State of California
Office of the Attorney General

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March 30, 2026

Submitted Via Federal Rulemaking Portal

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 9803 (Feb. 27, 2026) (CMS-6098-NC)

Dear Secretary Kennedy and Administrator Oz:

We, the undersigned Attorneys General of California, Arizona, Colorado, Delaware, Illinois, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Vermont, and Washington write in response to the request for information by the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (CMS) (collectively, the "Department") entitled "Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)."[1] The States share the Department's goal of fighting waste, fraud and abuse in the Medicaid program and all healthcare programs. Safeguarding public funds is an important, bipartisan, and shared obligation and has long been a joint endeavor between the States and the Department.

For over 50 years, the States have engaged in hundreds of state and federal investigations, joint task forces, commercial contractors and vendors, and other productive and cooperative

[1] CMS-6098-NC, 91 Fed. Reg. 9803 (Feb. 27, 2026), available at https://www.federalregister.gov/documents/2026/02/27/2026-03968/request-for-information-rfi-related-to-comprehensive-regulations-to-uncover-suspicious-healthcare.

interactions for the express goals of fighting fraud. The issues and concerns raised by the RFI do not lend themselves to short-form comprehensive solutions in the form of RFI comments in merely 30 days. As such, the States offer the following letter to emphasize their intention to fight fraud with the federal government. We note that fraud is best fought in collaboration with rather than in opposition to the States.

Indeed, in light of the federal government's recent public statements and administrative actions, the States are concerned that—rather than "crushing" genuine fraud—the Department's RFI will lead to rulemaking that further damages the collaborative relationship between the States and the federal government. The Department has recently engaged in an unfortunate effort to weaponize claims of "fraud" against certain states, seemingly motivated by politics rather than good governance.

As State Attorneys General, we have a duty to protect our residents and safeguard their health and safety. Healthcare coverage—and access to coverage—is crucial to the States; it improves population health, boosts economic stability, and reduces financial strain on public systems. The States therefore submit the following letter to highlight the States' robust anti-fraud practices and propose suggestions for future rulemaking.

I. THE STATES EXPEND CONSIDERABLE RESOURCES TO FIGHT FRAUD

The States engage in robust processes with their state agencies to analyze, flag, investigate, and prosecute fraud. The States engage in a three-pronged approach—administrative, civil, and criminal—to take action against violators and fraudsters. The States propose that any future rulemaking: (1) give the States better tools to improve detection, prevention, and prosecution of actual fraud; and (2) emphasize that the Department should work closely with State partners to identify and expand activities and processes with a proven track record of success. The States take their responsibility to safeguard Medicaid dollars seriously and remain committed to improving program integrity oversight.

A. State Agencies Work with the Department if there is Suspected Fraud

The federal and state administrators who oversee Medicaid, Medicare, and CHIP provide valuable oversight to ensure compliance with program rules and discourage bad actors from taking advantage of the programs. These administrators are experts in the programs they administer and are able to separate well-intentioned providers or beneficiaries' good-faith errors in complying with program rules from intentional fraudulent activities.[2] Traditionally, if the

[2] *See* 42 CFR § 433.304 ("Fraud (in accordance with § 455.2) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person"); *Medicare Fraud & Abuse: Prevent, Detect, Report*, Medicare Learning Network Booklet, Centers for Medicare & Medicaid (Jan. 2021), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf.

Department has concerns with claim documentation or a state's compliance with applicable statutes or regulations, it works directly with the state to cure any deficiencies. This approach makes sense because it ensures that eligible individuals continue to get access to healthcare in accordance with the law. *Harris v. McRae,* 448 U.S. 297, 308, 309 (1980) (Medicaid was designed as a "cooperative program" between state and federal governments).

On a day-to-day basis, Medicaid is administered by state Medicaid agencies."[3] The state agencies that oversee program integrity efforts related to Medicaid and CHIP use "audits, fraud detection, investigations, payment suspensions, cost recovery, [and] provider terminations" to ensure the integrity of these programs.[4] These tools allow the agencies to identify irregularities and trigger containment before improper payments are made. Once fraud is suspected, they can stop payments and take decisive steps, including working to support revocation of licenses and alerting managed care plans to stop payments, terminate contracts, and block further referrals and billing. Further, state agencies partner with law enforcement, like the State Attorneys General, "to support civil and criminal prosecution of bad actors."[5] Many state agencies are also members of the Healthcare Fraud Prevention Partnership (HFPP), "a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing."[6]

B. State Attorneys General are Effective at Prosecuting Fraud

The State Attorneys General also prosecute fraud after it is identified by their state agencies. These prosecutions not only recover billions of dollars in fraud against the taxpayers and patients—they have a deterrent effect on possible future fraudsters.

1. Medicaid Fraud Control Units Are Effective at Prosecuting Medicaid and CHIP Fraud

Medicaid Fraud Control Units (MFCUs) operate in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.[7] Most MFCUs are located within the offices of the

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[3] Elizabeth Hinton, et al., *5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments*, KFF News (Mar. 18, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-program-integrity-fraud-waste-abuse-and-improper-payments/.

[4] California's Response to CMS' Request for Program Integrity Action Plan, California Department of Health Care Services (Feb. 17, 2026) at 2, https://www.dhcs.ca.gov/Program-Integrity/documents/California%27s-Response-to-CMS%27-Program-Integrity-Request.pdf.

[5] *Id*.

[6] *About the Partnership*, The Healthcare Fraud Prevention Partnership (HFPP), Centers for Medicare & Medicaid Services, https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership/about.

[7] Medicaid Fraud Control Units, U.S. Department of Health and Human Services Office of Inspector General, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/

State Attorneys General.[8] MFCUs must be separate and distinct from the state Medicaid program to avoid conflicts of interest.[9]

MFCUs play a vital role in fighting healthcare fraud and protecting beneficiaries from abuse, neglect, and financial exploitation. They use a multidisciplinary model, employing attorneys, investigators, and auditors, to investigate and prosecute "complex Medicaid fraud and abuse and neglect of vulnerable individuals."[10] Many MFCU teams include medical professionals. The fifty-three MCFUs have obtained thousands of convictions and recovered billions of dollars in restitution.[11] MFCUs have prosecuted individual providers, hospitals, nursing homes, adult care homes, home health and hospice agencies, pharmacies, laboratories, durable medical equipment companies, and pharmaceutical manufacturers.[12]

The majority of MFCU's funding, 75%, is from the federal government, with 25% provided by the state.[13] The Inspector General of the U.S. Department of Health and Human Services (HHS-OIG) exercises oversight over MFCUs and annually recertifies each MFCU.[14] Criminal convictions and civil enforcement actions that hold persons accountable for complex fraud schemes deter potential fraudsters.[15] These investigations and prosecutions are resource intensive because they often involve: (1) complex fraud schemes that include LLCs, bank accounts, and multiple persons conspiring in the scheme; (2) manipulation of electronic records; and (3) defendants with significant resources represented by sophisticated law firms who litigate aggressively and seek delay.[16] As a result, many of these criminal prosecutions and civil enforcement actions can take years to resolve.

MCFUs have also demonstrably deterred the loss of many more billions of dollars in Medicaid overpayments.[17] Knowing that the States actively pursue civil and criminal penalties for healthcare fraud effectively serves to deter potential fraudsters.

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[8] *Id.*; *see, e.g..,* Division of Medi-Cal Fraud & Elder Abuse, State of California Department of Justice, https://oag.ca.gov/dmfea; https://www.azag.gov/issues/elder-affairs/senior-abuse/mfcu.

