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Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
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Re: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH

The Long-Term Post-Acute Care (LTPAC) Health IT Collaborative appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information regarding the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative. Our collaborative represents providers serving millions of Medicare and Medicaid beneficiaries across skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, hospices, assisted living facilities, and other LTPAC settings.

The LTPAC sector serves the fastest-growing segment of the U.S. population—adults aged 65 and older, with those over 85 increasing at the most rapid pace. These individuals typically present with multiple chronic conditions (multimorbidity), polypharmacy, cognitive and functional impairments, and complex social determinants of health. The populations we serve are among the most vulnerable to both healthcare fraud and to unintended consequences of well-intentioned fraud prevention measures.

We strongly support CMS's commitment to combating fraud, waste, and abuse in federal healthcare programs. These efforts protect taxpayer dollars, ensure program integrity, and safeguard vulnerable beneficiaries from predatory actors. However, based on our sector's experience with previous fraud prevention initiatives—particularly the concerning lessons from antipsychotic medication quality measures—we urge CMS to design CRUSH regulations that effectively target bad actors while protecting legitimate providers and ensuring continued access to appropriate care for our nation's most vulnerable populations.

Overarching Recommendations

Before addressing specific CRUSH sections, we emphasize several cross-cutting principles that should guide fraud prevention policy for LTPAC settings:

- **Use better data, not just stricter rules**: Enhanced interoperability and longitudinal patient data will improve fraud detection accuracy far more effectively than blanket restrictions that may harm legitimate care delivery. LTPAC providers frequently operate on older, non-standardized technology systems for which there are limited federal incentive programs — unlike the incentive structures (e.g., Meaningful Use/Promoting

Interoperability) that drove adoption of certified EHR technology in hospitals and physician practices. Applying newer, prospective fraud detection approaches that assume modern, interoperable system architectures to these older technology environments can result in inappropriately flagging legitimate providers. Furthermore, unlike community settings where a service can simply be withheld pending payer determination, LTPAC settings operate under the same mandatory care obligation as acute care hospitals: once care is ordered, providers must deliver it regardless of eligibility or payment uncertainty. CMS must account for this fundamental regulatory and operational difference.

- **Avoid unintended care disruption:** Fraud prevention measures must include safeguards to prevent interruption of medically necessary services, particularly for vulnerable LTPAC populations who depend on continuous medication access and coordinated care transitions. This concern directly implicates electronic prior authorization: prior authorization requirements are used by payers as a fraud, waste, and abuse control tool, but when LTPAC providers lack the technology infrastructure to submit electronic prior authorizations, they may default to manual (fax or mail) processes that payers may not accept or that introduce delays causing care disruptions. Managed care organizations and ACOs design prior authorization workflows based primarily on community or younger patient populations, frequently failing to account for the complex care needs and longer eligibility transitions of the LTPAC population.

- **Distinguish between fraud and appropriate clinical variation:** LTPAC care patterns differ significantly from acute care. Site-of-care-aware analytics are essential to avoid misclassifying normal LTPAC utilization as suspicious activity. Payer fraud detection systems are calibrated on broader or younger patient populations; when applied to LTPAC beneficiaries, they routinely generate false positives. What appears anomalous from a community care perspective often represents clinically appropriate, evidence-based care in the LTPAC context.

- **Leverage longitudinal ancillary and care data:** Ancillary service data (pharmacy, lab, rehabilitation services, radiology and imaging) and LTPAC longitudinal data provide critical context for validating care appropriateness and detecting true fraud patterns versus legitimate complex care management. The lack of incentives for LTPAC providers to adopt newer, interoperable technologies means that the payer community may be applying AI and algorithmic fraud detection to data that is incomplete, outdated, or non-standardized — a classic "garbage in, garbage out" problem. Findings from such analyses may inappropriately indicate fraud, waste, and abuse when the root cause is a technology gap, not provider intent.

- **Learn from past initiatives**: The antipsychotic quality measure experience demonstrates the serious risks when national policies fail to account for clinical appropriateness, data accuracy, and unintended consequences for patient care. This lesson extends to prior authorization policies and payment suspension decisions, where

technology barriers in LTPAC settings can create the appearance of non-compliance where none exists.

- **Recognize the link between eligibility complexity and perceived fraud**: A cross-cutting theme throughout this letter is that many patterns CMS may identify as suspicious in LTPAC claims data are directly attributable to the complexity and lag time of beneficiary eligibility determinations. Eligibility status in the LTPAC setting is not static or real-time: beneficiaries transition from hospital to SNF to home health to hospice; their Part A coverage days expire and renew; they move between traditional Medicare and Medicare Advantage; their spend-down status changes their Medicaid eligibility. Providers submit claims in good faith based on eligibility information available at the time of service, then must retroactively correct claims as true eligibility is resolved. These good-faith billing patterns, driven by systemic eligibility lag, must not be conflated with intentional fraud.

Section A: Program Integrity & Fraud Analytics

Enhanced Data Sharing and Integration

Recommendation 1: CMS should enhance data sharing and integration across Medicare Part A, Part B, Part C (Medicare Advantage), Part D, and Medicaid programs, with explicit inclusion of ancillary service provider data — particularly pharmacy, laboratory, rehabilitation services, and radiology and imaging — alongside LTPAC provider data as core fraud detection inputs.

The LTPAC sector generates rich longitudinal data through standardized assessment instruments (MDS, OASIS, IRF-PAI, LCDS, Hospice Item Set), medication administration records, care transitions, and interdisciplinary care plans. This data provides essential context for understanding utilization patterns, validating care appropriateness, and distinguishing legitimate complex care from fraudulent activity.

