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Advancing Health in America

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March 30, 2026

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

Submitted Electronically

RE: CMS–6098–NC Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

The AHA supports CMS' efforts to combat fraud, waste and abuse (FWA) in federal health care programs by holding accountable actors who flout their legal and compliance obligations. Hospitals are ever mindful of their obligation to properly bill for the services they provide to Medicare, Medicaid and Children's Health Insurance Program (CHIP) patients and incur great costs to do so. Specifically, we estimate that an average-sized hospital with 161 beds will have to spend more than $562,299 each year on regulatory compliance.[1] **Given that hospitals already operate under extensive oversight requirements, we urge CMS to ensure that any regulatory or programmatic changes related to FWA are appropriately data-driven and do not add unnecessary administrative burden for the nation's hospitals.** We look forward to working with the agency on tailored solutions that recognize the majority of providers act responsibly, while appropriately targeting bad actors.

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[1] AHA estimate based on analysis in *Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers* (available at https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf) and adjusted for hospital expenses in 2024.

Our specific recommendations follow and are discussed in greater detail in our attached comments.

Certain Medicare Advantage Organization (MAO) coverage and reimbursement practices would benefit from additional regulatory oversight and scrutiny to prevent FWA. These include complex prior authorization requirements and opaque coverage rules, network inadequacy and mid-year changes, restrictive and often proprietary medical necessity or coverage criteria and the impacts of MAO vertical integration. **We encourage CMS to use the data it already collects through Medicare Part C and D reporting, as well as MAO conduct providers flag for the agency, to inform audits and other enforcement tools necessary to address these problematic practices. In addition, we urge CMS to clarify that the Medicare Advantage (MA) noninterference clause in Section 1854(a)(6)(B)(iii) of the Social Security Act is not a broad bar on otherwise lawful federal oversight of MA plan compliance and that MAOs cannot evade oversight simply by recategorizing compliance with Medicare coverage rules as merely a private payment matter.**

Strong tools to prevent FWA are critical to maintaining public confidence in and sustaining the Medicaid and CHIP programs. Providers, like the states and CMS, are committed to Medicaid and CHIP program integrity and to safeguarding taxpayer resources while ensuring access to care for patients. **We recommend that CMS leverage and strengthen its existing oversight tools, processes and transparency requirements in Medicaid and CHIP, and that recent transparency and accountability initiatives be evaluated before any additional policy changes are proposed.**

Artificial intelligence (AI) is transforming care delivery in countless ways, supporting increased access, reduced administrative burden and improved outcomes. If used properly, AI tools can also support efforts to mitigate FWA in the health care ecosystem. **To support the responsible use of AI, we recommend strategies such as mitigating the risk of hallucinations for AI coding tools through vendor testing, curtailing inappropriate downcoding and automated payment reductions by insurers, ensuring insurer transparency on AI use, as well as clarifying coverage criteria and providing independent physician review of coverage denials.**

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Robyn Tessin, AHA director of payment policy, at rtessin@aha.org.

Sincerely,

/s/

Ashey Thompson
Senior Vice President
Public Policy Analysis & Development

Enclosure

BACKGROUND

In the CRUSH RFI, CMS solicits stakeholder feedback on potential regulatory changes that might be included in a potential future proposed rule, as well as other programmatic changes that could be implemented to make the agency more effective in combating FWA. CMS states that the RFI is issued in alignment with the administration's strategic objective and commitment to preserve and protect the integrity of government programs. The agency states that it is looking for ways to strengthen its fraud-fighting toolbox and invites public comments on how to achieve this.

MEDICARE ADVANTAGE

The AHA welcomes CMS' focus on identifying and closing vulnerabilities that allow bad actors to evade oversight in the MA program. We have long been concerned that certain MAO operations and policies could constitute FWA and warrant further scrutiny and regulatory response. As the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported to Congress in a recent semiannual report, the MA program has grown significantly, accounting for 32.8 million enrollees and more than half of all Medicare spending, totaling **$462 billion** in 2024.[2] The degree and speed of this expansion have enabled MAOs to grow operations without sufficient regulatory scrutiny of a host of coverage and reimbursement protocols which, in many cases, may run afoul of fundamental Medicare coverage requirements.

