



March 26, 2026

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

Submitted electronically via regulations.gov

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

Dear Administrator Oz:

As the Board Chair of the American Academy of Family Physicians (AAFP), representing 124,500 family physicians and medical students nationwide, I am writing to share feedback on a potential upcoming CRUSH proposed rule as requested in the [CRUSH RFI published on February 27, 2026](#).

Family physicians care deeply about fraud in Medicare and Medicaid as more than half of their patients are covered by these programs.ⁱ At the same time, family physicians are disproportionately burdened by documentation, prior authorization, and other reporting requirements intended to curb fraud and improper payments. Many of these requirements contribute to burnout while failing to target the small number of actors responsible for abusive billing and fraud.

Moreover, growing administrative requirements are driving physician consolidation, which reduces market competition and increases costs for all Americans. In fact, a 2023 American Medical Association survey found that “managing regulatory and administrative requirements” was the second-most cited reason for selling a physician practice, with 71 percent of physicians saying it was an “important” or “very important” factor in their decision-making.ⁱⁱ A growing body of evidence shows that physician consolidation has led to higher prices and spending, with no improvement in patient care.ⁱⁱⁱ We therefore urge CMS to carefully consider the impact of any new requirements intended to reduce fraud, waste, and abuse on family physicians.

We appreciate the opportunity to offer feedback on approaches to reduce fraud, waste, and abuse while discouraging unnecessary and ineffective administrative requirements. To that end, we encourage CMS to review the AAFP’s position paper, [Principles for Administrative](#)

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Simplification, which outlines suggested principles to ensure physicians can efficiently order the services and supplies patients need to manage their medical conditions. Further, the AAFP believes indiscriminate use of pre-payment and post-payment audits is a significant business disruption and administrative burden for the physician office. Finally, we believe physicians should be able to charge and receive payment for the charges associated with completing administrative requirements imposed by public or private payers, such as prior authorization, prescription changes made solely for formulary compliance, and forms or other requirements not directly related to patient care.

We look forward to providing more detailed recommendations in response to specific changes CMS proposes in future rulemaking. Below, we provide principles and considerations CMS should consider when developing policies to eliminate fraud, waste, and abuse, in response to selected sections of the RFI.

B. Enhanced Identity Proofing and Ownership Requirements

CMS has identified growing Medicare fraud risks linked to opaque international ownership structures that limit effective investigation and enforcement. In response, CMS is seeking stakeholder input on enhanced identity proofing and potential citizenship or legal residency requirements for individuals with an ownership interest in a Medicare-enrolled entity. Specifically, CMS asks:

- *What would be the impact on Medicare-enrolled entities if CMS established a requirement for U.S. citizenship or legal permanent residency for all individuals with an ownership or control interest of 5 percent or greater in a Medicare-enrolled provider or supplier?*

Family physicians are acutely aware of the current shortage of primary care physicians across the country and the important role International Medical Graduates (IMGs) play in addressing this shortage. Physician census data from 2024 shows there are 13,976 non-U.S. IMGs (IMGs who are not U.S. citizens) who are actively licensed in family medicine.^{iv} While there is no publicly available data describing employment status for IMGs, survey data from the 2024 American Board of Family Medicine Factbook suggests that 13 percent of early career family physicians report being a sole or partial owner/shareholder of a practice.^v Combining these statistics, we believe it is reasonable to estimate that approximately 1,800 family physicians would be impacted by a requirement for U.S. citizenship or legal permanent residency to own a full or partial share of a Medicare-enrolled provider. Assuming an average panel size of 1,700 patients (with an assumption that 33 percent of patients are age 65 and older), we believe just over a million Medicare beneficiaries would be adversely impacted by this approach.^{vi,vii} **The AAFP therefore strongly opposes any citizenship or legal permanent residency requirements for owners or part owners of a Medicare-enrolled provider.**

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We believe such a restriction would negatively impact health outcomes and reduce beneficiary access to care. Research suggests 64 percent of IMGs practice in Medically Underserved Areas (MUA) or Health Professional Shortage Areas (HPSA), and 45 percent practice in rural areas.^{viii} Moreover, nearly 21 million Americans live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians, aligning with the fact that states with a higher percentage of H-1B physicians are often those with lower physician density.^{ix} As such, it is important to support and expand pathways for IMG physicians to be able to enter the U.S. and care for our U.S. patients. This restriction would only discourage the robust IMG workforce from pursuing independent practice—effectively encouraging further physician consolidation while simultaneously reducing physician supply.

