March 30, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Administrator Oz:

On behalf of our medical group practices, the Medical Group Management Association (MGMA) thanks you for the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) request for information (RFI) related to comprehensive regulations to uncover suspicious healthcare (CRUSH). We appreciate CMS soliciting stakeholders' feedback on the most effective ways to reduce waste, fraud, and abuse. We look forward to working with you on targeted programmatic changes to make CMS more effective in reducing fraud while maintaining practices' ability to provide high-quality care to patients.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices, ranging from small private practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following perspectives.

Overview

MGMA supports CMS' commitment to exploring policy changes to reduce wasteful spending and fraudulent activities in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace. Medical groups take pride in providing healthcare services to Medicare beneficiaries and continue accepting patients with both Traditional Medicare and Medicare Advantage (MA) plans despite reimbursement failing to cover the cost of care. Unfortunately, while most Medicare providers are focused on serving the aging population in their communities, a small number of bad actors take advantage of vulnerable patients and waste beneficiary and taxpayer dollars. MGMA encourages CMS to develop and execute policies that target bad actors and remove them from the healthcare system. The agency should ensure new efforts to reduce fraud are directed at those most likely to commit fraud and do not introduce new

burdens or financial challenges that could impede practices' ability to provide high-quality care to patients.

Section A. Modifications to Program Integrity Requirements

CMS Question: CMS currently does not have an affirmative, regulatory authority to direct Medicare Advantage (MA) organizations and Part D plan sponsors to suspend payments to providers and suppliers that operate exclusively in Part C or Part D or both. Should CMS establish regulatory requirements that allow MA organizations and Part D sponsors to implement payment suspensions under circumstances similar to the payment suspension authority that exists for Traditional Medicare under 42 CFR 405.371, and require suspensions when directed by CMS?

MGMA Response: MGMA generally supports CMS' current authority for identifying and penalizing fraudulent actors, including conducting investigations, revocations, and re-enrollment bans, while helping to prevent fraudulent activities by providing education to reduce improper payments. CMS is a trusted and reliable entity with established procedures for investigating fraud. The authority to suspend payments should not be extended to third-party organizations, such as MA organizations, that may lack the judgment and credibility enjoyed by CMS. MA organizations' utilization policies demonstrate ongoing distrust of providers, and they should not be given the responsibility of identifying and penalizing fraudulent behavior.

While the growth of MA has led to innovations in providing value-based care and given beneficiaries new flexibilities, MA organizations have increasingly adopted utilization policies that lack transparency and inflict undue burden and financial stress on practices. Prior authorization requirements imposed by MA organizations inherently undermine providers' clinical decision-making and delay patient care. Additionally, MA organizations' opaque automatic downcoding policies arbitrarily downgrade some level 4 or 5 E/M codes to level 3, allowing them to underpay for services regardless of coding accuracy. Given MA organizations' track record of implementing these policies, we do not believe they have the capacity to act with discretion and target fraudulent actors and should not be given the same authority as CMS to suspend payment to providers.

Medical groups are already frustrated by the burdensome policies devised by MA organizations, and some have terminated MA contracts. The prospect of MA organizations having the authority to suspend payment based on what they deem to be fraudulent behavior could drive more practices to terminate MA contracts, leading to smaller networks and ultimately hurting patients.

Section C: Preclusion List and Medicare Advantage Enrollment Requirements

CMS 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?

MGMA Response: MGMA supports efforts to prevent fraudulent actors from shifting their billing from one payer to another. However, requiring all providers and suppliers to enroll in the Traditional Medicare program as a condition of billing MA plans would significantly increase

some practices' administrative workload and not effectively prevent fraudulent actors. Forcing providers who exclusively provide care to MA beneficiaries to enroll in Traditional Medicare would impose an unnecessary burden and not effectively identify or prevent fraudulent behavior.

Section F: Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions

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

MGMA Response: MGMA understands the importance of timely filed claims and CMS' interest in reducing the ability of providers to back-bill for fraudulent claims. Most claims are submitted within days or weeks of the service being provided. Practices want to receive prompt payment for their own cash flow purposes and strive to submit clean claims as quickly as possible. However, there may be specific situations, such as changes in a patient's Medicare eligibility or documentation issues, where practices may hold a claim for longer than a few months before filing. Additionally, if a practice is understaffed or experiencing a transition in administrative staff, claims filing could be slightly delayed beyond a few months. In all these situations, practices still aim to submit accurate claims as soon as possible and see the 1-calendar year claim filing deadline as a backstop, not a deadline. Removing this flexibility and reducing the claim filing deadline will not prevent fraudulent actors from back-billing as they will simply change the date of service on their claims.

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

Artificial Intelligence (AI) holds meaningful potential to support anti-fraud efforts including improving the accuracy and efficiency of medical record review, coding, and compliance. Realizing these benefits will require a thoughtful, risk-based policy approach and educational resources. CMS should utilize AI in program integrity in ways that are transparent, validated, and designed to support (rather than replace) human decision-making, while ensuring these tools do not inadvertently increase administrative burden for practices, automate flawed processes, or exacerbate inappropriate downcoding or denials. CMS policies should emphasize clear compliance guardrails that prioritize accuracy, continuous improvement, and education, positioning AI as a tool to strengthen program integrity rather than solely as a mechanism for punitive enforcement. Transparency, combined with appropriate human involvement, in both AI tool methodologies, outputs, and limitations, is essential to support provider trust and appropriate oversight. MGMA urges CMS not to rush widespread adoption of AI tools until they have been thoroughly tested in ways that don't impede prompt payment of claims.

Conclusion

We appreciate the opportunity to share our insights on how to prevent fraud without interfering with practices' ability to provide care. We look forward to working with CMS to explore targeted approaches that prevent wasteful spending without imposing a broad burden on medical groups

providing care to seniors. Should you have any questions, please contact Madison Hynes, Associate Director of Government Affairs, at mhynes@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs