

March 30, 2026

Dr. 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)

Dear Administrator Oz:

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH).¹

The National MLTSS Health Plan Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.² Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service (FFS) system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible.

We appreciate the administration's efforts to make CMS more effective in addressing fraud to protect taxpayer dollars and the Americans that the MLTSS Association serves.

LTSS cover a broad range of day-to-day services and supports needed by people with long-term conditions, disabilities, or frailty to live as safely and independently as possible. Medicaid is the largest payer for LTSS in the United States, serving almost 10 million Americans in 2023.³ The need for LTSS is expected to grow substantially in the coming decades, driven in large part by the population aging and more older Americans facing

¹ [Federal Register: Request for Information \(RFI\) Related to Comprehensive Regulations To Uncover Suspicious Healthcare \(CRUSH\)](#)

² Members include Aetna, AlohaCare, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community HealthChoices

³ [Characteristics of People Using Medicaid Long-Term Services and Supports | CMS](#)

significant disabilities. Projections indicate that the number of adults over age 65 with a significant disability will double between 2020 and 2065.⁴

LTSS can be delivered in facilities such as nursing homes, as well as in home and community-based settings (HCBS). Over the past decades, states have focused on rebalancing their LTSS systems by increasing access to HCBS. In 2023, over 87% of Medicaid LTSS users received HCBS, though HCBS accounted for only 64% of national Medicaid LTSS expenditures.⁵ HCBS helps to keep people in their homes, delaying or defraying the need for costly institutional services. Without access to HCBS, individuals receive LTSS in institutional settings at a much higher cost – resulting in wasteful expenditures of taxpayer dollars that could be spent more efficiently.

Managed care provides a proven, cost-effective way to deliver high-quality Medicaid HCBS. In 2023, fee-for-service (FFS) accounted for only 48% of LTSS users, but over 60% of total LTSS costs. In contrast, managed care accounted for almost 60% of all Medicaid LTSS users, but only 38% of total expenditures.⁶

As CMS contemplates actions to ensure the integrity of the Medicaid program, managed care offers solutions for effective oversight and delivery of HCBS. Below, we highlight how managed LTSS programs support broader Medicaid program integrity efforts while providing essential services to millions of Americans.

How Managed Care Supports Program Integrity

Within managed care, there are protections against fraud, waste, and abuse (FWA) embedded into the program at the Federal, State, and health plan level. These layers of protection work together to provide a comprehensive strategy for finding, resolving, and preventing instances of FWA.

Nationally, the Center for Medicaid and CHIP Services (CMCS) is responsible for managed care program integrity oversight at CMS. CMCS reviews documents, such as MCO contracts and state waiver applications, to ensure compliance with Federal Medicaid requirements. CMCS is also responsible for collecting managed care encounter data, which is used to measure state and health plan performance and monitor compliance with federal rules, supporting program integrity efforts.

⁴[Long-Term Care Services and Supports for Older Americans: Risks and Financing, 2022 Research Brief | ASPE](#)

⁵[Trends in Users and Expenditures for HCBS as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures, 2023 | CMS](#)

⁶[Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2023 | CMS](#)

In addition to Federal oversight, all state Medicaid programs must have mechanisms to identify and investigate fraud, and to refer suspected cases of fraud to the correct law enforcement agencies. States also have Medicaid Fraud Control Units (MFCU) that operate independently from Medicaid agencies.⁷ These MFCUs are tasked with investigating and prosecuting instances of potential Medicaid provider fraud. Independent ombudsmen also operate at the state level for consumers to raise concerns about the state’s Medicaid program. These ombudsmen collect and analyze issues raised to identify any patterns that may show the presence of FWA.

In states with Medicaid managed care, these protections go even further, as states are not only responsible for conducting program integrity activities for their managed care program, but also ensuring that managed care plans are operating their own. To ensure that only eligible members receive, and only eligible providers bill for services, MCOs must notify their state Medicaid agencies if they receive information about changes to either provider or member eligibility. To protect taxpayer dollars, MCOs must suspend payments to providers that states have found to have credible accusations of fraud and promptly report any overpayments due to potential fraud.⁸ MCOs are also required to implement systems to verify that services billed were actually delivered to their members.

At the plan level, internal MCO processes to detect and rectify potential instances FWA go far beyond what is required under state and Federal law. MCOs have their own compliance teams that monitor claims, encounter, and authorization data to identify potential FWA and conduct regular internal audits and other routine monitoring. Health plans also have their own special investigative units and the technology to do advanced analyses to identify issues that may otherwise go unnoticed. MCOs also have prior authorization procedures in place to proactively review services to ensure that only appropriate, medically necessary services are delivered to their members.

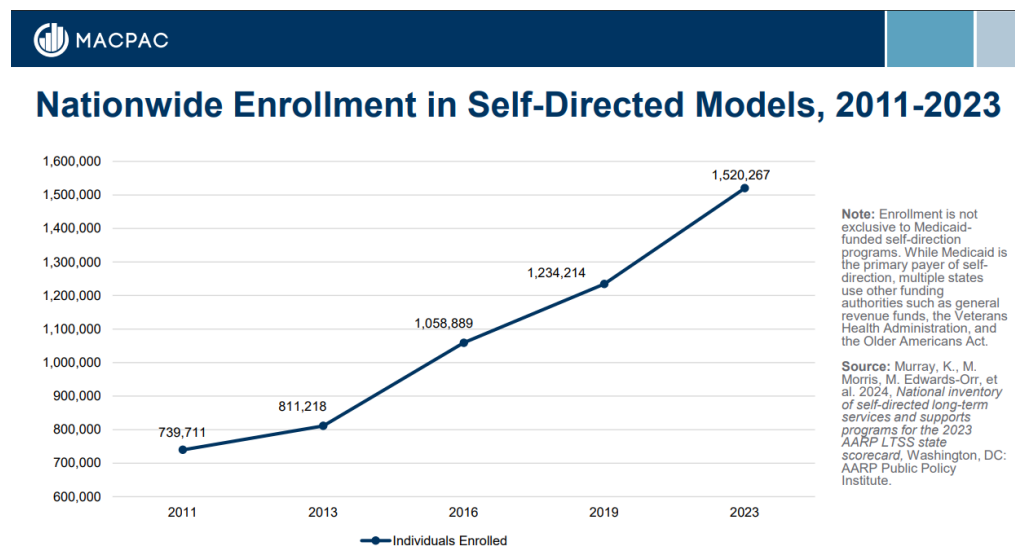
Within managed LTSS programs, care managers are responsible for conducting comprehensive assessments of members’ needs and developing appropriate service plans to meet those needs in the most cost-effective manner that supports the member’s health and independence. Services requiring prior authorization and high-cost services are further reviewed by MCO leadership. Because they work directly with members, caregivers, and providers, care managers have unique insight into their members’ needs, changes in

⁷ [Medicaid Fraud Control Units | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

⁸ [Managed care program integrity | MACPAC](#)

functional status, and any discrepancies between services authorized and delivered. This insight allows care managers to assess any potential instances of fraud and intervene in real-time, providing a layer of protection against FWA that is not possible through data analysis alone. Having care managers on the front line helps health plans to identify risks to program integrity early, while also maintaining person-centered care.

Within their MLTSS programs, many states have greatly increased opportunities for self-directed services over the past decade, with the number of individuals self-directing their care doubling nationally between 2013 and 2023.



This growth in self-direction was driven in large part by the COVID-19 Public Health Emergency, as states were encouraged to introduce new flexibilities for individuals receiving LTSS. Self-direction empowers individuals to have more control over how their care is delivered, resulting in care that is more tailored to the individual’s needs and preferences. Importantly, this personalized care also serves as a deterrent to potential FWA. As opposed to a traditional agency model, within self-direction, the individual receiving services is at the center of care planning and service delivery, providing a layer of direct oversight. If there are issues with service delivery or care quality, the individual self-directing their care is empowered to take immediate action, with additional support available from their MLTSS health plan. MLTSS health plans have also embedded significant program integrity protections into their self-direction programs.

⁹Self-Direction for Home-and Community-Based Services | MACPAC

Reflecting Federal efforts to strengthen HCBS program integrity, the 21st Century Cures Act required states to implement Electronic Visit Verification (EVV) systems by 2020.¹⁰ EVV captures and verifies that Medicaid-funded HCBS are delivered at the time and location they are billed for. The digital records created by EVV can be audited and reviewed by MCOs and state Medicaid agencies to ensure compliance with program requirements and individual service plans.

