



March 27, 2026

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the [Request for Information \(RFI\) Related to Comprehensive Regulations To Uncover Suspicious Healthcare \(CRUSH\)](#).

Medicaid agencies share the federal government's strong commitment to safeguarding Medicaid funds and preventing fraud, waste, and abuse (FWA). As the primary administrators of the program, states and territories serve on the front lines of program integrity efforts, deploying a range of oversight, audit, and enforcement tools to protect taxpayer resources while ensuring eligible individuals receive needed care. Because fraud schemes continue to evolve and increasingly span programs and jurisdictions, **sustained collaboration between federal, state, and territory partners is essential to strengthening existing tools, identifying emerging risks, and ensuring effective program integrity efforts across Medicaid.**

NAMD is a nonpartisan, professional community of leaders who provide health insurance to almost 80 million people through Medicaid and CHIP in the states, D.C. and the U.S. territories. NAMD elevates thought leadership on policy matters, amplifies the experience and expertise of state leaders, supports programs in continuous improvement and innovation, and optimizes partnerships to help millions live their healthiest lives.

NAMD's work is directly guided by Medicaid and CHIP leaders and grounded in collaboration, integrity, and practical solutions informed by the experiences of the communities these programs serve. Program integrity has always been a core component of this work. In our blog, [State and Territory Medicaid Programs Share the Federal Government's Interest and Urgency around Medicaid Program Integrity](#), we describe the many ways state and territory Medicaid agencies share a strong commitment with the federal government to ensuring the program operates as efficiently, effectively, and accountably as possible. Importantly, achieving that goal will not be possible without differentiating among the three components of FWA and identifying the best available means of addressing each of them. While **fraud** – intentional gaming of the program by

health care providers for their own financial benefit is justifiably top of mind, federal and state and territory Medicaid officials must also focus on **abuse** in the program, where services beyond what is medically necessary may have been provided either intentionally or unintentionally, as well as **waste** of Medicaid resources that results from inefficient provision of services. Each of these domains requires its own set of strategies and tactics to effectively address.

NAMD is pleased to offer information in response to CMS’s RFI on opportunities to strengthen program integrity and support Medicaid agencies in promoting program integrity. The perspectives reflected here were informed by Medicaid leaders and staff from all states and territories, including agency leadership and subject-matter experts in eligibility and enrollment, information technology, program integrity, financing, policy, and clinical oversight. These leaders represent decades of experience partnering with CMS to administer Medicaid and ensure that millions of families, children, pregnant women, adults, seniors, and people with disabilities receive critical health coverage.

NAMD appreciates CMS’s prioritization of program integrity and stands ready to partner with you on these efforts. We would value the opportunity to further discuss our recommendations in a follow-up meeting with CMS.

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Opportunities for CMS to Help with Program Integrity

In NAMD's blog, [Why and How States and Territories are Addressing Fraud, Waste and Abuse](#) and issue brief, [Why Did They Do It That Way? Program Integrity](#), we explore how Medicaid agencies have long served as the frontline stewards of federal and state Medicaid funds. For years, Medicaid agencies have shouldered the primary responsibility of establishing and cueing providers to utilization management standards, using a range of strategies including pre- and post-payment audits, and collaborating with offices of attorneys general and law enforcement to investigate and prosecute fraud. Given the increasing sophistication and brazenness of bad actors and the scope and severity of their fraud schemes, CMS and other federal agencies remain essential partners in preventing and addressing provider fraud.

As detailed in our blog, [What CMS Can Do to be of Additional Help with Fraud, Waste and Abuse](#), states and territories have well-defined accountabilities in stewarding use of federal and state Medicaid funds. However, program integrity risks are inherent in a program as complex and significant as Medicaid. This is in part due to the unique services Medicaid covers compared to other payers, such as home and community-based services (HCBS), an array of services supporting older adults and individuals with physical or developmental disabilities to remain in their communities rather than being placed in a nursing home or other institutional care setting. This cost-effective alternative to institutional care allows individuals to be active community members who volunteer, work, and attend school.

Because program integrity risks constantly evolve, no one state, territory, or level of government can go at it alone. A strong federal–state–territory partnership is essential to success. In consultation with Medicaid agencies, NAMD has identified ways CMS can further strengthen their fraud-fighting toolbox. We believe that a collaborative federal and state and territory partnership is essential to identifying, comprehensively investigating, remedying, and preventing future instances of FWA.

As you consider these areas for opportunity, NAMD stands ready to support CMS in these efforts.

1. Opportunities to Expand, Increase, and Make Training and Technical Assistance on Program Integrity More Available

Medicaid agencies share the federal government's commitment to anticipating and guarding against FWA. However, keeping pace with emerging schemes is complex and dynamic. As a result, Medicaid agencies and the federal government must work in close partnership to continually evolve the tools, strategies, and resources used to safeguard

program integrity. One such way is through expanding and broadening access to federal training and technical assistance on program integrity. This should also include expanded opportunities to engage with peers across states and territories to share promising practices and lessons learned.

To support these efforts, CMS should consider the following actions:

- **Expand the offerings of the Medicaid Integrity Institute (MII) and broaden access to trainings and workgroups.** Medicaid leaders consistently identify the Medicaid Integrity Institute (MII), organized by the CMS Center for Program Integrity (CPI), as a valuable resource for program integrity staff seeking training on a range of program integrity topics such as the Payment Error Rate Measurement (PERM) program, managed care oversight, law enforcement referrals, provider enrollment, and other core program integrity functions. However, MII programming is currently prioritized for Medicaid program integrity staff, though the 2026 MII curriculum does have limited capacity for other Medicaid agency staff to attend sessions. MII's trainings and areas of topical focus are highly impactful, centering federal expertise and best practices in core areas of program integrity such as effective audit design and implementation, maximizing data analytics tools, and snapshots of emerging program integrity trends. CMS should broaden access to these rich technical assistance sessions, materials, and trainings to a wider array of relevant Medicaid agency staff whose work intersects with program integrity. We acknowledge that such a change may require additional appropriations authority from Congress.
- **Amplify peer-to-peer learning opportunities among Medicaid agencies.** CMS should consider additional structured opportunities for Medicaid agencies to share program integrity strategies and discuss emerging challenges with their counterparts in other states and territories such as through widely available newsletters, webinars, webpages, summits, and toolkits.
- **CMS should take a more active role to amplify the importance of the Medicaid Fraud, Waste, and Abuse Technical Advisory Group (FWA-TAG), including convening more frequent meetings and expanding the reach of engagement opportunities.** CMS has a clear opportunity to strengthen collaboration with states and territories by playing a more active role in planning and facilitating FWA-TAG meetings and webinars, rather than relying primarily on state partners. This includes developing agendas, ensuring appropriate stakeholder participation through well-managed listservs, providing timely information and resources from CMS, and coordinating with national partners such as NAMD, the National

Association for Medicaid Program Integrity (NAMPI), and the National Association of Medicaid Fraud Control Units (NAMFCU). CMS should also increase the frequency of FWA-TAG subgroup meetings that focus on topics such as small states, provider enrollment, data analytics, and member fraud, which would increase the number of targeted forums for collaboration and problem-solving.

- **Promote stronger coordination between Medicaid agencies, program integrity units, and Medicaid Fraud Control Units (MFCUs).** Medicaid agencies rely on program integrity staff to identify FWA and on MFCUs to investigate and prosecute these cases. CMS should support these efforts by convening these partners and developing best practices to strengthen collaboration, clarify roles, and enhance the effectiveness of these interdependent relationships, either through the FWA-TAG, expanded MII course offerings, or another mechanism.

2. Opportunities to Increase Information Sharing and Visibility of State and Territory-Level Efforts

Medicaid agencies can benefit from greater information sharing across federal and state programs to enhance their ability to detect and prevent FWA. Because bad actors often operate across multiple public programs and jurisdictions, timely access to reliable information about provider actions, fraud trends, and enforcement activities is critical. CMS is uniquely positioned to facilitate this coordination and improve actionable information sharing across programs.