MA is already a stated enforcement priority for HHS and the Department of Justice (DOJ). In recent years, DOJ and HHS OIG have brought increasing numbers of enforcement actions against MAOs for improper conduct, particularly with respect to practices related to risk adjustment payments and relationships between MAOs and brokers. In July 2025, DOJ and HHS announced the reconstitution of the DOJ-HHS False Claims Act Working Group and listed MA as the very first priority enforcement area.[3] Most recently, the DOJ announced that one large insurer would pay $117,600,000 in a settlement to resolve allegations that it had fraudulently submitted or failed to withdraw inaccurate diagnosis codes for enrollees of its MA plans to increase its Medicare payments from CMS.[4] HHS OIG reported further that the insurer had refused to enter into a corporate integrity agreement and that, as a result, it would undertake additional monitoring of the insurer's compliance with federal health care programs. We appreciate the efforts to date to hold MAOs accountable for misconduct, and welcome continued enforcement in this space.

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[2] HHS OIG, *Semiannual Report to Congress: Spring 2025* (Spring 2025), https://oig.hhs.gov/documents/sar/10324/Spring_2025_SAR_508.pdf.
[3] DOJ, Office of Public Affairs, *Department of Justice and Department of Health and Human Services Form False Claims Act Working Group*, https://www.justice.gov/opa/pr/doj-hhs-false-claims-act-working-group.
[4] DOJ, Office of Public Affairs, *Aetna Agrees to Pay $11.77 Million to Resolve False Claims Act Allegations* (Feb. 22, 2023), https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations.

As outlined further below, AHA members continue to report MAO policies and practices that appear to undermine regulatory requirements that MA provide equivalent coverage to Original Medicare by improperly limiting beneficiary coverage for medically necessary items or services. We welcome CMS efforts to bolster the regulatory and enforcement framework to ensure the MAOs are held accountable to the laws and regulations intended to protect the beneficiaries they serve.

MAO Practices Limit Access to Care and Undermine Coverage Requirements

The AHA has written extensively about MAO coverage and reimbursement practices, including in a detailed letter to CMS in May 2024 in response to an RFI on MA data.[5] At that time, and subsequently, we have pointed to several practices which, in our assessment, allow MAOs to circumvent the fundamental requirement to provide coverage equivalent to Original Medicare. These practices also call into question whether the government is truly getting the benefit of its bargain with the MAOs. These areas and others would benefit from additional regulatory oversight and scrutiny to prevent FWA in this space. We provide a summary of our key concerns below.

1. **Improper Coverage Delays and Denials Due to Administrative Burden.**

MAOs continue to impose policies resulting in undue administrative burdens, including complex prior authorization requirements and opaque coverage rules that can lead to delays in care and wasteful and dangerous interference with prescribed treatments. These practices strain and financially burden the entire system, including by impeding patient access to care and diverting physician attention away from patient care and toward insurance-related administration or services.

2. **Network Adequacy Challenges and Mid-year Network Changes.**

Network (in)adequacy continues to be an area of great frustration for patients and providers alike. The AHA and its members continue to hear reports of patients who have selected an insurance plan based on access to a specific provider or service at certain locations, only to have the plan unilaterally change its policy mid-year to eliminate coverage for certain providers or settings. This kind of care disruption generates waste and inefficiency for patients and providers as well as impedes care access and continuity.

In the context of post-acute care, despite explicit statements by CMS that MAOs are required to cover certain categories of post-acute care services when coverage requirements are met, certain MAOs effectively fail to meet this requirement because they have not included these providers in their networks. Hospitals cannot discharge these patients without a safe discharge plan; the lack of post-acute care coverage therefore stalls the entire flow of care. For insurers to effectively require MA beneficiaries, who are

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[5] AHA, *Response to CMS Request for Information on Medicare Advantage Data and Oversight* (May 29, 2024), https://www.aha.org/system/files/media/file/2024/05/AHA-RFI-Response-to-CMS-on-Medicare-Advantage-Data-and-Oversight.pdf.

otherwise eligible for post-acute care, to remain unnecessarily in hospital beds badly needed by more acute patients is the definition of wasteful.

3. **Application of More Restrictive (and Often Proprietary) Medical Necessity or Coverage Criteria.**

MAOs are required by CMS to make medical necessity determinations in accordance with Original Medicare requirements, including rules established in statute, regulation, National Coverage Determinations, and Local Coverage Determinations. They are permitted to rely on additional publicly accessible internal coverage criteria in only limited circumstances. Yet, despite this rule and subsequent reinforcement in CMS communications, hospitals continue to report coverage denials of basic benefits based on inconsistent and more restrictive proprietary criteria. An alarming example of this is in the context of sepsis, as many MAOs have ceased to cover early sepsis interventions. We urge CMS to continue reinforcing these requirements and take additional steps to protect coverage of medically necessary care for MA beneficiaries.