C. Preclusion List and Medicare Advantage Enrollment Requirements

CMS has found gaps in the Medicare Advantage (MA) preclusion list that allow certain providers and suppliers that have been revoked from Traditional Medicare to continue billing MA plans, enabling fraudulent or abusive actors to evade oversight. CMS is therefore seeking stakeholder input on strengthening the preclusion list, including whether requiring enrollment in Traditional Medicare would better protect program integrity. Specifically, CMS asks:

- *What changes could CMS make to better effectuate the preclusion list to prevent Traditional Medicare-revoked providers and suppliers from continuing to bill MA plans?*

CMS created the preclusion list to reduce enrollment requirement burdens on Part D prescribers and providers while still protecting Medicare program integrity.^x Under this policy, the preclusion list only includes those revoked from Traditional Medicare with conduct CMS has determined to be “detrimental to the best interests of the Medicare program.”^{xi} As noted in the RFI, some providers and suppliers may be revoked from Traditional Medicare but CMS has not determined their conduct as “detrimental,” a classification that would exclude them from the preclusion list.

CMS does not publish a list of revoked providers who were excluded from the preclusion list, making it difficult to understand both the size of the problem and the potential impact on family physicians. The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) initiated an audit to analyze CMS data to identify revoked providers who were excluded from the preclusion list and understand why they were excluded and potential vulnerabilities.^{xii} This oversight activity underscores the importance of ensuring CMS preclusion list policies strike the right balance between targeting high risk conduct and avoiding unnecessary beneficiary harm from disruptions in access and continuity of care.

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Until this report is released, it is difficult to understand the potential size and impact of any regulatory proposals CMS is considering, and the categories of stakeholders impacted. CMS should improve transparency about revocation categories that do not result in placement in the preclusion list, such as publishing the aggregate number and general reasons for revocations that did not trigger preclusion. CMS should also implement policies to ensure continued beneficiary access to care when a provider is newly precluded, such as beneficiary transition access requirements to reduce disruption to care.

- *What operational, administrative, and financial impacts would a requirement to enroll in the Traditional Medicare program have on providers and suppliers that currently only bill MA plans?*
- *Should such a requirement apply only to high-risk provider and supplier types?*

Family physicians report that the process of enrolling in MA plans is more administratively burdensome, slow, and difficult compared to enrolling in Traditional Medicare. As such, we are discouraged by CMS comments in the RFI that suggest MA plans are not more effective at preventing enrollment by fraudulent providers. We encourage CMS to assess whether the processes and added steps MA plans require for provider enrollment are an efficient use of time for providers given their limited efficacy in preventing nefarious actors from participating. Although the vast majority of AAFP members are already enrolled and participate in Traditional Medicare, we [continue](#) to oppose the increased and unfunded administrative burden such a requirement would create for physicians, and recommend CMS exclude physicians from this requirement and focus instead on high-risk provider and supplier types.

- *Are there alternative mechanisms that could achieve similar program integrity objectives without requiring enrollment in Traditional Medicare?*

Unlike Traditional Medicare, MA plans have access to a wide range of utilization management techniques to prevent fraud, waste, and abuse. For example, plans may require physicians submit prior authorization requests that document and justify the use of a service, supply, or medication. It is discouraging to hear that MA plans' use of utilization management techniques combined with added provider enrollment requirements have failed to prevent claims by fraudulent actors. These plan-imposed management tools and administrative requirements create more overhead costs and drain the resources of well-intended physicians, while creating unnecessary and harmful delays for patients in accessing care. We encourage CMS to conduct more oversight of how MA plans use utilization management techniques and provider enrollment processes.

E. Reducing Risks from Non-Participating Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers in Medicare Advantage

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HHS OIG has found that non-participating DMEPOS suppliers are a source of fraud in MA, and seeks solutions related to curbing fraud, waste, and abuse by DMEPOS suppliers in MA. CMS asks:

- *What changes would MA organizations need to make to existing processes to promote the ability to effectively deter fraud, waste, and abuse and promote payment accuracy for non-participating DMEPOS suppliers?*

MA plans use various utilization management methods to prevent fraud, waste, and abuse, but many are burdensome and ineffective. We encourage CMS to increase oversight of MA plans' use of utilization management techniques. MA plans should bear the additional costs required to detect and prevent fraud, rather than passing the responsibility on physicians. Ineffective prior authorization and documentation requirements continue to reduce the time and resources available to physicians to care for their patients, and increase costs across the entire system, which raises costs for all Americans.

Existing pre-authorization and documentation requirements set by MA plans for DMEPOS often focus on inappropriate utilization rather than rooting out systemic fraud or abusive suppliers. We would encourage MA plans to consult with and learn from Accountable Care Organizations (ACOs) that have successfully identified and flagged major and substantial fraud, such as fraudulent catheter supplies, excessive pricing of skin substitutes, and other fraudulent or wasteful activities related to dispensing or use of supplies.^{xiii, xiv} ACOs have successfully detected and reported major instances of fraud even though they do not have access to the utilization management tools available to MA plans, such as network restrictions, prior authorization, and coverage criteria.

Further, we ask CMS to consider the AAFP's recommendations for Medical Supply Coverage Requirements as detailed in our position paper, [Principles for Administrative Simplification](#):

3. Medical Supply Coverage Requirements

Physicians should be able to efficiently order the services and supplies that patients need to manage their medical conditions. The current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to patient care.

Principles:

- *The physician's order should be sufficient. They should not have to complete multiple processes from various outside entities for patients to receive needed physical therapy, home health care, hospice care, or DME (including diabetic supplies).*

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- *Physicians should not be required to recertify DME supplies annually for patients with chronic conditions.*
- *Authorization supply forms should be standardized, so physicians are not required to complete a new process every time a patient switches brands, including but not limited to diabetic supplies. In addition, processes should be standardized to allow automated electronic health record (EHR) extraction of information needed for authorization.*
- *Physicians should not be required to attest to the patient's status when the service is provided by another licensed health professional (e.g., diabetic footwear).*

F. Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions

CMS seeks feedback about the impact of reducing the one-year claim filing deadline in Medicare Parts A and B for certain high-risk items and services.

- *How would a claim filing deadline of 90 to 180 calendar days, which is consistent with private industry norms, impact your practice?*

From an operational standpoint, shortening the filing deadline may create unintended consequences and risks for compliant providers. For example, in AAFP [testimony](#) to the House Ways & Means Committee in 2024, a family physician described how private plans would use shorter deadlines to penalize minor billing mistakes, adding financial pressures that eventually led to the closure of their independent practice:

"...health plans started clawing back money they had already paid because of minor billing mistakes, such as using the wrong site of service code, instead of allowing me to resubmit claims with the correct code because their time frame to resubmit had elapsed..."

Should CMS reduce the filing time limit, we encourage the deadline to apply only to the initial submission, as deadlines should not be used as a clock to limit the time available to physicians to submit a corrected claim or respond to additional requests for documentation. The claim filing submission window should apply to original submissions only—not appeals or redeterminations for claims that were submitted within the timely window.

- *Are there certain claim or provider types for which these deadlines would not be feasible?*

As noted above, appropriate guardrails must exist on claim filing deadlines to ensure that family physicians who operate in high volume, resource constrained practices and routinely manage complex claims involving care coordination, referrals, and Medicare Secondary Payer requirements, are not unfairly penalized when a claim requires additional information

or resubmission. Family medicine claims are often delayed due to factors outside the physician's control, including incomplete information from other providers, delayed eligibility determinations, and claim rejections that require correction and resubmission. A shortened filing window without exceptions for appeals or redeterminations would increase administrative burden, divert limited staff time from patient care, and heighten the risk that medically necessary services are denied solely due to administrative timing rather than clinical or billing appropriateness. Such a change would disproportionately affect small and independent family practices while offering limited protection against fraudulent billing.