To support these efforts, CMS should consider the following actions:

- **Expand and regularly update existing resources on best practices.** CMS should expand and update existing resources, for example, a provider enrollment self-assessment and process toolkit previously published by CPI.
- **Promote real-time data sharing on sanctioned or revoked providers, contractors, and billing entities.** CMS should support Medicaid agencies by establishing platforms that allow states and territories to more quickly access information on providers, contractors, or billers who are revoked, sanctioned, suspended, or otherwise disqualified by other public programs such as Medicare, the Department of Veterans Affairs (VA), or another state or territory's Medicaid or CHIP program. Currently, federal data focuses primarily on sanctioned providers. Expanding this to incorporate a wider array of known bad actors, including contracting and billing entities that may not directly provide services, would further strengthen program integrity activities. Some states operate state-level databases with this information that should serve as models for federal action.

- **Create routine, rapid channels for sharing fraud findings across public payers.** CMS should help facilitate more timely communication of fraud findings, enforcement actions, and provider disqualifications across federal, state, and territory programs. This includes the VA, Medicare, federal employee health benefits programs, and the marketplaces.
- **Maximize the use of T-MSIS data to support cross-state program integrity efforts.** CMS is uniquely positioned to leverage T-MSIS data across all states and territories to identify providers engaged in potentially fraudulent or inappropriate billing patterns spanning multiple jurisdictions. When adverse actions are taken in one state, CMS should notify other states where the provider is actively billing, enabling timelier and coordinated responses across states and territories.
- **Create a centralized location to promote visibility into national fraud trends, schemes, provider indicators, and visibility into federal enforcement actions.** Greater visibility into information and trends can help Medicaid agencies anticipate emerging risks and calibrate oversight activities accordingly. This should incorporate analyses from other federal partners, such as the HHS Office of the Inspector General, such that Medicaid agencies have a centralized repository of information on emerging program integrity risks.
- **Support states and territories in reporting and publishing program integrity metrics and sanctions.** CMS should provide best practices and guidance to help standardize how Medicaid agencies, their MFCUs, and Offices of Inspectors General report program integrity performance metrics and enforcement actions. CMS should also support these efforts by providing financial resources and infrastructure support to help states and territories build and sustain reporting capabilities, strengthen accountability, and improve cross-state learning.
- **Maintain and facilitate relationship with a list of vetted vendors.** CMS should support Medicaid agencies by maintaining a list of vetted vendors that provide program integrity tools, analytics, and related services. CMS should also encourage vendor commitments to support program integrity initiatives in an effort to consistently deliver value to taxpayers and improve Medicaid operations, similar to the [January 2026 pledges from Medicaid technology companies to support community engagement implementation and related Medicaid system improvements](#).
- **Promote clear and consistent federal expectations.** Clear federal guidance and aligned expectations across programs can strengthen oversight while reducing

unnecessary administrative burden. Guidance should be routinely reviewed at a regular cadence with Medicaid agencies, program integrity units, MFCUs, and other key program integrity partners to ensure federal expectations are clearly articulated and understood. In the context of turnover and staff changes across state and territory government, this recurring guidance refresher would promote preservation of institutional knowledge.

3. Opportunities to Improve Technology, Data, and Systems

Medicaid agencies increasingly rely on data analytics to identify potential FWA and prioritize investigative resources. However, the effectiveness of these efforts depends on access to high-quality data, modern analytic tools, and interoperable systems. CMS is well positioned to support states and territories by expanding access to federal data sources, strengthening cross-program analytic capabilities, aligning data with operational workflows, and by supporting investments in modernizing technologies that can improve detection and prevention.

To support these efforts, CMS should consider the following actions:

- **Facilitate state and territory access to federal analytic platforms and secure data-sharing tools.** Medicaid agencies can benefit from access to shared federal analytic platforms rather than building duplicative systems within their own agencies. This would also support federal and state and territory goals in reducing systems costs and maximizing the value of public resource investments in analytic tools.
- **Expand and invest in access to relevant federal and non-federal data sources and improve interoperability.** Access to additional datasets, such as managed care performance data, Medicare claims data for dually eligible individuals, the Do Not Pay system, Social Security Administration data, Unified Program Integrity Contractors, Internal Revenue Service information, List of Excluded Individuals and Entities (LEIE), TRICARE, tribal sources, and other verification databases would help provide Medicaid agencies with a more complete data environment for identifying suspicious activity and strengthening program oversight.
- **Strengthen Medicare and Medicaid analytic capabilities and streamline access to real-time Medicare data.** Medicaid agencies that administer programs for dually eligible individuals would benefit from tools that enable cross-program analysis of Medicare and Medicaid claims and encounter data in near real time. Expanded access to relevant Medicare datasets, improved dataset completeness,

