C+TAC
COALITION TO TRANSFORM ADVANCED CARE

March 30, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this RFI regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to care.

C-TAC commends CMS for its commitment to "crushing fraud" to protect taxpayer dollars and the Medicare beneficiaries we serve. Fraud, waste, and abuse undermine trust, increase costs, and divert resources from legitimate care particularly harming vulnerable populations who depend on Medicare and Medicare Advantage (MA) for access to life-sustaining services. However, we urge CMS to design CRUSH policies with explicit safeguards for people with serious illness and their family caregivers. These beneficiaries often living with advanced cancer, heart failure, dementia, chronic lung disease, renal failure, and other life-limiting conditions are disproportionately vulnerable to unintended consequences of well-intentioned program integrity actions. They rely on high-intensity services, complex equipment, and continuity with specialist providers; disruptions in access can lead to preventable hospitalizations, accelerated decline, and profound suffering for patients and their caregivers. We respectfully request that CMS adopt an explicit framework in any future CRUSH rulemaking that:

- Recognizes people with serious illness and family caregivers as a priority population requiring tailored safeguards in program integrity activities;
- Requires an "Access and Continuity Impact Analysis" for proposed CRUSH regulations to evaluate risks to high-need beneficiaries before implementation; and
- Embeds clear beneficiary protections including continuity-of-care requirements, notice obligations, and strengthened appeal rights into all new antifraud authorities.

Our specific comments below focus on Medicare fee-for-service and MA:

II. Cross-Cutting Principles for CRUSH Rulemaking

A. Stratify Program Integrity Analytics by Clinical Risk- CMS, its contractors, and MA organizations should stratify program integrity analytics, audits, and enforcement actions by clinical risk and complexity of the beneficiaries served, including serious illness, disability, and dual-eligible status, rather than only by provider or service type. High utilization and care intensity patterns that may signal fraud in a general population are often clinically appropriate and necessary for beneficiaries with serious illness. Examples of legitimate serious-illness care patterns that can trigger fraud alerts:

- Multiple prescribers and high medication volume (pain management, symptom control, polypharmacy);
- Frequent emergency department visits and hospital admissions (disease exacerbations, inadequate community supports);
- Overlapping home health, hospice, and palliative care services; (necessary coordination without duplication)
- High-cost diagnostic testing (targeted cancer genomics, molecular diagnostics for rare diseases); and
- Complex durable medical equipment needs (ventilatory support, hospital beds, mobility aids, communication devices).

CMS should direct contractors and MA plans to incorporate clinical review by serious illness subject matter experts before initiating payment suspensions, pre-payment edits, or revocations that affect providers predominantly serving high-need populations.

B. Implement Access and Continuity Safeguards- We urge CMS to require that program integrity activities include safeguards to prevent inappropriate disruption of medically necessary services for beneficiaries with serious illness.

C. Require Transparency and Monitoring- CMS should require contractors and MA organizations to track and publicly report key metrics related to program integrity actions affecting seriously ill beneficiaries, including:

- Number of beneficiaries with serious illness impacted by payment suspensions, revocations, or network terminations;
- Changes in emergency department utilization, hospitalizations, and hospice live-discharge rates following fraud actions; and

- Timeliness of care transitions and caregiver-reported disruptions.
- Avoidance of duplication of services when coordination of overlapping services is needed.

III. Section A: Modifications to Program Integrity Requirements (Medicare & MA)

C-TAC supports enhanced use of existing authorities including payment suspensions and pre-payment edits to expeditiously prevent bad actors from billing Medicare and MA. However, these tools must be applied with precision to avoid collateral harm to beneficiaries who depend on the affected providers. Our recommendations:

- *Require clinical review before suspending payments or revoking enrollment for providers predominantly serving seriously ill beneficiaries.* Many palliative care practices, hospices, oncology clinics, and home-based care providers serve patient populations with extraordinarily high utilization and costs. Antifraud algorithms that flag outlier billing patterns without accounting for patient acuity will generate false positives.

- *Extend payment suspension authority to MA with explicit continuity-of-care protections.* C-TAC supports CMS establishing regulatory authority for MA organizations to suspend payments to providers who operate exclusively in Part C or Part D when there are credible allegations of fraud. However, such authority must include:
    - Mandatory advance notice to affected enrollees with serious illness and their caregivers;
    - Continuity-of-care obligations allowing continued access to the provider during investigation or until a safe transition to an alternative provider is completed;
    - Expedited appeals for enrollees who dispute the suspension or termination.

- *Incorporate serious illness expertise into contractor and MA plan program integrity operations*. CMS should require Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), Zone Program Integrity Contractors (ZPICs), and MA organizations to have clinicians with serious-illness expertise review proposed program integrity actions particularly those affecting hospice, palliative care, complex home-based care, oncology, and high-intensity DMEPOS.

IV. Section C: Preclusion List and MA Enrollment Requirements

C-TAC understands CMS's concern that providers revoked from Traditional Medicare may shift billing to MA plans, circumventing program integrity oversight. However, any expansion of the preclusion list or new requirements for Traditional Medicare enrollment must be implemented in a manner that protects continuity of care for MA enrollees with serious illness. Our recommendation would be to require MA organizations to identify and protect enrollees with serious illness when their providers are precluded. If CMS requires Traditional Medicare enrollment as a condition of billing MA, implement phased rollout with access monitoring. A blanket requirement for all MA-billing providers to enroll in Traditional Medicare could

destabilize MA networks, particularly in underserved areas and for specialty services such as palliative care, hospice, and complex home-based care. We recommend:

- Phased implementation beginning with high-risk provider types where fraud is well-documented (e.g., certain DMEPOS suppliers, laboratories);
- Network adequacy assessments before requiring enrollment in service categories with known shortages (e.g., geriatrics, palliative care, home health);
- Transitional contracting provisions allowing MA plans to maintain relationships with existing legitimate providers during the enrollment transition; and
- Exemptions or alternative pathways for providers serving predominantly seriously ill enrollees in shortage areas.

V. S Laboratory Tests, DMEPOS, and Claim Filing Deadlines

Laboratory Tests (Section D)- C-TAC shares CMS's concern about fraud in genetic and molecular diagnostic testing. However, many of these tests including targeted cancer genomics, epilepsy panels, and infectious disease diagnostics are clinically essential for diagnosis, prognosis, and treatment selection in serious illness. Recommendations:

- Clinical peer review before suspending payments or blocking genetic/molecular tests for beneficiaries with serious illness, particularly active cancer treatment;
- Rapid provisional payment or expedited appeals when denial of testing would compromise safety or delay time-sensitive treatment decisions; and
- Transparency about MoIDX program requirements and coverage policies to reduce confusion and inadvertent denials.

DMEPOS- Non-participating DMEPOS suppliers who engage in fraud must be stopped. However, many seriously ill beneficiaries depend on complex equipment ventilators, hospital beds, mobility aids, communication devices that may come from specialized suppliers, including some that do not participate in Traditional Medicare. Recommendations:

- If CMS or MA organizations impose stricter requirements on non-participating DMEPOS suppliers, include emergency exception processes when equipment is medically necessary and no participating supplier can provide it in a timely manner;
- Expedited reconsideration pathways when denial threatens patient safety; and
- Network adequacy monitoring to ensure seriously ill MA enrollees retain access to critical equipment.

Shorter Claim Filing Deadlines- Reducing claim filing deadlines from one year to 90-180 days may help CMS detect and prevent fraud. However, for beneficiaries with serious illness, claim submission is often delayed due to:

- Complex multi-provider care with coordination challenges;
- Frequent care transitions (hospital, SNF, home, hospice);
- Cognitive impairment or caregiver burden affecting administrative capacity; and

- End-of-life care documentation completed after death.