[9] *See* 42 U.S.C. § 1396b(q)(2).

[10] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid Before the Subcomm. Oversight and Investigations of the H. Committee on Energy and Commerce*, 119th Cong. 2 (Feb. 2026) (statement of Kaye Lynn Wootton, Nat'l Ass'n of Medicaid Fraud Control Units President) https://d1dth6e84htgma.cloudfront.net/02_03_2026_OI_Hearing_Witness_Testimony_Wootton_1879fcc9fe.pdf.

[11] *Id.*

[12] *About the Medicaid Fraud Control Units*, National Association of Attorneys General, https://www.naag.org/about-naag/namfcu/about-the-medicaid-fraud-control-units/.

[13] *See* 42 U.S.C. § 1396b(a)(6); General Terms and Conditions, Medicaid Fraud Control Units, U.S. Department of Health and Human Services Office of Inspector General, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/terms-conditions/.

[14] Medicaid Fraud Control Units, U.S. Department of Health and Human Services Office of Inspector General, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/.

[15] Wootton Statement, supra n. 10.

[16] *Id.*

[17] *Id.*

The States continue to be active in fighting fraud.

- California, over the last ten years, has recovered nearly $740 million in Medi-Cal fraud-related criminal prosecutions.[18]

- The Minnesota Attorney General has secured over 300 convictions and over $80 million in judgments since 2019.

- The New Jersey Office of the Attorney General, through its Medicaid Fraud Control Unit, has likewise achieved significant success in combating fraud in recent years. For example, the Office has brought charges against an individual accused of submitting tens of thousands of fraudulent Medicaid claims and receiving millions of dollars in improper reimbursements.[19] New Jersey has secured significant financial recoveries, including the seizure of approximately $6.4 million under a final judgment by consent in a Medicaid fraud matter involving the submission of thousands of false claims for reimbursement.[20] Additionally, between FFY2016 and FFY2025, New Jersey recovered approximately $21,621,447 in criminal recoveries.[21]

- Massachusetts, in just Fiscal Year 2025 alone, recovered more than $139 million in criminal and civil enforcement actions, an 18:1 return on investment for the HHS-OIG federal grant expenditures during the same time period. [22]

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[18] Attorney General Bonta Denounces Trump Administration's Political Weaponization of Fraud, California Attorney General (Feb. 5, 2026), https://oag.ca.gov/news/press-releases/attorney-general-bonta-denounces-trump-administration%E2%80%99s-political-weaponization; Thompson, Don, *Oz Says California's Not Fighting Health Care Fraud, but Data Shows It's Part of a Larger Battle*, KFF Health News (Mar. 19, 2026), https://kffhealthnews.org/news/article/hospice-fraud-medicaid-mehmet-oz-cms-california/ (In fiscal year 2024, California recovered "more than 50% of all the criminal recoveries made by the anti-fraud units nationwide in fiscal 2024 even though the state made up only about 17% of enrollment.")

[19] *Essex County Man Charged with Submitting Thousands of False Bills to Medicaid, Stealing More than $3 Million*, New Jersey Office of the Attorney General (Sept. 23, 2025), https://www.njoag.gov/essex-county-man-charged-with-submitting-thousands-of-false-bills-to-medicaid-stealing-more-than-3-million/

[20] *AG Platkin Announces Over $6M Seized Under Judgment by Consent After Death of CEO in Medicaid Fraud Scheme*, New Jersey Office of the Attorney General (Feb. 12, 2024), https://www.njoag.gov/ag-platkin-announces-over-6m-seized-under-judgment-by-consent-after-death-of-ceo-in-medicaid-fraud-scheme/.

[21] Expenditures & Statistics (FY 2016-FY2025), Medicaid Fraud Control Units, U.S. Department of Health and Human Services, Office of Inspector General, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/#expenditures-statistics.

[22] Medicaid Fraud Control Units Annual Report: Fiscal Year 2025, U.S. Department of Health and Human Services Office of Inspector General, https://oig.hhs.gov/reports/all/2026/medicaid-fraud-control-units-annual-report-fiscal-year-2025/.

- In fiscal year 2024, "Arizona's MFCU conducted 14 joint investigations with [HHS-OIG], including a multiyear task force effort targeting fraud in the behavioral health industry."[23] As of June 2025, Arizona's MFCU's efforts to combat fraud in the behavioral health realm "alone resulted in dozens of convictions, over $140 million in recoveries, and the forfeiture of vehicles, real estate, and other assets."[24] Notably, within five years (2020 and 2025), the HHS-OIG recognized the exemplary work that Arizona's MFCU has done to fight healthcare fraud and awarded the unit the Inspector General's Award for Fighting Fraud, Waste, and Abuse.[25]

- In Washington, from FFY 2021 to present, Washington has recovered $63,821,932 in civil and criminal recoveries.

- In Oregon, Oregon's MFCU secured 207 criminal convictions, 80 civil settlements and obtained over $85 million in criminal and civil recoveries between FFY2016-FY2025.

- New York MFCU, from 2019-2025, has recovered $627 million by obtaining 321 civil settlements and judgments and criminal restitution orders. In that time, which included the disruption of court functions due to the COVID Pandemic, New York nonetheless secured 95 indictments for Fraud and 36 for Abuse and Neglect of Nursing Home Residents and other vulnerable persons, with 187 convictions of individuals and businesses.

In federal fiscal year 2025, MFCUs operating across all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands reported 1,185 convictions, 900 exclusions from federally funded health care programs, and 674 civil settlements and judgments that totaled $2 billion in recoveries.[26] Overall, MFCUs recovered $4.64 for every $1 spent in federal fiscal year 2025.[27]

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[23] Arizona Attorney General's Office Health Care Fraud Unit Earns National Award for Excellence in Fighting Fraud and Abuse, Arizona Attorney General's Office (June 25, 2025), https://www.azag.gov/press-release/arizona-attorney-generals-office-health-care-fraud-unit-earns-national-award.

[24] *Id.*

[25] *Id.*

[26] Medicaid Fraud Control Units Annual Report: Fiscal Year 2025, OEI-09-26-00140, Department of Health & Human Services, Office of Inspector General (March 2026), https://oig.hhs.gov/documents/evaluation/11553/OEI-09-26-00140.pdf.

[27] *Id.* at 8.

In just the past few years, the Massachusetts Attorney General's Office secured multiple convictions, including a five-year jail sentence against a provider who pretended to be a dentist,[28] and indicted multiple defendants who engaged in fraud in billing for recovery coaching and non-emergency transportation.[29] The Minnesota Attorney General successfully obtained a conviction for Medicaid fraud for over $7 million dollars.[30] In New Jersey, a defendant was convicted after a trial involving fraudulent billing of the Medicaid program for services never rendered, resulting in convictions for health care claims fraud, Medicaid fraud, and theft by deception.[31] Oregon's MFCU has obtained convictions on a wide array of Medicaid provider types from in-home care providers to licensed medical professionals to owners/administrators of clinical labs. And has also successfully pursued successful civil recoveries from hospitals, care facilities, medical clinics and pharmaceutical companies. Oregon's MFCU also aggressively prosecutes abuse and neglect allegations including obtaining a 58-month prison sentence of an Adult Foster Home owner/operator for severe neglect of a disabled patient.