streamlined data use agreements, and technical assistance to support integration into Medicaid analytics environments would significantly enhance states' and territories' ability to detect suspicious activity among individuals and providers enrolled in both programs and develop a more comprehensive picture to identify FWA in near real time.

- **Expand the use of advanced analytics and artificial intelligence tools and recommend appropriate safeguards for implementing new technology.** CMS should support states and territories by advancing the use of artificial intelligence, machine learning, and other predictive analytics tools that identify patterns, and provide states and territories with safeguards surrounding the usage of these new tools. Federal support for these tools could help states deploy more sophisticated analytics without duplicating development efforts. Nonexclusive examples of helpful activities include resourcing a Medicaid analytics-specific component of CPI and using T-MSIS data to engage in predictive analytics and flag patterns of potential fraud on a national basis.
- **Provide enhanced federal funding for program integrity technology investments.** Investments in modern data systems, analytic tools, and interoperable technology infrastructure can significantly accelerate the identification of fraud and reduce improper payments. This could take the form of a grant program or other flexible funding mechanism, which we acknowledge may require Congressional action.
- **Convene regular technology briefings for states and territories.** CMS should host periodic briefings to highlight emerging technologies, analytic tools, and innovative program integrity approaches that states may consider adopting.
- **Host technical forums or innovation summits focused on program integrity tools and technologies.** CMS should support states and territories by convening technical forums or program integrity innovation summits that highlight emerging technologies, advanced analytic tools, opportunities to optimize artificial intelligence, and other approaches that may strengthen fraud detection and prevention efforts.
- **Strengthen the technical capacity and timeliness of federal data hubs and matching functions required under Public Law 119-21, which CMS refers to as the “Working Families Tax Cut” (WFTC) legislation,** including systems such as PARIS and other existing sources of provider data.

- **Addressing systems-related implementation challenges associated with WFTC legislation**, which will reduce the potential for FWA, **notably**:
 - resolving outstanding questions related to policy interpretation (e.g. around exemptions from work and community engagement requirements) that will equip states to move ahead with systems work and avoid expensive re-work in the future;
 - building on CMS' recent work in achieving cost concessions and signals around [procuring support from new IT vendors through the federal GSA Schedule](#);
 - working with the federal Food and Nutrition Service (FNS) to align how like SNAP and Medicaid policy requirements are operationalized – an applied example is how household size is counted;
 - integrating additional data sources (e.g. VA data and Department of Education data) into the Federal Data Hub to help routinize adjudication of exemptions;
 - use of the federal government's purchasing power and influence to reduce the per transaction cost of using the Federal Data Hub and other related sources; and
 - identifying and scaling information technology solutions that can either layer on existing systems or be implemented as modules (e.g. for verification of various features of community engagement requirements for which we currently lack current interoperability between Medicaid systems and other data sources).

4. Opportunities for Specialized and Tailored Support to States and Territories on High-Risk Service Areas

Certain service areas and provider types present elevated risks for FWA. Medicaid agencies would benefit from targeted federal support to strengthen oversight in these high-risk areas, ensuring that states and territories have the tools and flexibility needed to respond to emerging risks while maintaining appropriate access to high-quality services for Medicaid and CHIP members who need them.

To support these efforts, CMS should consider the following actions:

- **Support more frequent reverification of high-risk providers.** Many Medicaid agencies report that they already conduct enhanced monitoring of providers in high-risk service areas. CMS should support these efforts by facilitating more frequent reverification processes and providing guidance on best practices.