However, current fraud detection systems often operate in silos, analyzing Part A claims separately from Part D pharmacy data or ancillary service claims, or examining hospital readmissions without visibility into SNF or home health utilization. This fragmentation creates blind spots that both allow sophisticated fraud to go undetected and generate false positives when normal LTPAC care coordination appears anomalous without proper context.

Specific recommendations:

- **Integrate ancillary service data — including pharmacy, laboratory, rehabilitation services, and radiology and imaging — as core fraud prevention tools**: Ancillary service data collectively reveals utilization patterns, clinical appropriateness, and care coordination across the full spectrum of LTPAC services. Pharmacy data in particular reveals medication utilization patterns, polypharmacy management, care transitions, and

clinical appropriateness indicators that are essential for validating LTPAC claims. Similarly, rehabilitation service data (PT, OT, SLP) documents therapy intensity and duration relative to documented patient goals; laboratory data validates clinical decision-making and monitoring frequency; and radiology and imaging data contextualizes diagnostic workup patterns for this high-acuity population.

- **Link assessment data with claims data** – MDS, OASIS, and other assessment instruments document functional status, cognitive status, clinical complexity, and care needs that provide critical context for evaluating whether utilization patterns are appropriate for patient acuity.
- **Enable cross-program data matching** – Beneficiaries often move between traditional Medicare and MA, or between Medicare and Medicaid. Fraud detection systems must track beneficiaries across programs to identify scheme patterns.
- **Support FHIR-based interoperability standards** – Require use of HL7 FHIR implementation guides developed by the PACIO Project for functional status, cognitive status, transitions of care, and medication reconciliation to enable standardized, computable data exchange for fraud detection analytics.
- **Require electronic prior authorizations across payers**: CMS should require all payers contracting with Medicare and Medicaid programs to implement electronic prior authorization (ePA) capabilities consistent with the CMS Interoperability and Prior Authorization Final Rule. LTPAC providers lacking the technology infrastructure to submit electronic prior authorizations are disproportionately affected when payers decline manual submissions, creating care gaps and billing delays that may be misidentified as fraud. Investment in ePA adoption in the LTPAC sector should be supported through dedicated funding and technical assistance, analogous to the Promoting Interoperability incentive programs for hospitals and eligible professionals.
- **Include ancillary service data as core fraud prevention inputs**: Fraud detection analytics must incorporate data from the full range of ancillary services utilized in LTPAC settings, including pharmacy, rehabilitation therapy (PT, OT, SLP), laboratory, radiology, and DME. Limiting fraud detection to primary facility claims misses the longitudinal care picture and creates false anomalies when ancillary patterns are evaluated out of context.

Site-of-Care-Aware Fraud Models

Recommendation 2: Fraud detection models must be site-of-care-aware and calibrated to the LTPAC patient population to account for legitimate clinical and operational differences between LTPAC settings and acute or ambulatory care.

LTPAC settings differ fundamentally from hospitals and physician practices in population characteristics (older, more complex, longer lengths of stay), care models (interdisciplinary teams, emphasis on function and quality of life), documentation requirements (standardized assessments), and clinical patterns (polypharmacy, chronic disease management, palliative care). Fraud detection algorithms trained primarily on acute care data will systematically flag normal LTPAC utilization as suspicious, creating false positives that burden legitimate providers

with audits, payment suspensions, and enforcement actions while allowing actual fraud to evade detection.

Critical point: All fraud detection algorithms deployed in LTPAC contexts must be trained and validated on LTPAC-specific patient populations — older adults with multimorbidity, polypharmacy, cognitive impairment, and functional limitations. Applying AI or algorithmic models trained on younger, healthier, or community-based populations to the LTPAC setting will produce systematically biased results that misclassify appropriate LTPAC care as anomalous.

Examples of LTPAC-specific considerations:

- **Medication utilization:** Complex medication regimens are clinically appropriate for LTPAC populations with multiple chronic conditions. High medication counts or specific therapeutic classes (anticoagulants, insulin, pain management, behavioral health medications) may appear anomalous compared to younger, healthier populations but reflect legitimate treatment of multimorbidity.
- **Laboratory and diagnostic testing:** SNF residents requiring skilled care often need frequent monitoring (INR for anticoagulation, glucose for diabetes, wound cultures, urinalysis). Testing frequency appropriate for this population may trigger fraud alerts if compared to ambulatory norms.
- **Therapy utilization**: Post-acute rehabilitation settings appropriately provide intensive physical, occupational, and speech therapy. Duration and frequency appropriate for recovery from stroke, orthopedic surgery, or deconditioning differ markedly from outpatient therapy patterns.
- **Hospice election and disenrollment**: Hospice patients with non-linear disease trajectories (heart failure, COPD, dementia) may experience clinical improvements warranting disenrollment, or may elect hospice multiple times. These patterns reflect appropriate care, not fraud.

Specific recommendations:

- Develop LTPAC-specific fraud detection models that account for these clinical and operational differences
- Incorporate clinical appropriateness indicators from standardized assessments (MDS acuity scores, OASIS functional status, cognitive assessments)
- Validate fraud detection algorithms on LTPAC populations before deployment
- Provide transparent documentation of model assumptions, training data sources, and performance metrics to enable LTPAC providers to understand and respond to fraud alerts

Guardrails on Payment Suspensions

Recommendation 3: Implement robust guardrails on payment suspensions, including rapid appeals processes and continued payment for beneficiary-critical services (particularly medications) to prevent disruption of care.

