

March 30, 2026

The Honorable Dr. Mehmet Oz  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-6098-NC  
Submitted electronically to: <https://www.regulations.gov>

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

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) request for information (RFI). NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care cost. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model.

ACOs are strong stewards of the Medicare program and play an important role in regularly identifying instances of suspected fraud, waste, and abuse as part of their ongoing efforts to reduce costs and improve patient care. Given their access to longitudinal claims data and their accountability for population-level spending, ACOs are uniquely positioned to partner with CMS to strengthen program integrity.

To further safeguard the Medicare program, preserve patient access, and enhance ACOs' ability to detect fraud, waste, and abuse, we urge CMS to:

- Strengthen its collaboration with ACOs by improving reporting pathways, feedback mechanisms, and information sharing;
- Better equip ACOs with tools to identify and prevent fraud, waste, and abuse;
- Ensure that ACOs are not held financially accountable for expenditures associated with fraud, waste, and abuse that are outside of their control; and
- Expand and refine targeted program integrity efforts to combat fraud, waste, and abuse in high-risk areas.

### **ACOs as Front-Line Partners in Identifying Fraud, Waste, and Abuse**

ACOs routinely analyze claims data to identify care gaps, support clinical interventions, and manage utilization and spending. These same analytic capabilities enable ACOs to identify anomalous billing patterns that may indicate fraud or abusive practices, which ACOs report to CMS and the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG).

ACOs are a critical front-line partner in identifying fraud, waste, and abuse and serve as an early warning system for program integrity risks. For example, through their routine review of Medicare data, ACOs identified Medicare payments for skin grafts rose from \$1.6 billion in 2022 to \$4.5 billion in 2023 and \$10.2 billion in 2024. These utilization patterns were inconsistent with clinical need and billing practices. ACOs brought these findings to CMS and its program integrity partners, prompting policy changes that are expected to generate significant savings for the Medicare program and improved outcomes for Medicare beneficiaries.

Despite efforts to report suspected fraud, waste, and abuse, ACOs frequently report that they do not receive confirmation that reports were received or acted upon. In many cases, ACOs continue to observe the same billing patterns in subsequent claims data without any indication that corrective action has been taken. This uncertainty creates challenges for participation and continued investment in accountable care models, which in turn could cut off an important pipeline of critical information to CMS.

***We urge CMS to strengthen its collaboration with ACOs by improving reporting pathways, feedback mechanisms, and information sharing.***

ACOs would benefit from streamlined and standardized mechanisms to report suspected fraud, waste, and abuse to CMS and the HHS OIG, including clear submission pathways and defined data elements. We also urge CMS to establish a consistent feedback loop, including acknowledgement of receipt and updates on whether reports have been triaged, investigated, or resolved.

We further urge CMS to provide timely notification to ACOs when high-confidence fraud patterns are identified, including when claims are held for investigation or routed through escrow. This information would allow ACOs to take more timely action to protect beneficiaries and limit further improper payments.

In addition, CMS should improve cross-payer coordination so that supplemental insurers and other affected payers are notified when significant fraud schemes are identified. This would help prevent continued downstream payments associated with fraudulent claims.

### **Program Integrity Tools to Support ACOs**

***NAACOS urges CMS to consider ways to better equip ACOs with tools to identify and ideally prevent fraud, waste, and abuse.***

While ACOs are expected to be stewards of Medicare spending, but largely operate in a retrospective, “pay-and-chase” environment, where suspect billing is identified only after claims have been submitted and, in many cases, paid.

Providing ACOs with more timely and actionable data would improve their ability to identify and validate suspect billing and take steps to mitigate its impact. This is particularly important because suspect billing not only drives unnecessary healthcare spending, but can lead to direct patient harm when inaccurate claims data interferes with access to medically necessary care. When fraudulent claims appear in a beneficiary's record, coverage for needed services or supplies may be delayed or denied because eligibility appears to have been exhausted. For example, a beneficiary may require therapeutic diabetic shoes, but Medicare records indicate the shoes were already furnished by an out-of-state supplier – an item the beneficiary did not request nor receive. In some cases, the supplier is no longer operational, leaving limited recourse to resolve the issue. When these inaccuracies cannot be corrected in a timely manner, beneficiaries may be unable to access or may be forced to pay out of pocket for medically necessary care.

Access to more complete and timely information would allow ACOs and treating clinicians to better validate services and prevent these situations. For example, data confirming whether DME was ordered by a treating provider and supported by a corresponding visit would strengthen oversight and improve care coordination.

We also urge CMS to strengthen beneficiary protections by ensuring that beneficiaries receive timely and understandable notification when services are billed in their name and have access to a rapid, user-friendly process to correct inaccurate records. Treating clinicians should also have a mechanism to attest when services or supplies were not ordered so that eligibility for medically necessary care can be restored.

### **Ensure ACOs are Held Harmless**

***NAACOS urges CMS to ensure that ACOs are not held financially accountable for expenditures associated with fraud, waste, and abuse that are outside of their control.***

Under current policy, ACOs may be held responsible for spending tied to suspected or confirmed fraudulent activity, even when the ACO identified and reported the activity. This undermines the incentives of accountable care and may discourage participation in two-sided risk models.

CMS has taken an important step through its Serious, Anomalous, and Highly Suspect (SAHS) policy. However, the policy is too narrow in scope and must be refined to better address the realities of fraud, waste, and abuse. In particular, CMS should expand the policy to address localized instances of fraud and allow for adjustments at the ACO or county level.

CMS should also broaden the criteria used to identify SAHS-related billing that should be excluded from ACO financial calculations, including:

- Claims where CMS payment is held in escrow while under review;
- Claims determined to be fraudulent or submitted by providers under federal indictment or investigation;
- DMEPOS claims not supported by a treating provider referral or corresponding office visit;
- Claims from DMEPOS suppliers with a threshold level of reversals in a performance year;
- Claims for billing codes previously identified as SAHS in prior years; and

- Claims with significant volume increases for specific billing codes compared to historical ACO benchmarks.

CMS should also consider applying a materiality threshold across all criteria that would require claims to represent a minimum percentage (e.g., 0.5%) of the ACO's benchmark and not be furnished by an ACO participant.

We also urge CMS to align reopening policies with the timelines of OIG and Department of Justice investigations. Allowing ACOs to reopen prior financial determinations when fraud is confirmed would ensure that organizations are not permanently held accountable for improper payments.

### **Better Oversight of High-Risk Providers**

#### ***NAACOS urges CMS to expand and refine targeted program integrity efforts to combat fraud, waste, and abuse in high-risk areas.***

DMEPOS remains an area of high risk, with anomalous billing patterns identified across multiple codes, including orthotics, wound care supplies, continuous glucose monitor supplies, and urinary catheters. ACOs have found that these billing patterns often lack evidence of a corresponding treating provider order or a related clinical encounter. This poses ongoing risks for taxpayer loss and beneficiary harm.

As CMS considers additional actions to strengthen its program integrity interventions for high-risk providers, such as DMEPOS suppliers, we urge CMS to consider pre-payment edits triggered by anomalous code-level billing patterns, enhanced documentation requirements, and strengthened supplier enrollment and monitoring. For skin substitutes and similar services, CMS should consider additional safeguards related to medical necessity documentation standards, utilization limits, and site-of-service safeguards to ensure that payment aligns with clinical appropriateness.

We also commend CMS for recent actions to mitigate DMEPOS program integrity risks, including implementation of a six-month nationwide moratorium on new DMEPOS supplier enrollments. Additionally, as part of this RFI, CMS seeks input on strengthening its existing surety bond requirements, including increasing bond amounts for DMEPOS suppliers and potentially expanding these requirements to other provider types. Surety bonds have proven effective in reducing fraud by creating an additional barrier to entry for unscrupulous or "fly-by-night" operations. NAACOS supports the continued use and strengthening of surety bond requirements for high-risk provider categories, including DMEPOS suppliers. For example, we urge CMS to consider increasing the required surety bond amount to at least twice an entity's average monthly billing for DMEPOS suppliers and other high-risk providers with high volumes of Medicare claims. This approach would better ensure that CMS can recoup overpayments and help deter bad actors from entering the program.

Additionally, as CMS considers enhanced identify proofing measures, such as expanding current fingerprinting requirements, we urge the agency to coordinate with states to avoid introducing duplicative requirements. For example, some states already require fingerprinting as part of their medical licensure processes.

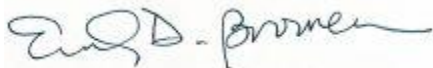
Finally, NAACOS strongly urges CMS to maintain the current one-year claims filing deadline. While many providers and suppliers submit claims within the first few months following service delivery, there are certain circumstances that may require additional time, such as coordination of benefits and secondary

payer determinations. Shortening the filing deadline could create significant administrative and financial challenges for compliant providers and suppliers, particularly those navigating complex billing scenarios. If CMS chooses to move forward with a shortened deadline, we recommend that the agency narrowly tailor the policy to specific high-risk provider and supplier types and operationalize a clear exceptions process to allow entities to request an extension when appropriate. However, we caution that this approach may increase burden as providers would need to make changes to distinguish between types of services within their billing systems.

## CONCLUSION

ACOs are committed to improving quality and reducing unnecessary spending in Medicare and are well-positioned to serve as partners to CMS in identifying and addressing fraud, waste, and abuse. We urge CMS to strengthen collaboration with ACOs through improved information sharing, enhanced program integrity tools, and appropriate financial protections. These steps will help stop fraud, waste, and abuse, while ensuring beneficiaries are protected and ACOs remain viable. We look forward to continued partnership. If you have any questions, please contact Aisha Pittman, senior vice president of government affairs at NAACOS at [aisha\\_pittman@naacos.com](mailto:aisha_pittman@naacos.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Emily D. Brower". The signature is fluid and cursive, with a horizontal line extending to the right.

Emily D. Brower  
President and CEO  
NAACOS