- **Develop national risk indicators for high-risk services and providers.** CMS should work with states and territories to identify and publish national indicators of elevated fraud risk across certain service categories, and which providers may pose the highest risk.
- **Standardize documentation expectations and high-risk provider criteria.** Clear documentation requirements for high-risk services, along with consistent criteria for identifying high-risk providers and revocation pathways, could strengthen oversight and reduce opportunities for bad actors to move between programs or jurisdictions.
- **Establish clear service-level limits and utilization thresholds.** CMS should work with Medicaid agencies to develop clearly defined parameters for services that have previously presented with elevated fraud risks, while allowing appropriate flexibility based on service type and program design.
- **Establish a “cool-off period” following enrollment denial.** CMS should establish a defined period (e.g., six months), during which a provider is not permitted to reapply after an enrollment denial, helping to reduce repeated applications and strengthen provider screening efforts.

5. Opportunities to Enhance Efficiency of Medicaid Service

Addressing waste and inefficient use of Medicaid resources is a core element of every state and territory’s Medicaid program, as well as a long-standing strategic priority for the federal government. It is important to think of waste as conceptually distinct from fraud and abuse, and addressing waste and inefficiency invites thoughtful analysis of opportunities to address core drivers of spending growth in the program. Medicaid agencies have been active for years in working to bend the cost curve of the program through an array of innovative practices, including value-based purchasing strategies, incorporating lower-cost sites of service and provider types, and designing fiscal incentives

- **“Rebalancing” long-term services and supports.** Medicaid currently pays for 1 in 2 dollars spent in the US on long-term services and supports (LTSS). Medicaid support for LTSS will grow over time as national demographic trends lead to increased need for older adults to access Medicaid-funded LTSS. LTSS includes nursing home services as well as an array of home and community-based services on which 9.7 million (2023) Medicaid members rely. The latest annual report on national spending that is prepared by Mathematica for

CMS, [Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid LTSS Users and Expenditures, 2023](#), indicates that:

- In 2023, national Medicaid LTSS expenditures totaled \$228.6 billion, with HCBS accounting for \$145.9 billion and institutional services accounting for \$82.7 billion.
- The average LTSS expenditure per LTSS user in 2023 was \$23,620, compared to \$22,109 in 2022. People who received institutional services continued to have much higher average expenditures (\$54,462 per user) than people who received HCBS (\$17,298 per user).
- From 2022 to 2023, HCBS users as a percentage of total Medicaid LTSS users grew by 7.5% from 79.64 to 87.14 percent. Similarly, HCBS expenditures as a percentage of total Medicaid LTSS expenditures increased by 12.8% from 51.01 to 63.81 percent in that period.

[Rebalancing has been defined by the Centers for Medicare and Medicaid Services \(CMS\)](#) as, “achieving a balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care.” This is intended to give Medicaid members greater choice in where they live and from whom they receive LTSS. It is also a key means of optimizing state spending on LTSS and freeing up resources for other priorities.

While significant progress has been made in increasing the proportion of members who receive Medicaid LTSS in non-institutional settings, continuing to shift the share of expenditures in that direction requires additional attention and effort. An action that CMS could readily take is to expand and reissue the [Long-Term Services and Supports Rebalancing Toolkit](#) that was last updated in 2020. This provides a capsule of the history and trends of the rebalancing effort, outlines Medicaid authority pathways, and billboards case examples of state best practice, but could usefully be expanded to include current day strategies to better integrate services and supports for people who are eligible for Medicaid and Medicare (“duals”) as well as to articulate strategies for “right sizing” nursing home beds to account for lower demand.

- **Pharmacy spending.** Despite significant work by states to control the rate of Medicaid cost growth, pharmacy spending remains a significant cost driver for the Medicaid program. Per KFF, between FY 2017 and FY 2023, Medicaid

spending net of rebates on prescription drugs grew by 72% and in FY 2023, prescription drugs accounted for approximately 6% of total Medicaid spending.

Simply put, states do not have sufficient leverage to intercept the overall cost trend, much less accommodate emerging extraordinary costs for such interventions as anti-obesity medications and cell and gene therapies. Historically, the federal government has relied on the longstanding structure of the Medicaid Drug Rebate Program and otherwise delegated responsibility for Medicaid cost controls (e.g. purchasing compacts, utilization management strategies) to the states. Given the above cost trends, but also the co-occurring interest in enabling access to promising but costly obesity treatments and cell and gene therapies, this is untenable ongoing.