Payment suspension is a powerful tool for preventing ongoing fraud losses, but when applied to legitimate providers or based on false-positive fraud alerts, it can cause immediate and severe harm to vulnerable beneficiaries. This risk is particularly acute for ancillary services on which LTPAC beneficiaries depend for continuous care. Pharmacy services and medication access are the most time-sensitive: LTPAC beneficiaries often require uninterrupted medication therapy for chronic conditions (anticoagulation, insulin, cardiovascular medications, seizure medications, behavioral health medications), and even brief interruptions can result in adverse events, hospitalizations, or mortality. Interruptions to rehabilitation services (PT, OT, SLP) can halt functional recovery following surgery or acute illness. Suspension of laboratory monitoring can leave clinicians unable to safely manage anticoagulation, renal function, or infection. Each of these ancillary service categories carries distinct patient safety risks when payment suspension disrupts access.

This risk is particularly acute for pharmacy services and medication access. LTPAC beneficiaries often require continuous medication therapy for chronic conditions (anticoagulation, insulin, cardiovascular medications, seizure medications, behavioral health medications). Even brief interruptions can result in adverse events, hospitalizations, or mortality.

Eligibility system improvements: A critical and frequently overlooked driver of apparent billing anomalies in LTPAC settings is the lag time inherent in Medicare and Medicaid eligibility determinations. Beneficiaries transition across settings and programs rapidly — a patient may move from hospital inpatient status to Part A SNF coverage to Part B outpatient status to hospice within weeks — and eligibility determinations do not always keep pace with these transitions. Providers bill in good faith based on the best eligibility information available at the time of service, then must retroactively adjust claims as eligibility is confirmed or changed. This good-faith, system-driven billing behavior has every appearance of irregularity when examined retrospectively by fraud detection algorithms that do not account for eligibility lag. CMS should:

- Invest in real-time eligibility verification infrastructure that enables LTPAC providers and pharmacies to confirm beneficiary eligibility status at the point of care and point of prescription
- Establish clear safe harbors for good-faith billing errors attributable to eligibility lag times, distinguishing these from intentional fraudulent billing
- Require fraud detection models to incorporate eligibility transition timelines before flagging claims as anomalous
- Provide guidance to LTPAC providers on documentation practices that support good-faith compliance when eligibility is uncertain

Specific recommendations:

- **Establish rapid appeal processes** – Providers subject to payment suspension based on fraud allegations must have access to expedited review (within 10 business days) with clear standards of evidence and opportunity to present clinical documentation supporting care appropriateness.

- **Continued payment for beneficiary-critical services** – During payment suspension appeals, CMS should continue payment for medications and other services where interruption would pose immediate health risks. These payments could be subject to recoupment if fraud is ultimately confirmed.
- **Graduated enforcement approach** – Before imposing payment suspension, CMS should employ graduated interventions (provider education, prepayment review, focused audits) except in cases where immediate suspension is necessary to prevent ongoing harm or loss.
- **Site-of-care context in suspension decisions** – Payment suspension decisions should account for the provider's role in beneficiary care. For example, suspending payments to a beneficiary's only available home health agency or hospice provider creates access-to-care crises that harm innocent beneficiaries.
- **Transparency in fraud detection methods** – Providers should receive clear information about the specific utilization patterns, claims, or data elements that triggered fraud alerts, enabling them to provide clinical context and correct data errors.

Section C: MA Preclusion List & Enrollment Requirements

Targeted, Risk-Based Approaches

Recommendation 4: The Collaborative supports targeted approaches that focus on high-risk providers and provider categories rather than broad mandates affecting all Medicare Advantage participants.

The Collaborative notes that because MA plan fraud detection and credentialing systems are typically designed around their broader member populations, which skew younger and healthier than the LTPAC-specific beneficiary cohort, applying these systems uniformly to LTPAC providers will produce inaccurate population reference data and systematically misidentify LTPAC utilization patterns as suspicious. CMS should require MA plans to develop LTPAC-aware credentialing and fraud detection parameters.

More effective strategies include:

- **Enhanced screening for high-risk provider categories**: Apply heightened scrutiny to provider types with documented fraud patterns (e.g., certain DMEPOS categories, laboratory types, specific therapy provider models).
- **Risk-based credentialing requirements:** MA plans should be required (or incentivized) to implement risk-stratified credentialing processes that apply enhanced verification to high-risk providers while streamlining enrollment for established, low-risk providers. Credentialing standards must account for the LTPAC-specific licensing and accreditation frameworks (hospice certification, home health CoPs, SNF participation requirements) that differ from acute care provider standards.

- **Cross-program enrollment monitoring**: CMS should monitor providers who are revoked from traditional Medicare or one MA plan and attempt to re-enroll through other MA plans. This requires data sharing between CMS and MA plans.
- **Expanded preclusion list transparency and due process**: Providers placed on the preclusion list should receive clear notice of the basis for preclusion, opportunity to present evidence of compliance, and a defined pathway for removal from the list after demonstrating sustained compliance.
- **Robust eligibility determination support**: A significant source of perceived fraud in the LTPAC and MA context is the difficulty of identifying a patient's correct insurance coverage at the time of care delivery. Beneficiaries may simultaneously be enrolled in MA, traditional Medicare, and Medicaid and their eligibility status in each may shift as assets are spent down, as hospital stays alter Part A benefit periods, or as plan enrollments change mid-year. CMS should work to improve real-time eligibility transparency for providers serving these populations.

Support for Centralized Provider Integrity/Credentialing System

Recommendation 5: The Collaborative supports creation of a centralized provider integrity and credentialing system that prevents bad actors from evading detection without disrupting legitimate pharmacy and LTPAC providers.

