March 30, 2026

VIA Electronic Submission to http://www.regulations.gov/

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

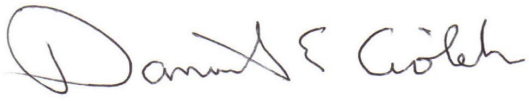
Re: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) [RIN 0938–AV97]

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent over 15,100 long term and post-acute care (LTPAC) facilities, or 1.1 million skilled nursing facility (SNF) beds and over 300,000 assisted living (AL) beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD). We appreciate the opportunity to comment on the *Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)*.

Healthcare fraud harms beneficiaries, providers, and taxpayers by diverting limited resources away from improving and maintaining optimum health for individuals. We welcome this opportunity to discuss strategies that could be effective in better targeting efforts to identify and remove bad actors from the healthcare financing ecosystem, and to prevent them from entering at all. However, we caution that such efforts, including new regulations to uncover suspicious healthcare billing, should be designed thoughtfully and scaled in a targeted manner that focuses on high risk activities and does not impose undue additional burden and regulatory compliance costs on the vast majority of healthcare providers that are honorable in pursuing a mission to provide high quality healthcare. We offer the following comments in response to the RFI questions from this perspective.

If you have questions about any of our comments, please contact Daniel E Ciolek at dciolek@ahca.org.

Sincerely,



Daniel E Ciolek, PT, MS, PMP
Associate Vice President, Therapy Advocacy

Response to RFI Questions

A. Modifications to Program Integrity Requirements (91 FR 9804)

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

AHCA/NCAL Comment: The administration, HHS, and CMS have emphasized a desire to leverage artificial intelligence (AI) capabilities to scrub federal, state, and public sources for information that could help identify and prevent fraud. Providers submitting enrollment data regarding ownership will be submitting sufficient information that could easily be verified through those channels, rather than adding on more costly and time-consuming reporting, fingerprint, and criminal background requirements for additional lower risk parties on top of the existing requirements of owners. It may also speed up the provider enrollment process.

Similarly, most providers are legitimately submitting appropriate claims and should not be subject to additional arbitrary burdensome pre- or post-pay audits processes when AI technology could more effectively prevent and identify potential fraud activity under existing statutes and regulations by targeting high-risk activity.

A note of caution we offer is that like human reviewers, any AI technology algorithms used for this purpose should account for individual providers that furnish care for special populations that may account for atypical utilization patterns. Additionally, AI-driven recommendations should reflect policies that were in place on the date of service, which will require CMS to provide audit trails for AI-driven recommendations that cite specific time-stamped policies.

Finally, AI driven recommendations for audits or denials, whether pre- or post-pay, should have human oversight to assure that specialty providers or those with unique patient populations are not disproportionately targeted for audits or claim denials which can directly impact beneficiary access to care if they have conditions or care needs that require specialized services.

RFI Question: Are there ways to modify provider enrollment (including revocation), medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility to expeditiously prevent bad actors from engaging in fraud, waste, and abuse? (See, for example, Title 42 Code of Federal Regulations (CFR) 405.371 et seq. (payment suspension), part 424, Subpart P, especially 424.510 (general requirements), 424.516 (additional requirements), 424.530 (enrollment denial), 424.535 (revocation), and 424.540 (deactivation of billing privileges).)

AHCA/NCAL Comment: In our July 14, 2025 comments to the Department of Health and Human Services (HHS) in response to the Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation To Make America Healthy Again [Docket: AHRQ-2025-0001], we offered the following recommendations to revise the regulations at 42 CFR 424.502 to establish a minimum reporting threshold for reporting (SNF ADP information for certain disclosable categories) so that reporting would be limited to those organizations and individuals that could significantly influence SNF day-to-day operations over an extended period of time. The current ambiguity means that CMS is wasting valuable fraud prevention resources on investigating individuals and organizations that provide nominal ancillary support services to a SNF/NF, rather than those in roles that have more opportunity to be engaged in fraud schemes. We ask CMS to consider the following recommendations we submitted previously:

SNF Provider Enrollment Disclosure

AHCA/NCAL Recommendation: CMS should revise the off-cycle SNF provider enrollment revalidation regulatory definition of Additional Disclosable Party (ADP) and the revalidation deadline as follows:

- CMS issue an Interim Final Rule (IFR) revising the definitions in 42 CFR 424.502 to establish a minimum reporting threshold for reporting (SNF ADP information for certain disclosable categories.
- CMS rescind the mandatory off-cycle SNF provider enrollment revalidation process and resume the normal five-year cycle or extend the off-cycle revalidation deadline until such time that the IFR or intermediate sub regulatory guidance is implemented establishing a minimum reporting threshold for certain ADPs.

Background:

AHCA/NCAL supports appropriate provider enrollment transparency to support the Administration's efforts at preventing fraud and abuse. However, the level of regulatory burden should be reflective of the level of program integrity risk. Prior to and since the implementation of enhanced SNF provider enrollment reporting requirements for the newly defined Additional Disclosable Parties (ADPs) AHCA/NCAL has requested that a minimum threshold be established for reporting the new entities so that reporting would be limited to those organizations and individuals that could significantly influence SNF day-to-day operations over an extended period of time. This is not a one-time provider enrollment revalidation issue. This issue adds to a permanent burden due to the longstanding time sensitive provider enrollment change of information (COI) reporting requirements for any disclosed individual or organization. Focusing on the ADP definition in regulation to better align transparency reporting requirements with the potential program integrity risk of the disclosed organization or individual will better achieve the Administration's dual objectives of reducing regulatory burden for providers and the Federal government while preventing fraud and abuse.

AHCA/NCAL Rationale:

1. Congress did not intend or require the new SNF ADP reporting requirements to be as extensive as existing ownership and management disclosure requirements.

Sec. 6101(A) of the Balanced Budget Act (BBA) amended § 1124 of the Social Security Act (42 U.S.C. 1320a-3 by inserting the SNF ADP reporting requirement under a new subsection (c)(5). Notable is that the preceding new subsection (c)(4) states the following:

> (4) NO EFFECT ON EXISTING REQUIREMENTS.- Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

We believe that such a subsection statement is an acknowledgement that the Secretary has the authority to establish different reporting requirements within the regulatory SNF ADP definitions for newly established SNF ADP entities, as long as the reporting requirements for those ownership and management control entities subject to reporting requirements prior to the enactment of the BBA are not diminished. CMS has already applied this statutory flexibility by modifying some

ADP reporting requirements such as the reporting of social security numbers of new reportable ADPs and could do so again by establishing rational minimum ADP reporting thresholds.

2. The lack of a minimum threshold for reporting of the new SNF ADP reporting categories creates an unnecessary burden on providers (especially smaller and under-resourced) that utilize support staff and contracted services on a time limited or intermittent basis, and it creates administrative compliance conflicts with existing 30- and 90-day Change of Information (COI) transaction regulations at 42 CFR 424.516.

The longstanding §424.516 regulatory requirements to maintain active enrolment status require that any changes to reportable organizations or individuals be reported by the provider:

> (1) Within 30 days for a change of ownership or control (including changes in authorized official(s) or delegated official(s)) or a change, addition, or deletion of a practice location;
>
> (2) All other changes to enrollment must be reported within 90 days.