Therefore, our recommendations are to:

- Carve out extended filing timeframes for beneficiaries with serious illness or when claims involve hospice, palliative care, or post-death services;
- Retain and expand flexibilities to accommodate good-cause exceptions; and
- Require contractors to provide clear, accessible guidance to caregivers and estate representatives about filing deadlines for decedents' claims.

VI. Artificial Intelligence in Coding Oversight and Hospital Billing

C-TAC supports exploring AI tools to improve coding accuracy and reduce improper payments. However, AI systems must be rigorously validated to avoid systematic undercoding or denial of conditions common in serious illness such as cachexia, delirium, severe frailty, complex pain syndromes, and multi-organ dysfunction. Recommendations:

- Validate AI tools for accuracy in high-acuity, multi-morbid populations- AI models trained primarily on general Medicare populations may misclassify or underweight diagnoses prevalent in serious illness. CMS should require:
    - Stratified validation by clinical risk and complexity;
    - Ongoing monitoring of coding accuracy for seriously ill beneficiaries; and
    - Public reporting of audit error rates by risk group.

- Require human clinical review with serious-illness expertise for contested cases-AI recommendations should be advisory, not determinative. Human reviewers with expertise in serious illness must be able to override AI outputs, and beneficiaries must have accessible appeal pathways.

- Prohibit AI-based denial algorithms without transparent clinical criteria- Automated denials without human review and clear clinical rationale erode trust and delay necessary care. CMS should require that any AI-based denial system disclose its clinical logic, allow beneficiary access to the rationale, and provide expedited appeal pathways.

VII. Beneficiary Solicitation and Contact

Beneficiary Solicitation- C-TAC strongly supports expanding prohibitions on unsolicited contact beyond DMEPOS suppliers to other high-risk provider types and additional communication channels (text, email, social media). Seriously ill beneficiaries and their caregivers are frequent targets of fraudulent schemes offering "free" genetic tests, "free" equipment, or cash incentives. Recommendations:

- Extend the prohibition to laboratories offering genetic testing, non-participating DMEPOS suppliers, and other high-risk categories;
- Expand prohibited communication modes to include text, email, and social media;

- Explicitly allow patient-initiated contact and clinician-referred contact necessary for coordination of serious-illness care (e.g., hospice intake, palliative care consultations);
- Prohibit DMEPOS suppliers and laboratories from using third-party marketing agencies to circumvent solicitation bans.

Beneficiary Contact About Suspicious Claims- CMS's proposal to contact beneficiaries about potentially suspicious claims could help detect fraud early. However, outreach must be designed with accessibility and caregiver involvement in mind. Recommendations:

- Allow beneficiaries to designate authorized caregivers or representatives to receive and respond to fraud-related communications on their behalf;
- Use multi-modal communication options (mail, phone, secure portal) accessible to people with cognitive impairment, low literacy, or limited English proficiency;
- Provide plain-language materials co-designed with caregivers and serious-illness advocates; and
- Clearly distinguish legitimate CMS communications from scams, using consistent branding and authentication methods.

VIII. Beneficiary and Caregiver Engagement in CRUSH Implementation

Program integrity policies that affect high-need beneficiaries should be informed by the lived experience of patients and caregivers. CMS has a strong tradition of stakeholder engagement; we urge that this tradition extend explicitly to CRUSH implementation. Recommendations:

- Establish a CRUSH Serious Illness Advisory Workgroup including beneficiaries, family caregivers, palliative care clinicians, hospice providers, and serious-illness advocacy organizations to advise CMS on design, implementation, and monitoring of CRUSH policies in Medicare and MA.
- Require MA organizations and major contractors (MACs, UPICs) to incorporate input from beneficiary and caregiver advisory councils when designing fraud education materials, beneficiary contact strategies, and appeals processes affecting high-need populations.
- Pilot and evaluate new program integrity interventions with explicit monitoring for impacts on access, continuity, and outcomes for beneficiaries with serious illness before broad implementation.

Thank you for the opportunity to comment on this proposed notice. If you have any questions, please contact me, Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

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