4. **Medical Loss Ratio Impacts of Intercompany Eliminations.**

As we described in more detail in May 2025 letters to the Federal Trade Commission and the DOJ, MAOs are vertically integrating in an effort to retain premium dollars.[6,7] Acquiring physician practices, laboratories, and pharmacy benefit managers enables large insurance companies to steer patients toward their own providers and distributors, directing health care spend into their own entities. As we wrote in those letters, these practices undermine transparency and disaggregate care, restrict patient choice of providers and decrease care access. In addition to the impact on MLR, it increasingly appears that some insurers used this vertical integration to destabilize competition.[8,9] Any efficiency that may be generated by this integration appears to benefit certain insurers themselves, rather than the beneficiaries whose health they are obligated to safeguard.

Additional Data Reporting, Controls and Monitoring May Help Address These Challenges

To ensure that MAOs are meeting their obligations to CMS, taxpayers and their enrolled Medicare beneficiaries, the AHA urges the agency to more fully use its existing oversight authorities to support robust and timely programmatic enforcement. CMS already collects extensive data through Medicare Part C and Part D Reporting Requirements, and these

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[6] AHA, *Comments on the Department of Justice Request for Information on Anticompetitive Deregulations* (May 2025), https://www.aha.org/system/files/media/file/2025/05/AHA-Comments-on-DOJ-Anticompetitive-Deregulations-RFI.pdf.

[7] AHA, *Comments on the Federal Trade Commission Request for Information on Anticompetitive Deregulations* (May 2025), https://www.aha.org/system/files/media/file/2025/05/AHA-Comments-on-FTC-Anticompetitive-Deregulations-RFI.pdf.

[8] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00155

[9] https://www.nytimes.com/2024/10/19/business/drugstores-closing-pbm-pharmacy.html?searchResultPosition=4

data should be actively analyzed and operationalized to identify noncompliance and prompt corrective action where warranted.

During this required reporting process, CMS has clear authority not only to monitor plan performance, but also to use reported data to inform audits, compliance actions and other enforcement tools necessary to address the problematic behaviors described above. At the same time, we encourage CMS to strengthen and expand mechanisms that allow providers to flag concerning MAO practices directly to the agency. Providers are often the first to observe patterns of inappropriate denials, payment delays or administrative barriers. Incorporating those insights would enable CMS to identify and address emerging issues far more quickly than reliance on beneficiary complaints or retrospective reviews alone.

The AHA stands ready to work with CMS to identify specific, actionable opportunities to strengthen MA oversight and ensure that enforcement mechanisms meaningfully protect beneficiaries and uphold program integrity.

The Noninterference Clause, Properly Construed, Does Not Bar Regulation or Enforcement of Federal Law

In response to concerns like those the AHA raises in the previous sections, MAOs often point to Section 1854(a)(6)(B)(iii) of the Social Security Act, "the MA noninterference clause," as limiting oversight of their activities.

This clause provides: "(iii) Noninterference.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part."

Oftentimes, MAOs will endeavor to recharacterize issues that are fundamentally coverage determinations or matters of compliance into mere contractual disputes and invoke this clause to block further scrutiny. For example, some MA plan policies are reclassifying the question of whether an inpatient admission satisfies Medicare's level-of-care requirements, such as the Two-Midnight Rule, as contractual payment disputes that cannot be appealed under coverage policies.[10] These practices raise serious concerns that plans are intentionally reframing issues of regulatory compliance as contractual payment disputes to avoid CMS oversight, the CMS-prescribed appeals framework, and effectively rewrite Medicare coverage standards through purported contract administration.

However, when read properly, the language of the MA noninterference clause prevents compelled contracting and government-imposed pricing structures in private contracts; it does not create a sweeping safe harbor that insulates MAOs from generally applicable

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[10] AHA, *AHA Urges Aetna to Rescind Level of Severity Inpatient Payment Policy* (Sept. 15, 2025), https://www.aha.org/lettercomment/2025-09-15-aha-urges-aetna-rescind-level-severity-inpatient-payment-policy.

oversight designed to ensure compliance with federal coverage, benefit, appeals and program integrity requirements. Nowhere does this provision preclude CMS from ensuring MAOs comply with their legal obligations.

We urge CMS to clarify that the MA noninterference clause is not a broad bar on otherwise lawful federal oversight of MA plan compliance and that MAOs cannot evade oversight simply by recategorizing compliance with Medicare coverage rules as merely a private payment matter. We encourage CMS to reassert the agency's authority to oversee MAO reimbursement protocol to ensure that it is not running afoul of Medicare coverage policy, inappropriately shirking responsibility to pay for care, or creating unnecessary burden for patients and providers.

This interpretation is also necessary to avoid market distortions and preserve a genuine free market. The noninterference clause has the explicit objective of "promoting competition" in MA and Part D. But there is no competition if one side can wholly disregard Medicare coverage rules while continuing to receive capitated federal payments intended to pay for furnishing Medicare-covered benefits. When MAOs are effectively permitted to use contract administration to avoid or dilute federal coverage standards, competition turns on regulatory arbitrage rather than on efficiency, quality, service or innovation. That distorts market incentives, suppresses fair competition, and rewards plans that can most aggressively externalize the costs of noncompliance onto providers, beneficiaries and the Medicare program itself. The resulting dynamic is especially concerning because once such practices prove financially advantageous to one MAO, they tend to spread across the MA market. We caution CMS not to convert (or permit to be converted) a limited statutory protection against compelled contracting and price-setting into an insurmountable hurdle that gives MAOs a free pass to evade federal standards.

Importantly, CMS has already made clear in guidance that MAOs may not evade federal oversight by recharacterizing coverage decisions as post-payment reimbursement disputes. CMS has repeatedly stated that when an MAO refuses to provide or pay for services, in whole or in part, including decisions regarding the type or level of services furnished, such as inpatient versus outpatient care, those actions constitute organization determinations under MA regulations.[11] However, the AHA is deeply concerned that despite these important steps, these practices persist.

Furthermore, policies that reclassify coverage issues as payment disputes undermine the rights of Medicare enrollees. If these policies were rightfully adjudicated as coverage determinations, they would afford patients certain rights and benefits. For example, patients would have the right to appeal a coverage determination when an insurer decides a patient needs observation-level care, unilaterally overriding the treating physician's determination to admit a patient to inpatient care. When handled as payment disputes rather than coverage

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[11] CMS, *Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F),* Question 9 (Feb. 6, 2024), https://www.cms.gov/files/document/hpms-memo-faq-coverage-criteria-and-utilization-management-020604pdf.pdf.

determinations, insurers try to shield themselves with the noninterference clause, thereby depriving patients of certain rights and benefits.

Federal capitation payments are intended to finance the delivery of Medicare-covered care in accordance with federal rules, not to subsidize business practices that evade those rules. Guidance clarifying the proper, limited scope of the noninterference clause would help protect beneficiaries from hidden cost shifting, reduce improper financial pressure on providers, and better ensure that taxpayer dollars support medically necessary care rather than avoidable administrative gamesmanship.

Accordingly, the AHA recommends that CMS clarify that the MA noninterference clause should not be construed to bar generally applicable federal oversight of MAO compliance with coverage, benefit, appeals, payment integrity and program integrity requirements. Such clarification would help CMS advance the goals identified in the RFI – protecting patients, improving affordability, promoting fair competition and safeguarding taxpayer dollars.

MEDICAID

Strong tools to prevent FWA are critical to maintaining public confidence in and sustaining the Medicaid and CHIP programs. Providers, like the states and CMS, are committed to Medicaid and CHIP program integrity and to safeguarding taxpayer resources while ensuring access to care for patients. Below, we propose a framework for CMS to keep in mind as it considers regulatory or programmatic changes to address FWA in the Medicaid and CHIP programs.

This framework should be grounded in the regulatory distinctions of FWA set forth in 42 CFR § 455.2 and reflected in the National Association of Medicaid Directors' (NAMD's) articulation of Medicaid program integrity principles, particularly the distinction between intentional fraud and administrative or operational errors.[12] Consistent with that framework, CMS' approach should reflect the following principles:

- **Policies should not treat providers as presumptive wrongdoers,** recognizing that fraud requires intentional deception and that the vast majority of providers act in good faith in navigating complex Medicaid requirements.
- **Any suspension or recoupment of payment should occur only after due process has been completed,** including appropriate notice and opportunity to respond.
- **Liability should be aligned with responsibility,** and providers should not be held financially accountable for errors or operational failures attributable to state Medicaid agencies or Medicaid managed care organizations, particularly where providers relied in good faith on official eligibility determinations, authorizations, payment systems or guidance.

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[12] https://medicaiddirectors.org/resource/state-and-territory-medicaid-programs-share-the-federal-governments-interest-and-urgency-around-medicaid-program-integrity/

In short, enforcement should be targeted, proportional and evidence-based. Likewise, it should respect due process and appropriately distinguish between fraud and abuse and mere administrative error. Adhering to these basic principles will strengthen program integrity without undermining provider participation or beneficiary access to care.

With this framework in mind, the AHA below offers further recommendations on key issues related to program integrity in state Medicaid financing sources and payment approaches.