A national provider integrity database could:

- Consolidate enrollment, licensure, sanctions, and quality data across federal and state programs
- Enable real-time verification of provider credentials and compliance status
- Track providers across NPIs, TINs, and ownership structures to prevent identity-shifting schemes
- Provide both traditional Medicare and MA plans with access to consistent, comprehensive provider integrity information
- Streamline enrollment for legitimate providers by eliminating duplicative verification processes
- Support enhanced ownership transparency

Critical implementation considerations:

- Ensure accuracy of data and clear dispute resolution processes when providers are incorrectly flagged
- Protect against false positives that could harm legitimate providers' ability to participate in federal programs
- Account for LTPAC-specific licensing and credentialing requirements that differ from acute care provider standards
- Provide adequate transition timelines and technical assistance for LTPAC providers and MA plans to adapt systems and workflows

- Address cybersecurity vulnerabilities - LTPAC providers operating on older, less-resourced IT infrastructure face heightened cybersecurity risk. Data breaches, ransomware incidents, or compromised billing systems in LTPAC settings can create the appearance of fraudulent billing patterns when claims are corrupted or when providers must reconstruct billing records post-incident. CMS should recognize cybersecurity vulnerabilities as a contributing factor to claims anomalies in LTPAC settings and provide technical assistance and resources to support cybersecurity infrastructure improvements in these under-resourced environments.

Section F: Claims Filing Deadlines

Strong Opposition to Shortened Deadlines Without Exceptions

Recommendation 6: The Collaborative strongly opposes shortened claims filing deadlines (90–180 days) without explicit exceptions for LTPAC providers, pharmacies, and complex patient populations.

Current Medicare Part A and Part B claims filing deadlines (generally one calendar year from date of service) reflect the operational realities of healthcare delivery, including care transitions, retroactive eligibility determinations, coordination of benefits, and administrative processing time. Shortening these deadlines to 90–180 days would create severe operational challenges for LTPAC providers and pharmacies.

A fundamental point: shortened deadlines, when applied to LTPAC settings, presume fraud or negligence where the actual cause is well-documented operational and systemic factors, primarily the lag time in eligibility determinations. CMS should not design deadline policy around an assumption of bad faith by LTPAC providers who are billing in good faith under circumstances where eligibility, prior authorization, and coordination of benefits are all subject to delays outside the provider's control.

LTPAC-Specific Billing Dependencies

- **Retroactive eligibility determinations**: Beneficiaries frequently enter LTPAC settings (particularly SNFs following hospital discharge) with uncertain or pending Medicare eligibility. Eligibility may be determined retroactively after state Medicaid processing, hospital coverage determinations, or Medicare Secondary Payer investigations. Shortened deadlines could force providers to file claims before eligibility is confirmed, resulting in denials and recoupment.
    - *Illustrative use case (contributed by Collaborative members): A beneficiary is admitted to a SNF from an acute hospital. The hospital's claim for the inpatient stay, which determines the beneficiary's Part A SNF benefit eligibility, is still pending appeal at Day 90. The SNF cannot finalize its Part A claim until the hospital's benefit period determination is resolved. Under a 90-day deadline, the*

SNF faces a choice between filing an incorrect claim or losing reimbursement entirely through no fault of its own.

- **Care transitions and delayed information**: LTPAC billing often depends on information from prior care settings (hospital discharge summaries, physician orders, prior authorization determinations) that may not be available within 90-180 days of admission. Home health agencies cannot file claims until physicians sign orders and care plans, which may occur weeks after the initial visit.
    - *Illustrative use case: A beneficiary is admitted to home health following SNF discharge. The certifying physician's signature on the plan of care is delayed due to a physician practice transition. At Day 90, the home health agency has provided multiple weeks of covered services but cannot submit a timely claim for all of them because the plan of care remains unsigned. Under shortened deadlines, these legitimate claims would be forfeited.*
- **Complex documentation requirements**: LTPAC claims require extensive clinical documentation from standardized assessments (MDS, OASIS), interdisciplinary care plans, physician certifications, and therapy documentation. Completing this documentation within 90-180 days while simultaneously providing direct patient care is operationally infeasible for many smaller providers.
- **Coordination of benefits and Medicare Secondary Payer**: Determining primary payer responsibility for dual-eligible beneficiaries or those with employer-sponsored coverage often takes months. Shortened deadlines would force LTPAC providers to file claims before payer responsibility is resolved, leading to incorrect billing and recoupment.
    - *Illustrative use case: A SNF resident has an employer-sponsored plan as a potential secondary payer. Resolution of Medicare Secondary Payer (MSP) liability takes 150 days. Under a 90-day deadline, the facility must either file without MSP resolution (creating potential compliance exposure) or lose the claim.*
- **Resource constraints and administrative capacity**: Many LTPAC providers are small, rural, or under-resourced organizations with limited billing staff. Unlike large health systems with dedicated revenue cycle departments, these providers may have 1–2 billing personnel managing complex Medicare and Medicaid requirements for hundreds of residents or patients.

Ancillary Service Specific Billing Dependencies

- **Medication synchronization and administration records**: Pharmacies serving LTPAC settings must reconcile medication administration records (MARs) from facilities before billing Part D plans. This reconciliation process, essential for accurate billing and fraud prevention, often extends beyond 90-180 days.
- **Prior authorization determinations**: Many ancillary services require prior authorization that may not be approved within shortened timeframes. For example, Pharmacies may dispense medications pending authorization, with billing contingent on final approval.

- **Beneficiary responsibility and dual-eligible processing**: Determining beneficiary cost-sharing for dual-eligible individuals requires coordination between Medicare Part D and Medicaid, which can extend beyond 90-180 days.
- **Retroactive formulary changes**: Part D plans may implement mid-year formulary changes or coverage determinations that require pharmacies to resubmit or adjust claims after the initial submission.