We interpret this to mean that any changes to the newly required reportable SNF ADPs would meet Condition 2 and such changes would need to be reported via a COI provider enrollment Form CMS-855A transaction within 90 days of the initiation of that organization or individual performing a potentially reportable activity, and again when that organization or individual concludes their employment or contractual obligations, regardless of the level of effort involved.

Our interpretation is supported by the current CMS SNF provider enrollment sub-regulatory guidance that states the following:

> *There is no minimum threshold for disclosure in terms of: (1) the length of time the party must have furnished the services, served on an ADP's governing board, etc.; (2) the degree and extent of involvement with the SNF's day-to-day operations; and (3) the volume of the furnished services, functions, etc. As an illustration, it is unnecessary for a person's dealings with the SNF to be equivalent to at least 0.33 full-time employees (FTEs) to qualify for disclosure. Even if certain services were furnished for only a very brief period, by a temporary employee, and only one time (rather than, for example, for three-month periods every 18 months), disclosure is required. Likewise, suppose the party helped establish clinical policies. The assistance need not have involved all the SNF's clinical policies for all aspects of its operations. If it only pertained to a portion (even a small one) of the facility's entire clinical policies, this is sufficient to require disclosure.*

However, our members' experiences with the current provider enrollment and COI reporting process prior to and since the implementation of the new SNF ADP reporting requirements has created substantial and excessive reporting burdens. For example, under the current ADP definition, with no minimum reporting threshold, a SNF provider could be subject to Medicare payment suspension or disenrollment for not reporting COI transactions for vacation or maternity coverage, one time or irregular emergency therapy or nursing staffing, or a nursing consultant coming to the SNF one day per year to assess, provide training, or making recommendations to update a policy.

Additional burdens occur when SNF providers attempt to submit a new COI transaction, but cannot, because the MAC has not yet completed processing a previously submitted provider enrollment transaction.

By CMS' own conservative estimates, the net SNF burden to report the newly required ADPs on the updated provider enrollment form is substantially higher than reported in the Final Rule.

- Personnel hours to complete the updated form is 484 percent higher.
- The total cost to complete the updated form is 392 percent higher.

AHCA/NCAL members report to us that the actual reporting burden and cost is markedly greater and will persist with the related increase in COI reporting without minimum reporting thresholds on place.

3. Congress did not specify in Sec. 6101(A) of the BBA and CMS did not mandate in the Final Rule that the new SNF ADP provisions be implemented via an off-cycle revalidation process.

Without explicit statutory or regulatory policy to implement a mandatory off-cycle provider enrollment revalidation process, we believe the Secretary has the authority to rescind the off-cycle revalidation schedule and related additional revalidation fees without promulgating a regulatory change and instead implement the new ADP requirements at the next schedule revalidation for the individual SNF provider. At a minimum, if not rescinded, the SNF off-cycle revalidation process should be suspended until a minimum threshold for reporting of the new SNF ADP reporting categories is implemented.

Conclusion
Establishing reasonable thresholds with the definition of SNF ADPs would substantially reduce the administrative burdens and costs on SNF providers, MACs, and CMS officials as well as reduce risks to provider disenrollment. At the same time, we can still uphold the Administration's fraud and abuse prevention priorities by better aligning resources to those entities that are more likely to impact SNF operations.

RFI 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?

AHCA/NCAL Comment: In addition to our above comments, we believe the CMS policy requiring an on-site provider enrollment inspections and site verification screenings for a SNF/NF is an unnecessary burden that slows down the provider enrollment, change of ownership, and revalidation processes. It is also a redundant process that wastes taxpayer dollars while diverting valuable program integrity fraud prevention efforts away from high-risk provider settings.

Per Section 10.6.20.B of chapter 10 of the Medicare Program Integrity Manual, the Medicare site visit contractor does the following minimal activities that are duplicative of existing less burdensome and costly methods for CMS to verify a listed SNF/NF location is operational:

(1) Documenting the date and time of the visit, and including the name of the individual attempting the visit.
(2) Photographing the provider/supplier's business for inclusion in the provider/supplier's file. All photographs will be date/time stamped.

(3) Fully documenting observations made at the facility, which could include facts such as (a) the facility was vacant and free of all furniture, (b) a notice of eviction or similar documentation is posted at the facility, and (c) the space is now occupied by another company.
(4) Writing a report of the findings regarding each site verification.
(5) Including a signed site visit report stating the facts and verifying the completion of the site verification.

In terms of the extent of the visit, the SVC will determine whether the following criteria are met: (i) the facility is open; (ii) personnel are at the facility; (iii) customers are at the facility (if applicable to that provider or supplier type); and (iv) the facility appears to be operational. This will require the site visitor(s) to enter the provider/supplier's practice location/site rather than simply conducting an external review. If any of the four elements ((i) through (iv)) listed above are not met, the contractor will, as applicable - and using the procedures outlined in this chapter and in existing CMS instructions - deny the provider's enrollment application pursuant to § 424.530(a)(5)(i) or (ii) or revoke the provider's Medicare billing privileges under § 424.535(a)(5)(i) or (ii).

We recognize that §1866(j) of Title XVIII of the Social Security Act provides provider enrollment regulatory flexibility to the Secretary to *"determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier."*

We also note that provider screening regulations at 42 CFR 424.518 currently does apply an arbitrary blanket requirement for an on-site provider enrollment visit screening for a SNF/NF under subsections (b) and by default (c) despite the fact that existing brick-and-mortar SNF/NF providers as well as newly enrolling or change of ownership providers are already subject to mandatory state agency site surveys prior to being able to provide resident care services. CMS would be better able to target potentially fraudulent providers that are not otherwise independently verified as open and able to operate by an official government agency or accreditation organization that already performs site-visits if it redirected resources from these redundant and unnecessary provider enrollment revalidation contractor SNF/NF visits towards those provider types where there is no independent verification of the operating status of the provider at the listed address by a state agency or accreditation organization.

However, we believe this RFI offers the opportunity for CMS to reconsider the current blanket regulatory requirement for a brick-and-mortar 24/7/365 SNF/NF residential care facility under 42 CFR 424.518 to be subject to such Medicare site visit contractor visits, and instead modify the regulation to have the MAC confirm with the state agency, accreditation organization, or other more efficient methods, such as social media posts, to verify the SNF/NF is operational.

RFI Question: Should CMS establish regulatory requirements that allow MA organizations and Part D sponsors to implement payment suspensions under circumstances like the payment suspension authority that exists for Traditional Medicare under 42 CFR 405.371, and require suspensions when directed by CMS?

AHCA/NCAL Comment: We believe that it is reasonable to protect taxpayer dollars to expect consistent Medicare payment suspension policies under 42 CFR 405.371 to apply to all Medicare services and providers regardless of whether furnished through traditional fee-for-service models or via Part C or Part D plans. While we support the intent of 42 CFR 405.371 within Traditional Medicare, where payment suspension authority is centralized at CMS, directly tied to program integrity, subject to defined safeguards and periodic review, and designed to protect the Medicare Trust Fund rather than payer financial interests. Medicare Advantage and Part D operate under materially different dynamics, with payment decisions delegated to private plans, already aggressive utilization management, and heavy reliance on

documentation and technical claims processes. In this context, extending similar suspension authority directly to plans—without parallel real-time CMS-level controls—risks exacerbating existing patterns of inappropriate denials, technical clawbacks, and significant administrative burden on providers. Some plans audit nearly 100% of claims, inundating providers, particularly smaller organizations that lack the infrastructure to keep pace, creating conditions where plans benefit from volume-driven administrative burden rather than substantiated risk. Accordingly, we support CMS's authority to direct payment suspensions in MA and Part D in narrowly defined, fraud-related circumstances consistent with 42 CFR 405.371, but have significant concerns about granting independent suspension authority to plans absent strong safeguards such as real-time confirmation of fee-for-service provider eligibility status effective dates.

B. Enhanced Identity Proofing and Ownership Requirements (91 FR 9804)

RFI Question: What would be the impact on Medicare-enrolled entities if CMS established a requirement for U.S. citizenship or legal permanent residency for all individuals with an ownership or control interest of 5 percent or greater in a Medicare-enrolled provider or supplier?

AHCA/NCAL Comment: We believe that such a suggested blanket requirement to impose citizenship or legal residency requirements for ownership for such a small percentage of ownership of already highly regulated brick-and-mortar residential care facilities such as a SNF/NF would create challenges for some providers to obtain necessary financing to remain operating. CMS already has a robust process for vetting such owners, for example, in Chapter 10 of the Medicare Program Integrity Manual (Publication 100-08), guidance on foreign owners is in section 10.6.7.3.

If such a citizenship or legal residency requirement for ownership were to be codified, it should permit regulatory flexibility to target efforts at provider types at high risk for Medicare fraud perpetrated through international fraud schemes, and with a much higher investment percentage than five percent, rather than applying the same requirement universally across all provider types.

RFI Question: CMS currently requires fingerprinting and criminal background checks for all individuals with a 5 percent or greater ownership interest in a provider/supplier organization that is part of the ''high'' risk category as described in 42 CFR 424.518. Should this be expanded to include, for instance, the provider's managing employees, less than 5 percent owners, or other individuals who are affiliated with or working for the organization?

AHCA/NCAL Comment: We believe that imposing such additional extensive fingerprinting and criminal background checks to provider's managing employees, less than 5 percent owners, or other individuals who are affiliated with or working for the organization raises significant concerns and would do little to curb Medicare fraud schemes for several reasons, and we would oppose any of the variations presented in the question.

First, CMS provides no evidence that there is a significant fraud risk associated with such individuals, particularly in the SNF/NF provider buildings of our members. Expanding cost and burden without justification would only divert limited CMS resources away from targeting known high- risk fraud scheme bad actors.

Second, such an expansion pulls valuable CMS resources away from targeting areas of high fraud risk by focusing on paper compliance activities that have an extremely low to nonexistent benefit to cost ratio. Since October 2024, SNF/NF providers are already required to report as part of their provider enrollment requirements more ownership, management control, and additional disclosable parties than any other type of provider. The massive amount of administrative data that now needs to be reported by the over 14,000 SNF/NF providers has

overwhelmed the providers, the Medicare Administrative Contractors (MACs), state agencies, and CMS officials and the agency's online Provider Enrollment, Chain, and Ownership System (PECOS). What CMS initially anticipated would be a 3-month process for all SNFs to update their Medicare enrollment data has been extended multiple times, and even after 16 months it is not complete, and has been indefinitely suspended to permit CMS to catch up on processing provider enrollments across all provider types.

Third, the core managing employes of a SNF/NF provider including the nursing home administrator, physician medical director, nursing director, and others as applicable, are typically in regulated professions licensed by the states and are also often required to undergo background checks for their licensure and employment applications. Adding additional fingerprinting and background check requirements to be performed by the MACs would be redundant and add more cost, add paperwork burden, and slow down the provider enrolment process without meaningfully reducing claim fraud.

Fourth, people with less than 5 percent ownership present an extremely insignificant risk of having sufficient leverage or influence in the commission of fraudulent billing by a SNF/NF provider. Requiring fingerprinting and criminal background checks on such negligible investors adds more cost, adds paperwork burden, and slows down the provider enrolment process.

Finally, any proposal to require fingerprinting and background checks for other undefined individuals who are affiliated with or working for the organization would reflect a complete lack of understanding of how healthcare operations work, particularly in the SNF/NF setting. Unlike a large hospital system that may be able to have most services furnished in-house by hospital employees, most SNF/NF providers have less than 100 beds, and about half of SNFs/NFs are owned by small independent operators. Therefore, many services such as therapy, pharmacy, dietary and others are likely to be provided through arrangements with outside vendors. Some of these services, such as nursing consultants, may only be needed one day or week per year.

Requiring fingerprinting and background checks on these individuals would create delays in care from qualified professionals and caregivers which could harm beneficiaries and would create a massive administrative nightmare while not meaningfully reducing fraud risk. As we discussed in our second reason above, there have been severe challenges in implementing the paperwork-only requirement of SNF/NF providers to report on additional disclosable parties (ADPs), particularly external entities that provide services to the SNF/NF such as therapy providers, nursing staffing agencies, clinical consultants, pharmacists, and more. In many cases, these independent businesses refuse to provide organizational details the SNF/NF is required to report.

CMS has recognized these challenges could put beneficiary access to care at risk if the SNF/NF provider lost their Medicare certification due to such a paperwork technicality and has provided guidance to the MACs to not hold up a SNF/NF provider enrollment if they made a good faith effort to obtain the requested data (See Section VII of the CMS GUIDANCE FOR SNF ATTACHMENT ON FORM CMS-855A). Adding a fingerprinting and criminal background check requirement for such outside vendors that *"are affiliated with or working for the organization,"* but who present a nearly zero percent fraud scheme risk, would not only result in delayed care from vendors that would agree to such administrative overreach, but in many cases would result in beneficiary access to care problems in areas, especially rural, where there are no other vendor options available for the SNF/NF to obtain such specialized services.

RFI Question: What alternative identity proofing measures could effectively verify the identity and location of owners while balancing program integrity objectives with the operational needs of legitimate Medicare providers and suppliers?

AHCA/NCAL Comment: The administration, HHS, and CMS have emphasized a desire to leverage artificial intelligence (AI) capabilities to scrub federal, state, and public sources for information that could help identify

and prevent fraud. Providers submitting enrollment data regarding ownership will be submitting sufficient information that could be easily verified through those channels, rather than adding on more costly and time-consuming reporting, fingerprint, and criminal background requirements for additional lower risk parties on top of the existing requirements of owners. It may also speed up the provider enrollment process.

RFI Question: Are there specific provider or supplier types for which enhanced identity proofing and citizenship or residency requirements would be most critical to preventing fraud?

AHCA/NCAL Comment: As we have stated above, the SNF/NF provider type is already subject to the most rigorous provider enrollment reporting and verification processes compared to all other provider types. Absent evidence that brick-and-mortar inpatient SNF/NF providers present a meaningful risk of involvement in international fraud schemes, we do not believe any additional enhanced identity proofing and citizenship or residency requirements for the SNF/NF provider sector are currently necessary. If anything, we would recommend that CMS reconsider and roll back some of the recently implemented additional disclosable parties (ADP) reporting requirements, which have diverted CMS and the MAC resources from targeting and investigating true billing bad actors.

RFI Question: Are there additional individuals on the enrollment record for whom enhanced identity proofing and citizenship or residency requirements would help prevent fraud?

AHCA/NCAL Comment: Per our comments above describing the SNF/NF experience with the recently expanded additional disclosable parties (ADP) provider enrollment requirements, we do not believe there is any reason to expand this requirement in the SNF/NF setting. Doing so would only add burden, increase operating costs, and potentially negatively impact beneficiary access to needed care without targeting the true risk areas for fraud.