In Michigan, between November 2024 and February 2026, the Michigan MFCU reached civil settlements with seven Durable Medical Equipment (DME) and medical supply companies totaling over $6.3 million as part of an overall Michigan MFCU effort to remedy DME providers

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[28] *Milton Man Sentenced to a Total of Five Years in the House of Corrections and Ordered to Pay Restitution for Practicing Dentistry Without A License, Illegally Prescribing Controlled Substances, and Medicaid Fraud*, Massachusetts Office of the Attorney General (Feb. 6, 2026) https://oig.hhs.gov/fraud/enforcement/milton-man-sentenced-to-a-total-of-five-years-in-the-house-of-corrections-and-ordered-to-pay-restitution-for-practicing-dentistry-without-a-license-illegally-prescribing-controlled-substances-and-medicaid-fraud/; *see also*, *AG's Office Secures Guilty Plea, Suspended Sentence And Restitution From Rhode Island Resident Who Stole More Than $220,000 From Worcester Rest Home And Its Elderly Residents*, Massachusetts Office of the Attorney General (March 6, 2026), https://www.mass.gov/news/ags-office-secures-guilty-plea-suspended-sentence-and-restitution-from-rhode-island-resident-who-stole-more-than-220000-from-worcester-rest-home-and-its-elderly-residents.

[29] *AG's Office Secures Indictments Against Peabody Alcohol and Drug Counselor and Her Businesses for More Than $850,000 in MassHealth Fraud*, Massachusetts Office of the Attorney General (Feb. 2, 2026), https://www.mass.gov/news/ags-office-secures-indictments-against-peabody-alcohol-and-drug-counselor-and-her-businesses-for-more-than-850000-in-masshealth-fraud; *AG's Office Secures Indictments Against Waltham-Based Non-Emergency Medical Transportation Provider And Former Owner Over Money Laundering And Medicaid Fraud Scheme,* Massachusetts Office of the Attorney General (Feb. 11, 2026), https://www.mass.gov/news/ags-office-secures-indictments-against-waltham-based-non-emergency-medical-transportation-provider-and-former-owner-over-money-laundering-and-medicaid-fraud-scheme.

[30] *Abdifatah Yusuf found guilty of bilking Medicaid program out of over $7.2 million*, Minnesota Attorney General's Office (Aug. 12, 2025) https://www.ag.state.mn.us/Office/Communications/2025/08/12_Yusuf.asp

[31] Caregiver Found Guilty of Defrauding Medicaid of Roughly $45K by Billing for Caretaking Services in New Jersey While Working at Her Teaching Job in Michigan, New Jersey Office of the Attorney General (Nov. 15, 2023), https://www.njoag.gov/caregiver-found-guilty-of-defrauding-medicaid-of-roughly-45k-by-billing-for-caretaking-services-in-new-jersey-while-working-at-her-teaching-job-in-michigan/

fraudulently billing Medicaid for (1) CPAP and RAD/BiPAP accessories within the 10-month capped rental period; and (2) capped rentals (i.e. CPAP, BiPAP/RAD, hospital beds, oximeters, nebulizers, TENS, cough stimulators, lifts, and wheelchairs) after the 10-month rental period in violation of Michigan Medicaid policy. In December 2025, the Michigan MFCU reached settlements with four pharmacy owners for billing Medicaid for medically unnecessary over-the-counter COVID-19 test kits, taking advantage of relaxed rules during the COVID-19 pandemic, and for billing Medicaid for medications and products that they did not dispense to patients. In total, these settlements will return approximately $3.75 million to Michigan Medicaid and the U.S. government.

In California, several hospice operators were arrested for Medicaid fraud,[32] felony indictments were obtained against healthcare providers,[33] and healthcare clinic operator was sentenced to four years in jail and restitution.[34] The state further obtained multimillion dollar settlements for Medicaid fraud with a startup online pharmacy,[35] a pharmaceutical manufacturer,[36] the owners of laboratories,[37] and health care providers and a public health agency.[38]

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[32] *Attorney General Bonta Announces Seven Arrests for Hospice Fraud: My Office is On It!*, California Attorney General's Office (Feb. 5, 2026), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-seven-arrests-hospice-fraud-my-office-it;

[33] *Attorney General Bonta Announces Indictment of Southern California Healthcare Provider for Medi-Cal Fraud of Nearly $60 Million*, California Attorney General's Office (Sept. 18, 2024), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-indictment-southern-california-healthcare.

[34] *Attorney General Bonta Secures Sentencing of Southern California Healthcare Operator for Medi-Cal Fraud*, California Office of the Attorney General (June 27, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-secures-sentencing-southern-california-healthcare.

[35] *Attorney General Bonta Announces $15 Million Settlement Against Silicon Valley Startup Online Pharmacy for Medi-Cal Fraud Scheme*, California Office of the Attorney General (Feb. 7, 2023), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-15-million-settlement-against-silicon-valley.

[36] *Attorney General Bonta Combats Medi-Cal Fraud, Announces a $47 Million Settlement Against QOL Medical*, California Office of the Attorney General (Jan. 30, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-combats-medi-cal-fraud-announces-47-million-settlement.

[37] *Attorney General Bonta Combats Medi-Cal Fraud, Securing a $10 Million Settlement Against Southern California Provider*, California Office of the Attorney General (Jan. 30, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-combats-medi-cal-fraud-securing-10-million-settlement.

[38] *Attorney General Bonta Announces $68 Million Settlement Against Four Health Care Providers for Medi-Cal Fraud*, California Office of the Attorney General (June 29, 2023), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-68-million-settlement-against-four-health-care.

In Washington, civil recovery was obtained from the fraudulent overbilling of leased oxygen equipment.[39] In a joint settlements with the federal government, Washington further obtained the recovery of $22 million from a health care and hospital system that fraudulently billed Medicare, Medicaid, and other federal health care programs for medically unnecessary neurosurgery procedures,[40] and the recovery of $3.7 million against a different hospital and healthcare system.[41]

2. The States Target Bad Business Practices

The State Attorneys General act to prosecute fraud and preserve continuation of care for patients in need of medical care. These investigations and prosecutions against bad actor Medicare, Medicaid, CHIP, and private insurance providers and businesses include civil and criminal charges, disgorgement, license revocation, and shutting down facilities. In cooperation with other state agencies, many State Attorneys Generals can pursue False Claims Act actions to disgorge their fraudulent gains without endangering beneficiaries' access to care.

State Attorneys General can also pursue corporate or insurance fraud investigations and/or False Claims Acts investigations against bad actor businesses. This can include not only repayment of illegally obtained funds, but criminal convictions.

New Jersey has brought charges against individuals for submitting fraudulent claims for services performed by unlicensed individuals, as well as for conduct endangering vulnerable patients.[42] In addition to these prosecutions, New Jersey has also participated in multistate enforcement efforts, including a $202 million settlement with a pharmaceutical manufacturer for an illegal kickback scheme that resulted in false claims to government healthcare programs,[43] as well as a separate multistate settlement exceeding $230 million resolving allegations of

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[39] *Lincare to pay Washington state $1.15 million in AG Ferguson's Medicaid fraud investigation*, Washington State Office of the Attorney General (Jan. 13, 2025), https://www.atg.wa.gov/news/news-releases/lincare-pay-washington-state-115-million-ag-ferguson-s-medicaid-fraud.

[40] *Providence Health & Services Agrees to Pay $22.7 Million to Resolve Liability From Medically Unnecessary Neurosurgery Procedures at Providence St. Mary's Medical Center*, United States Attorney's Office Eastern District of Washington (April 12, 2022), https://www.justice.gov/usao-edwa/pr/providence-health-services-agrees-pay-227-million-resolve-liability-medically.

