion and Enrollment

C3: Would MA plans support a requirement for all providers and suppliers to enroll in the Traditional Medicare (Fee-for-Service) program as a condition of billing MA plans?

Medicare Part A and B providers are already required to be enrolled in Medicare. MA plans also contract with other service providers to support delivery of supplemental benefits. These services are not Medicare A nor B services and may be provided by both medical and non-medical providers or entities. We see no reason for these entities to have to enroll into

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traditional Medicare to bill an MA plan for non-Medicare services. We do not think that an expansion of this requirement is necessary.

Section F — Claim Filing Deadlines

F1: How would a claim filing deadline of 90 or 180 days impact your organization?

LeadingAge does not support shortened deadlines to address fraud, waste, and abuse. We believe this would cause legitimate claims to be forfeited, financially destabilizing many compliant Medicare providers. All LeadingAge providers are required to maintain sequential billing which by its very nature delays billing. For home health and hospice providers, clinicians must certify patients before billing services. The paperwork from clinicians may be delayed and the claim cannot be filed until it is received. Members shared they had claims upwards of $600,000 in dispute for 9 months without resolution. Those situations may easily max out a 90 to 180 day billing period and could put the financial stability of compliant providers at risk. CMS should strongly consider a categorical exclusion for Medicare Part A hospice, home health, and skilled nursing facility claims from any shortened filing deadline. If CMS does decide to move forward with these provision, we recommend it only be applied to the initial claim submission, not the clean claim submission.

F2: Are there certain claim or provider types for which these shorter deadlines would not be feasible?

For many LeadingAge members, their approach to claims submission is very conservative. They expressly hold back bills that have issues, and those sometimes need weeks or months to resolve. The continued intensity of audit contractors raises concerns about missing deadlines as providers need to resubmit claims after discussions with MACs.

F3: What would be the best way to implement a shorter claim filing deadline?

If CMS implements a shorter claim filing deadline, we strongly recommend that hospice, home health, and skilled nursing claims be exempt from a shorter claim filing deadline. CMS should retain the current 12-month deadline for all claims and, if it pursues shorter deadlines for other provider types, should include a clear, explicit exemption for Medicare hospice, home health, and skilled nursing benefits under Part A.

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Section G — Artificial Intelligence in Medicare Advantage Coding Oversight and Hospital Billing

G1: What types of AI solutions are most effective and efficient for assisting human coders with large volumes of records?

The most useful AI solutions are the ones that help human coders review records faster without taking coding decisions out of their hands. That includes computer-assisted coding tools, natural language processing tools that pull relevant diagnoses or procedures from documentation, chart triage tools that help prioritize which records need closer review, and risk adjustment review tools that flag likely coding opportunities or discrepancies. The strongest solutions fit into existing workflows, surface relevant documentation clearly, and help coders focus their time on the records that need the most attention.

G2: What key features and learning capabilities should an AI solution include to improve accuracy, incorporate coder feedback, and prevent errors or hallucinations?

An effective AI solution should show exactly why it is suggesting a code and point the reviewer back to the supporting documentation. It should include confidence levels, keep a record of reviewer actions, and allow coder feedback to be captured and used to improve future performance. It should have guardrails so it does not suggest codes not clearly supported by the record. Audit trails, version control, and regular performance monitoring are also important.

G3: How should AI-generated coding recommendations be displayed to human reviewers, and what compliance risks should be considered?

AI-generated recommendations should be shown as suggestions, not final decisions. Reviewers should see the proposed code, the exact documentation supporting it, and any confidence indicator. The system should make it easy for the reviewer to accept, reject, or revise the suggestion without consequences. The main compliance risks include unsupported coding recommendations, overreliance on automation, upcoding concerns, and poor documentation of how decisions were made.

G4: What lessons have been learned from implementing AI solutions, including pricing structures and use within cloud-based IT environments?

Implementation matters as much as the product itself. Even a strong tool will fall short if documentation is inconsistent, integration is weak, or staff are not trained. Organizations usually do better when they start with a focused pilot. Pricing varies — per chart pricing,

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per user licensing, or enterprise subscription models — and the full cost often includes implementation, integration, training, and support. In cloud-based environments, organizations need to pay close attention to security, privacy, access controls, and how well the solution fits into the broader IT environment.

G5: Are there AI solutions that address coding issues related to overpayments and underpayments for compliance oversight?

Yes. AI can help identify unsupported codes that may contribute to overpayments and missed codes that may contribute to underpayments. It can flag inconsistencies between documentation and submitted codes, identify patterns suggesting a need for further audit review, and support retrospective compliance monitoring. The most valuable tools support balanced payment integrity work rather than focusing only on revenue capture.

G6: How could AI be used to increase the efficiency and accuracy of hospital billing?