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

CMS is requesting stakeholder input on the availability, use, effectiveness, and costs of artificial intelligence (AI) tools—including machine learning and related technologies—to support accurate and efficient abstraction of diagnoses from medical record documentation during medical records reviews.

The AAFP recommends that CMS draw a clear and enforceable distinction between fraudulent AI-assisted upcoding and legitimate AI tools that support accurate clinical documentation and coding. AI systems that automatically inflate diagnosis or procedure codes without physician review present a true fraud risk and warrant aggressive oversight. We support CMS' focus on high-risk scenarios, such as billing departments or third-party billing companies deploying AI to select codes at scale without adequate physician involvement. For these uses, the AAFP supports safeguards grounded in physician accountability, including robust human oversight, audit controls, and transparency requirements, while maintaining that physicians remain legally and clinically responsible for claims submitted under their NPI. Any safeguards should seek to prevent misuse without resorting to blanket tool prohibitions.

Distinct from the potential fraud scenarios above is a rapidly growing class of AI tools used directly by primary care physicians at the point of care, including ambient documentation and EHR-integrated coding assistance. These physician-facing tools are reviewed and approved by the treating clinician before claims submission and are designed to improve documentation accuracy, capture clinical nuance, and translate physician-approved information into appropriate codes, thereby reducing administrative burden amid severe physician burnout. **The AAFP views these tools as aligned with our long-standing position that AI should preserve clinician autonomy, reduce administrative workload, and augment — not replace — physician judgment.** CMS policy should explicitly recognize this distinction and align AI-assisted coding safeguards with related federal efforts at ASTP/ONC and FDA to avoid conflicting or duplicative requirements for physicians and practices.

Specifically, CMS seeks feedback on the following topics:

- *What key features and learning capabilities should an AI solution include to improve accuracy, incorporate coder feedback, and prevent errors or "hallucinations"?*

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The AAFP supports the responsible use of AI to assist with coding accuracy only when such tools are designed with strong guardrails, transparency requirements, and ongoing human oversight. As we have repeatedly cautioned, opaque algorithms and “black-box” technologies, particularly those deployed by insurers without physician input or full clinical context, risk undermining clinical accuracy, patient safety, and trust in Medicare Advantage and other federal programs.

AI solutions used for Medicare Advantage coding oversight [should be explicitly designed](#) to prioritize accuracy, clinical validity, and program integrity over speed, automation, or cost containment. At a minimum, AI-assisted coding tools should be required to:

- provide clear, explainable, and auditable rationales for any suggested codes or coding changes, directly linking recommendations to specific elements of the patient’s clinical documentation rather than claims-only criteria;
- incorporate continuous, structured human feedback loops that meaningfully improve model performance over time rather than reinforce prior errors;
- include clear safeguards to prevent “hallucinations” or unsupported outputs, such as technically constraining the model so that it can only generate recommendations grounded in verifiable documentation contained within the medical record; and
- undergo regular validation, re-testing, and monitoring in real-world clinical environments, including across diverse practice settings such as small, independent, rural, and underserved practices, to identify performance drift, bias, or degradation over time.

Consistent with [our concerns](#) about insurer-driven algorithms used for downcoding, utilization management, and prior authorization, CMS should explicitly caution against reliance on AI systems that are trained primarily on claims, billing data, or retrospective utilization patterns without sufficient clinical context. Such systems risk amplifying existing biases, undervaluing the complexity of longitudinal primary care, and prioritizing payment optimization over clinical accuracy and patient needs. AI tools must be designed to include human oversight, support clinical judgment, and should never function as autonomous decision-makers in coding or payment determinations. We believe AI has the potential to improve accuracy and consistency in coding, but only if deployed transparently, grounded in full clinical documentation, continuously informed by human expertise, and governed by safeguards that place patient care and program integrity first.