[41] *MultiCare Health System to Pay Millions to Settle Fraud Case*, United States Attorney's Office Eastern District of Washington (Feb. 4, 2026), https://www.justice.gov/usao-edwa/pr/multicare-health-system-pay-millions-settle-fraud-case.

[42] *Two Women Charged with Health Care Fraud for Allegedly Illegally Providing Medical Services*, New Jersey Office of the Attorney General (Jan. 26, 2026), Two Women Charged with Health Care Fraud for Allegedly Illegally Providing Medical Services - New Jersey Office of Attorney General.

[43] *AG Platkin Announces State Joins $202 Million Nationwide Bipartisan Settlement with Gilead Sciences for Kickback Scheme,* New Jersey Office of the Attorney General (July 15, 2025), https://www.njoag.gov/ag-platkin-announces-state-joins-202-million-nationwide-bipartisan-settlement-with-gilead-sciences-for-kickback-scheme/.

underpaid Medicaid rebates,[44] further underscoring the State's commitment to protecting public funds and program integrity.

California has indicted healthcare clinic operators on felony charges[45] and the owner of a residential care home[46] for fraud. California has also launched an initiative aimed at protecting patients and families from hospice fraud.[47]

Massachusetts has obtained numerous convictions against applied behavioral analysis,[48] home health,[49] and adult foster care[50] operators on fraud charges, and has secured large, multi-million dollar civil settlements with owners, operators, and even private equity investors[51]

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[44] *Acting AG Platkin Announces Mallinckrodt to Pay More Than $230 Million to Settle Lawsuit Alleging Underpayment of Medicaid Drug Rebates,* New Jersey Office of the Attorney General (July 26, 2022), https://www.njoag.gov/acting-ag-platkin-announces-mallinckrodt-to-pay-more-than-230-million-to-settle-lawsuit-alleging-underpayment-of-medicaid-drug-rebates/.

[45] *Attorney General Bonta Secures Sentencing of Southern California Healthcare Operator for Medi-Cal Fraud*, California Office of the Attorney General (June 27, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-secures-sentencing-southern-california-healthcare.

[46] *Attorney General Bonta: Owner of Placer County Residential Care Home Arrested and Charged With Medi-Cal Fraud*, California Office of the Attorney General (March 20, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-owner-placer-county-residential-care-home-arrested-and.

[47] *Confronting Hospice Fraud: Attorney General Bonta Launches Public Awareness Campaign to Protect Californians and Prevent Abuse Within Hospice Care System*, California Office of the Attorney General (Aug. 6, 2025), https://oag.ca.gov/news/press-releases/confronting-hospice-fraud-attorney-general-bonta-launches-public-awareness.

[48] *Essex County Man Convicted, Sentenced After Trial For Submitting False MassHealth Claims For Autism Behavioral Health Treatment*, Massachusetts Office of the Attorney General (Feb. 26, 2025), https://www.mass.gov/news/essex-county-man-convicted-sentenced-after-trial-for-submitting-false-masshealth-claims-for-autism-behavioral-health-treatment.

[49] *Chelmsford Couple Pleads Guilty In Connection With Medicaid Fraud Scheme To Exploit The Unhoused* Massachusetts Office of the Attorney General (Sept. 21, 2023), https://www.mass.gov/news/chelmsford-couple-pleads-guilty-in-connection-with-medicaid-fraud-scheme-to-exploit-the-unhoused.

[50] *AG Campbell Secures Guilty Plea From Ringleader Of Worcester-Based Home Health Fraud Scheme Exploiting Vulnerable Residents* Massachusetts Office of the Attorney General (Sept. 15, 2025), https://www.mass.gov/news/ag-campbell-secures-guilty-plea-from-ringleader-of-worcester-based-home-health-fraud-scheme-exploiting-vulnerable-residents.

[51] *Private Equity Firm and Former Mental Health Center Executives Pay $25 Million Over Alleged False Claims Submitted for Unlicensed and Unsupervised Patient Care,* Massachusetts Office of the Attorney General (Oct. 14, 2021), https://www.mass.gov/news/private-equity-firm-and-former-mental-health-center-executives-pay-25-million-over-alleged-false-claims-submitted-for-unlicensed-and-unsupervised-patient-care; *see also AG Campbell Announces $4 Million Settlement With Nursing Home Chain For Significant Staffing And Care Failures Resulting In Resident Neglect,* Massachusetts Office of the Attorney General (June 10, 2024), https://www.mass.gov/news/ag-campbell-announces-4-million-settlement-with-nursing-home-chain-for-significant-staffing-and-care-failures-resulting-in-resident-neglect.

who defraud taxpayers through the Medicaid program. In Washington, the MFCU brought felony charges for a fraudulent psychotherapy clinic.[52] Since 2020, Arizona's MFCU has indicted 168 individuals and businesses, with 73 having already pleaded guilty and other verdicts obtained after criminal trial as part of the state's efforts to prosecute and help stop fraud in behavioral healthcare.

In 2025, New York MFCU launched an innovative "Cease, Desist & Recover" initiative where 54 Non-Emergency Transportation providers were directly warned – by MFCU Detectives placing the specific analysis in the owners' hands so there can be no argument that they were ignorant of the activities at their companies-- that they were engaged in overbilling, to cease immediately or face additional consequences, and also for some providers to pay specific sums.[53] That direct approach led to many of those providers shutting down, and other settlements and seven new lawsuits recovered over $13 million from 16 transportation providers.[54]

State Attorneys General along with other state agencies also pursue disciplinary action, including suspending or rescinding licenses to practice medicine. For example, in four years, California has revoked the licenses of more than 280 hospices for fraud.[55] In New Jersey, a licensed pharmacist was charged with selling fraudulent COVID-19 vaccination record cards and entering false information into a State-managed database of COVID-19 vaccination records, and the State Board of Pharmacy initiated disciplinary proceedings against the provider's license.[56]

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[52] *Attorney General files criminal charges against Spokane-based health business for fraud, organized crime*, Washington State Office of the Attorney General (Dec. 16, 2022), https://www.atg.wa.gov/news/news-releases/attorney-general-files-criminal-charges-against-spokane-based-health-business.

[53] *Attorney General James Puts Medical Transportation Industry on Notice, Announces New Actions to Stop Ongoing Fraud*, New York Office of the Attorney General (June 30, 2025), https://ag.ny.gov/press-release/2025/attorney-general-james-puts-medical-transportation-industry-notice-announces-new.

[54] *Attorney General James Secures More Than $13 Million in Sweeping Takedown of Transportation Companies for Defrauding Medicaid*, New York Office of the Attorney General (June 30, 2025), https://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation.

[55] *In the four years since Governor Newsom's new hospice provider ban took effect, California has revoked more than 280 licenses*, California Governor's Office (Jan. 27, 2026), https://www.gov.ca.gov/2026/01/27/in-the-four-years-since-governor-newsoms-new-hospice-provider-ban-took-effect-california-has-revoked-more-than-280-licenses/.

[56] *Acting AG Platkin Announces the Arrest of Hudson County Pharmacist Charged with Selling Fake COVID-19 Vaccination Record Cards to Individuals Who Did Not Receive the Vaccine,* New Jersey Office of the Attorney General (July 1, 2022), https://www.njoag.gov/acting-ag-platkin-announces-the-arrest-of-hudson-county-pharmacist-charged-with-selling-fake-covid-19-vaccination-record-cards-to-individuals-who-did-not-receive-the-vaccine/.