AI can improve hospital billing in several parts of the process: charge capture, claim scrubbing, denial prediction and prevention, documentation review before submission, and prioritizing claims or work queues. It can also help identify missing information, mismatches between documentation and billed services, and patterns behind denials or underpayments.

Section H — Beneficiary Solicitation and Contact

What means of communication do Medicare beneficiaries find are being used to solicit them? How do beneficiaries respond to inappropriate direct solicitation?

LeadingAge has seen the most concerning solicitation of Medicare beneficiaries in hospice. Many beneficiaries experience door-to-door solicitation including in assisted living facilities and nursing homes. Members in California report hospices offering monthly birthday parties, new TVs for the common room, and regular lunches provided for staff. There is documentation of bonuses to staff/contractors who sign up a certain number for hospice.

Many Medicare beneficiaries are not aware that the outreach could be a scam, nor are they aware of the limitations on their Medicare coverage when they enroll in hospice. One California PACE member had a beneficiary attend an outing where they were given $75 to sign up for hospice. CMS needs to establish a distinction between informed choice and choice. There should be an expectation that hospice providers will explain the full scope of the hospice benefit. CMS should pursue expanded prohibition against unsolicited contact

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to home health and hospice providers. CMS should also work with Congress to add hospice to Section 1861(ee)(2)(D) of the Social Security Act to allow patients full choice of providers.

Section I — Prepayment Verification and Beneficiary Outreach

CMS should generally not attempt any prepayment verification outreach to Medicare beneficiaries and their representatives. For patients recuperating from acute care in skilled nursing or home health or those transitioning to hospice, the timing is especially difficult. Many beneficiaries are experiencing difficult transitions including those at the end of life. One exception is that CMS should send EOB notification immediately following hospice election to all beneficiaries nationwide. This notice should include clear instructions for how to report unauthorized enrollment. This EOB notification is important for hospice since unauthorized hospice enrollment jeopardizes beneficiary access to other Medicare benefits.

Section J — Surety Bond Requirements

CMS should revisit the current home health agency surety bond requirements at 42 CFR 441.16 (originally established in 1998) and consider whether similar requirements should be put in place for hospices. CMS should also look at increasing the bond amount and creating tougher actions against non-compliant bond companies. Undercapitalization can be a major red flag for an intent to defraud. CMS should work with home health and hospice sector to identify ways to meaningfully update capitalization requirements generally, including establishing more parameters around which banks and financial institutions can provide proof of operating funds and requiring the MACs and survey agencies to do more checks on the legitimacy of attestations. Section K — Medicaid and CHIP

Section K — Medicaid and CHIP

K1: Is there any way that CMS should better leverage or expand its statutory or regulatory program integrity oversight authority?

CMS, in partnership with states, have abundant tools via existing statutory and regulatory avenues to combat fraud. Federal Medicaid fraud programs involve a coordinated effort between federal and state agencies, primarily the Department of Health and Human Services (HHS), its Office of Inspector General (OIG), the Department of Justice (DOJ), and state-level Medicaid Fraud Control Units (MFCUs). At the federal level, the OIG follows a

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standard protocol whereby the agency conducts particularized audits of individual Medicaid programs followed by investigations, and inspections to identify, prevent, and penalize specific fraud and abuse within HHS programs, including Medicaid. They have the authority to exclude individuals and provider entities convicted of criminal fraud from participating in all federal healthcare programs. Additionally, in all federal coverage programs that use managed care, health plans work with state and federal partners to operate robust anti-fraud programs that form the frontline for prevention and detection. LeadingAge strongly supports this process and encourage reforms that would invest in and strengthen these existing oversight and enforcement measures that provide targeted and evidence-based accountability for bad actors.

State Medicaid programs could consider more scrutiny and investment in Medicaid case management as a gatekeeper for unnecessary services and assuring that participants are receiving services delineated in their service plans. Case managers could be provided aggregated reports about services billed or paid for each participant within their caseload. Technology could support analysis of where services are billed at a level different than hours outlined in an individual's person-centered service plan.

K2: Should CMS require states to mandate high-risk providers revalidate more frequently than every 5 years, and if so, how frequently?

As we noted in A2, revalidation can be an important tool for high-risk providers which could include some programs in Medicaid, if implemented with intent. Currently, in many states, provider revalidation in Medicaid is primarily a paper exercise for providers that will do little to root out unscrupulous providers and impose additional burden on good providers. This is particularly true in rural areas where many Medicaid providers serving older adults are small, family-owned businesses with little capacity to absorb additional administrative burden on already menial Medicaid reimbursements. Any additional off-cycle revalidations would have to be targeted and combined with site visits and an evaluation of billing patterns compared to actual census and other records.

K3: What tools or technologies can CMS or states use to enhance program integrity in Medicaid, CHIP managed care, and fee-for-service programs?

CMS should support states in development of data matching and comparison interfaces. The standardization of data across multiple states and CMS is inadequate to support a robust data analysis infrastructure. States must retain autonomy to build their programs, services, intervals, and other Medicaid parameters in a manner that suits their population and needs. CMS can support states in building data bridges and shared applications to improve parity and comparability of state-specific data.

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We caution CMS against an overreliance or overconfidence in technology's ability to stay ahead of fraudulent schemes. Technology is a tool that can help identify patterns, but a human level of review by humans with knowledge of the programs are critical. This is particularly true in Medicaid as there is so much variation state to state. Additionally, technology is available to those who are committing fraud and they are utilizing it, so a combination of efforts is critical.

K4: What tools or guidance can CMS give to states to enhance program integrity?

CMS along with their partners in the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) have eyes into successfully prosecuted fraud schemes. Through this knowledge, federal partners can support states' program integrity efforts by analyzing cases of fraud and establishing a postmortem review process that helps with targeting of the next scheme. Following these reviews, CMS can quickly share information with states on the structure of the fraudulent activity, the duration, the avenue the bad actors exploited, and how programs should be monitored or tightened to minimize future vulnerabilities.

K5: What ways can CMS improve the prevention, identification, and resolution of fraud, waste, and abuse related to non-federal share financing sources, including intergovernmental transfers (IGT)?

The financing of Medicaid non-federal share, including IGTs, has long been codified and allowable. LeadingAge opposes changing of the IGT infrastructure without a plan to replace the funding. If CMS or Congress establishes a new path for non-federal share financing, significant time must be afforded to states using IGTs or CPEs to transition from these arrangements. In many states these mechanisms are used to support nursing homes and school-based healthcare for students. At a time when Medicaid financing is being cut back, this is money that these settings can ill afford to lose.

K10: What data or information should be made publicly available to allow for transparency in Medicaid?

Data standardization would be necessary before transparency and public posting of data is pushed. Adequate context in any public posting would help analysts understand where definitional differences are, what data integrity scrubs have been done. Additionally, definitions must be included to differentiate errors from identified fraud. Overpayments and payment error rates are not fraud. Overpayments can occur for a multitude of reasons, most which are not the fault of the provider: a nursing home resident's change in

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income or assets, improper coding in a batch file upload for managed care claims, improper rates in managed care systems, or administrative keying error on a claim. LeadingAge supports transparency, but making sure the data is consumer friendly and accurate is an important component of true transparency.

K11: How can CMS help states better prevent, identify, and address fraud in high-risk service areas such as housing stabilization, behavioral health, PCA services, and nonemergency medical transportation?

The most effective strategies at combatting fraud in these services is to establish standards for enrollee/recipient feedback. CMS can support states by establishing maximum case-loads for case managers (which would mean asking Congress to enhance the federal match for these types of services to ensure states can hire enough case managers). CMS can establish best practices for enrollee participation in reporting of service receipt. These processes could include beneficiary responses to quality and experience measures or be limited to attestations depending upon a state's goals.

Including recipients of services as program integrity safeguards improves understanding of delivered or missed services and increases oversight. Any expectations for recipients should be the responsibility of case managers or state regulators to facilitate. Including providers in this process could support responses though there would have to be a quality assurance layer given the presence of poor providers in the system.

Section L — State-Specific Medicaid and CHIP Questions

L1: What statutory or regulatory changes are needed to strengthen states' ability to effectively reduce fraud, waste, and abuse in Medicaid and CHIP?

Prior to imposing additional requirements on states, states should be given the opportunity to review their existing tools and analyze the efficacy of current fraud, waste, and abuse prevention and mitigation opportunities. States are already afforded abundant tools in monitoring and eliminating fraud, waste, and abuse. Should additional requirements be imposed on states, accompanying funding must be made available to support those efforts. Recent changes in Medicaid financing from HR1 will significantly curtail states' abilities to fund portions of their Medicaid programs, limiting their ability to allocate new funds for potential new requirements – if fraud, waste, and abuse prevention is a true priority, increasing federal funding for these activities for states is paramount.

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L5: What successful strategies have certain states implemented that others can replicate as best practices?

Some states do not require licensure or certification of some classes of HCBS providers. LeadingAge has heard from our state affiliates and providers alike that licensure or certification of those provider classes would be desirable to protect the reputations of good quality providers. Minimum provider qualifications for HCBS providers protect good providers, Medicaid beneficiaries, and Medicaid program integrity. States deploying certification or licensure requirements should consider other existing frameworks under which providers are deemed worthy, including certification by Medicare, Veteran's Affairs, Older Americans' Act, and County Human Services organizations. States should balance the desired objective of protecting the Medicaid program with the inevitable additional administrative burden that will follow.

Thank you for the opportunity to provide feedback on this request for information. Please contact Mollie Gurian at mgurian@leadingage.org with any questions.

Sincerely,

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