RFI Question: What challenges would these requirements create for entities with foreign parent companies, international investors, or legitimate cross-border business structures?

AHCA/NCAL Comment: We believe that such a suggested blanket requirement to impose citizenship or legal residency requirements for ownership for such a small percentage of ownership of already highly regulated brick-and-mortar facilities such as SNF/NF would create challenges for some providers to obtain necessary financing to remain operating. CMS already has a robust process for vetting such owners, for example, in Chapter 10 of the Medicare Program Integrity Manual (Publication 100-08), guidance on foreign owners is in section 10.6.7.3. This existing process, while adding burden, has been successful at permitting adequate vetting of foreign investors in the SNF/NF setting and should remain as the standard.

If such a requirement to further restrict foreign investment were to be codified, it should permit regulatory flexibility to target efforts at provider types at high-risk for Medicare fraud perpetrated through international fraud schemes while not harming legitimate SNF/NF operations and investors. Such flexibilities could include grandfathering clauses for existing good faith foreign investors and considering a much higher ownership citizenship or legal residency investment percentage requirement than five percent for SNF/NF settings, rather than applying the same blanket prohibition requirement universally across all provider types.

C. Preclusion List and Medicare Advantage Enrollment Requirements (91 FR 9805)

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

AHCA/NCAL Comment: We believe it is reasonable, in order to protect taxpayer dollars, to apply consistent Medicare preclusion list policies to revoked providers across all Medicare services, regardless of whether furnished through traditional fee-for-service models or via Part C Medicare Advantage plans. CMS has appropriately required MA organizations and Part D sponsors to deny payment for items and services furnished, ordered, or prescribed by individuals or entities on the CMS Preclusion List; however, operational limitations in how preclusion and revocation data are communicated and applied have allowed some providers revoked in Traditional Medicare to continue billing MA plans. Rather than imposing additional screening or compliance burdens on MA organizations—particularly small plans and I-SNPs—CMS should strengthen the effectiveness of the preclusion framework through more centralized, CMS-directed enforcement, including improved real-time data integration across PECOS, NPPES, and MA encounter systems; push real-time revocation and preclusion alerts to plans via HPMS; and CMS-directed claim denial requirements when a provider is precluded due to revocation. A CMS-led approach would better effectuate the intent of the preclusion list while avoiding disproportionate administrative burden or unintended network disruption.

RFI Question: Does the current preclusion list adequately serve the needs of MA organizations in identifying and preventing payments to providers and suppliers that pose fraud, waste, or abuse risks?

AHCA/NCAL Comment: While the preclusion list is an important program-integrity tool, it does not consistently or adequately serve MA organizations' needs in identifying and preventing payments to providers and suppliers that pose fraud, waste, or abuse risks due to limitations in how revocation and preclusion information is operationalized. As stated previously, we note that the current preclusion list can be improved by aligning preclusion list policies across traditional fee-for-service models and Part C Medicare Advantage plans, through a more centralized, CMS-directed approach.

RFI Question: 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?

AHCA/NCAL Comment: AHCA/NCAL supports CMS' goals to eliminate fraud in the Medicare program. However, we do not believe that a blanket requirement for all MA providers and suppliers to enroll in the Traditional Medicare program is necessary or appropriate; instead, it would be excessive and duplicative, adding significant administrative burden and waste to providers and MA plans, and it is unclear of how such are requirement would impact the fee-for-services SNF QRP and VBP programs if there is an infusion of enrolled providers that do not furnish care to fee-for-service beneficiaries. Additionally, the existing Traditional Medicare provider enrollment and revalidation processes are lengthy and resource-intensive for participating providers. As noted previously, CMS has indefinitely suspended the SNF provider enrollment revalidation process to permit CMS to catch up on processing provider enrollments across all provider types resulting from the recent significant expansion of SNF/NF reporting requirements. Mandating fee-for-service enrollment for MA billing for long term and post-acute care providers would not meaningfully advance program integrity and instead would compound operational challenges—adding more complexity for providers, MA plans, and the federal government without producing clear fraud mitigation results. Moreover, CMS has alternative, less burdensome strategies available—such as strengthening preclusion list alignment and improving real-time provider status reporting—to identify and remove bad actors more effectively. These approaches advance CMS' program integrity goals without imposing unnecessarily duplicative enrollment obligations.

It is noteworthy that most SNF/NF providers participating in MA are already enrolled in Traditional Medicare, meaning this proposal would add administrative burden for minimal practical benefit. Imposing fee-for-service enrollment would exacerbate existing participation challenges in a sector already operating under significant workforce and operational pressures. For these reasons, we support a carveout for SNF/NF providers should CMS require MA providers enroll in fee-for-service as a condition of participation. Such an exemption would

prevent duplicative enrollment requirements and reduce the operational and administrative burden on plans, providers, and the federal government.

RFI Question: Should such a requirement apply only to high-risk provider and supplier types?

AHCA/NCAL Comment: Mandating provider enrollment for high-risk provider and supplier types should be assessed on a case-by-case basis; as stated previously, long term and post-acute care providers are already subject to a significantly higher level of administrative enrollment transparency requirements than other provider types. Moreover, these providers are typically already enrolled in Medicare fee-for-service by virtue of serving a high proportion of Medicare beneficiaries.

RFI Question: What operational, administrative, and financial impacts would a requirement to enroll in the Traditional Medicare program have on providers and suppliers that currently only bill MA plans?

AHCA/NCAL Comment: Long term and post-acute care providers frequently operate under resource constraints, including workforce shortages and fragmented data and technology systems. In this context, requiring traditional fee-for-service enrollment could introduce operational and financial pressure, particularly for smaller or independent providers. Instead, CMS should also take steps to improve the SNF provider fee-for-service enrollment process and address the backlog of already submitted provider enrollment revalidations. If required in the future, CMS should consider supports such as simplified enrollment pathways leveraging artificial intelligence to reduce extensive and duplicative reporting requirements for entities whose information is already available to CMS, and flexible implementation timelines for long term and post-acute care providers.

RFI Question: Are there alternative mechanisms that could achieve similar program integrity objectives without requiring enrollment in Traditional Medicare?

AHCA/NCAL Comment: We appreciate CMS' focus on program integrity and saving taxpayer dollars and underscore support from a coordinated infrastructure across traditional fee-for-service models and Part C Medicare Advantage. CMS could strengthen data sharing between fee-for-service and Medicare Advantage while improving accuracy, timeliness, and accessibility for MA plans. Additionally, there are several ways that CMS could prevent revoked fee-for-service providers from billing MA plans without requiring MA-only providers to enroll in fee-for-service.

Maintaining a real-time preclusion list aligned across Medicare fee-for-service and MA would allow the federal government and MA organizations to recognize and root out bad actors quickly. We believe that any individual provider precluded from fee-for-service Medicare for cause should also be precluded from Part C Medicare Advantage participation during the applicable preclusion period, regardless of provider categorical risk assignment in 42 CFR 424.518.