State and territory programs are grateful for renewed federal interest in this area. The [Cell and Gene Therapy Access Model](#), in which 32 states, the District of Columbia and Puerto Rico are participating, as well as the recently announced [GENEROUS](#) and [BALANCE](#) models, have promise in acting on the federal government's influence and purchasing power to reduce costs through Most Favored Nation pricing and/or increased rebates. Other potential ideas to help states and territories with drug costs include:

- enhancing federal Medicaid match for a given class of drug/CGT;
- mandating additional rebates under the Medicaid Drug Rebate Program;
- developing risk corridors or reinsurance approaches;
- creating a stand-alone coverage group for people with specified conditions (e.g. sickle cell disease) that is associated with enhanced federal match; and/or
- developing a distinct program as Congress did for coverage of HIV/AIDS drugs under the Ryan White program.

6. Opportunities for Templates, Frameworks, and Guidance That Would Support Medicaid Program Integrity Efforts

Medicaid agencies would benefit from the development of new or revised, timely federal frameworks, templates, and guidance that support program integrity practices, while allowing flexibility for state and territory implementation. Developing shared tools and reference materials could help Medicaid agencies reduce administrative burden and support program oversight.

To support these efforts, CMS should consider the following actions:

- **Develop timely program integrity programming templates, model frameworks, and service-specific audit standards.** CMS should provide states and territories with adaptable templates, model frameworks or contract language, and service-specific audit standards that Medicaid agencies could tailor for use with providers and other program partners. This could also include frameworks and best practices for working with managed care organizations (MCOs) to prevent, detect, and address fraud and abuse. Additionally, CMS should develop model investigation and audit strategies for emerging schemes, enabling Medicaid agencies to more effectively identify and review potential bad actors.
- **Provide technical assistance, guidance, and elevate best practices on prepayment review and service verification.** CMS should offer resources, guidance, and technical assistance to Medicaid agencies seeking to implement or strengthen prepayment claim review processes and verification of services delivered in community settings to reduce improper payments.
- **Support application programming interface (API)-based submissions and data exchange.**
- **Standardize program integrity metrics.** Establishing common metrics for investigations, recoveries, referrals to law enforcement, and other program integrity activities would improve transparency and allow for more consistent measurement of outcomes across states and territories. These metrics should be developed in close collaboration with state and territory Medicaid leaders.
- **Produce model business requirements for federal policy-related systems changes that states and territories could elect to adopt.**
- **Establish standardized extrapolation methodologies for Medicaid audits.** While Medicare has well-defined guidelines for how extrapolations are conducted, comparable standards are not consistently articulated for Medicaid. CMS should develop a standardized, Medicaid-specific framework to promote consistency, transparency, and defensibility in audit practices across states and territories.
- **CMS should helpfully partner with states to develop national toolkits for applied behavioral analysis (ABA) and supportive housing services that articulate:**
 - best practice standards for assessment of needs, as well as template assessment tools;

- standard service definitions, not just for the services that quickly became the exclusive focus for coverage but also other, potentially lower cost, services that could benefit these populations;
- provider credentials and scopes of work;
- utilization management standards (e.g. tiering of service according to the acuity and complexity of an individual’s needs; circumstances under which the service can be delivered remotely, if at all); and
- guidance on interplay with and avoidance of duplication with related services; e.g.:
 - in the case of ABA services, guidelines for how Medicaid coverage relates to school-based coverage under Individual Education Plans (IEPs); and
 - in the case of supportive housing services, guidelines for how Medicaid coverage relates to traditional housing-based supports such as resident services coordinators.

7. Opportunities for CMS to Strengthen Administrative and Operational Support for States and Territories

Medicaid agencies identified several areas where administrative and operational flexibility or support from CMS would strengthen program integrity efforts while allowing states and territories to respond more quickly to emerging risks. Streamlining federal processes and strengthening collaboration between federal and state partners will improve the timeliness and effectiveness of fraud detection and response.

To support these efforts, CMS should consider the following actions:

- **Accelerating the time frames in which CMS is responding to reports of fraud raised by state attorneys general and MFCUs.**
- **Retaining and strengthening procedural pathways to address FWA.** This is inclusive of pathways through which states and territories can surface findings of FWA and work collaboratively with CMS on mutually negotiated corrective action plan (CAP) that encourages open sharing of data, additional research and investigation, and a holistic orientation that ensures adherence to required provider qualifications and performance standards but also continued access to vital services by eligible Medicaid members.

- **Partnering with Medicaid agencies on alternatives to the traditional multi-year, multi-component Advance Planning Document (APD) process.** This includes means of supporting agile procurement and implementation models to effectuate more rapid cycle and iterative systems development, including systems development and adoption of technology to strengthen FWA efforts.
- **Allow states and territories to trigger expedited federal review when emerging fraud patterns appear.** Establishing a mechanism for states and territories to request expedited federal review when suspicious activity is identified would help prevent fraud from spreading across programs.
- **Strengthen consequences for provider non-responsiveness in audits and reviews.** Current PERM audit processes may designate errors when providers fail to respond to CMS auditor requests, which can overstate a state or territory's error rate, despite the issue stemming from provider non-compliance. CMS should establish clearer and more actionable remedies for non-responsive providers, such as creating a centralized list of providers excluded from Medicare and Medicaid participation because of their non-responsiveness during audits and reviews. CMS should also consider mechanisms such as automatic payment holds or suspensions when providers do not respond to audit, investigation, or review requests in a timely manner, helping ensure accountability while reducing administrative burden on states.
- **Conduct audits of managed care plans.** PERM audits do not currently include managed care. CMS could consider conducting separate, but comparable audits of managed care plans.

8. Opportunities to Support Program Integrity Efforts Across the Stakeholder Continuum

A wide range of stakeholders play an important role in preventing, identifying, and reporting potential FWA. Strengthening expectations, communication, and tools across this stakeholder continuum could enhance early detection and improve coordination between Medicaid agencies, providers, plans, vendors, and members.

To support these efforts, CMS should consider the following actions:

- **Establish clearer program integrity expectations for Medicaid MCOs, accountable care organizations, administrative services organizations (ASOs).** CMS should provide more standardized guidance regarding effective

oversight of MCOs, ACOs, and ASOs program integrity programs and functions, including expectations related to monitoring, reporting, and coordination.

- **Encourage stronger safeguards among Medicaid vendors and contractors.** CMS should promote expectations and best practices for vendors that support Medicaid program administration, including safeguards related to data security, claims processing, and fraud detection.
- **Strengthen provider education and engagement on program integrity.** CMS should support Medicaid agencies by promoting educational resources, training materials, and guidance that help providers understand service-specific program integrity requirements, billing expectations, and reporting responsibilities. This is especially important for provider types that are newly incorporated into Medicaid structures and may not have previous familiarity with Medicaid requirements, such as behavioral health providers who have been historically funded through block grant mechanisms.
- **Support member engagement in fraud detection and reporting.** Medicaid agencies use a range of tools to allow Medicaid members to report suspected fraud, including fraud hotlines, program integrity unit (PIU) reporting lines, and online reporting forms. CMS should support Medicaid agencies by sharing best practices in amplifying these resources.

Thank you for the opportunity to provide comments on the Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

NAMD looks forward to continuing to partner with CMS to strengthen program integrity efforts.

Sincerely,



Melisa Byrd
NAMD Board President
Medicaid Director
D.C. Department of Health Care Finance (DHCF)

Appendix

If you are interested in more resources on program integrity, we encourage you to explore NAMD's recent publications and topics on the issue.

- NAMD Webpage: [Program Integrity and Audits](#)
- Issue Brief: [Why Did They Do It That Way? Program Integrity](#) (June 2025)
- Three-Part Blog Series (February 2026):
 1. [State and Territory Medicaid Programs Share the Federal Government's Interest and Urgency around Medicaid Program Integrity](#)
 2. [Why and How States and Territories are Addressing Fraud, Waste and Abuse](#)
 3. [What CMS Can Do to be of Additional Help with Fraud, Waste and Abuse](#)