- *How should AI-generated coding recommendations be displayed to human reviewers, and what compliance risks should be considered and mitigated?*

The AAFP [urges](#) CMS to ensure that AI-generated coding recommendations are presented to human reviewers in a manner that reinforces, rather than undermines, professional judgment and due process. AI outputs should be clearly labeled as advisory and non-determinative, with visual and functional design choices that avoid creating implicit pressure to accept AI

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recommendations without critical review. To mitigate compliance and liability risks, CMS should require that AI-assisted coding systems:

- clearly distinguish between human-entered codes and AI-suggested recommendations;
- allow reviewers to easily accept, modify, or reject AI suggestions without additional administrative burden; and
- avoid creating audit trails that penalize clinicians or coders for appropriately overriding AI outputs.

We are particularly concerned that poorly designed interfaces may create a “rubber-stamp” dynamic, where AI suggestions are treated as presumptively correct for purposes of audits, enforcement, or payment recoupment. The AAFP recommends CMS clarify that acceptance or rejection of AI-generated recommendations cannot be used as a proxy for intent, negligence, or fraud. We also request CMS clarify that ultimate accountability remains with the organization deploying the AI tool as opposed to individual clinicians.

- *What lessons have been learned from implementing AI solutions, including pricing structures and use within cloud-based IT environments?*

The AAFP [encourages](#) CMS to carefully consider lessons learned regarding the cost, scalability, and operational impact of AI solutions deployed through cloud-based and software-as-a-service (SaaS) models. While these technologies may offer efficiencies at scale, they often involve ongoing subscription costs, data integration expenses, and workflow changes that are not adequately reflected in existing payment structures. We urge CMS to ensure that adoption of AI tools remains voluntary, appropriately compensated, and sensitive to practice variation, while avoiding AI deployment that exacerbates consolidation pressures or shifts unfunded technology costs onto physicians.

CMS should recognize that AI-driven coding oversight tools, particularly those adopted or required by Medicare Advantage plans, may indirectly impose costs and administrative burdens on physician practices, including smaller, independent, and rural practices that lack negotiating leverage or technical infrastructure. We recommend CMS avoid policies that effectively mandate the use of specific AI technologies without corresponding consideration of cost transparency, flexibility, and payment alignment.

- *Are there AI solutions that address coding issues related to overpayments and underpayments, and can those AI solutions be used for compliance oversight?*

The AAFP [supports](#) the use of AI and advanced analytic tools that promote payment accuracy in a balanced, equitable, and clinically-grounded manner, including tools capable of identifying both overpayments and underpayments. As reflected in [recent AAFP letters](#), technology that meaningfully improves accuracy can support program integrity and reduce administrative waste when transparently designed and appropriately governed. However,

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CMS should exercise significant caution in using AI for compliance oversight or enforcement purposes, particularly where tools are opaque, proprietary, or applied asymmetrically to physicians compared to payers.

The AAFP's experience with algorithm-driven downcoding, utilization management, and prior authorization underscores the risks of deploying AI systems that lack transparency, rely on incomplete data, or prioritize cost containment over clinical accuracy. In multiple instances, insurers have applied algorithmic tools – sometimes described as “payment integrity” or “coding accuracy” technologies – without disclosing their methodologies, clinical assumptions, or validation processes. These practices have contributed to inappropriate underpayments, limited appeal pathways, and the erosion of trust between physicians and payers.

The AAFP acknowledges the potential for AI systems to be successfully designed to address both over- and under-coding, including identifying missed diagnoses, inaccurate claims adjustments, and improper payment delays. However, CMS should ensure that any AI tool used for oversight purposes should be governed by clear standards that define its role, limitations, and appropriate use. Specifically, CMS should ensure that:

- AI-assisted analyses are used to inform, not replace, human review and due process;
- AI tools are not used as the sole or primary justification for payment suspension, recoupment, or enforcement actions; and
- oversight applications are applied symmetrically to identify under-coding and missed payments, not solely to increase recoveries or reduce payments to physicians.

We strongly caution against the use of opaque or proprietary “black box” AI systems in compliance contexts. Black-box algorithms obscure accountability, prevent meaningful challenges or corrections, and risk amplifying existing biases embedded in claims data and utilization patterns. In compliance and oversight settings, such opacity undermines trust and raises serious concerns about fairness, accuracy, and consistency with statutory and regulatory protections.

We recommend CMS make clear that AI is a support tool for program integrity, not an automated enforcement mechanism. As such, the AAFP urges CMS to ensure that any use of AI in compliance oversight be accompanied by transparency requirements, disclosure of methodologies, opportunities for clinician engagement, and robust procedural protections for physicians and other clinicians, including clear notice, meaningful appeal rights, and access to human review.

K. Medicaid and CHIP

CMS seeks stakeholder feedback on regulatory authority expansion to reduce fraud, waste, and abuse in Medicaid and CHIP. Specifically, CMS asks:

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- *Is there any way that CMS should better leverage or expand its statutory or regulatory program integrity oversight authority?*

As discussed in our [response](#) to the 2025 Marketplace Integrity proposed rule, we recommend that CMS continue to place accountability on entities with operational control and scale rather than shifting the consequences of system failures onto beneficiaries. CMS' recent success in reducing improper agent-driven activity illustrates that focused oversight and enforcement at the system level is more effective than broad restrictions that risk undermining coverage stability and access to care. In the Marketplace, CMS documented that enforcement actions aimed at agent and broker misconduct reduced agent- and broker-facilitated plan changes by nearly 70 percent in 2024, underscoring the effectiveness of placing oversight where operational control resides.^{xv}

AAFP urges CMS to build on this approach by operationalizing program integrity authority through measurable guardrails and enforceable accountability, rather than relying primarily on retrospective attestations. Evidence indicates that program integrity gaps often reflect incomplete or inconsistent corrective action, not a lack of statutory authority. The Government Accountability Office found that state auditors identified more than 300 Medicaid audit findings annually between FY 2019 and FY 2021, and that nearly 60 percent of Medicaid single audit findings were repeat findings, signaling that corrective actions frequently fail to resolve underlying vulnerabilities.^{xvi} To address this, CMS can verify the effectiveness of existing corrective action processes across Medicaid and CHIP programs, rather than relying solely on paper documentation for compliance. For example, CMS can support this verification by encouraging state use of all-payer claims databases (APCDs), which allow states to compare Medicaid utilization and billing patterns across payers. This cross-payer visibility can help identify persistent billing anomalies and duplicative services that may not be evident in single-payer data. Evidence demonstrates that states operating APCDs conduct significantly more targeted Medicaid fraud and abuse investigations, reflecting enhanced detection capacity rather than increased underlying fraud.^{xvii}

Further, CMS can condition continued participation in Medicaid and CHIP programs for plans, agents, brokers, and other intermediaries on demonstrated compliance with standardized, auditable program integrity controls that reflect their operational scale and control over enrollment, claims, and payments. Concurrently, CMS can use existing authority to establish clear escalation pathways when these entities fail to remediate repeat or systemic integrity deficiencies.

- *How can CMS better prevent, identify, and 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?*

The AAFP [believes](#) that all people should have access to essential health care services, regardless of immigration status. While we recognize CMS' responsibility to address fraud,

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waste, and abuse in Medicaid and CHIP programs, we urge CMS to take a thoughtful approach when addressing access to care for these individuals. Our members frequently witness the harmful consequences of administrative confusion or fear causing individuals to delay seeking care, often resulting in higher rates of emergency visits and uncompensated care costs. Accordingly, we urge CMS to ensure that immigration-related integrity efforts preserve access to emergency services and other statutorily permitted benefits. Further, as CMS has recognized across other portions of this RFI, inappropriate enrollments most often stem from state- or plan-level process failures and opacity in agent or broker practices. Program integrity efforts will be most effective when focused on correcting system-level vulnerabilities without deterring eligible individuals from seeking appropriate care.

- *How can CMS better prevent fraud, waste, and abuse associated with the differential payment of public and private providers?*

It is essential that CMS' integrity efforts in this area distinguish high-risk payment arrangements from differential payments that are statutorily defined and integral to access, particularly for rural providers and Federally Qualified Health Centers (FQHCs). Rural health clinics and FQHCs operate under unique payment methodologies that reflect higher fixed costs, lower patient volume, workforce shortages, and the need for predictable reimbursement to retain physicians. AAFP urges CMS to focus integrity oversight on opaque or high-risk payment structures, rather than applying broad restrictions to all differential payments. CMS can strengthen oversight by improving the transparency and auditability of supplemental and directed payments, while evaluating whether differential payments are linked to measurable access, workforce stability, or service availability outcomes. Importantly, any new integrity controls should be paired with patient access assessments to avoid destabilizing rural and safety-net providers that serve as the backbone of primary care delivery.