Non-federal Share Financing Including Intergovernmental Transfers

Medicaid's federal-state financing partnership depends on federal matching funds combined with lawful state share financing sources, including provider taxes and intergovernmental transfers (IGTs), to support access to coverage and services. IGTs are a long-standing and lawful component of Medicaid's federal-state financing structure.

IGTs play a substantial role in Medicaid financing nationwide. According to the Government Accountability Office, IGTs and other local government funds accounted for approximately 12% of total Medicaid funding in 2018, a decrease from 15% in 2008.[13] Many states use these funds to support supplemental payments intended to stabilize hospitals and health systems that provide care to a disproportionate share of Medicaid patients, including individuals who are dually eligible for Medicaid and Medicare. These funds also are used to support other payments more broadly, including for Medicaid-covered services.

CMS can most effectively promote program integrity related to non-federal share financing by emphasizing transparency and clarity, and leveraging existing tools, rather than imposing new substantive restrictions on financing sources, such as IGTs. Federal statute and long-standing CMS regulations require that IGTs consist of public, non-federal funds and prohibit impermissible provider donations or payment recycling. CMS reviews and approves state plan amendments, waiver authorities, UPL demonstrations, DSH methodologies and managed care directed payments to ensure compliance with these requirements. States must also disclose financing sources through required funding assurances and financial reporting systems, including CMS-64 expenditure reporting, and are subject to routine program integrity reviews, audits, and oversight by CMS and HHS OIG. Collectively, these guardrails provide multiple layers of state and federal oversight to ensure that IGT-financed Medicaid payments are transparent, lawful and appropriately support beneficiary access to care.

Medicaid Payment Approaches and Rate Variation

States and Medicaid Managed Care Organizations have broad authority to set payment rates, subject to CMS review and approval.[14] For example, states can establish a base

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[13] https://www.gao.gov/assets/gao-21-98.pdf

[14] Section 1902(a)(30)(A) of the Social Security Act requires that such payments be consistent with efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population.

payment and adjust that payment for certain hospital types, such as acute care, children's or other hospital types. States use supplemental payments to sustain essential services such as emergency care, primary care, maternal and child health care, behavioral health services, supplement graduate medical education, and reduce Medicaid payment shortfalls, among other state policy objectives. These payments are subject to CMS approval and are implemented within a comprehensive statutory and regulatory framework. While approaches vary across states and service levels, payments made to hospitals on average are lower than the cost of caring for Medicaid patients.[15]

Payment variation reflects the unique and important roles that each hospital and health system plays within a state's Medicaid delivery system. There is significant variation across communities in terms of local needs, the types of services provided, patient populations served and local commitments. Payment policies that reflect these differences appropriately account for variations in underlying costs, statutory and community-driven service needs, levels of uncompensated care and responsibilities that extend beyond the delivery of individual patient services. Policies that label payment differences as fraudulent may hinder access to essential services and disrupt Medicaid delivery, without significantly improving program integrity.

Because supplemental payments play a critical role in supporting access to care, CMS' efforts to prevent and address FWA related to these payments must be carefully considered and based on clear statutory and regulatory standards. Rather than pursuing broad policy overhauls or taking sweeping action to restrict or further limit the use of supplemental payments, we encourage CMS to focus on effective use of existing review processes and targeted technical assistance.

Specifically, we recommend CMS continue to rely on and strengthen existing review and approval processes, including state plan amendments, SDP preprints, actuarial certifications, audits and financial reporting. A primary goal should be consistency in the implementation of processes, such as preprint review, to support states as they seek to comply with regulatory and statutory requirements. These review mechanisms already provide meaningful safeguards and should be used appropriately to identify discrete instances of noncompliance.

Finally, we urge CMS to consider assessing the effectiveness of existing transparency and oversight initiatives before pursuing broad policy changes or enforcement actions related to differential provider payment or supplemental payments. For example, the 2024 Access Final Rule established new requirements aimed at enhancing transparency, oversight and public accountability. These include mandates for public posting of fee-for-service rates as well as conducting comparative analyses of Medicaid and Medicare payment levels.[16] States are actively implementing these requirements, many of which include phased-in compliance timelines extending through 2026 and beyond. As CMS considers additional program integrity actions associated with provider payment methodologies, allowing these

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[15] https://www.aha.org/costsofcaring

[16] https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf

policies to take effect will provide CMS with more complete and reliable information while avoiding duplicative oversight and unnecessary administrative burden.