3. Marketplaces

The majority of the fraud associated with health insurance marketplaces authorized by the Affordable Care Act (ACA) involves bad actors trying to scam people who are eligible for marketplace subsidies. Further, the majority of fraud that occurs in the exchanges happens on the federal level, not the state level.[57]

The State Attorneys General—as part of their general corporate and insurance fraud prosecution—work to investigate scams and protect consumers. For example, the California Attorney General's office shut down private health insurance websites that misled state residents by imitating legitimate plans on Covered California, the state's only official ACA marketplace.[58] Subscribers who were duped by these scam plans would have lost out on valuable subsidies designed to make legitimate health insurance more affordable, as well as consumer protections guaranteed by the ACA to protect rights to coverage. The Massachusetts Attorney General's Office recently obtained a judgment against three health insurance companies for $50 million in consumer relief and $114 million in civil penalties as a result of their deceptive practices targeted at those seeking health insurance through the Massachusetts marketplace (among others).[59]

II. THE DEPARTMENT'S ANTI-FRAUD PUSH SHOULD BE BASED ON SOUND METHODOLOGY

The Department's recent claims of fraudulent activity in its communications with many of the States appear to be based upon broad and unsupported claims rather than specific evidence of wrongdoing. The States urge that any future rulemaking ensures that the Department relies upon clear definitions of fraudulent activity.

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[57] *See Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist*, U.S. Government Accountability Office (Dec. 3, 2025), https://www.gao.gov/assets/gao-26-108742.pdf (evaluating fraud on the federal exchanges. The state exchanges do not report the same levels of fraudulent activity).

[58] *Attorney General Kamala D. Harris Shuts Down Imitation 'Covered California' Websites, Provides Tips for Consumers*, California Office of the Attorney General (Nov. 14, 2013), https://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-shuts-down-imitation-%E2%80%98covered-california%E2%80%99.

[59] *See Superior Court Orders Health Insurance Companies To Pay Over $165 Million For Deceptive Sales Scheme That Cheated Massachusetts Consumers* (Jan. 6, 2025), https://www.mass.gov/news/superior-court-orders-health-insurance-companies-to-pay-over-165-million-for-deceptive-sales-scheme-that-cheated-massachusetts-consumers; *Commonwealth of Massachusetts v. The MEGA Life and Health Insurance Co. et al*., Suffolk Superior Court Civ. Action No. 0684CV044110-BLS1, Commonwealth's Statement of Undisputed Facts in Support of Motion for Partial Summary Judgment as to Liability and for Permanent Injunction with Defendants' Responses at 36-38, 44-45, 71-72 (¶¶ 110, 114, 117, 140-43, 153, 222-24) (Docket File Ref. Nbr. 73); Joint Pre-Trial Memorandum, Exhibit A-Agreed Facts at 14 (¶ 78) (First docket entry after Docket File Ref. Nbr. 198).

A. Payment Errors are Not Necessarily Fraud

The Department should make clear the difference between intentional fraud and administrative or paperwork errors. CMS's Payment Error Rate Measurement (PERM)[60] program explicitly states that "the improper payment rate is not a 'fraud rate' but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements." PERM estimates are measures of compliance error, not indicators of intentional wrongdoing.[61] Improper payments often reflect documentation deficiencies, eligibility-processing issues, or other administrative compliance problems, not intentional deception. In fact, the Department admitted that some of its claims of fraud in California incorporated billing that was not necessarily improper or fraudulent.[62] Collapsing improper payments, abuse, and fraud into a single category misleads the public, inflates perceptions of criminal misconduct, and risks misdirected policy action.

Of the Medicaid improper payments identified by CMS in its 2025 fact sheet, 77% were the result of insufficient documentation, which CMS itself states "is generally not indicative of fraud or abuse."[63] Many payments were to an eligible recipient for an eligible service and were flagged for administrative errors. The States believe that improper payments are a less robust target for fraud enforcement than the submission of false claims to Medicaid that results from reckless disregard, or knowing or intentional misconduct.

B. High Utilization Is Not Necessarily Fraud

The States encourage the Department not to interpret high utilization of services as itself evidence of fraud.

State-specific programs—which are approved by the federal government—are in fact why Medicaid is effective. States have the autonomy to shape their programs based upon the specific needs of their population. These program variations reflect state priorities and unique state health challenges. This can include Medicaid expansion, differing income limits, and special programs to address local health and demographic concerns.

For example, with regards to home and community-based services, the Department has recently issued a series of letters to various States claiming that there are high rates of fraud

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[60] Payment Error Rate Measurement Program, Centers for Medicare & Medicaid, https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm.

[61] Mathers, et al., *A Look at the Medicaid Payment Error Rate Measurement (PERM) Program and Upcoming Changes and Impacts*, KFF (Feb. 13, 2026), https://www.kff.org/medicaid/a-look-at-the-medicaid-payment-error-rate-measurement-perm-program-and-upcoming-changes-and-impacts/.

[62] *Oz Says California's Not Fighting Health Care Fraud, but Data Shows It's Part of a Larger Battle*, *supra* n. 18.

[63] *Fiscal Year 2025 Improper Payments Fact Sheet*, Centers for Medicare & Medicaid, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet.

relating to hospice care, in-home supportive services, and Medicare billing by durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) companies and imposed moratoriums. Some of these categories of care are indeed areas where both the States and the federal government are rightly concerned about elevated rates of fraud, and the States already target their anti-fraud activities accordingly. But an increase in expenditures for services connected to an aging population is not alone evidence of fraud.

To the contrary, the growth in such services is based upon decades of federal policy response to major demographic change such as the aging of the Baby Boom generation and guided by national civil rights priorities that focus on de-institutionalizing people with disabilities and ensuring people can remain in their homes and communities. Both Republican and Democratic administrations have reinforced that direction. The Deficit Reduction Act of 2005 created a state plan Home and Community-Based Services (HCBS) option (Section 1915(i)) and the Money Follows the Person Program to help people transition from institutions to the community. The ACA established the Community First Choice option (Section 1915(k)) and the Balancing Incentive Program, and the Obama administration emphasized community integration through Medicaid policy and enforcement of disability rights law. President Trump's first administration emphasized this priority again in 2020 in its "Toolkit to Accelerate State Efforts to Rebalance Long-term Care Systems and Enhance Home and Community-Based Services for Eligible Medicaid Beneficiaries" published on November 2, 2020.

III. THE STATES' RESPONSES TO THE RFI

The States make the following proposals in response to the RFI.

This section is organized to follow the subheadings and the order of questions asked in the RFI.

A. Modifications to Program Integrity Requirements

1. Working with the States Will CRUSH Fraud

The Department says it is looking for ways to "strengthen its fraud-fighting toolbox," including ways to better use existing statutory authority. 91 Fed. Reg. at 9804.

Any proposed rule will be most effective at crushing fraud when it works in tandem with existing state processes to fight fraud. The States welcome additional resources, funds, or programs that measure and fight fraud in cooperation with the federal government.

The MFCUs work closely with federal, state, and local agencies. At the federal level, MFCUs frequently conduct joint investigations with HHS-OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), Internal Revenue Service (IRS), U.S. Drug Enforcement Administration (DEA), United States Postal Service (USPS), and other

investigative agencies.[64] MFCUs also often coordinate with the U.S. Department of Justice and with local U.S. Attorneys' Offices.[65] Many MFCUs have attorneys on staff who are appointed as Special Assistant U.S. Attorneys.[66] Continuing this coordination would help address the Department's concerns outlined in the RFI regarding "Reducing Medicare Fraud Related to Laboratory Tests," "Reducing Risks from DMEPOS Suppliers in Medicare Advantage," and "Beneficiary Solicitation" as they related to Medicaid beneficiaries. 91 Fed. Reg. at 9805-06. The Department could also refer more cases to State Attorneys General to pursue bad actor lab operators and DMEPOS providers for fraudulent activities and for prosecution of unscrupulous persons trying to scam beneficiaries.