AI-enabled detection could help identify bad actors and suspicious billing patterns without requiring fee-for-service enrollment. However, current AI tools are often hospital-oriented and AI training datasets systematically underrepresent older adults, particularly those in long term and post-acute care settings. This leads to biased algorithms that perform poorly or produce harmful recommendations when applied to geriatric populations. AI-powered clinical decision support tools often lack integration with geriatric-specific clinical practice guidelines, which can lead to inappropriate fraud detection. AI tools must be able to detect appropriate long term care billing and claims patterns, including complex polypharmacy, chronic conditions, cognitive impairment, and post-acute recovery patterns. High-risk populations, such as long term and post-acute care patients, should have all AI-identified fraud patterns be reviewed by a human agent trained to recognize clinically appropriate patterns of care. AI can only

be deployed to achieve program integrity if federal agencies coordinate governance and infrastructure-building, security and safety guardrails are enforced, and tools are tailored to elderly and medically complex populations. We support the allowance of AI-generated documentation to satisfy regulatory documentation requirements in skilled nursing facilities (42 CFR 483.20, 483.21), provided the AI tool meets transparency and accuracy standards.

F. Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions (91 FR 9806)

Due to the significant risk of fraud, waste, and abuse with certain high-risk items and services (for example, DMEPOS), CMS is seeking feedback about the impact of reducing the Medicare Parts A and B (Traditional Medicare) 1-calendar year claim filing deadline for high-risk items and services, including but not limited to DMEPOS. Ensuring claims are filed more promptly will assist CMS in evaluating data and reduce the ability of providers to back-bill for fraudulent claims.

RFI Question: How would a claim filing deadline of 90 to 180 calendar days, which is consistent with private industry norms, impact your practice?

AHCA/NCAL Comment: We do not believe that reducing the Medicare claim filing deadline from the current 1-calendar year standard to 90 or 180 days would be appropriate for the SNF provider setting. Such a change would create unnecessary administrative challenges and result in increased inappropriate payment denials for providers furnishing medically necessary and legitimate care. While most SNF providers submit Medicare claims within the suggested 90- or 180-day window, there are many legitimate circumstances under which SNF claims submission may take longer to a Medicare MAC. Such a policy change would disproportionately and negatively impact the SNF sector.

First, SNF providers typically bill claims monthly due to the nature of the inpatient services being provided on a 24/7 basis and the complexities involved with the bundled SNF PPS PDPM payment model. Such a requirement would effectively and unfairly reduce the SNF billing compliance window to as short a period as 60 days from the date of service. Changing SNF billing timing or frequency would create additional administrative burden and risk of errors by providers and the MACs than the current billing process.

Second, over half of Medicare beneficiaries are enrolled in Medicare Advantage plans (MA). Given a beneficiary's right to disenroll from an MA plan and CMS administrative file posting lag time, the SNF provider may not be aware of the change until receiving a denial from the MA plan. In such cases, under Medicare law, the SNF can then submit the claim to the Medicare Part A MAC for appropriate claim processing. Such activities may take longer than 90- or 180-days from the date of service but are easily accomplished within the current 1-calendar year window.

Third, similar to the Medicare Advantage issue, SNF providers often provide care to Medicare beneficiaries that may appear to be primarily covered by commercial health insurers, auto accident insurers, workers compensation insurers the Veteran's Affairs (VA), or other government entities, and submit claims to those entities only to receive notices that those entities are not responsible for paying the claim. In such cases, under Medicare law, the SNF is legitimately permitted to submit a Medicare claim for furnished services. Such activities may take longer than 90- or 180-days from the date of service but are easily accomplished within the current 1-calendar year window.

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

AHCA/NCAL Comment: As discussed in our response to the above question, we do not believe the shorter claim submission deadlines of 90- or -180 days are feasible or appropriate for SNF providers for the reasons described.

RFI Question: What would be the best way to implement a shorter claim filing deadline for certain high-risk items and services? What are the benefits or drawbacks of imposing a shorter claim filing deadline for all of the following:

++ All claims filed by specific high-risk provider or supplier types (for example DMEPOS suppliers).
++ All claims filed for specific high-risk items or services.
++ All claims filed by specific providers who are high-risk.
++ Some other method(s).

AHCA/NCAL Comment: As we have discussed above, we do not believe any claim submission timeline shortening is appropriate for the SNF sector. We also do not believe there is evidence to justify carving out specific providers or specific services furnished by SNF providers. Such policy carve-outs would only add administrative burden, create risk for more errors, and most importantly, would not mitigate any of the three key problems we describe above regarding the disproportionate negative impact on good faith SNF providers.

RFI Question: Would it be beneficial to apply this standard to all items and services rather than only to high-risk items and services to reduce unnecessary administrative complexity?

AHCA/NCAL Comment: No. Per our above comments, we do not believe any claim submission timeline shortening is appropriate for the SNF sector and would disproportionately create more problems by denying appropriate services than preventing fraud schemes.

RFI Question: Would the current flexibilities in 42 CFR 424.44 or additional flexibilities for a shorter claim filing deadline be appropriate to support such a change, and if so, what would those flexibilities be?

AHCA/NCAL Comment: No. Per our above comments, we do not believe any claim submission timeline shortening in regulation is appropriate for the SNF sector and would disproportionately create more problems by denying appropriate services than in preventing fraud schemes.

G. Artificial Intelligence in Medicare Advantage Coding Oversight and Hospital Billing (91 FR 9806)

CMS is seeking input from stakeholders about the availability, use, efficacy, and cost of using artificial intelligence (AI), based on machine learning and other methods, to assist with accurately and efficiently abstracting diagnoses from medical record documentation as part of a medical records review. More specifically, CMS is seeking input on the following topics:

RFI Question: What types of AI solutions (including commercial off-the-shelf (COTS) products) are most effective and efficient for assisting human coders with large volumes of records?

AHCA/NCAL Comment: We strongly believe that any AI solutions used in long term and post-acute care settings must prioritize usability, interoperability, and burden reduction to be effective. AHCA/NCAL stresses that digital coding tools in these settings must be accessible, secure, user-friendly, and capable of integrating with fragmented EHR systems. The most effective AI solutions for coding support in long term and post-acute care settings are those that are structured, rules-based, and appropriately trained to understand the clinical

complexity of the population. Given resource constraints and the fact that the LTPAC sector did not receive any HITECH dollars, solutions that are open-source and require minimal customization are the most effective.

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

AHCA/NCAL Comment: AI systems should be transparent, safe, secure, and well-governed, especially in care settings serving medically vulnerable populations such as SNF/NFs. AI tools should enable coders to see why the model surfaced a given suggestion; incorporate coder acceptance or corrections into the model's iterative improvement; include constraints such as automated flagging of recommendations and prevention of unsupported diagnoses; bias mitigation checks to ensure equitable and population-relevant technology design; and strong security and privacy protections. These features ensure accuracy while preserving critically important human oversight.

Further, current AI training datasets systematically underrepresent older adults, particularly those in long term and post-acute care settings. This leads to biased algorithms that perform poorly or produce harmful recommendations when applied to geriatric populations. Moreover, AI-powered clinical decision support tools often lack integration with geriatric-specific clinical practice guidelines, which can lead to inappropriate fraud detection. AI tools must be able to detect appropriate long term care billing and claims patterns, including complex polypharmacy, chronic conditions, cognitive impairment, and post-acute recovery patterns. High-risk populations, such as long term and post-acute care patients, should have all AI-identified fraud patterns be reviewed by a human agent trained to recognize clinically appropriate patterns of care.