MEDICARE CLAIM SUBMISSIONS

Medicare Part A and Part B claims generally must be filed within 12 months of the date of service. CMS seeks feedback on the impact of reducing this timely filing deadline for high-risk items and services, including but not limited to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). **We support CMS' goal of working to better identify fraudulent claim submissions, but shortening the filing deadline for items and services furnished by hospitals and health systems would add unnecessary burden.** Given the level of care hospitals routinely provide, particularly for inpatient services, the claim submissions process often requires significant time and staffing resources. Specifically, despite hospitals' best efforts to prepare clean claims for submission, sometimes they must be reopened or resubmitted. Multiple rounds of communication with a hospital's Medicare Administrative Contractor (MAC) are often necessary for such rebilled claims. And, after submitting supporting documentation requested by the MAC, a hospital may not receive a response for months. This lengthy back-and-forth occurs all while the 12-month filing clock continues to run.

The staff and other resources involved in such claim submissions for facility services can be substantial. For example, long length of stay cases, particularly when a patient has exhausted their Part A benefit and is using lifetime reserve days, require hours of administrative staff and clinician time to prepare and support the claim. In addition, high-acuity cases such as transplants or other complex surgical procedures often take even more time to document and bill. Significant hospital staff time is spent to ensure medical necessity is supported and appropriately documented. When clinicians must undertake claims review, that time and attention must be diverted from patient care. While providers appreciate the investments CMS has made to improve the Medicare claim submissions portal, they often have had to resort to faxing voluminous documentation to the MACs. Reducing the timely filing deadline would only create further strain on hospital resources at a time when the Medicare patient population is growing larger and more complex.

INPATIENT REHABILITATION FACILITY REVIEW CHOICE DEMONSTRATION

As noted, we strongly support CMS' efforts to protect the integrity of the Medicare program and combat fraud. That said, we are concerned that certain programmatic approaches, such as the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD), may not be the most efficient or effective use of resources for hospitals or for CMS. Programs that subject entire categories of providers or claims to blanket review, absent evidence of elevated fraud risk, divert both provider and agency resources away from more meaningful activities.

The IRF RCD reflects a fundamental misalignment between program design and stated fraud-fighting objectives. Specifically, CMS has justified this demonstration as a tool to assist in identifying and investigating potential Medicare fraud. However, the agency has not presented evidence of any fraud in the IRF setting. Instead, it has relied on improper

payment rates as a proxy for fraud risk, despite longstanding acknowledgment that improper payments are not synonymous with fraud. For example, improper payments often arise from minor or technical documentation deficiencies — such as missing signatures or administrative oversights — that do not suggest inappropriate care, ineligible beneficiaries, or intent to defraud Medicare. Indeed, despite being operational for more than two years, the IRF RCD has not resulted in any fraud enforcement outcomes, such as referrals or prosecutions. At the very least, this calls into question its value as a fraud prevention tool.

In addition, the RCD subjects 100% of claims to review, which is an imprecise and resource-intensive strategy that imposes a significant administrative burden on providers. Indeed, claims are ultimately affirmed at a very high rate. Yet providers must divert scarce clinical and administrative resources — often including dedicated full-time staff — to comply with review requirements. To the extent the agency seeks to address improper payments outside of its fraud efforts, provider education, technical assistance and targeted audits represent a far more efficient and constructive alternative. Clear guidance, outreach and feedback can improve compliance, reduce error rates and preserve access to care without imposing unnecessary burden or mischaracterizing providers as bad actors. **As such, we urge the agency to end the IRF RCD program and instead reallocate these resources in ways that more directly address potential fraud within the Medicare program.**

ARTIFICIAL INTELLIGENCE AND HOSPITAL CODING, BILLING AND REVENUE CYCLE FUNCTIONS

AI is transforming care delivery in countless ways, supporting increased access, reduced administrative burden and improved outcomes. If used properly, AI tools also can support efforts to mitigate FWA in the health care ecosystem — goals to which hospitals are also steadfastly committed. For example, AI tools can be used to decrease waste by streamlining scheduling, flagging coding issues, and transcribing clinical documentation — all aspects of care delivery that are often costly, and administratively burdensome. In general, more than a quarter of all health care spending goes to administrative tasks — totaling more than $1 trillion annually.[17] These administrative burdens have contributed to the financial instability of many hospitals, and in the face of such headwinds, many hospitals have either scaled back services or closed outright.[18] To make matters worse, the potential misuse of AI by certain large commercial payers to inappropriately deny prior authorizations and claims has exacerbated issues with administrative waste and driven up costs.

To support the responsible use of AI to detect fraud, minimize waste and mitigate abuse, we suggest:

- Mitigating risk of hallucinations for AI coding tools through vendor testing.