2. The Department Should Be Judicious in its Information Requests

The Department requests information on "[w]hat changes could CMS or its contractors make to existing processes to promote their ability to effectively deter fraud, waste, and abuse and promote payment accuracy and efficiency, including by more expeditiously gathering actionable information." 91 Fed. Reg. at 9804.

To the extent the Department gathers data from inquiries to the States, the States request that any proposed rule give the States sufficient time to respond to requests. The Department has recently sent letters to states demanding responses in a short time frame about the different states' anti-fraud programs and demanding corrective action plans.[67] The responses to broad information requests can be time-consuming and cumbersome to assemble.

Further, as discussed on page 11, every state Medicaid program is different. This includes the manner of data collection. As such, large scale data requests from the federal government require commitment of intensive resources from the States because the data the federal

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[64] Wootton Statement, supra n. 10.

[65] *Id*.

[66] *Id.; see, e.g., Former CEO of Non-Profit Nursing Home Pleads Guilty to Misapplication of Property*, United States Attorney's Office District of Massachusetts (Feb. 27, 2026), https://www.justice.gov/usao-ma/pr/former-ceo-non-profit-nursing-home-pleads-guilty-misapplication-property; *United States Sues Skilled Nursing Company, Executives and Consultant for Fraudulent Billing* United States Attorney's Office District of Massachusetts (Feb. 25, 2025), https://www.justice.gov/usao-ma/pr/united-states-sues-skilled-nursing-company-executives-and-consultant-fraudulent-billing.

[67] *State of Maine Responds to CMS Medicaid Letter, Highlights Steps Taken under Mills Administration to Fight Fraud,* Maine Office of the Governor (Mar. 6, 2026), https://www.maine.gov/governor/mills/news/state-maine-responds-cms-medicaid-letter-highlights-steps-taken-under-mills-administration; *Maine Response to HHS OIG re: Corrective Action Plan regarding Rehabilitative and Community Support services,* Maine Department of Health and Human Services (Mar. 4, 2026), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/2026-03/MaineDHHS-OMS%20Response%20to%20A-01-24-00006.pdf; Ali Swenson & Anthony Izaguirre, *Trump administration widens its anti-fraud efforts with a Medicaid probe in New York*, AP News (Mar. 4, 2026), https://apnews.com/article/oz-medicaid-new-york-fraud-investigation-a00bd997ee5b8d839254144377c3b167; California's Response to CMS' Request for Program Integrity Action Plan, *supra* n. 4.

government's questions do not necessarily match how a State chooses to collect data. The States must run analyses and clean the data to make it usable. A proposed rule that provides guidelines regarding information requests should ensure that States are given sufficient time to respond to such requests. The States want to work with the federal government to provide necessary information, but recent requests have been extensive and time-consuming.

3. Data Analytics

The Department requests information on "types of analytics, methodologies, or data-driven approaches would be most effective in identifying indicators of potential fraud, waste, or abuse." 91 Fed. Reg. at 9804.

The States seek trainings on the most up to date technology and data analytic tools for fighting fraud. Currently, the National Association of Medicaid Fraud Control Units (NAMFCU), a division of the National Association of Attorneys General, lacks federal funding for multi-state training. Federal funding for NAMFCU training would be helpful to ensure consistent availability of such training to all MFCUs.

B. Enhanced Identity Proofing and Ownership Requirements

The Department requests stakeholder feedback about provisions that would include enhanced identity proofing of individuals associated with Medicare-enrolled entities and impose citizenship or legal residency requirements for ownership. 91 Fed. Reg. at 9804.

With respect to enhanced identity proofing of individuals associated with Medicare-enrolled entities, the States see potential benefit to program integrity from enhancing identity proofing for Medicare and Medicaid enrolled entities during the provider enrollment process.

However, with respect to citizenship or legal residency requirements, the States do not believe it would be beneficial to create limitations for ownership. Immigrants and other non-citizens play a significant role in the healthcare sector, contributing to both the healthcare workforce and as business owners. Nearly 2.8 million immigrants were employed as health-care workers in 2021, accounting for more than 18 percent of the 15.2 million people in the United States in a health-care occupation.[68] Reducing the ability of non-citizens to provide services in the healthcare sector only serves to reduce access to care.

Limiting who can be involved in Medicare also threatens to stereotype non-citizens as more likely to engage in fraud than U.S. citizens. There is no such evidence.

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[68] Jeanne Batalova, *Immigrant Health-Care Workers in the United States*, Migration Policy Institute (April 7, 2023), https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2021.

C. Artificial Intelligence in Medicare Advantage Coding Oversight and Hospital Billing

The Department is seeking input from stakeholders about the availability, use, efficacy, and cost of using artificial intelligence (AI) to assist with accurately and efficiently abstracting diagnoses from medical record documentation as part of a medical records review. 91 Fed. Reg. 9806.

The States suggest that to the extent any proposed rule discusses use of AI to identify possible fraud, that the rule emphasize the importance of conducting an appropriate law enforcement investigation in compliance with state and federal laws and Constitutions, assessing findings made on the basis of admissible evidence, and bringing criminal and/or civil proceedings as appropriate based on applicable legal standards. Fraud is a fact-specific investigation. Any anomalies flagged by AI are not dispositive for fraud and should not be the sole basis for taking action against a state, provider, or enrollee.

To prevent unintended consequences of increased risk of patient identity theft and more Medicaid and Medicare fraud, the States recommend any use of AI be required to be conducted under stringent AI-use policies that prevent sensitive data from being disclosed on open and unsecure AI tools. AI tools have the potential to produce biased or incorrect conclusions depending on factors like whether the data it was trained upon has a high error rate (like the Systematic Alien Verification for Entitlements (SAVE) Program database), or if the underlying data does not reflect the population on which the tool is applied.[69] Further, the Department should ensure maximum transparency to the States and the public of any AI tools that it ultimately uses—including implementing transparency and explainability requirements, and regular and publicized risk assessments. Finally, the Department should ensure that any AI output is substantively reviewed by staff with appropriate training and expertise to ensure accuracy, safety, and fairness of the AI tools.

D. Surety Bonds

The Department requests feedback on strengthening the requirement that DMEPOS suppliers are required to maintain a surety bond of at least $50,000 in order to enroll and maintain enrollment in Medicare, in accordance with section 1834(a)(16) of the Act (and as codified in 42 CFR 424.57(d)). 91 Fed. Reg. at 9807. The Department further asks for suggestions to "strengthen surety bond requirements in Medicaid and CHIP, for example, with respect to Medicaid and CHIP home health providers." *Id*.

The States note that surety bonds are useful tools for ensuring that a Medicaid program has the potential to offset losses from a Medicaid provider that violates the law and thereafter has insufficient assets for the state to recover. Surety bonds also provide a window for practical private-sector business to assess whether another potential private-sector

[69] Bjorn Hoffman, *Biases in AI: Acknowledging and Addressing the Inevitable Ethical Issues*, Front. Digit. Health (Aug. 20, 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12405166/#.

business has a sufficiently valid business model to be a good risk. Such a determination saves a state program from having to make such assessments.

The States recommend that, in all circumstances where a provider must furnish a surety bond for Medicare enrollment, the coverage of such a bond should be mandated to include Medicaid and CHIP as well.