Recommendations for Claims Filing Deadline Policy

- **Maintain existing timelines for LTPAC and pharmacy** – Retain the current one-year claims filing deadline for SNF, HH, IRF, LTCH, hospice, and Part D pharmacy and ancillary service providers (laboratory, rehabilitation therapy, and radiology and imaging) serving LTPAC populations.
- **Create explicit LTPAC and pharmacy exceptions:** If CMS proceeds with shortened deadlines for other provider types, establish clear regulatory exceptions for LTPAC providers and ancillary service providers (including pharmacy, laboratory, rehabilitation services, and radiology and imaging), with detailed definitions of qualifying circumstances.
- **Extended timelines for dual-eligible and MSP claims:** Provide automatic extensions for claims involving dual-eligible beneficiaries, Medicare Secondary Payer determinations, or retroactive eligibility.
- **Establish "good cause" extension process:** Create a streamlined process for providers to request deadline extensions when billing delays result from circumstances beyond their control (missing hospital records, pending eligibility, care transition complications, state Medicaid processing delays).
- **Graduated implementation with monitoring:** If shortened deadlines are implemented, phase them in gradually (e.g., 270 days, then 180 days) with mandatory monitoring of claims denial rates, provider participation, and beneficiary access to care. Suspend implementation if monitoring reveals adverse impacts on LTPAC access or beneficiary care.
- **Technical assistance and education:** Provide comprehensive guidance, training, and technical assistance to LTPAC providers and pharmacies on claims filing processes, common delay scenarios, and strategies for meeting deadlines.

Section G: AI in Coding & Billing

Support for AI Adoption with Critical Safeguards

Recommendation 7: The Collaborative supports the adoption of artificial intelligence (AI) in healthcare coding, billing, and clinical decision support, but emphasizes that AI deployment in LTPAC settings must include mandatory human oversight, robust auditability requirements, LTPAC population-specific validation, and clear appeals processes for providers whose legitimate billing patterns are flagged by AI systems.

AI tools hold promise for reducing administrative burden, improving coding accuracy, detecting fraud patterns, and supporting clinical decision-making. However, LTPAC populations and care models present unique challenges that require specific safeguards. Because of the technology and data quality gaps discussed throughout this letter, providers operating on older systems may be flagged by AI fraud detection tools even when their practices are entirely compliant. Special appeals pathways must be available to providers who appear anomalous to AI systems but are legitimate actors operating within an under-resourced technology environment.

Human-in-the-Loop Requirements

- **Mandatory human oversight:** AI-generated coding, billing, prior authorization, and clinical recommendations must be reviewed and validated by qualified human professionals (certified coders, billing specialists, clinicians) before submission to payers or implementation in patient care.
- **Override capability**: Clinicians and administrative staff must retain the ability to override AI recommendations when clinical judgment or specific patient circumstances warrant deviation from algorithmic outputs.
- **Documentation of AI-assisted decisions**: Medical records and billing documentation should clearly indicate when AI tools contributed to coding, billing, or clinical decisions, enabling retrospective review and quality improvement.

Auditability and Transparency Requirements

- **Algorithm transparency:** AI vendors should be required to provide transparent documentation of model purpose, training data sources, validation methods, performance metrics, limitations, and known bias risks through AI model cards.
- **Audit trails**: Certified health IT and billing systems should maintain audit trails showing the evidence sources and reasoning pathways underlying specific AI recommendations, enabling providers to understand whether recommendations are based on current, high-quality evidence or outdated data.
- **Explainability**: AI tools should provide clinically meaningful explanations of recommendations that allow users to evaluate appropriateness for specific patients and care contexts.
- **Post-market surveillance**: CMS should establish mechanisms for monitoring AI tool performance in real-world settings, including reporting of algorithm errors, unexpected outcomes, or suspected bias, particularly when deployed in LTPAC contexts where population characteristics differ markedly from training data.
- **AI governance and compliance frameworks**: Given the rapid adoption of AI as a "new and shiny" tool across healthcare, CMS must establish clear governance requirements: guardrails, compliance standards, and accountability mechanisms that ensure AI is deployed safely and equitably across all care settings, including LTPAC.

LTPAC-Specific Validation and Customization

- **Validation on LTPAC populations**: AI tools used for LTPAC coding, billing, or clinical decision support must be validated on older adults with multimorbidity, polypharmacy, cognitive impairments, and functional limitations. Tools trained exclusively on younger, healthier populations will perform poorly or generate harmful recommendations when applied to LTPAC patients.
- **Polypharmacy and drug interaction detection**: AI tools must account for complex medication regimens common in LTPAC settings, including assessment of cumulative anticholinergic burden, drug-disease interactions, renal dose adjustments, and deprescribing opportunities.
- **Functional and cognitive status integration**: AI coding and clinical decision support tools should integrate functional status (ADLs, IADLs), cognitive status (CAM, PHQ-9), and social determinants data from standardized LTPAC assessments. Clinical appropriateness cannot be evaluated based solely on diagnoses and procedures.
- **Site-of-care-aware recommendations**: AI tools must be programmed to account for LTPAC care settings. Medication dosing recommendations should reflect reduced renal function common in older adults, and therapy intensity recommendations should account for post-acute rehabilitation goals versus chronic maintenance therapy.

Integration with Ancillary Services and EHR Data

- **Interoperability requirements:** AI tools should leverage standardized data exchange formats (HL7 FHIR, NCPDP SCRIPT, X12) to access comprehensive patient data across pharmacy systems, EHRs, and care settings, including the full scope of ancillary service data (rehabilitation therapy, laboratory, radiology, DME) that characterizes LTPAC care.
- **Real-time medication reconciliation** — AI-enabled medication reconciliation tools can improve accuracy and reduce burden at care transitions, but must be integrated with pharmacy records, hospital discharge summaries, and LTPAC admission assessments.
- **Fraud detection accuracy:** AI fraud detection systems should incorporate ancillary service, pharmacy, and longitudinal LTPAC data to improve accuracy and reduce false positives. For example, detecting inappropriate prescribing patterns requires access to medication administration records, not just prescription claims.

