

# Summary of Public Comments Submitted in Response to CMS's CRUSH RFI

## Overview

The Trump administration has elevated Medicaid, Medicare, and Affordable Care Act (ACA) program integrity as a central domestic policy priority. The Centers for Medicare and Medicaid Services (CMS) advanced this initiative by issuing the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) [Request for Information](#) (RFI) on February 27, 2026.

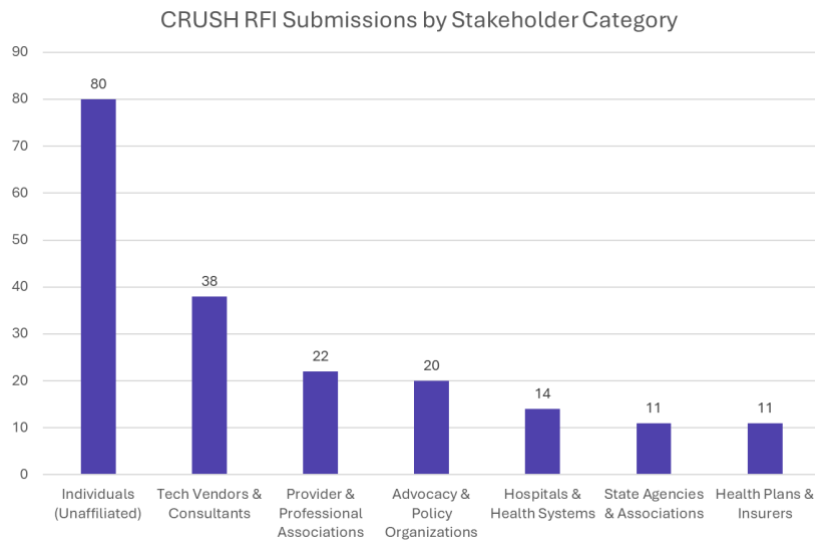
The RFI seeks public input on a wide range of potential regulatory actions, including Medicaid financing mechanisms (Intergovernmental Transfers or IGTs, supplemental payments, and state-directed payments), provider enrollment and screening, eligibility verification, and expanded Federal oversight authority. Together, the statutory framework established by H.R. 1 and the breadth of stakeholder responses underscore the significance of this effort and its potential implications for future CMS policy.

# Snapshot of Respondents

CMS received 768 public comments, approximately 340 of which are currently posted to CMS’s website. CMS has not indicated whether additional submissions will be released.

The analysis below reflects 196 submissions relevant to the Medicare, Medicaid, and the ACA programs reviewed as of April 24, 2026. Full comment details are available [here](#).

Individuals (primarily licensed insurance agents self-attesting to program experiences) and technology vendors accounted for the largest share of submissions, representing approximately 27 percent and 13 percent of comments, respectively. Medicare Advantage oversight, ACA agent and broker fraud, and AI-enabled detection generated a substantial portion of the comment volume. State Medicaid Agencies were comparatively underrepresented, despite their central role in Medicaid program design, financing, and operational oversight.



## Key Themes Across Submissions

Submissions reflected a broad range of stakeholder types and program areas. The discussion below focuses on themes most salient to Medicaid financing and program integrity:

State Medicaid Agencies and safety-net hospital advocates emphasized ongoing strain on state administrative systems and the need for improved cross-program coordination. Commenters cited persistent eligibility backlogs stemming from post-PHE redeterminations, limited real-time data sharing, particularly between Medicaid and the ACA Marketplace, and cautioned that additional federal requirements could exacerbate existing pressures absent investments in data infrastructure and operational capacity.

## Transparency and Standardized Reporting Infrastructure

Policy and advisory organizations and state audit and program integrity offices called for more consistent and accessible data to support effective oversight. Key recommendations included machine-readable public reporting of IGTs, supplemental payments, and state-directed payment flows; encounter-level data reporting from MCOs rather than capitation summaries; and expanded Payment Error Rate Measurement (PERM) methodology to cover managed care claims and to conduct full eligibility reviews each cycle, not just claims audits.

## Shift to Proactive Program Integrity Tools

Technology vendors, Medicaid managed care organizations, and program-integrity stakeholders emphasized the need to move upstream in fraud prevention. Recommendations included AI-driven anomaly detection, enhanced provider screening and enrollment checks, cross-state data matching for providers operating across jurisdictions, and mandatory integration of tools such as the Federal “Do Not Pay” database into routine claims adjudication.

## Balancing Oversight with Financing Stability

State agencies, rural and safety-net hospital associations, and Medicaid managed care plans stressed the importance of preserving core financing mechanisms while enhancing oversight. Commenters emphasized maintaining IGT-funded supplemental payments that support rural hospitals and public providers, safeguarding safety-net plan capitation structures, and avoiding policy changes that could inadvertently reduce access or destabilize provider finances, particularly absent evidence of fraud in Federally compliant arrangements.

## | Medicaid Financing Structure Concerns

Several think tanks argued that improper payments stem primarily from structural features of Medicaid financing rather than isolated bad actors or instances of fraud. Commenters pointed to open-ended Federal matching and financing mechanisms like IGTs and provider taxes as creating incentives to maximize drawdowns of Federal funds. Commenters further contended that current audit frameworks may understate improper payment levels and called for stronger verification requirements, reduced reliance on self-attestation, and more fundamental changes to oversight in high-risk service areas such as home and community-based services (HCBS), non-emergency medical transportation (NEMT), applied behavioral analysis (ABA), and substance use disorder (SUD).

## Implications and Next Steps

While the administration has characterized Medicaid fraud as widespread, an April 2026 issue brief from the Medicaid and CHIP Payment and Access Commission (MACPAC), the nonpartisan congressional advisory body for the program, found that documented instances of fraud, waste, and abuse account for a small fraction of Federal Medicaid spending. MACPAC notes that the true extent of fraud, waste, and abuse is unknown and note that the Payment Error Rate Measurement (PERM) program, referenced as a primary federal tool for measuring improper payments, focuses largely on fee-for-service claims and cannot distinguish between fraud and unintentional errors. For example, 74 percent of the \$31.1 billion of the \$610.8 billion (5.1 percent) in Medicaid payments identified as improper in 2024 were solely due to missing documentation rather than evidence of fraudulent intent.<sup>1</sup>

CMS has not announced a formal proposed rule, and the RFI does not commit the agency to any specific action. As the agency considers next steps, the ability to quantify the actual prevalence of fraud, waste, and abuse will be critical to ensure that any enforcement tools are well-targeted and proportionate.

Sellers Dorsey will continue to monitor developments in this space, including any proposed rulemaking, sub-regulatory guidance, and State Medicaid Director letters issued in response to the CRUSH record, and will assess implications for clients as the regulatory landscape evolves.