E. Medicaid and CHIP

1. A Proposed Rule for Fighting Fraud Should Have Sufficient Factual Basis

The Department states it has taken "bold steps to address significant, systemic Medicaid fraud that has been discovered in multiple states." 91 Fed. Reg. 9807. The States vehemently disagree with the Department's characterization that certain state programs are overrun with "systemic" fraud or that any fraud has been recently "discovered" by the Department. Indeed, many if not most of the Department's examples of fraud are issues that the States first identified and disclosed to the Department. Nor is there is any factual basis to believe that fraud, waste and abuse related to particular services is confined to "certain states." Any proposed rulemaking should acknowledge that all parties seek the same goals of conserving public dollars for actual healthcare needs and affirm that the federal government will follow statutory processes and not punish States for bringing information about fraud to the federal government's attention.

In MFCU cases involving Medicaid and CHIP industry sectors, the key fraud vulnerability is misuse of clients' personal information by unscrupulous providers to submit false claims. In the MFCUs' experience, a neutral third-party brokering the relationship between the providers of such services and the clients of such services could help alleviate these vulnerabilities.

2. The Department Should be Measured in its use of Deferral

The Department seeks information on ways "CMS should better leverage or expand its statutory or regulatory program integrity oversight authority." 91 Fed. Reg. 9807.

CMS's broad-based use of deferrals or withheld funds from state Medicaid programs should be little used options, and the Department should ensure continuation of care. The States propose that any rulemaking emphasizes that the deferral of Medicaid and CHIP dollars to a state is an extreme option and only to be conducted after first working collaboratively with the state. Further, the States are concerned by the Department's actions to seek both deferral of funds *and* withholding of funds based on the same allegations and targeting the same dollars.

Deferring or withholding significant amounts of federal funding against an entire state agency in cases of potential fraud is too blunt an instrument. Withholding state funds does not pinpoint fraudulent actors and fails to have a deterrent effect on actual sources of fraud, most of which occurs by private parties, and not at a uniform statewide level. Nor does it enable the

States to target fraudulent activity. Instead, it introduces instability into provision of healthcare services to vulnerable populations who depend on these programs.

Withheld funds can lead to service disruptions, late payroll, or provider closures. The consequences of these closures fall upon healthcare recipients. If Medicaid funds are withheld, to make up the shortfall, States will be forced to cut services or cut reimbursement rates. This has potential costs to state and private hospitals through increased charity care, and to the States from covering emergency medical treatment for recipients who lost coverage.

Finally, this lack of funding can cause enrollees to lose access to coverage. Even if the deferred funding is later reinstated, the harm has been done. Research indicates that enrollees who experience fluctuations in coverage are more likely to forgo preventative services and medication and are more likely to end up in the hospital with a preventable condition.[70] In addition, there are administrative costs associated with disenrolling an enrollee and then subsequently processing a new application, as may happen with funding disruptions.[71]

Therefore, a proposed rule should direct that all efforts be taken to ensure the States can provide continuity of care to their residents.

3. High Risk Provider Enrollment

The Department requests information on whether CMS should "require that states require their high-risk providers to revalidate more frequently than every 5 years." 91 Fed. Reg. 9807. The Department also asks what tools or guidance it can give to states to enhance program integrity in the Medicaid and CHIP managed care and fee-for-service programs. *Id*.

The States believe that high-risk provider enrollment can be productively addressed. Many MFCU investigations reveal that key individuals initially associated with a new provider become unaffiliated or cease involvement after enrollment. While the reasons for the disaffiliation can range from carelessness to intentionally nefarious, it is important for states to be able to identify when a key provider is acting merely as "strawperson" for high-risk providers. As these individuals and entities are often both Medicaid and Medicare providers, the Department could develop positive identification methods accessible to both State and federal regulators and enforcement agencies. Such a method could involve a universal portal which a provider can access online and register or deregister affiliations in real time.

4. Individuals who do not have satisfactory immigration status for full Medicaid or CHIP benefits

The Department requests information on ways for CMS to "better prevent, identify, and

[70] *Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care*, the Commonwealth Fund (June 11, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.

[71] *Id*.

address Medicaid and CHIP fraud, waste, and abuse in the context of individuals who do not have satisfactory immigration status for full Medicaid or CHIP benefits who are accessing services inappropriately." 91 Fed. Reg. 9807.

Regarding services, it is uncommon for the immigration status of a patient receiving healthcare to have a negative impact on the Medicaid program. Further, as discussed on page 12, some states provide state-funded care for individuals with unsatisfactory immigration status, as permitted under the laws that provide for state variation in programs. Use of such state programs is not fraud.

In general, the majority of fraud is committed by bad actor providers or businesses, rarely beneficiaries.[72] Unscrupulous providers will engage in fraud by means of fictitious services, up-coding of services, provision of medically unnecessary services, and substandard provision of services. A focus on the immigration status of individuals in need of healthcare distracts from the illegal activity of providers.

5. Enhancing Program Integrity in Managed Care

In response to the Department's question as to what data or information should be made publicly available that would allow for transparency in Medicaid by states, health plans, and providers (91 Fed. Reg. at 9807) the States suggest that requiring disclosure from managed care companies would improve federal and state ability to protect Medicaid program integrity.

Fraud in both Medicare and Medicaid by providers and subcontractors has long existed within networks administered by managed care organizations, and sometimes within the managed care organizations themselves. Managed care organizations make too few quality fraud referrals to MFCUs despite the existence of fraud within their networks. Managed care organizations have resolved findings of illegal billing as overpayments because they wished to increase their revenue; at other times, managed care organizations have resolved suspicious provider billing by terminating their contract with a provider because they wished to avoid the risk of financial loss that litigation or a referral could bring.

Lack of uniformity in how managed care organizations report their encounter data reduces efficiency in state MFCU investigations and data mining work. Further collaboration between the States and the Department can better protect program integrity through stronger managed care contract terms, enhanced requirements for managed care organizations to staff their investigative units sufficiently to make sufficient numbers of quality fraud referrals to state MFCUs, and requirements for uniform standardized data reporting by managed care organizations.

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[72] *5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments*, *supra* n. 3; *The Department of Health & Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report of Fiscal Year 2023* (Dec. 2024), https://oig.hhs.gov/documents/hcfac/10087/HHS%20OIG%20FY%202023%20HCFAC.pdf (no beneficiary fraud found in listing).

Specifically, annual disclosure requirements for managed care organizations' compensation and bonus amounts and criteria for their Presidents, Chief Executive Officers and high managerial agents, for the numbers and amounts of overpayments collected, for the numbers of providers whose contracts were terminated, and the number of fraud referrals accepted by the state MFCU would help protect Medicaid program integrity.

6. Responding to Recovery Audit Contractor (RAC) Findings

The Department requests information on which "best practices and standardized processes should states implement when responding to recovery audit contractor (RAC) findings." 91 Fed. Reg. at 9807.

The States note that they appreciate RAC findings with referrals shared with their MFCUs by the Department and federal contractors. Best practices for States upon receipt of offered RAC referrals include review of utilization of the suspected provider fraud in the referral, review of current and overall utilization by the provider, consideration and evaluation of information within the referral along with other data available to the MFCU, identification of any risk of or actual patient harm resulting from the suspected fraud, and consideration of existing investigations, matters and priorities. Best practices also include the MFCU's consideration of these factors and ensuring the MFCU has the ability to make the decision to accept or reject the referral after considering available resources.

F. State-Specific Medicaid and CHIP Questions

1. Further Use of Federal Data Bases

The Department requests information on whether "further use of federal databases, such as Do Not Pay (DNP), or non-federal databases provide states with more complete information to move further away from a pay-and chase model and towards pre-pay review." 91 Fed. Reg. at 9807.