Liability and Accountability Frameworks

- **Shared accountability models**: CMS should work with state medical boards, professional liability insurers, and legal experts to develop guidance on shared accountability when AI tools contribute to coding, billing, or clinical decisions.
- **Vendor and payer liability standards**: AI vendors should not be permitted to shift liability risk entirely to LTPAC providers through indemnification agreements. Model

contract language should establish equitable risk-sharing between vendors and providers.

- **Protection for appropriate use:** Providers who follow AI recommendations in good faith, with appropriate human oversight and documentation, should be protected from fraud allegations or billing denials when algorithms generate incorrect outputs.

Section K & L: Medicaid & CHIP Program Integrity

Improve Interoperability and Real-Time Data Exchange

Recommendation 8: CMS should prioritize improving interoperability and real-time data exchange across states, providers, pharmacies, and payers as the foundation for effective Medicaid and CHIP program integrity.

The fragmented nature of Medicaid — with 56 different state and territorial programs, multiple managed care plans within each state, and limited data sharing between Medicare and Medicaid — creates opportunities for fraud while simultaneously burdening legitimate providers with duplicative reporting and conflicting requirements.

Specific recommendations:

- **Expand TEFCA to include Medicaid data:** All state Medicaid programs and Medicaid managed care plans should be required to participate in TEFCA Qualified Health Information Networks (QHINs), enabling nationwide exchange of beneficiary clinical, eligibility, and utilization data.
- **Standardize data exchange using FHIR:** Require use of HL7 FHIR standards for Medicaid data exchange, aligned with USCDI and LTPAC-specific PACIO implementation guides for functional status, cognitive status, transitions of care, and medication reconciliation.
- **Real-time eligibility verification:**Enable real-time verification of Medicaid eligibility at point of care and point of prescription, reducing billing errors, retroactive denials, and provider burden. This is particularly important in LTPAC settings, where eligibility can shift rapidly as beneficiaries transition across settings and as spend-down thresholds are reached. The lack of real-time eligibility contributes directly to billing anomalies that are frequently mischaracterized as fraud.
- **Cross-state data matching for dual eligibles:** Beneficiaries who move between states or use services across state lines should have their eligibility, utilization, and care plans accessible across state Medicaid programs.
- **Integrate Medicare and Medicaid data for dual eligibles:** Full integration of Medicare Part A/B/D and Medicaid claims, assessment, ancillary service, and pharmacy data for dual-eligible beneficiaries would dramatically improve fraud detection, care coordination, and program integrity while reducing burden on providers serving this population.

- **Tie eligibility processes to program integrity:** CMS should explicitly link eligibility system improvements (real-time verification, reduced retroactive changes) to program integrity goals. Many LTPAC billing anomalies identified as potential fraud are eligibility issues. Improving eligibility infrastructure will reduce both genuine fraud (through better verification) and false positives (through better provider transparency) simultaneously.

Avoid Overly Burdensome Revalidation Requirements

Recommendation 9: CMS and states should avoid implementing overly frequent provider revalidation requirements that create administrative burden without meaningfully improving program integrity.

Provider revalidation serves important program integrity goals by verifying ongoing licensure, compliance, and operational status. However, excessively frequent revalidation (e.g., annual or biennial) creates substantial administrative burden for LTPAC providers without commensurate fraud prevention benefits.

Specific recommendations:

- **Risk-based revalidation schedules:** Apply frequent revalidation to high-risk provider categories while maintaining longer cycles (5 years) for established, compliant providers with strong track records.
- **Streamlined revalidation for multi-state providers:** Create reciprocity mechanisms that allow providers licensed and enrolled in multiple state Medicaid programs to complete a single comprehensive revalidation rather than duplicative processes in each state.
- **Automated verification where possible:** Leverage technology to automate verification of licensure, accreditation, and sanctions through interfaces with state **Revalidation burden assessment**: Before implementing new revalidation requirements, CMS and states should assess the administrative burden on providers, particularly small, rural, and under-resourced LTPAC organizations, and ensure that burden is proportionate to fraud risk.

Promote Longitudinal, Patient-Centered Analytics

Recommendation 10: CMS should promote longitudinal, patient-centered analytics for fraud detection rather than claim-by-claim review approaches that lack clinical context.

Traditional fraud detection focuses on individual claims or short timeframes, examining whether specific services are medically necessary or correctly coded. While this approach can identify certain types of fraud, it fails to detect sophisticated schemes and generates false positives when individual claims appear anomalous without broader clinical context.

Advantages of longitudinal, patient-centered analytics:

- **Clinical appropriateness assessment:** Evaluating utilization across a patient's entire care journey (hospital → SNF → home health → outpatient) enables assessment of whether patterns align with clinical needs and care goals.
- **Pattern detection:** Sophisticated fraud often involves networks of providers, beneficiaries, and services that appear legitimate in isolation but form suspicious patterns when analyzed longitudinally across programs.
- **Reduced false positives:** Individual high-cost or high-utilization episodes may appear suspicious but are clinically appropriate when understood in the context of patient complexity, care transitions, and longitudinal needs.
- **Care quality integration:** Linking utilization data with outcomes (readmissions, mortality, functional status, patient-reported outcomes) helps distinguish high-quality, appropriate care from waste or fraud.

Specific recommendations:

- Develop fraud detection algorithms that analyze beneficiary utilization patterns across settings and over time
- Integrate claims data with clinical data from assessments, care plans, and health information exchange
- Use predictive analytics to identify beneficiaries at risk for fraudulent schemes (e.g., beneficiary recruitment for unnecessary services) and intervene proactively
- Evaluate provider performance using episode-based or population-based metrics rather than only service-level review

Leverage Ancillary Services and LTPAC Data as Core Fraud Prevention Tools

Recommendation 11: CMS should leverage ancillary service data,encompassing pharmacy, laboratory, rehabilitation services, and radiology and imaging, alongside LTPAC longitudinal data as core inputs for fraud detection and care validation, not peripheral data sources.

Ancillary services are integral to LTPAC care delivery, not supplementary. The issues raised below about pharmacy data apply broadly to the full ancillary service category; pharmacy examples are provided to illustrate the principle.

Ancillary service data collectively provides:

- Service utilization patterns cross-referenced against functional, diagnostic, and clinical assessment data to validate care appropriateness

- Longitudinal trending of service intensity relative to documented patient goals, acuity, and outcomes
- Cross-service pattern detection that identifies when combinations of ancillary services across pharmacy, lab, rehab, and imaging are consistent with, or inconsistent with, documented clinical conditions

Pharmacy data specifically provides:

- Medication utilization patterns that reveal clinical appropriateness, adherence, polypharmacy issues, and potential diversion schemes
- Drug-diagnosis concordance that validates whether prescribed medications align with documented conditions
- Prescriber patterns that may indicate inappropriate prescribing, kickback schemes, or pill mill operations
- Beneficiary medication access that reveals potential access barriers or medication non-adherence affecting outcomes

Laboratory data provides:

- Monitoring frequency patterns that validate clinical management of high-risk conditions (anticoagulation, renal function, diabetes, infection)
- Diagnostic test utilization relative to documented diagnoses and care plans
- Evidence of appropriate clinical response to abnormal results, supporting care quality and appropriateness

Rehabilitation services data (PT, OT, SLP) provides:

- Therapy intensity and duration patterns relative to documented functional status, diagnosis, and rehabilitation goals (from MDS and OASIS assessments)
- Progression and discharge patterns that distinguish appropriate post-acute rehabilitation from over- or under-utilization
- Functional outcome data that links service utilization to measurable patient improvement

Radiology and imaging data provides:

- Diagnostic workup patterns appropriate to the LTPAC population's high prevalence of complex, comorbid conditions
- Utilization patterns contextualized against clinical indicators that justify imaging in this high-acuity population

LTPAC assessment data provides:

- Functional and cognitive status assessments (MDS, OASIS) that document care needs and appropriateness of services
- Care transitions data that reveals discharge planning quality and post-acute care coordination

- Interdisciplinary care plans that document care goals, preferences, and the rationale for specific interventions
- Quality metrics and adverse events that reveal whether utilization is associated with positive or negative outcomes

Critical Lessons from Project PAUSE: The Dangers of Data-Driven Policy Without Clinical Context

Background on CMS Antipsychotic Quality Measure

The LTPAC sector's experience with CMS's antipsychotic medication quality measure provides critical cautionary lessons for CRUSH implementation. This experience demonstrates how well-intentioned fraud and abuse prevention efforts, when based on incomplete data analysis and lacking clinical context, can inadvertently harm the very populations they aim to protect.

In 2012, CMS implemented a quality measure targeting antipsychotic medication use in nursing homes, driven by concerns about inappropriate "chemical restraint" of residents with dementia. The measure was incorporated into the Five-Star Quality Rating System, creating financial and reputational incentives for nursing homes to reduce antipsychotic prescribing

The Data Accuracy Problem

The measure was reportedly informed by commercial claims data analysis that suggested widespread inappropriate use. However, the data analysis that suggested "fraud" or "abuse" in LTPAC settings did not adequately account for:

- Appropriate clinical indications for antipsychotic use beyond the narrow list of diagnoses included in the measure
- The difference between inappropriate use as chemical restraint versus evidence-based treatment of neuropsychiatric symptoms (NPS) of dementia
- The complexity of behavioral health needs in the aging population, particularly residents with Lewy body dementia, Parkinson's disease dementia, or other neuropsychiatric conditions requiring antipsychotic treatment
- The lack of alternative FDA-approved treatments for many neuropsychiatric symptoms of dementia

A particularly instructive data integrity problem: Collaborative members have noted that the underlying data analysis included psychotropic prescribing at assisted living facilities and other non-regulated care sites alongside SNF data, treating all as equivalent, when in fact only SNFs are subject to the federal regulatory framework requiring documentation of clinical justification for antipsychotic use. This conflation of different care settings, each with different regulatory requirements and patient populations, is precisely the type of data quality failure that CRUSH must avoid.

Unintended Consequences: Restricting Appropriate Care

Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness), an ad hoc coalition of national patient and professional organizations, has documented multiple serious unintended consequences of the antipsychotic quality measure:

1. **Restricted access to appropriate treatment**:The measure penalizes nursing homes for prescribing antipsychotics unless residents have one of a narrow set of approved diagnoses. This has resulted in facilities pressuring physicians to avoid prescribing antipsychotics even for residents with severe neuropsychiatric symptoms for whom these medications are clinically appropriate and evidence-based.

2. **Failure to distinguish appropriate from inappropriate use:** The measure does not assess whether antipsychotic use is clinically justified or whether appropriate protocols for monitoring and dose reduction are followed. It simply counts the number of residents receiving antipsychotics, treating all use as problematic.

3. **Diagnostic coding manipulation**: The Manatt Health white paper (November 2025) and recent HHS Office of Inspector General investigations (March 2026) found evidence that some nursing homes inappropriately diagnosed residents with schizophrenia to "mask" antipsychotic use and avoid quality measure penalties, rather than accurately documenting neuropsychiatric symptoms of dementia.

4. **Interference with medical practice:** Project PAUSE maintains that the quality measure interferes in the practice of medicine and prevents patients from receiving treatment their physicians deem clinically necessary and appropriate, directly conflicting with patient-centered care principles.

5. **Outdated clinical approach:** The measure, now nearly 15 years old, does not reflect current clinical practice guidelines for managing neuropsychiatric symptoms in dementia or recent evidence on appropriate antipsychotic use in older adults.