The AAFP urges CMS to approach behavioral health program integrity with precision, recognizing that integrity interventions in this service area carry unusually high patient-access risks. Family physicians routinely manage the downstream consequences when behavioral health access is disrupted; crisis utilization rises, emergency department visits increase, and continuity of care deteriorates. Program integrity strategies must therefore target the true sources of risk while explicitly protecting eligible patients and physician-led care delivery. CMS should require states to move beyond retrospective attestations and demonstrate platform-level data visibility and performance metrics for behavioral health services. In 2021, OIG found that some states could not distinguish telehealth behavioral health services from in-person services in their data, preventing basic oversight, outlier detection, and targeted audits.^{xviii} Thus, CMS should emphasize measurable, operational safeguards that prevent harm early. For example, CMS can require states to ensure that MCOs submit encounter data with sufficient completeness and accuracy to allow state agencies to better monitor and audit behavioral health service delivery.

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Further, the AAFP recommends CMS explicitly encourage states to prioritize oversight toward high-volume organizational entities and billing patterns that match OIG's high-risk telehealth indicators, rather than applying blanket restrictions on behavioral health services writ large. For example, OIG's audit of Colorado's Medicaid Applied Behavior Analyses (ABA) program identified tens of millions of dollars in improper payments driven by documentation and credentialing failures.^{xix} CMS can leverage these OIG findings by helping states implement targeted, service-specific safeguards for high-risk behavioral health services, including standardized documentation and billing guidance, risk-based post-payment reviews paired with provider education, oversight of prior authorization contractor procedures, and timely follow-through on identified improper payments. Importantly, these actions must be paired with continuity-of-care protections to avoid disrupting access for eligible patients and shifting crisis burden onto family physicians and primary care settings. This approach aligns with GAO and OIG recommendations to focus program integrity efforts on known vulnerabilities rather than broad service-level restrictions.^{xx}

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

CMS also seeks feedback on regulatory strategies to prevent fraud in FFE and SBE, both facilitated marketplaces where individuals and small businesses may purchase private insurance coverage. Specifically, CMS asks:

- *How could CMS strengthen program integrity, including fraud prevention and consumer protection, in both the FFE and SBEs by—(1) better leveraging existing regulatory oversight authority; and (2) identifying areas where additional regulatory authority may be needed?*
- *How could CMS improve regulations to strengthen oversight of agents, brokers, web-brokers, and direct enrollment entities including compliance standards, training, and fraud prevention in both the FFE and SBEs?*

In our recent [response](#) to the 2027 Notice of Benefit and Payment Parameters, we wrote in support of CMS' policy to review and enforce compliance against lead agents for insurance agencies. We continue to support CMS in its continued efforts to protect enrollees from agents and brokers who fail to comply with regulations designed to safeguard consumers. Coverage decisions must prioritize the best interests of consumers. However, commissions earned by agents and brokers create conflicts of interest. Whenever financial incentives have the potential to influence coverage decisions, CMS must rigorously enforce regulations to prevent misconduct and protect consumers. Thus, we encourage CMS to pursue proposed changes in CY27 NBPP to distinguish conduct related to consumer enrollment from conduct related to consumer marketing; establish new standards of conduct and additional consumer protection requirements for agents, brokers, and web-brokers; and introduce new broker marketing restrictions to reduce the influence of financial incentives from agents and brokers on consumers.

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AAFP further urges CMS to ensure that federal oversight keeps pace with the delegation of enrollment functions to private entities. Current tools, including the State-Based Marketplace Annual Reporting Tool (SMART), are largely retrospective and rely on annual attestations and audits. As we noted in [our NBPP comments](#), such tools cannot substitute for platform-level monitoring and audit requirements when eligibility and enrollment operations are conducted outside the Exchange's own systems. CMS should therefore leverage its regulatory authority to require platform-specific performance data, operational visibility, and audit access for agents, brokers, and direct enrollment partners. This includes authority to monitor agent and broker activity occurring within EDE platforms, where CMS and states may otherwise lack direct insight into how enrollment actions are initiated and executed.