The States recommend that information from federal databases be vetted before relied upon as supporting evidence of fraud. In multiple communications, the Department has referenced results from the SAVE Program and the U.S. Department of Treasury's Do-Not-Pay (DNP) list as evidence of fraud. These databases are flawed and can be inaccurate. For example, SAVE is used to check immigration status for eligibility of benefits; yet, many applicants' immigration statuses cannot be verified during an initial SAVE query due to a variety of data-related errors, including "an issue electronically locating the records;" "conflicting data" within the databases used by SAVE; or "the nature of the applicant's status."[73] Analysts have emphasized the shortcomings in SAVE's data, including the lack of comprehensive or up-to-date

[73] Guide to Understanding SAVE Verification Responses, U.S. Department of Homeland Security, U.S. Citizenship and Immigration Services (April 2022) at 2, https://www.uscis.gov/sites/default/files/document/guides/SAVE-Guide%20to%20Understanding%20SAVE%20Verification%20Responses.pdf.

information on all individuals' citizenship or immigration status.[74] The Treasury Department's Do Not Pay list raises similar concerns involving reliability.[75]

Regarding moving further away from a pay-and-chase model and towards pre-pay review (91 Fed. Reg. at 9807), for the States, pre-payment review mechanisms can be a useful tool to provide a Medicaid agency or managed care organization with the opportunity to assess a provider's billing trends and to require a provider to answer questions and substantiate implausible claims. The current limitation of many federal healthcare databases to federal agency use only is an unnecessary limitation. As such, the States welcome further database access.

G. Federally Facilitated Exchange (FFE) and State-Based Exchanges (SBEs)

The Department requests information on strengthening program integrity in both the FFEs and the SBEs, including strengthening oversight of brokers. 91 Fed. Reg. 9808.

As discussed in the States' comment letter in response to Proposed Rule: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,[76] the majority of fraud happening in the exchanges—including broker fraud—is occurring on the federal level. Agent misconduct is an issue specific to the FFE rather than a marketplace-wide concern. As outlined in the States' letter, the Department can take action to address such fraud and should do so.

For example, California has significantly reduced fraudulent enrollment from unscrupulous brokers by sending users a one-time code to share with an agent. It further mandates secure consumer involvement through delegation processes, including portal management, call center authentication, and passcode verification, an active duplicate enrollment monitoring and resolution processes, and maintains a centralized fraud management team.

Pennsylvania similarly allows only agents designated by the consumer to access the user's account. Other SBEs use multiple tools to prevent, mitigate, and shut down fraudulent enrollments including logging information recording changes, multi-factor authentication to access accounts, broker certification and all carrier appointments requirements, and rescissions in cases of fraud. The Department should consider mandating similar controls at the federal level.

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[74] Jasleen Singh and Spencer Reynolds, *Homeland Security's "SAVE" Program Exacerbates Risks to Voters* (July 21, 2025), https://www.brennancenter.org/our-work/research-reports/homeland-securitys-save-program-exacerbates-risks-voters.

[75] *Testimony of Linda Miller before the Subcomm. on Government Operations of the H. Committee on Oversight and Government Reform*, 117th Cong. (March 31, 2022) (statement of Linda Miller, Principal at Grant Thornton, LLP, head of Fraud & Financial Crimes Practice, former Assistant Director in the Forensic Audits and Investigative Service group at The Government Accountability Office (GAO)), https://docs.house.gov/meetings/GO/GO24/20220331/114566/HHRG-117-GO24-Wstate-MillerL-20220331.pdf.

[76] Docket No. CMS-2025-0020-0011 (formerly CMS-9884-P), RIN 0938–AV61, 90 Fed. Reg. 12,942 (Mar. 19, 2025); letter available at https://www.regulations.gov/comment/CMS-2025-0020-23836.

The Department further requests information on preventing fraud at the point of enrollment and reduce reliance on post-payment recovery ("pay-and-chase"). 91 Fed. Reg. 9808. California's SBE's experience demonstrates that fraud prevention is most effective at the point of enrollment, rather than relying on post-payment recovery mechanisms.

H. Additional Suggestions to Strengthen State Fraud Fighting

As the Department moves forward in its efforts, the States suggest that it strengthen the States' abilities to fight fraud with the Department by prioritizing efficiency in investigations; focusing on Medicaid managed care organizations; increasing staffing requirements at certain for-profit nursing homes; and strengthening oversight of brokers in federal and state health insurance marketplaces.

1. Enhanced Efficiency in Investigations

As healthcare fraud impacts all government healthcare programs, federal and state systems for obtaining information should be mutually supportive.

The States suggest increasing the ability of State MFCUs to issue investigation demands. An MFCU is theoretically able to issue a demand for information under 42 U.S.C. §1320a-7(b)(12)(D) and 42 CFR §1001.1301(a)(1)(iv), (3). However, those federal requirements have substantial limitations and limited enforcement mechanisms. First, they are limited to investigations of violations of federal statutes. Second, the enforcement mechanism, discretionary exclusion, requires HHS-OIG involvement. Third, in the absence of action by HHS-OIG, a state can only turn to federal court to enforce this obligation.

The States recommend that the Department amend the regulation to give additional enforcement capabilities, including simultaneous withholding of Medicare payments to providers that a state program integrity unit or MFCU can impose if found in violation of the obligation to produce records.

2. Nursing Homes

The States recommend that the Department enact a revised federal minimum staffing rule for for-profit nursing homes that have an indicator of potential fraud.

Numerous investigations have uncovered Medicaid and Medicare fraud by the owners of for-profit nursing homes. MFCU findings also reflect that this fraud has resulted in preventable neglect, abuse, and suffering of this vulnerable nursing home population.

Investigative findings also demonstrate that too many for-profit nursing home owners nationwide violate the law and operate the nursing homes with insufficient staffing levels so they can illegally siphon out Medicare and Medicaid funds through collusive related party transactions for inflated rent, management or consulting services, loans, staffing company services or therapy. Investigating and bringing legal remedies in these fraud and neglect cases

are part of MFCUs' core mission. Doing so requires significant resources. To enhance provider compliance, the States urge the Department to prevent such fraud by enacting a revised federal minimum staffing rule for for-profit nursing homes that have an indicator of potential fraud.[77]

Similarly, to increase efficiency in state and federal investigations of nursing home fraud and neglect, and to deter fraud, the States urge the Department to lift its suspension announced in December 2025 of certain nursing home financial disclosure requirements.[78]

IV. CONCLUSION

The States are happy to continue their longstanding partnership with the federal government to fight fraud in publicly funded healthcare programs. We encourage the Department to continue working with the States and consider additional tools for the States to use to protect the integrity of these important programs. We urge the Department to ensure that any proposed rulemaking to crush fraud remains bipartisan and apolitical. We also call upon the Department to reconsider any changes that would place undue burdens on the States' ability to provide healthcare coverage to its enrollees.

Sincerely,

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[77] Letter re: CMS-3442-IFC, Repeal of Minimum Staffing Standards for Long-Term Care Facilities (Feb. 2, 2026), https://oag.ca.gov/system/files/attachments/press-docs/Repeal%20of%20Minimum%20Staffing%20Standards%20for%20LTC%20Facilities%20Comment%20Letter%202026.02.02.pdf#xd_co_f=M2RjNTQ1ODUtMjBlOC00ZDdiLWFjZGQtODAyNDc5YmZlOGM0~

[78] *Id.*

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