ASHA
American
Speech-Language-Hearing
Association

March 27, 2026

The Honorable Robert F. Kennedy Jr.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6098-NC
P.O. Box 8013
Baltimore, MD 21244-8013

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

Dear Secretary Kennedy:

The American Speech-Language-Hearing Association (ASHA) writes to offer comments on the Request for Information (RFI) regarding the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098-NC) initiative.

ASHA is the national professional, scientific, and credentialing association for more than 247,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. SLPs identify, assess, and treat speech, language, swallowing, and cognitive communication disorders. ASHA members practice in hospitals, skilled nursing facilities, inpatient rehabilitation facilities, outpatient clinics, schools, home health, and private practices. They experience firsthand how insurer policies directly shape patient access, outcomes, and affordability.

As a provider representative organization, ASHA believes strongly in prosecuting fraud, waste, and abuse (FWA) in federal and private or commercial health insurance programs. ASHA members are U.S. taxpayers who bill these programs while serving people with disabilities who are enrolled beneficiaries. In order to best support efforts to prosecute FWA, it is important that the Department first develop a universal definition for those terms so all stakeholders can work collaboratively and consistently to identify and address them.

ASHA recommends adopting the definitions of FWA put forward by the National Association of Medicaid Directors, which defines *fraud* as when a Medicaid provider, member, or other stakeholder provides false information to get a Medicaid agency to cover care or services in an intentional manner; *waste* as the overutilization or inappropriate utilization of services in a way that results in unnecessary costs to the Medicaid program in an unintentional manner; and *abuse* as when a Medicaid provider or member acts in a way that is not consistent with accepted medical, fiscal, or business standards (such as medical necessity, utilization management, and billing standards), resulting in unnecessary cost to the Medicaid program.[1,2]

Defining these terms is critical, because it helps determine where the Department should best direct its efforts. During the formation of the One Big Beautiful Bill Act last year, many lawmakers focused on improper payment rates in Medicare and Medicaid.[3] Based on a fact sheet the Centers for Medicare & Medicaid Services (CMS) released in January 2026, those

rates of improper payments often include services provided with insufficient documentation, and most improper payments occurred in situations where a reviewer could not determine if a payment was proper because of insufficient documentation from a state or provider.[4] In fact, of the FY 2025 Medicaid improper payments, 77.17% were the result of insufficient documentation, "which is generally not indicative of fraud or abuse" according to the fact sheet. CMS' Payment Error Rate Measurement (PERM) program specifically articulates that improper payments are not measures of fraud or indicators of intentional wrongdoing, but instead are measures of compliance error.[5,6]

The Department should focus on rooting out true FWA, which requires a different analysis than improper payment analysis. Using information that includes only the broader improper payment category inflates perceptions that FWA is rampant and does not help identify and prosecute true FWA. It will instead drive providers away from federal programs for fear of being swept up in broad and baseless audits. ASHA members have reported that weathering administrative hurdles like program integrity audits is one of the reasons they are leaving insurance plan networks as enrolled providers.

Suspension of Medicare Payment to Providers

Significant evidence suggests that Medicare Advantage (MA) plans have not effectively or appropriately implemented FWA prevention mechanisms—such as prior authorization—already at their disposal. For example, a study of prior authorization denials issued by MA plans in contract year 2021 determined that 82% of the 2 million prior authorization denials were ultimately overturned in favor of the beneficiary and their clinical care teams. This study reinforced the findings of the Office of Inspector General (OIG) that there has been a pattern of MA plans diverting patients away from post-acute care facilities, even in cases where alternative facilities offered by MA plans were not clinically sufficient to meet beneficiary needs.[7]

A report from the OIG identified a pattern in which MA plans "delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules." Although MA plans are required to cover the same services as traditional Medicare, data and the experience of clinicians indicate a clear deviation from MA organizations' coverage obligations.[8]

In 2024, the Senate Permanent Subcommittee on Investigations released a report based on 280,000 pages of documents obtained from the largest MA plans. The Subcommittee found that these companies systematically and intentionally used prior authorization to boost profits by creating barriers to medically necessary services in post-acute care facilities. Further, the Subcommittee found that for one of the largest MA plans, denial rates for skilled nursing facilities grew nine-fold between 2019 and 2022 alone.[9]

Given this evidence, proposals that would expand MA plans' ability to further impede access to care for Medicare beneficiaries and jeopardize the financial solvency of clinicians and facilities are deeply concerning. Accordingly, ASHA cannot support efforts that would allow MA plans to suspend payments.