Key Recommendations from Project PAUSE

Project PAUSE has repeatedly urged CMS to:

- Revise the quality measure to distinguish between appropriate and inappropriate antipsychotic use, rather than treating all use as problematic
- Expand exclusion criteria to account for residents with neuropsychiatric symptoms of dementia and other conditions for which antipsychotics represent evidence-based treatment
- Remove the measure from the Five-Star Quality Rating System or retire it entirely until it can be respecified to avoid penalizing appropriate care

- Develop supplemental quality measures that assess the appropriateness of prescribing practices, monitoring protocols, and dose reduction attempts

CMS has made only limited revisions to the measure over the past 13 years, and as of early 2026, stakeholders continue to report that the measure restricts access to appropriate treatment for nursing home residents with behavioral health needs.

Lessons for CRUSH Implementation

The antipsychotic measure experience offers critical lessons for CRUSH:

1. **Data accuracy matters**: Policy decisions based on inaccurate or incomplete data can misidentify appropriate care as abuse. Before implementing CRUSH regulations based on utilization data analysis, CMS must rigorously validate data quality, ensure that analytic methods account for clinical complexity, and engage clinicians in interpreting patterns.

2. **One size does not fit all**: The assumption that LTPAC utilization patterns should mirror acute or ambulatory care patterns is fundamentally flawed. LTPAC patients are older, sicker, and require more intensive services. Fraud detection must account for these differences.

3. **Clinical context is essential:** Utilization that appears "high" or "unusual" in aggregate data may be entirely appropriate when clinical context is understood. CRUSH regulations must enable providers to present clinical justification for utilization patterns before imposing penalties.

4. **Unintended consequences are real and harmful:** Well-intentioned fraud prevention measures can inadvertently restrict access to medically necessary care, particularly for vulnerable populations. CRUSH regulations must include monitoring mechanisms to detect and respond to unintended consequences.

5. **Engage clinical experts in policy design:** The antipsychotic measure was developed with insufficient input from geriatric medicine specialists, long-term care physicians, consultant pharmacists, and other LTPAC clinical experts. CRUSH regulations must be designed in partnership with these clinical voices.

6. **Measure what matters:** Simply counting the frequency of a service or medication tells you nothing about appropriateness. CRUSH regulations should evaluate whether care aligns with evidence-based guidelines, patient goals, and quality outcomes, not just whether utilization exceeds arbitrary thresholds.

The Need for Nuanced Fraud Prevention

The Project PAUSE experience illustrates a critical distinction: the "abuse" in question is not providers over-treating patients to generate revenue (the traditional fraud framework), but rather the risk that patients are not receiving the right medications for their clinical needs due to policy-driven prescribing restrictions.

This inversion of the fraud prevention paradigm — where well-intentioned measures inadvertently create barriers to appropriate care — must inform CRUSH implementation. Fraud prevention should target actors who knowingly bill for unnecessary services or engage in financial schemes, not clinicians making good-faith treatment decisions for complex patients based on current evidence and professional judgment.

Conclusion

The LTPAC Health IT Collaborative strongly supports CMS's commitment to combating fraud, waste, and abuse through the CRUSH initiative. Protecting taxpayer dollars and safeguarding vulnerable beneficiaries from fraudulent schemes are critical priorities that align with our mission to improve care quality and health outcomes for the populations we serve.

However, the success of CRUSH depends on designing regulations that effectively target intentional bad actors while protecting legitimate providers and preserving beneficiary access to appropriate care. The cautionary lessons from the antipsychotic quality measure, Project PAUSE's ongoing advocacy, and the broader experience of LTPAC providers with fraud prevention initiatives demonstrate the serious risks when national policies are implemented without adequate consideration of:

- Data accuracy and validation
- Clinical context and appropriateness
- Site-of-care differences in patient populations and care models
- Unintended consequences for vulnerable beneficiaries
- Operational feasibility for small, rural, and under-resourced providers
- The fundamental role of eligibility complexity and technology gaps in creating the appearance of fraud where none exists

Our recommendations across the CRUSH RFI topics share common themes:

- **Better data, not just stricter rules:** Invest in interoperability, longitudinal analytics, and integration of clinical context, including investment in LTPAC-specific technology infrastructure, rather than relying solely on utilization thresholds and payment restrictions.
- **Site-of-care awareness:** Develop LTPAC-specific fraud detection models trained and validated on LTPAC populations that account for the legitimate differences between post-acute care populations and acute or ambulatory care.
- **Eligibility as a root cause, not fraud:** Recognize that many billing anomalies in LTPAC settings are attributable to systemic eligibility lag and real-time verification gaps, not provider intent. Address root causes before imposing enforcement actions.

- **Graduated enforcement:** Employ education, prepayment review, and targeted audits before imposing payment suspensions or program exclusions that can harm innocent beneficiaries.
- **Rapid appeals and due process:** Establish clear, expedited mechanisms for providers to present clinical evidence when fraud allegations are based on utilization patterns that reflect appropriate care for complex patients.
- **Monitoring for unintended consequences:** Track the impact of CRUSH regulations on beneficiary access to care, quality outcomes, and provider participation, with mechanisms to modify regulations that create unintended harm.

The LTPAC sector stands ready to partner with CMS in designing and implementing CRUSH regulations that achieve program integrity goals while preserving the care delivery infrastructure that serves our nation's most vulnerable populations. We appreciate the opportunity to provide input and welcome ongoing dialogue to ensure that fraud prevention efforts protect both taxpayer dollars and patient care.

For further information or dialogue, please contact Michelle Dougherty, LTPAC Health IT Collaborative Convener, at leaders@ltpachit.org.

Sincerely,

The LTPAC Health IT Collaborative

For a list of LTPAC Health IT Collaborative members, please visit www.LTPACHIT.org