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

AHCA/NCAL Comment: We believe that all AI-generated outputs be displayed in a safe and secure manner that is easy to interpret and integrated directly into coders' existing workflows. Effective and transparent presentation would include clear differentiation between AI-generated suggestions and coder-entered diagnoses; confidence levels or supporting evidence links to enable human reviewers to evaluate validity; minimal workflow disruption with seamless integration into systems and interfaces; and audit logs capturing AI and human coder actions as well as overrides for compliance review.

CMS should also consider compliance risks, first of which is over-reliance on AI outputs. In the LTPAC setting, billing and service patterns are skewed towards more expensive, hands-on and intensive services by virtue of clinical complexity. AI tools must be able to detect appropriate long term care service patterns, including complex polypharmacy, chronic conditions, cognitive impairment, and post-acute recovery patterns. CMS should also consider whether compliance with AI poses documentation integrity risks, or if coders feel pressured to accept algorithmic suggestions that may not be aligned with the provider's recommendations. Further, AI-generated coding recommendations may induce hallucinated diagnoses or AI-suggested conditions not supported by medical documentation—these types of "unlinked" diagnoses can contribute to inappropriate payments to MA plans. AI tools targeting LTPAC populations must undergo validation against population-relevant cohorts including geriatric and chronic impairments and demonstrate transparency in their decision-making logic and auditability of the AI outputs, particularly when involving generative AI technology. Finally, CMS should consider the high likelihood of potential bias or accuracy failures in geriatric, chronically ill, or multimorbid populations. AI models trained predominantly on younger cohorts may recommend inappropriate medication dosages, fail to account for age-related pharmacokinetics, or overlook fall risk factors specific to frail older adults.

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

AHCA/NCAL Comment: Our broader AI comments in our February 23, 2026 comments to the Department of Health and Human Services (HHS) in response to the Request for Information (RFI): Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care [RIN 0955-AA13] highlight several key lessons relevant to AI deployment in the long term and post-acute care sector:

- Clinical Decision Support (CDS) versus Decision Support Interventions (DSI): Under the HTI-1 Final Rule, distinctions between CDS software and DSI must account for workflow-critical interventions in LTPAC settings, such as glucose monitoring in diabetes management, delirium detection, fall risk assessment, and polypharmacy optimization. Many AI tools operating in these domains directly impact patient safety and outcomes.
- Algorithmic Transparency and Accountability: AI tools targeting LTPAC populations must undergo validation against population-relevant cohorts including geriatric and chronic impairments and demonstrate transparency in their decision-making logic and auditability of the AI outputs, particularly when involving generative AI technology. Vendor accountability for algorithmic bias affecting safety outcomes should be enforced, particularly for tools addressing conditions prevalent in older adults and those with multiple chronic conditions.
- Age-Inclusive Standards: Regulatory frameworks should mandate age-stratified data collection and validation in real-world data (RWD) studies to mitigate age bias in AI algorithms. Current clinical trials frequently underrepresent geriatric patients, leading to biased algorithms that may recommend inappropriate care pathways for o Value-Based Payment Alignment: Payment models should incentivize the use of high-value AI interventions that improve outcomes for complex, high-need populations. Alternative payment models (APMs) and value-based care arrangements should explicitly include quality measures and risk-adjustment methodologies that account for LTPAC populations.
- Coverage for AI-Enabled Remote Monitoring: Medicare and Medicaid should expand coverage for AI-enabled remote patient monitoring (RPM), ambient AI, and other technologies regardless of where the beneficiary is residing that support aging in place, resident safety, and reduce preventable hospitalizations and emergency department visits.
- Infrastructure Investment: Reimbursement mechanisms should support the underlying infrastructure required for AI adoption, including interoperability investments, workforce training, and technical assistance for small and rural providers.
- Mandate Age-Stratified Validation (42 CFR Part 412, 413, 482, 483, 484, 485): Require AI tools used in clinical care to undergo validation testing on age-stratified cohorts, particularly for tools intended for use in Medicare populations. Validation should include performance metrics specific to geriatric patients and demonstrate absence of age-based bias.
- Algorithmic Transparency Requirements (45 CFR Part 170): Under the Office of the National Coordinator (ONC) Health IT Certification Program, establish certification criteria for AI-enabled clinical decision support tools that require disclosure of training data characteristics, model performance on diverse populations, and explanation of decision logic. FHIR®-based event-condition-action rules per HL7 Clinical Reasoning modules should be used to enforce transparency.
- Interoperability Standards for Geriatric Data (45 CFR 170.315): Expand the United States Core Data for Interoperability (USCDI) to include geriatric-specific data elements captured in PACIO Project FHIR® implementation guides: functional status (ADLs/IADLs), cognitive assessments (PHQ-9, CAM), advance directives, standardized medication profiles, social determinants of health, and caregiver support information.
- Privacy and Security Safeguards (45 CFR Parts 160, 164): Clarify HIPAA applicability to AI-generated clinical insights and establish standards for de-identification, consent management, and audit trails for AI tools that access or generate protected health information.

- Reduction of Administrative Burden: AI tools that automate documentation, quality reporting, and administrative tasks should be incentivized through payment policy to facilitate workflow transitions to reduce provider burden and allow clinicians to focus on direct patient care.

Successful adoption requires targeted, sector-specific funding and incentives for interoperable, equitable digital tools.

RFI Question: Are there AI solutions that address coding issues related to overpayments and underpayments, and can those AI solutions be used for compliance oversight?

AHCA/NCAL Comment: We believe there are AI solutions that can support identification of coding anomalies tied to both overpayments and underpayments, but CMS must adopt a governance-first approach. AI systems can support compliance in many ways, including by flagging mismatches between documentation and coded diagnoses, identifying patterns of upcoding in large MA plans, tracking coder-level variation, and highlighting missing or duplicative entries across EHR modules. However, we caution that AI should not exacerbate disparities or introduce unintended bias, particularly in geriatric, multimorbid, and institutionally based populations. These populations will likely have more complex diagnoses, clinical characteristics, care needs, and claims data than their younger, community-based counterparts.

Human oversight remains essential, especially for this unique and highly complex population. CMS should maintain clear guardrails around AI's use in compliance, ensuring that tools are transparent, validated, and reliable in the LTPAC population, and reduce administrative burden without creating new audit obligations. Importantly, CMS should ensure that audit and claw back guardrails are put into place for compliance oversight and focus on egregious practices by MA organizations. CMS could also leverage AI and advanced analytics to assess whether MA plans' internal coverage criteria are consistent with Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and other applicable Medicare coverage standards. This type of review would be particularly valuable given that many plans have internal coverage criteria that do not align with regulations in 42 CFR 422.101, imposing undue administrative burden and excessive denials for post-acute care services, despite compliance with Medicare coverage rules. Similarly, as per the CMS 2024 Part C and Part D Program Audit and Enforcement Report, MA plans have repeatedly been documented denying post-acute care services in SNF settings, arguing that the beneficiary did not need services despite meeting medical necessity criteria.

We have also heard from providers that some MA plans or third party delegated entities may be using AI tools to track patterns in post-acute care appeals and then communicating with providers regarding the volume of appeals submitted. If used in a manner that pressures providers or indirectly discourages appeals, such practices could undermine beneficiaries' statutory appeal rights and warrant closer CMS scrutiny. In addition, stakeholders have reported a significant increase in the issuance of Notices of Medicare Non-Coverage (NOMNCs) over weekends. CMS could leverage artificial intelligence and data analytics to examine whether there are disproportionate patterns of weekend NOMNC issuance, particularly given that many post-acute care facilities have limited administrative staff availability during weekends. In such circumstances, notices may not be addressed until the following business day, potentially resulting in delays in appeal initiation and increased financial liability for providers for otherwise covered days of care. Identifying these patterns would help CMS assess whether timing practices may be inadvertently undermining beneficiary appeal rights or creating inappropriate provider liability. CMS can address MA plan's overly restrictive criteria for services, medical necessity determinations, Notices Of Medicare Non-Coverage (NOMNC) determinations, and other insidious practices through appropriately trained AI compliance tools.

J. Surety Bonds (91 FR 9807)

RFI Question: We request public feedback on means of strengthening our existing surety bond requirement such as increasing the required bond amount, expanding the types of Medicare providers and suppliers that must maintain a surety bond.

AHCA/NCAL Comment: We do not believe that blanket implementation of Surety Bonds for SNF/NF providers would be a rational policy approach. Unlike some other provider types that do not provide services at a fixed physical location or provide intermittent services at a location but can easily move on creating challenges for pay-and-chase fraud prevention efforts, SNF/NF providers do not have such potential pay-and-chase mobility as they furnish residential care services 24/7/365 in a brick-and-mortar and highly regulated locations with fixed assets.

Additionally, since October 2024, SNF providers have had a much more rigorous provider enrollment transparency reporting requirement than any other Medicare provider or supplier type with expanded reporting of ownership, operational control, and additional disclosable parties (ADPs).

Finally, CMS just recently introduced for cost reporting periods ending on or after September 30, 2025, the most significant overhaul to SNF cost reports in 15 years. The new requirements are centered on the transition from the legacy Form CMS-2540-10 to the updated Form CMS-2540-24. The additional fraud prevention details include items such as; 1) Facilities must now provide separate reporting for Medicare Advantage/HMO and Medicaid HMO census and revenue data, moving away from grouping them with "Other" payers, 2) A new dedicated column in Worksheet A requires reporting contract labor costs for all cost centers, not just direct care and therapy, and 3) Separate lines have been added for specific costs including: Quality Assurance and Performance Improvement (QAPI), In-service education and training, Patient transportation (Part A), and Preventive vaccines (now a reimbursable cost center).

Such transparency reporting should provide CMS information that would be much more likely effective in preventing or identifying fraud schemes without adding a Security Bond cost burden for a type of provider where most are smaller volume settings that operate on razor-thin margins. Specifically, according to the MedPAC March 2025 Report to Congress, the median SNF had 100 beds, while ten percent of facilities had 176 or more beds and ten percent of facilities had 50 or fewer beds, while the SNF all-payer profit margin in 2023 was 0.4 percent (negative 1.3 percent in 2022).

K. Medicaid and CHIP (91 FR 9807)

We are seeking stakeholder feedback on how to expand CMS' regulatory authority to act expeditiously to prevent, identify, and address instances of fraud, waste, and abuse in Medicaid and CHIP. We are also soliciting suggestions about cutting-edge technological tools that could be harnessed to advance this work.

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

AHCA/NCAL Comment: AHCA/NCAL supports program integrity efforts that are accurately targeted to provider types and service categories with documented fraud risk. Before pursuing new regulatory authorities, we encourage CMS to prioritize proportionate application of existing statutory authorities, using risk-based screening frameworks that concentrate oversight resources on identified bad actors rather than applying uniform additional scrutiny across all Medicaid provider types. As we detail in our responses to subsequent questions in this section, long-term and post-acute care providers operating in SNF/NF settings are already subject to extensive concurrent oversight requirements under federal and state licensing, certification, and provider

enrollment frameworks. Expanding Medicaid program integrity authority without calibrating its application to actual risk by provider type risks displacing limited CMS and state agency resources from genuine fraud schemes toward providers with legitimate billing patterns.

RFI Question: In order to strengthen program integrity oversight of provider enrollment, should CMS require that states require their high-risk providers to revalidate more frequently than every 5 years, and if so, how frequently?

AHCA/NCAL Comment: AHCA/NCAL does not believe that requiring more frequent revalidation than the current five-year cycle is warranted for SNF/NF providers in the Medicaid program. SNF/NF providers are subject to mandatory state licensing surveys and federal certification surveys under 42 CFR Part 483, which constitute independent, ongoing verification of operational status and regulatory compliance on a cycle that is independent of, and in many cases more frequent than, the Medicaid revalidation process. Since October 2024, SNF/NF providers have also faced significantly expanded Medicare provider enrollment transparency requirements under the Additional Disclosable Party (ADP) framework — requirements that have already placed substantial administrative burden on providers, Medicare Administrative Contractors, and CMS itself, extending what was projected as a three-month compliance process to more than sixteen months without completion. That same rule expanded Medicaid SNF/NF enrollment reporting regulatory requirements including definitions; reporting of governing bodies, each officer, director, member, partner, trustee, or managing employee; each Medicaid required additional disclosable party; and the organizational structure. Any change to Medicaid revalidation frequency for high-risk providers should be grounded in documented evidence of fraud risk specific to the provider type in question, should account for existing independent oversight mechanisms applicable to that provider type, and should not extend to provider categories already subject to multiple concurrent verification processes. A risk-stratified approach — one that distinguishes between provider types with demonstrated vulnerability to fraud schemes and those subject to independent ongoing regulatory oversight — would more effectively protect program integrity without imposing unnecessary administrative burden on compliant providers.

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

AHCA/NCAL Comment: Please refer to our comments in Sections A and G of this letter regarding AI and advanced analytics as program integrity tools. Those principles apply equally in the Medicaid context. We specifically emphasize that any AI tools deployed in Medicaid program integrity must be validated against geriatric and medically complex populations, which are substantially underrepresented in most commercial AI training datasets. Failure to validate against these populations create risks of generating false positives that disrupt access to legitimate long-term and post-acute care services for some of the most clinically vulnerable Medicaid enrollees.

RFI Question: What tools or guidance can CMS give to states to enhance program integrity in the Medicaid and CHIP managed care and fee-for-service programs?

AHCA/NCAL Comment: CMS can strengthen state program integrity capacity by providing clear sub-regulatory guidance on risk-based screening frameworks that allow states to allocate limited investigative resources to provider types and service categories with documented fraud risk patterns. Guidance that operationalizes proportionate scrutiny — calibrated to evidence of risk rather than applied uniformly across all provider types — would reduce administrative burden on providers in highly regulated care settings while enabling states to concentrate on oversight activity where the risk of fraud is highest.

RFI Question: What data and information should states report to CMS to ensure that fraud, waste, and abuse is being identified, investigated, and resolved?

AHCA/NCAL Comment: Data reported by states to CMS should be accurate, timely, and actionable. Reporting requirements should be proportionate to the documented risk profile of the provider type or service category being monitored and should not themselves become administrative burdens that divert state agency resources from direct program integrity activity. CMS should work with states to ensure that data collection instruments are sufficiently specific to distinguish between billing errors, documentation deficiencies, and fraud — distinctions that have material consequences for providers and for the accuracy of program integrity reporting.

RFI Question: What best practices and standardized processes should states implement when responding to recovery audit contractor (RAC) findings?

AHCA/NCAL Comment: AHCA/NCAL recommends that CMS establish the following minimum standards for state Medicaid RAC programs applicable to long-term and post-acute care providers. RAC audit scope and sampling methodology should be transparent and grounded in documented risk indicators specific to the provider type and service category under review. Broad retrospective audits without documented rationale impose substantial burden on providers and frequently yield high appeal reversal rates, which indicates that resources are being directed toward compliant providers rather than genuine bad actors. Timelines for audit completion, overpayment demand issuance, and appeals resolution should be defined in regulation or contract, not left to contractor discretion. Indefinite holds on payment pending audit resolution creates cash flow uncertainty for providers operating under the constrained financial conditions that are well-documented in MedPAC, MACPAC, and OIG reporting. The appeals process for RAC findings should be meaningfully accessible, with clearly defined standards of review and timely decisions at each level. CMS should require states and their RAC contractors to track and report appeal reversal rates by contractor and by provider type, providing accountability for audit accuracy over time. Extrapolation of overpayment findings from sampled claims to unreviewed claims should not occur absent documented evidence of a systemic billing error pattern, and providers should retain the right to contest both the underlying finding and the extrapolation methodology in the appeals process.

RFI Question: What data or information should be made publicly available that would allow for transparency in Medicaid by states, health plans, and providers?

AHCA/NCAL Comment: AHCA/NCAL supports appropriate transparency in Medicaid program integrity activities. Information made publicly available should be accurate, clearly contextualized, and should distinguish between audit findings and fraud determinations — particularly given that a meaningful proportion of audit findings are reversed on appeal. Public reporting that characterizes preliminary or contested findings as fraud before an adjudicative process is complete risks reputational harm to providers that are ultimately found to have billed correctly and in full compliance with applicable coverage and billing standards.

RFI Question: How can CMS further enhance the Healthcare Fraud Prevention Partnership (HFPP) to strengthen fraud detection within state agencies and law enforcement?

AHCA/NCAL Comment: AHCA/NCAL supports investment in cross-payer data sharing through the HFPP as a mechanism for identifying fraud patterns that cross Medicaid, Medicare, and commercial payer boundaries. Effective cross-payer fraud detection can improve accuracy in distinguishing between provider billing patterns consistent with the clinical complexity of the population being served and scheme-based fraud — a distinction that is particularly important for long-term and post-acute care providers serving geriatric and medically complex populations.

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

AHCA/NCAL Comment: Please refer to our detailed comments in Sections A and G of this letter. Those recommendations apply fully in the Medicaid context, with particular emphasis on the need to validate AI fraud detection tools against Medicaid-enrolled LTPAC populations, which have substantially higher rates of chronic illness, cognitive impairment, and complex polypharmacy than the commercial populations on which most AI training datasets are based.

L. State-Specific Medicaid and CHIP Questions (91 FR 9807)

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

AHCA/NCAL Comment: AHCA/NCAL urges CMS to ensure that any statutory or regulatory changes intended to strengthen fraud prevention are proportionate to documented risk by provider type, preserve due process protections for providers subject to adverse actions, and avoid imposing administrative burdens on compliant providers that divert resources from direct care delivery. Changes that expand state enforcement authority without corresponding safeguards for accurate identification of fraud risk could displace limited oversight capacity from genuine bad actors toward providers operating lawfully within applicable coverage and billing standards.

RFI Question: What regulatory or administrative changes could CMS make to empower states to—(a) pursue bad actors; and (b) better coordinate program integrity efforts with the federal government, law enforcement, and other states?

AHCA/NCAL Comment: States are best positioned to identify and pursue bad actors when they have access to accurate and timely federal program integrity data and when coordination mechanisms between state Medicaid agencies, CMS, and law enforcement partners are clearly defined. CMS can improve this coordination by ensuring that state access to relevant federal databases, including PECOS and NPPES, is current, reliable, and accessible to state program integrity staff in a timely manner. Clear guidance on when and how states should escalate findings for federal coordination, and on the respective roles of state Medicaid Fraud Control Units and CMS contractors in joint investigations, would reduce duplicative activity and improve enforcement efficiency.

RFI Question: What data or tools would facilitate state program integrity activities?

AHCA/NCAL Comment: Please refer to our comments on tools and technologies in Section K of this letter. Risk-stratified data analytics tools that allow states to focus investigative resources on service categories and provider types with documented fraud risk are preferable to broad-based audit programs that apply uniform burden across all Medicaid provider types. CMS can support state capacity by providing access to validated risk-scoring models and by sharing documented fraud pattern data that allows states to calibrate their investigative priorities based on current threat intelligence rather than static categorical risk designations.

RFI Question: Would further use of federal databases, such as Do Not Pay (DNP), or non-federal databases provide states with more complete information to move further away from a pay-and-chase model and towards pre-pay review?

AHCA/NCAL Comment: AHCA/NCAL supports the principle of moving toward pre-payment review where the underlying data systems are sufficiently accurate to avoid disrupting legitimate claims. However, federal databases used for pre-payment review, including the Do Not Pay database, have documented accuracy

limitations that have resulted in inappropriate payment holds for providers operating in full compliance with Medicaid enrollment and billing requirements. Any expansion of pre-payment review relying on these databases should include robust and timely error correction mechanisms, clearly defined timelines for resolving disputed holds, and meaningful provider appeal rights. Pre-payment review that results in sustained payment interruption for compliant providers can directly impair beneficiary access to care, particularly in long-term and post-acute care settings where providers cannot defer service delivery pending payment resolution.

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

AHCA/NCAL Comment: States that have achieved the most effective program integrity outcomes have done so by implementing risk-stratified frameworks that concentrate heightened scrutiny on service categories and provider types with documented fraud patterns, while reducing administrative burden on lower-risk providers with established compliance histories and independent oversight. CMS can support replication of these approaches by developing and disseminating risk-stratification guidance tailored to state Medicaid program structures, with particular attention to distinguishing between provider types subject to independent ongoing regulatory oversight and those operating without equivalent verification mechanisms.

RFI Question: What is the best way for states to learn about the most up to date technology or data analytic tools available to effectively reduce fraud, waste, and abuse in Medicaid and CHIP?

AHCA/NCAL Comment: CMS can help states stay current on available fraud detection technology by maintaining and updating a repository of vetted fraud detection tools and data analytic approaches, including documented implementation costs, performance metrics on Medicaid-relevant populations, and evidence of validation against provider types and service categories relevant to each state's program structure. This would support states in making evidence-based technology adoption decisions without duplicating evaluation efforts across state lines.

RFI Question: What incentives could be put in place for states to proactively engage in program integrity efforts, and what new penalties might be necessary to address non-compliance by states?

AHCA/NCAL Comment:

AHCA/NCAL supports the use of positive incentives to encourage proactive state program integrity investment, such as enhanced federal financial participation for investments in fraud detection infrastructure and data analytics capacity. We do not offer specific recommendations regarding penalty structures for state non-compliance, as this involves federal-state fiscal relationships outside AHCA/NCAL's direct membership interest.

Conclusion

We appreciate the opportunity to comment on this RFI and stand ready to work collaboratively with CMS, and other federal partners to prevent bad actors from entering the Medicare and Medicaid programs and to weed out bad actors currently participating. Please contact the following individuals at AHCA/NCAL for questions or needed follow-up to specific RFI topics:

- Provider Enrollment & Fee-for-Service Medicare: Daniel Ciolek at dciolek@ahca.org
- Medicare Advantage: Nisha Hammel at nhammel@ahca.org
- Medicaid: Grant Beebe at gbeebe@ahca.org