Administrative Burden of Requiring Medicare Provider Enrollment

Audiologists and SLPs are not required to treat Medicare beneficiaries under traditional Medicare or MA. When a traditional Medicare beneficiary contacts an audiologist or SLP who is not an enrolled provider, the clinician must inform the beneficiary that they need to seek care from a Medicare-enrolled provider. This is because traditional Medicare mandates enrollment

and claim submission by suppliers such as audiologists and SLPs. However, mandatory enrollment and claims submission does not apply to MA plans per Section 42 CFR 422.100(b) of the Code of Federal Regulations.[10] If a clinician elected to enter into a contract with an MA plan, requiring enrollment with traditional Medicare creates a new and unnecessary administrative burden.

This burden is compounded by a fraud prevention mechanism that "deactivates" a clinician's enrollment when a claim has not been submitted for six months. Because the audiologist or SLP has no intention of treating traditional Medicare beneficiaries and submitting these claims, they would constantly have to reactivate their enrollment just to maintain their status with MA plans.

Additionally, MA plans are paid for administrative processes, such as provider credentialing, as part of their contracts with CMS. Requiring enrollment in traditional Medicare will likely increase spending for the federal government and disincentivize MA plans from appropriately managing the administrative functions for which they are responsible.

Therefore, we urge CMS to refrain from requiring Medicare enrollment for audiologists and SLPs contracting with MA plans, as this requirement is unnecessary, administratively burdensome, and undermines efficient plan management.

Reducing Risks From Nonparticipating Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers in Medicare Advantage

Access to DMEPOS—alongside medical rehabilitation and habilitation services and assistive devices and technologies—often determines whether a person can return to work, remain in their home, or avoid institutional care. The patients served by ASHA members rely on a wide range of medical equipment and devices, including but not limited to cough-stimulating devices (E0482), speech-generating devices with synthesized speech and multiple access methods (E2510), and auditory osseointegrated devices (L8690).

ASHA is not aware of meaningful differences in enrollment or fraud prevention standards for DMEPOS suppliers based on whether they enroll as participating or nonparticipating providers. All DMEPOS suppliers seeking to enroll in and bill Medicare must meet the same core requirements, including accreditation, obtaining a National Provider Identifier (NPI), enrolling through the Provider Enrollment, Chain, and Ownership System (PECOS), and securing a surety bond regardless of whether the organization ultimately elects to be participating or nonparticipating.

In the RFI, CMS refers to an OIG Work Plan Project, Project Number: OEI–02–24–00310; however, this work appears to be ongoing, and it is unclear whether it distinguishes between participating and nonparticipating suppliers. Similarly, the most recent OIG Report on this topic, published in October 2025, does not appear to make a distinction related to fraud rates based on the suppliers' enrollment status. Given the ongoing work, it may be premature to draw conclusions regarding the relative risk of fraud associated with nonparticipating providers.

Accordingly, ASHA recommends CMS refrain from implementing policy changes that differentiate between participating and nonparticipating DMEPOS suppliers without clear supporting evidence. CMS should instead await the results of ongoing OIG analyses before considering any modifications to enrollment or program integrity requirements.

Artificial Intelligence

While ASHA strongly supports the detection and elimination of FWA in health care, it is essential to maintain data privacy, impartial determinations, and timely access to medically necessary services for all people.

ASHA urges caution in using AI to assist with prior authorization determinations, abstracting diagnoses from medical record documentation, or any other use case that impacts a patient's ability to access care. Even such simple administrative tasks can lead to harm. For example, an AI tool that transcribed nearly 7 million medical visits had a known history of hallucinating content in medical transcripts and records.[11] Payers then use these sometimes-faulty transcripts and records to make decisions about care.[12] Some facilities ask patients to allow their AI-generated data to be shared with for-profit companies, including vendors that develop these tools, and incorrect outcomes may train algorithms and compound future errors.

While AI may reduce paperwork and delays, it can also cause serious harm when it overrides or interferes with individualized clinical judgment or access to care determinations. Therefore, it is essential to keep humans in the loop and in the lead—particularly in efforts to identify FWA—to prevent incorrect adverse determinations that delay or deny needed access to care, resulting in patient harm. Without strong guardrails and transparency requirements, the benefits of AI may not outweigh the risks. Yet HHS leans strongly toward deregulation. Therefore, we urge HHS to take a balanced approach that advances appropriate innovation while ensuring strong protections are in place to safeguard patients and preserve access to care.[13]

To operationalize this balanced approach, ASHA urges CMS to create standards for transparency and public disclosure of AI use, including information on underlying datasets, training protocols, algorithm validation and adherence to clinical guidelines.[14] Patients need to know when AI is used in clinical care or benefit determinations, including clear explanations of the purpose, function, and scope of each use.[15] Transparency measures must also include public identification of any known limitations or biases of AI used in an easily accessible and understandable way. Finally, it is essential that patients and providers have recourse to appeal adverse determinations involving AI, including review by a qualified human representative of the payer.

Beneficiary Solicitation/Contact

In the 2025 and 2026 MA Plan Contract Year rulemaking cycles, CMS has solicited feedback on a variety of beneficiary protections, including policies related to beneficiary solicitations. ASHA appreciates the work done to date to identify problems with beneficiary solicitations and solutions for these problems and has provided feedback to CMS on this topic in prior comments.[16] Given the work already undertaken, CMS should first evaluate the effectiveness of existing policies to determine whether additional protections or modifications are warranted.

Surety Bonds

In order to enroll as a provider in Medicare, DMEPOS suppliers must maintain a surety bond of at least $50,000. When this requirement was implemented in 2009, its goal was to deter fraud and recover overpayments. It is not clear whether that goal has been effectively achieved, as CMS recovered only $263,000 in overpayments from $50 million in surety bonds identified for collection between October 2009 and April 2011.

To better assess whether its programmatic goals are being achieved, CMS' Office of Evaluation and Inspections is already completing a project on this topic.[17] That project will examine: "(1) the total amount of outstanding DME overpayments that became eligible for surety bond collection in CY 2023, (2) the total amount of outstanding DME overpayments that have been collected and left uncollected from surety bonds, (3) potential obstacles DME Medicare Administrative Contractors and CMS face in collecting outstanding DME overpayments from surety bonds, and (4) potential changes that could make surety bonds a more effective tool to deter fraud and recover DME overpayments." Findings from this work will be critical to answer the questions that have been laid out in this RFI.

Additionally, ASHA recognizes that small private practices provide a significant amount of care to Medicare and Medicaid beneficiaries in their communities. Increasing financial requirements—such as increasing the surety bond value threshold—for programmatic participation will make it harder for these small businesses to survive financially.

Therefore, ASHA urges CMS to defer any increases to surety bond requirements until the Office of Evaluation and Inspections' findings are available. CMS should also carefully consider the impact of any changes on small and community-based providers to avoid unintended reductions in access to care.

Medicaid and CHIP

State Medicaid agencies are under extreme financial pressure due to several factors, including funding reductions from the One Big Beautiful Bill Act, rising long-term care costs, and more individuals entering Medicaid. They are also facing higher administrative expenses related to more frequent eligibility redeterminations and expanded oversight activities.[18] State Medicaid agencies are charged with prosecuting FWA as a condition of receipt of federal funds to administer their state Medicaid programs. However, constrained resources and understaffing make it increasingly difficult to fulfill their duties to investigate fraud.