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[17] "Active steps to reduce administrative spending associated with financial transactions in US health care," Sahni, N., et. al., Health Affairs Scholar, Volume 1, Issue 5, November 2023, qxad053, https://doi.org/10.1093/haschl/qxad053.

[18] https://www.kaufmanhall.com/insights/thoughts-ken-kaufman/implications-national-hospital-flash-report-hospital-operations

- Curtailing inappropriate downcoding and automated payment reductions by insurers.
- Ensuring insurer transparency on AI use, clarifying coverage criteria and providing independent physician review of coverage denials.

Below are our detailed recommendations.

Mitigating Risk of Hallucinations for AI Coding Tools Through Vendor Testing. AI tools can be used to enhance coding speed, accuracy and consistency when deployed within a strong compliance and auditing framework. Some examples of AI solutions that augment coding workflows include anomaly detection analytics to identify outlier coding patterns for review and corrective action, rules-based engines that flag incompatible or missing elements for coding conventions, and computer-assisted coding support tools that provide recommendations on potential codes based on evidence from the record.

Hospitals and health systems continually assess the strengths and limitations of all AI models they use, including coding tools. The "black box" nature of many AI systems can make it more challenging for hospitals and health systems to identify flaws in models that may affect the accuracy and validity of an AI tool's analyses and recommendations. For example, there are reports of some AI tools producing "hallucinations" or false results based on flaws in model design or biases in underlying data. These factors underscore the importance of ongoing developer testing (both pre-deployment and post-deployment) to maintain AI model validity.

Hospitals and health systems have worked to adapt their governance processes for AI use to meet the pace of technology advancement, often using multi-disciplinary teams to review AI use cases, technologies and value over time. According to the AHA Health IT supplemental survey, 74% of hospitals have multiple teams responsible for evaluating predictive AI, including (but not limited to) senior leaders, department leaders and IT staff, with many having specific committees for machine learning and/or clinical decision support.[19]

While hospitals remain committed to ensuring AI tools are accurate, safe and effective, this should not rest solely on hospitals and health systems. **As such, we urge the administration to support the development of post-market measurement and evaluation standards for vendors.** Standards should include performance metrics, evaluation thresholds and communication requirements for ongoing performance to end users. For coding tools in particular, controls should include routine validation of AI outputs against coding guidelines, identification of sources for recommendations, audit trails that retain the underlying clinical evidence supporting any recommended code, and escalation pathways for uncertainty or conflicting documentation. Vendors must also provide transparency regarding model updates and performance.

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[19] https://healthit.gov/data/data-briefs/hospital-trends-use-evaluation-and-governance-predictive-ai-2023-2024/

Vendor testing standards could be especially beneficial for supporting the use of AI for hospitals serving rural and underserved communities. Like all hospitals, these organizations want to ensure AI tools are used safely, effectively and robustly. However, these organizations may not have the staff or resources to support ongoing measurement activities, slowing their adoption and deployment of AI coding tools.

Curtailing Inappropriate Downcoding and Automated Payment Reductions by Insurers. AI can support accurate coding and documentation as well as prevention and detection of both overpayments and underpayments when embedded within a compliance framework. To be clear, increases in coding intensity are not driven by more aggressive coding processes or AI tool use, but by multiple other factors.

Perhaps most significantly, patient acuity has grown in recent years. As shown by the AHA's recently released Cost of Caring report, an aging population and the increasing prevalence of chronic disease continue to raise the level of complexity and intensity of hospital care.[20] At the same time, advances in medicine have enabled more routine and lower-acuity care to move to outpatient settings, leaving hospitals to care for an inpatient population with greater clinical and resource needs. Together, these shifts have created a new normal wherein many hospitals are treating a greater share of patients requiring intensive services, specialized staffing and around-the-clock capacity. A recent AHA/Vizient analysis found that hospital case-mix index — a standard measure of how sick patients are — rose by about 5% between 2019 and 2024, indicating that a larger share of hospital care is devoted to higher-acuity patients with multiple conditions, greater clinical needs and longer stays.[21] The continued rising prevalence of chronic diseases, such as heart disease, cancer and liver disease, also underscores the rising acuity of patients that hospitals treat.[22] Aside from patient acuity, other significant changes in coding guidelines for Evaluation and Management (E/M) codes and transition in diagnostic code versions (from ICD-9 to ICD-10 and in the future to ICD-11) may also impact the distribution of codes as data stabilize.

Hospitals have auditing and coding compliance programs to ensure they are appropriately capturing patient acuity levels and meeting regulatory requirements. As described above, hospitals are achieving this goal both with and without the use of AI, but always with a commitment to accuracy and program integrity.