Finally, as AAFP's NBPP comments emphasized, enrollment fragmentation disproportionately harms low-income, rural, and limited-digital-literacy populations, who already face significant barriers to coverage. For these consumers, improperly framed questions, inconsistent interfaces, or unauthorized plan changes can result in prolonged gaps in coverage, delayed care, and financial hardship. CMS should therefore explore requiring FFEs and SBEs to adopt private enrollment models to maintain clear fallback pathways that allow consumers to confirm eligibility and consent independently of web-broker interfaces. CMS should also consider requirements for multilingual notices, clear timelines, and accessible consumer-support mechanisms to be embedded in any platform where agents or brokers can influence enrollment decisions.

- *How could CMS expand its regulatory authority to incentivize insurance agencies to thoroughly vet assigned agents, brokers, and web-brokers assisting consumers with enrollment in FFE plans and hold agencies accountable for activities relating to these individuals?*

Penalizing consumers for improper enrollments they may unknowingly face shifts responsibility away from the real stewards of enrollment integrity: insurers. Insurers play a pivotal role in enrollment workflows, marketing strategies, premium billing, subsidy reconciliation, and broker compensation structures. When incentives prioritize rapid enrollment growth or retention without corresponding accountability, the risk of consumer harm increases.

To incentivize insurers to thoroughly vet enrollment partners, and to ensure insurer accountability, the AAFP recommends that CMS require insurers to actively monitor, audit, and remediate enrollment discrepancies associated with their plans, rather than shifting the consequences of improper enrollment onto consumers through coverage termination or premium repayment. For example, CMS can require insurers to specifically certify that agent and broker compensation structures do not incentivize inappropriate plan switching or enrollment without consumer consent.

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We also recommend that CMS hold insurers accountable for patterns of improper enrollment, including repeated unauthorized switches, high rates of consumer complaints, or discrepancies between enrollment records and consumer intent. For example, CMS can impose financial penalties or Marketplace participation restrictions when insurer-linked enrollment channels generate repeated consumer harm.

- *How could CMS expand its regulatory authority to enhance oversight of enhanced direct enrollment (EDE) partners?*

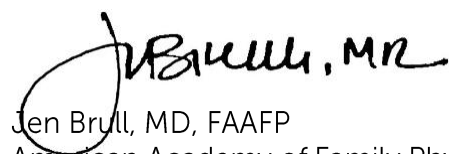
The AAFP appreciates CMS' efforts to strengthen program integrity and consumer protections in FFE and SBE markets, particularly as CMS considers expanded use of agents, brokers, web-brokers, and Enhanced Direct Enrollment (EDE) pathways. Family physicians see firsthand how improper enrollments, unauthorized plan changes, and coverage disruptions translate into delayed care, financial hardship, and downstream strain on primary care and behavioral health systems.

Given the limited real-world implementation of SBE-EDE models and the documented scale of unauthorized agent and broker activity, AAFP urges CMS to proceed cautiously in encouraging expanded reliance on EDE unless such expansion is conditioned on clear, enforceable consumer protection and program integrity standards. As AAFP emphasized in our response to the CY 2027 Notice of Benefit and Payment Parameters, when eligibility and enrollment functions are operationally offloaded to third parties, the separation of operational control and accountability increases the risk that errors, beneficiary harm, and improper enrollments will occur without a clear enforcement pathway, leaving both beneficiaries and states exposed.

This risk is heightened in EDE environments, where private platforms have the technical capacity to shape how consumers input information, interpret eligibility questions, and navigate plan selection. Without platform-level guardrails and operational transparency comparable to those used by CMS in the FFE, expanded private enrollment pathways risk recreating known integrity challenges rather than mitigating them.

We thank you for the opportunity to share information in advance of potential rulemaking on fraud, waste, and abuse. Should you have any questions, please contact Julie Riley, Senior Strategist, Regulatory and Federal Policy, at jriley@aaafp.org.

Sincerely,

A handwritten signature in black ink that reads "Jen Brull, MD". The signature is written in a cursive, flowing style.

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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