For example, during a recent Joint Legislative Oversight Committee on Medicaid hearing, North Carolina Department of Health and Human Services staff reported that North Carolina Medicaid receives around 375 reports of fraud per month but has the capacity to investigate only 50.[19] With better funding, Medicaid agencies like North Carolina could work to investigate already existing claims of fraud, rather than diverting limited funds away from these agencies to test new programs.

While State Medicaid agencies maintain program integrity units, they also work closely with Medicaid Fraud Control Units (MFCUs), a wing of the Department of Justice within each state, to prosecute FWA. State MFCUs are extremely efficient but underfunded, recovering $4.64 for every tax dollar spent, usually through civil penalties stemming from fraud investigations.[20] In fiscal year 2024 alone, states' MFCUs reported over 1,185 convictions and $2 billion in recoveries.[21]

Cutting additional monies allotted to state Medicaid programs and other existing Medicaid program integrity efforts in order to increase new or alternative program integrity efforts would exacerbate existing financial pressures on state Medicaid agencies and undermine states' ability to carry out their statutory and regulatory obligations.

ASHA strongly advises against withholding federal Medicaid funds as a strategy to combat FWA. This approach fails to isolate the actions of bad actors and instead places undue penalties

on beneficiaries and high-quality providers serving some of the nation's most vulnerable populations. Given that Medicaid programs already struggle to attract providers because of low payment rates and high administrative burden, additional financial strain could further limit access to care.[22] The Department should instead prioritize strengthening and adequately funding existing program integrity tools available to states and the federal government.

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

ASHA strongly supports program integrity and opposes FWA in any form. However, we are concerned that certain eligibility verification changes could unintentionally create administrative barriers for eligible individuals—particularly those with cognitive and/or communication disabilities who may face challenges navigating verification requirements.

Minor differences between information patients report on their marketplace health insurance applications and data from other trusted sources are common. When these data matching issues (DMIs) occur, the marketplace must ask for document resubmission to confirm application information. This process can create administrative burden for patients, who may need to resubmit detailed information about income, citizenship or immigration status, and other coverage information.

For individuals with cognitive impairments, language disorders, and/or other communication disabilities, responding to verification requests and compiling documentation can be especially challenging. If they fail to submit acceptable documents by the deadline stated in the notice, they could lose coverage and/or premium subsidies, even when they are otherwise eligible.

CMS should carefully evaluate how any program integrity efforts could increase the volume of DMI-related documentation requests. Increased administrative burden on both marketplaces and enrollees could reduce enrollment and disrupt coverage for otherwise eligible individuals.

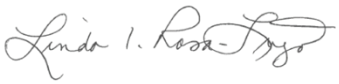
Therefore, ASHA urges CMS to ensure that verification notices are clear and easy for consumers to understand. CMS should also streamline documentation requirements to reduce unnecessary administrative burden. Applicants must be given adequate time to respond to verification requests. In addition, CMS should monitor whether increased verification requirements result in eligible individuals losing coverage due to procedural issues rather than true ineligibility.

Program integrity efforts should be balanced with policies that ensure eligible individuals can reasonably navigate verification requirements and maintain or obtain coverage, including those with cognitive and/or communication disabilities.

In this context, when developing policies related to agent/broker activity, it is essential to consider their vital role in helping patients access needed care. A 2017 study revealed that low health literacy may occur even among well-educated patients and suggests that a majority of patients in the free clinic studied had trouble comprehending and following through on health information.[23] Notably, patients identified completing the required forms for government programs, including Medicare and Medicaid, as their greatest challenge.[24] Given the prevalence of low health literacy and the fact that it is frequently associated with social and economic factors, it is a serious potential barrier to health care access.[25] ASHA strongly advocates for comprehensive access to and coverage of audiology and speech-language pathology services and supports facilitating pathways to enrollment for eligible individuals. This includes allowing agents/brokers the flexibility to assist eligible patients in FFE and SBE enrollment.

We appreciate the Department's attention to these important issues. If you have additional questions, please contact Caroline Bergner, director of health care policy for Medicaid, at cbergner@asha.org.

Sincerely,



Linda I. Rosa-Lugo, EdD, CCC-SLP
2026 ASHA President

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