The introduction of EVV into self-directed services introduced a new layer of protection against FWA. As providers, Financial Management Services (FMS), health plans, and states have had time to adjust to these new requirements, we believe there are opportunities to build upon this foundation to scale best practices and further enhance program integrity.

We encourage CMS to work with MCOs, beneficiaries, and stakeholders to develop guidance and best practices to enhance program integrity and address concerns related to exceptions. Guidance could address exceptions, specifically when a service is provided in good faith, but technical issues with the EVV system prevent proper documentation. Codifying these exceptions would provide stakeholders with clear processes for addressing non-compliance due to technical issues. Finally, we recommend that CMS also consider how to utilize EVV to determine not only when and where services are delivered, but exactly what occurs between when a caregiver signs in and out. We believe there are opportunities for CMS to issue additional guidance about service documentation to strengthen existing program integrity protections.

Currently, state program design choices govern whether states directly contract with FMS providers within their self-direction programs, or if they allow MLTSS plans to hold these contracts. There is an opportunity for CMS to work with stakeholders to develop and provide additional guidance and technical assistance to states on the impacts of these decisions to assist states in making the choice that works best for their self-direction programs and for individuals who self-direct. We believe that MLTSS health plans can play a more significant role in program integrity oversight when they manage the contracts with FMS providers. When MLTSS plans hold contracts directly with FMS providers, they can select the highest quality providers, perform pre-payment audits of claims against EVV data, integrate data and reporting, and embed further protections into the FMS' processes. When states contract directly with FMS providers, MLTSS health plans often lack these

¹⁰ [EVV Requirements in the 21st Century Cures Act - Workshops | CMS](#)

opportunities to review data in real time and implement other innovative approaches to program oversight and quality incentives.

Within MLTSS self-direction programs, health plans also perform a range of oversight actions before a caregiver is approved to participate in the program, including the use of E-Verify and background checks. To build upon the oversight tools available within Medicaid LTSS programs, we recommend that CMS work with stakeholders to develop consistent identifiers for direct care workers. CMS could also work to strengthen the National Provider Identifier (NPI) generation process. Tighter process controls and validation during NPI creation would help to mitigate existing challenges, including false addresses and opacity of ownership structures. These changes would enable better oversight and tracking within and across programs to more easily and quickly identify potential duplicative records or services.

When a caregiver has been approved to provide services, MLTSS plans facilitate ongoing education and training for caregivers and individuals to clarify program requirements and minimize any accidental improper billing. Completion of trainings could be tied to caregiver identification numbers, allowing for oversight of training completion across state HCBS programs.

One of the structural challenges in addressing FWA is a lack of accessible data. While MLTSS health plans have built robust infrastructure to monitor, analyze, and audit their own data, they are working only within the context of their own organizations. Patterns of potential FWA may only become visible when reviewing statewide data from multiple sources. There is also a need for health plans to have insight into services delivered to their members that are carved out of managed care in their state. Access to this information would allow MLTSS health plans to utilize their data analysis infrastructure to identify potential duplicative or unnecessary services. When data is siloed and systems cannot communicate with each other, program integrity protections are limited in their impact.

We recommend that CMS, informed by best-practices from states and stakeholders, promulgate guidance that supports data sharing, analysis, and communication within states and across programs. When CMS is considering this guidance around data use, we believe that CMS can also support greater Medicare and Medicaid beneficiary data protections by adding additional data-protection measures and more stringent rules regarding the types of organizations and providers who can access this information. When MLTSS plans are empowered and supported by accessible data, they can play a key role in identifying and addressing potential FWA.

Conclusion

Within MLTSS, managed care organizations employ a large range of tools to prevent and detect FWA. Program integrity is at the heart of managed care operations, ensuring that taxpayer dollars are used effectively and appropriately. The industry looks forward to partnering with state and Federal agencies to advance program integrity efforts and safeguard the future of the Medicaid program.

In closing, the MLTSS Association appreciates CMS' efforts to proactively seek stakeholder input on strategies to strengthen program integrity and protect federal health care programs from FWA. We welcome the opportunity to work with CMS to provide additional feedback and operationalizing any future policy changes. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Mary Kaschak". The signature is fluid and cursive, with a large initial "M" and "K".

Mary Kaschak
Chief Executive Officer