For this reason, the AHA is deeply troubled by practices by certain insurers to unilaterally and inappropriately downcode and reduce payments to hospitals and other providers. In recent years, insurers, including many of the large, multi-state commercial insurers, have implemented "E/M downcoding programs," often using automated edits, to unilaterally reduce reimbursement for higher-level E/M visits unless providers submit additional documentation and pursue appeals. This misuse of automation not only fails to improve

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[20] https://www.aha.org/costsofcaring
[21] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/4574b4a787a34fe19770530a255c6f22?v=26a172b9
[22] https://www.trillianthealth.com/hubfs/2025 Trends Shaping the Health Economy Report %7C Trilliant Health.pdf

coding and payment accuracy but also adds waste and burden to the system. **We urge CMS to take steps to prevent insurers from systematically reducing reimbursement and forcing providers to engage in overly burdensome appeals processes simply to be paid for the medically necessary care they have provided to a patient.**

Ensuring Payer Transparency on AI use, Clarifying Coverage Criteria and Providing Independent Physician Review of Coverage Denials. A key driver of excessive administrative costs for hospitals and health systems and waste within the broader ecosystem is the onerous requirements imposed by commercial insurers to check patients' eligibility for coverage, bill for payment, and process prior authorizations and coverage denial appeals. Most claims initially denied by insurers (for example, 70% of Medicare Advantage plan claims) are ultimately paid, meaning a significant amount of administrative cost is wasteful.[23]

Commercial insurers' use of AI to determine disposition of claims and prior authorizations has exacerbated inappropriate denials. A U.S. Senate Permanent Subcommittee on Investigations report from 2024 found that certain plans had significant increases in prior authorization denials, in part driven by automated tools, and that the use of AI for prior authorization potentially targeted financial gain over medical necessity.[24]

To mitigate these inappropriate denials, the AHA has advocated for the following principles to protect timely patient access to necessary care: (a) ensuring insurer transparency on AI use, (b) clarifying coverage criteria and (c) providing independent physician review of prospective coverage denials.

Ensuring Insurer Transparency on AI Use. As health insurers expand AI utilization, providers and patients are generally unaware when AI tools are used in prior authorization or claims processes, much less have visibility on the inputs that drove a recommendation for approval or denial. Indeed, recent data from a survey of payers across 16 states conducted by the National Association of Insurance Commissioners show that only 23% of plans disclose to providers how and when AI is used.[25] While many insurers contend that AI is only used to speed up adjudication and make existing processes more efficient, providers and patients are concerned that AI is being used to prevent access to treatment. To promote trust and understanding, health insurers need to be forthright with patients and providers by disclosing all tasks completed by AI, including specific functions performed and the previous non-automated manner in which these tasks were completed before tools were available.

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[23] https://premierinc.com/newsroom/policy/80-premier-members-call-for-medicare-advantage-changes-to-address-payment-denials-and-delays

[24] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf

[25] https://content.naic.org/sites/default/files/inline-files/NAIC%20AI%20Health%20Survey%20Report%20.pdf

Clarifying Coverage Criteria. According to health insurers, the primary purpose of coverage criteria—often referred to as medical necessity criteria — is to ensure that services are safe, effective and evidence-based, while preventing unnecessary utilization and controlling costs.[26]

For these criteria to effectively impact clinician prescribing, physicians must understand payers' parameters for medical necessity. As some plans transition the processing of coverage determinations to AI, such determinations need to be based on clear, well-sourced, publicly available criteria and prohibited from using undisclosed or machine-determined rules. This guardrail would ensure that providers and patients can clearly understand and abide by the specific rules applied to a prospective care plan.

Providing Independent Physician Review of Coverage Denials. An insurer's decision to prevent a patient from receiving coverage is an extraordinary disruption in patient and provider expectations, and can have substantial impacts on health outcomes. Particularly in cases of prior authorization, denying a prescribed treatment can delay care and requires a clinician and the patient to either navigate a time-consuming appeals process or determine an alternative treatment path.

The gravity of such a decision demands that insurer denials are correct and do not inappropriately prevent access to necessary care. While AI might help insurers review claims and issue approvals and payments more expeditiously, it should not be able to deny coverage without appropriate human oversight. As a result, insurers should only issue clinically-based denials after an independent review by an appropriately trained clinician with expertise relevant to the procedure. This approach, which is consistent with CMS requirements for MA plans, protects patients from improper denials and disruptions in vital treatment.

[26] https://www.ahip.org/documents/Prior-Authorization-FAQs.pdf