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March 30, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz:

On behalf of AMGA, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Health Care (CRUSH).

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA appreciates CMS' continued focus on strengthening program integrity and shares the agency's commitment to identifying and preventing fraud, waste, and abuse (FWA) across federal healthcare programs. At the same time, we urge CMS to ensure that new program integrity policies are carefully calibrated to avoid unintended consequences for the vast majority of providers who are operating in full compliance with Medicare and Medicaid requirements. As CMS considers potential regulatory and operational changes under the CRUSH initiative, it is critical that efforts to address bad actors do not impose unnecessary administrative burden, disrupt care delivery, or undermine the infrastructure supporting high-value, coordinated care.

Across the topics raised in the RFI, we urge CMS to employ several overarching principles to guide its approach to strengthening program integrity:

- Use targeted, risk-based tactics, leveraging advanced data analytics to identify high-risk providers, services, and geographies rather than applying broad, one-size-fits-all requirements across the healthcare system.

- Prioritize the use of modern technologies, including artificial intelligence (AI), while ensuring appropriate safeguards, transparency, and human oversight.
- Align policies with the realities of modern care delivery, particularly within integrated systems that rely on team-based care, shared infrastructure, and longitudinal patient relationships.
- Reduce, rather than expand, duplicative or inconsistent administrative requirements, particularly where such requirements do not meaningfully improve program integrity outcomes.

Our detailed responses to specific topics within the RFI follow.

Program Integrity Authorities and Tools

With respect to CMS' request for feedback on strengthening its program integrity authorities and tools, AMGA supports the continued use and refinement of prepayment and post-payment review mechanisms, as well as payment suspension authorities, where there is clear evidence of elevated risk. However, these tools should be deployed in a targeted manner informed by data analytics, rather than through universal documentation or audit requirements applied to all providers. CMS should invest in real-time and near real-time data monitoring capabilities that allow for earlier identification of aberrant billing patterns, thereby reducing reliance on retrospective audits that can be administratively burdensome and disruptive.

In addition, AMGA strongly recommends greater standardization across Medicare Administrative Contractors (MACs) with respect to medical review policies, documentation expectations, and audit processes, as current variability creates unnecessary complexity and compliance challenges for providers operating across multiple jurisdictions.

Preclusion List and Medicare Advantage Alignment

AMGA appreciates CMS' focus on improving the preclusion list and strengthening alignment between Traditional Medicare and Medicare Advantage (MA) program integrity efforts. While we support closing gaps that allow revoked providers to continue billing MA plans, we caution against policies that would require all MA network providers to enroll in Traditional Medicare as a condition of participation. Such a requirement would introduce significant administrative burden without a clear corresponding benefit to program integrity. Instead, CMS should prioritize improved data sharing and transparency between CMS and MA plans regarding provider revocations, exclusions, and other program integrity actions, enabling MA organizations to make more informed network participation decisions.

DMEPOS Oversight and Supplier Fraud Prevention

Regarding fraud risks associated with non-participating durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, AMGA strongly supports CMS' focus on supplier-level oversight and billing patterns as the primary focus of program integrity intervention. Physicians and other ordering practitioners should not be subject to additional documentation or administrative requirements intended to address supplier-driven fraud. CMS should instead

streamline and standardize DMEPOS documentation requirements, including consolidating existing standards into a single, clear framework and allowing clinical documentation in the medical record to satisfy written order requirements when all necessary elements are present.

CMS should also advance interoperability solutions that support electronic ordering and documentation exchange, reducing reliance on manual processes that are more susceptible to error and fraud. Program integrity efforts in this area should be directed toward identifying anomalous supplier billing behavior rather than scrutinizing routine physician ordering practices.

Claims Submission and Timely Filing Requirements

AMGA urges CMS to proceed with caution if it amends the current one-year timely filing deadline for Medicare Parts A and B claims. While shorter filing windows may have utility in narrowly defined, high-risk contexts, broadly reducing the claims submission timeframe could create significant operational challenges for providers, particularly those operating in complex, integrated systems with high patient volumes.

Importantly, accelerating filing deadlines may produce unintended program integrity consequences by incentivizing rapid claim submission behaviors that are more characteristic of fraudulent actors than compliant providers. Fraudulent entities often submit claims quickly to maximize payment before detection, whereas legitimate providers frequently require additional time to ensure claims are complete, accurate, and supported by appropriate clinical documentation. As such, a shortened filing window could inadvertently advantage bad actors while penalizing providers who are prioritizing compliance and accuracy. More limited filing deadlines should be focused on clearly defined high-risk supplier categories and implemented with sufficient flexibility to account for legitimate delays in claims submission.

Artificial Intelligence in Program Integrity and Payment Oversight

AMGA appreciates CMS' interest in leveraging AI to enhance coding accuracy, medical record review, and fraud detection. AI has significant potential to strengthen program integrity by identifying anomalous billing patterns, improving the efficiency and consistency of review processes, and enabling earlier detection of fraud, waste, and abuse.

To be effective in this context, AI must be implemented within a clear, transparent, and risk-proportionate framework. AI tools should support—not replace—clinical and programmatic judgment, particularly where they inform payment determinations, coding validation, or medical necessity review. CMS should require appropriate guardrails, including human review prior to adverse actions, transparency in how AI outputs are used, and ongoing validation to ensure accuracy and mitigate bias. Without these safeguards, AI-driven processes risk generating false positives, inappropriate denials, and unnecessary administrative burden for compliant providers.

AMGA also cautions against the use of AI in ways that effectively reinterpret or re-adjudicate established coverage policies. AI-enabled tools used in claims review or prior authorization must operate within existing National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) unless changes are made through formal rulemaking. Allowing AI to implicitly shift medical necessity standards outside of transparent policy processes would create uncertainty and undermine provider confidence in Medicare's coverage framework.

In addition, CMS should clearly define accountability when AI is used in program integrity activities. Where AI informs audit findings, payment denials, or recoupments, providers must have visibility into the basis for those determinations and access to appropriate appeal pathways. Responsibility for AI-driven decisions should not be obscured across CMS, contractors, and technology vendors.

Finally, CMS should prioritize the use of AI to prevent improper payments prospectively, rather than relying solely on retrospective enforcement. AI-enabled tools can support accurate coding, identify documentation gaps, and promote compliance before claims are submitted, reducing both improper payments and the need for burdensome audits. A forward-looking, provider-supportive approach will better align program integrity efforts with CMS' broader goals of efficiency, accuracy, and reduced administrative burden.

Medicaid, CHIP, and Cross-Program Integrity

Finally, AMGA supports CMS' efforts to improve program integrity across Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. Given the shared challenges across these programs, CMS should prioritize enhanced data sharing and coordination with states, including the dissemination of timely information on emerging fraud trends, high-risk provider types, and problematic service categories.

CMS also has an opportunity to develop and share advanced analytics tools and algorithms with state Medicaid agencies to support more proactive and targeted program integrity efforts, particularly considering the constrained fiscal and operational environment in which many states are currently operating.

Conclusion

AMGA appreciates CMS' commitment to strengthening program integrity and addressing fraud, waste, and abuse across federal healthcare programs. We encourage CMS to pursue a targeted, data-driven approach that focuses enforcement efforts on high-risk actors while minimizing administrative burden on compliant providers and supporting the continued evolution of integrated, high-value care delivery. We look forward to continued collaboration with the agency as it considers next steps under the CRUSH initiative.

Should you have questions, please do not hesitate to contact Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or ddrevna@amga.org.

Sincerely,



Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA