The Colorado Health Foundation™

March 27, 2026

Honorable Dr. Mehmet Oz
Administrator of the Centers for Medicare and Medicaid Services
Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically via Regulations.gov

RE: Comments on Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) [RIN: 0938-AV97; CMS-6098-NC]

Dear Administrator Dr. Oz,

Thank you for the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) request for information related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH). The Colorado Health Foundation (CHF or the Foundation) is writing to express our strong support for the critical role that Medicaid, the Children's Health Insurance Program (CHIP), Marketplaces, and Medicare play in creating affordable access to healthcare for millions of people across the country. We oppose additional burdensome and costly regulations focused on fraud, waste, and abuse and instead urge CMS to invest in and strengthen these programs which are crucial to health nationwide, including in Colorado.

The Colorado Health Foundation is a statewide, nonprofit and nonpartisan philanthropic organization with a mission to improve the health and wellbeing of Coloradans. Through community engagement, research, grantmaking, and private sector investments, the Foundation aims to ensure that everyone in Colorado has what they need to be healthy. We strongly support Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus (Colorado's CHIP program), Connect for Health Colorado (Colorado's ACA marketplace), and Medicare. Cumulatively, more than 2.6 million Coloradans receive their health coverage through these programs, as noted in the table below. They are essential to people's health and well-being as well as the strength of Colorado's economy.

Program	Number of Coloradans Insured (% of population)
Medicaid (Health First Colorado)	> 1,236,302 (> 20%)
Children's Health Insurance Program (Children's Health Plan Plus (CHP))	75,103 (1.2%)
ACA Marketplace (Connect for Health Colorado)	277,228 (4.6%)

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Medicare	1,033,082 (17%)
Total	2,621,715 (> 43%)

Program integrity is central to each of these programs, and responsible stewardship of public funds is a joint federal-state obligation. An existing suite of program integrity tools—when fully and properly utilized—already provides robust safeguards against fraud, waste, and abuse. At a time of significant systemwide change resulting from the One Big Beautiful Bill Act and other recent policy shifts, it is imperative that CMS focus on strengthening these programs, not on imposing burdensome new administrative requirements for consumers, providers, or states to navigate.

As you consider recommendations in response to this RFI, we urge you to:

- Support existing program integrity processes and refrain from creating burdensome new regulations for states, providers, and consumers; and
- Focus federal policy on strengthening these programs by streamlining enrollment processes to minimize coverage losses and strengthen access to care.

Medicaid (Health First Colorado) and Children's Health Plan Plus (CHP+)

Medicaid plays a vital role in the health system in Colorado and across the nation, making health coverage available to 96 million people nationwide. It ensures finances the delivery of primary and acute medical services ranging from preventive care and behavioral health services to emergency care and obstetrics. It is also the largest payer of long-term services and supports (LTSS) including delivery of essential home and community-based services (HCBS). Medicaid is jointly funded by a partnership between the federal and state governments and is designed and administered by each state within federal parameters. The Children's Health Insurance Program (CHIP) is a similarly vital program for the provision of comprehensive medical services for low-income children and pregnant women. Medicaid, known as Health First Colorado in our state, insures more than 1.2 million individuals while CHIP, known as Children's Health Plan Plus (CHP+) in Colorado, insures more than 75,000 additional Coloradans. This includes children, pregnant individuals, people with disabilities, low-income adults, older adults, many people in rural communities, and many individuals from historically marginalized communities. Medicaid and CHP+ insure more than one in four Coloradans (21% of our population), and half of Colorado's children.

We believe that responsible stewardship of public dollars is important, especially in our Medicaid and CHIP programs. Because of this ongoing commitment between states and the federal government, numerous safeguards against waste, fraud, and abuse are currently in place including Corrective Action Plans. These processes are working well to prevent, detect, and address waste, fraud, and abuse. In 2024, $579.73 billion, or 94.9 percent of all Medicaid dollars, were categorized as proper federal payments. The payments that were outliers, known as improper Medicaid payments, include

overpayments, underpayments, and payments lacking sufficient documentation to verify accuracy—such as missing paperwork, coding errors, or incomplete eligibility information. The vast majority of these are ultimately deemed to be correct once all documentation is submitted and verified through existing program integrity processes.

Each year, CMS conducts Payment Error Rate Measurement (PERM) audits in approximately one-third of the states so that each state is reviewed on a three-year cycle. A state's improper payment rate is calculated by dividing the total value of identified overpayments and underpayments within a representative sample—including Medicaid eligibility determinations, fee-for-service claims, and managed care payments—by the state's total Medicaid expenditures. CMS also reports a national improper payment rate, which was 6.12 percent in the most recent data. As reinforced by CMS, this rate is not a measure of fraud, but rather an indicator of payments that do not fully comply with program requirements; over 75 percent (77.12 percent in 2025) are attributable to insufficient documentation and may be resolved with complete and accurate records.

In conjunction with federal efforts to track Medicaid program outlays, states utilize a variety of their own customized tools and initiate a wide variety of program integrity efforts to protect federal dollars. As described by the National Association of Medicaid Directors, states already employ audit strategies, data analytics, and reporting to detect fraud and abuse. States routinely conduct formal investigations into potential fraud and abuse through their Medicaid Fraud Control Unit (MFCU) together with CMS's Medicaid Integrity Program. States also have existing processes to take corrective action either to recoup funds, exclude providers with a history of committing fraud, and/or enforce civil and criminal penalties for violations. In FY2024, the HHS Office of the Inspector General reported that MFCUs achieved 1,151 convictions and recovered $1.4 billion.

Colorado's Department of Health Care Policy & Financing (HCPF) is at the forefront of these efforts, leveraging several resources and tools to ensure good stewardship of taxpayer dollars. From July 2023 to February 2025, HCPF utilized both retrospective recoveries and prospective cost avoidance to reduce inappropriate Medicaid spending by $300 million. The table below features additional information from HCPF detailing efforts to protect against waste, fraud, and abuse in Colorado.

Ensuring proper payments are made to qualified providers	• *Preventing overpayment by conducting pre-payment reviews of high cost and high risk claims* • *Using technology to identify improper provider billings while rejecting or correcting overbilling before payment is made* • *Updating provider eligibility daily to ensure only valid providers are paid* • *Reviewing provider claims through a contracted vendor, as required by federal law, to reduce improper payments and recoup overpayments* • *Conducting post-payment reviews for Long Term Services and Supports to ensure proper billing. HCPF reviews a minimum of 5,000 claims each year to meet CMS requirements;* ***in state fiscal year (FY) 2023 - 24, HCPF recovered $1.36 million through these post payment reviews.***

Ensuring only those who are eligible are enrolled	• *Checking member eligibility annually and proactively disenrolling people who move out of state.* ***Last quarter, (HCPF) outreached 23,138 members who may have moved and enrolled in another Medicaid program to terminate cases and prevent overpayments from duplicate coverage.*** • *Removing deceased members and recouping capitation payments:* ***HCPF processes have recovered $7.64 million in capitations from 2017 through February 2025***
Recovering improper payments and payments from third parties where appropriate	• *Ensuring Medicaid is the payer of last resort:* ***HCPF achieves approximately $20 million quarterly in cost savings*** *from the denial of claims for proper coordination with a commercial carrier and* ***approximately $250 million quarterly in cost savings*** *from the denial of claims for proper coordination with Medicare* • ***HCPF FY 2024 - 25 Fraud Waste and Abuse and Third-Party Liability (TPL) recoveries and cost avoidance efforts currently average about $20 million per month.***

Table text from "Colorado Medicaid Fact Sheet: Protecting Against Fraud, Waste and Abuse" April 2025, HCPF

In addition to state-led efforts like these ones in Colorado, other federal entities like the Government Accountability Office (GAO) and the Medicaid and CHIP Payment and Access Commission (MACPAC) regularly produce recommendations to inform CMS and Congress in improving approaches to reduce waste, fraud, and abuse. The National Association of Medicaid Directors (NAMD) has also produced guidance[1] informed by states' successful innovations that include approaches to:

- **Avoid abuse** by creating national toolkits around assessment, utilization management and quality standards for Medicaid-covered services. These resources have arisen from engagement with families and provider organizations, CMS guidance, and coverage mandates enacted by state legislatures, all focused on addressing the needs of historically underserved people. Two leading examples of this explore services for people with autism spectrum disorder and people with mental health conditions or substance use disorder.

- ***Reduce waste*** *by:*
  - Avoiding the historical phenomenon of "first dollar" spending on eligibility and payment processing systems in each individual Medicaid program, as CMS' recent announcement around partnerships with tech vendors has helpfully begun to address, with an immediate focus on equipping states to implement systems-related aspects of OBBBA as cost-effectively as possible while avoiding expensive future re-work;
  - Continuing to bring the influence and purchasing power of the federal government to bear on controlling the cost and rate of growth of Medicaid covered prescription drugs, as the administration and the Centers for Medicare and Medicaid Innovation (CMMI) have proposed to do with several new demonstrations (Cell and Gene Therapy Access Model, GENEROUS and BALANCE)

[1] https://medicaiddirectors.org/resource/state-and-territory-medicaid-programs-share-the-federal-governments-interest-and-urgency-around-medicaid-program-integrity/

- Supporting state Medicaid programs in "rebalancing" long-term services and supports (LTSS) for older adults and people with disabilities from more costly institutional settings to home and community-based settings.

We urge CMS to carefully weigh any policy changes that the agency considers to target waste, fraud and abuse and ensure that these efforts do not negatively impact access to care or further marginalize vulnerable communities, especially given that the evidence shows that fraud-related convictions and monetary recoveries are much more common among Medicaid providers than Medicaid beneficiaries.

Health Insurance Marketplace

The state's health insurance marketplace, Connect for Health Colorado, is an important source of comprehensive coverage for people who do not qualify for Medicaid or Medicare or lack affordable employer-sponsored insurance. This includes people who work for a small business, are self-employed, or are between jobs. Despite a rise in insurance premiums following the expiration of federal enhanced premium tax credits, 277,228 Coloradans enrolled in marketplace insurance. The marketplace has also contributed to substantial coverage gains for people of color who are less likely to be enrolled in employer-sponsored insurance and more likely to be uninsured.

While we support efforts to eliminate fraud and abuse, we are deeply concerned that increasing paperwork requirements will impose an undue burden on consumers. Administrative barriers disproportionately harm low-income families and other marginalized groups. This concern is particularly pronounced for families with lower incomes who are more likely to experience volatile income that makes it more difficult to predict and report their annual income. As noted by Connect for Health Colorado, there have been no reports of unauthorized or fraudulent enrollments, due in large part to multiple strategies deployed to create a secure enrollment environment – including, a comprehensive certification process for brokers and agents, Multi-Factor Authentication (MFA) for account access, and customer-led authorization of brokers.

Given the recent wave of recent regulatory changes to the Marketplace – as well as pending proposals, including those implementing provisions of H.R. 1 – we strongly urge CMS to refrain from pursuing actions that would further increase consumer burden during a period of pronounced change. Consumers are navigating new eligibility restrictions and onerous enrollment requirements. Though Colorado has been able to provide limited financial relief through a new state-funded program, Colorado Premium Assistance, Coloradans are also grappling with significant premium increases without enhanced federal enhanced premium tax credits. We encourage CMS to allow for flexibility in how state-based marketplaces promote program integrity, empowering them to deploy innovative initiatives tailored to needs of their consumers.

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Medicare

The Medicare program is the primary source of health coverage for individuals age 65 and older, individuals with certain long-term disabilities, and individuals with end-stage renal disease (ESRD). There are four main components of the program: Part A hospital insurance, Part B medical insurance, Part C also known as Medicare Advantage (MA), and Part D prescription drug benefit. Traditional Medicare can have high deductibles and cost-sharing requirements with no limit on out-of-pocket expenses, leading many individuals to purchase private Part D and Medigap plans or enroll in MA. As of November 2025, there are 69.7 million Medicare enrollees, 51.1 percent of whom were enrolled in MA. About 90 percent of all enrollees are eligible based on their age. In 2024, Colorado had 1.03 million Medicare enrollees, accounting for about 17 percent of the state population. The age and health status of the Medicare population mean that many beneficiaries live with chronic conditions or other health problems, so any actions that limit access to services or supplies for Medicare beneficiaries are especially impactful given the amount of medical care required by its enrollees.

Medicare's eligibility and enrollment parameters make enrollment fraud rare. Instead, most concerns regarding fraud in Medicare are related to improper payments and fraudulent providers, especially medical supply companies. Existing program integrity efforts focus on these areas and are working well. The vast majority of payments are made properly, including 92.3 percent of Traditional Medicare payments, 94.4 percent of MA payments, and 96.3 percent of Part D payments. The nonpartisan Government Accountability Office (GAO) estimates that improper payments, which include underpayments and overpayments due to errors in addition to fraud, totaled $87.1 billion in 2024. Notably, about 70 percent of improper payments are due to insufficient documentation or miscoding and are often considered appropriate when those mistakes are corrected.

HHS and CMS are already engaged in robust and successful Medicare program integrity processes. Additionally, ongoing program integrity efforts caused the rate of improper payments to decline from 12.7 percent in FY 2014 to 7.6 percent in FY 2024. CMS's Center for Program Integrity (CPI) leads much of the work to promote program integrity in Medicare through its Medicare Integrity Program, alongside the Office of the Inspector General (OIG). The agency utilizes extensive audits, evaluations, and investigations that can lead to enforcement actions, including civil or criminal penalties. The Medicare Integrity Program is a highly efficient oversight program with $14.9 billion in savings for Medicare in FY 2023, amounting to $8.30 for every dollar spent on the program. The HHS OIG also conducts and supervises audits, investigations, and evaluations to identify systemic weaknesses that allow opportunities for fraud and abuse. When needed, OIG collaborates with the Department of Justice (DOJ) to carry out enforcement against those suspected of engaging in Medicare fraud, including a variety of criminal and civil investigations within Medicare. DOJ also leads large-scale operations like Operation Gold Rush to prevent and recover payments from fraudulent Medicare billing schemes. In February, CMS also announced a six-month moratorium on new Medicare enrollment for seven categories of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) companies, citing $1.5 billion in suspected fraudulent

billing last year. CMS says it plans to explore additional safeguards and will publish information on providers/suppliers whose Medicare participation is revoked. However, there is some concern that this action will create delays in access to medical supplies if existing suppliers cannot meet demand, although CMS stated its belief that the current supplier network is adequate to maintain beneficiary access.

While this system already functions well to identify potential sources of Medicare fraud and abuse, the size and complexity of the program leave several areas for potential improvement. The nonpartisan Government Accountability Office (GAO) regularly makes recommendations to CMS to improve its programs, and maintains several open recommendations related to fraud and improper payments, including conducting provider enrollment revalidations prioritizing moderate and high-risk provider types, and enhancing the timeliness of audits to improve the efficiency of reducing and recovering improper payments. The recent examples of catheter and durable medical equipment fraud and improper skin substitute spending demonstrate the importance of early identification of suspicious billing patterns to proactively prevent fraud and waste. As explored during the Crushing Fraud Chilli Cookoff competition, CMS could use technology to identify suspicious billing patterns and investigate potential violations of Medicare requirements. However, access to Medicare services and DMEPOS is critical to the health of beneficiaries, so all actions to promote program integrity must prioritize patient access to necessary items and services. For example, CMS should halt the Innovation Center's WISeR prior authorization model and avoid any future efforts that similarly have the potential to create barriers and delays to medically necessary care. Targeted actions enable CMS to continue its efforts to improve program integrity by focusing on known sources of concern without directly impacting beneficiary coverage or care.

Closing

Over the course of the last year, with the passage of the One Big Beautiful Bill (H.R. 1) and a series of new regulations, federal policy has put Medicaid and Marketplace coverage in a precarious position. H.R. 1 included more than $900 billion in cuts, the largest funding reductions in Medicaid's 60-year history. The Congressional Budget Office estimates that 10 million individuals nationwide, and more than 100,000 Coloradans, will lose their health insurance coverage as a result. Congress' decision not to renew enhanced Premium Tax Credits at the end of 2025 further jeopardized access to health coverage by putting affordable marketplace coverage out of reach for millions of additional individuals. These cuts severely impact states' budgets, including causing a $1 billion shortfall in Colorado's budget this year and multi-billion dollar losses over the next decade. The changes also put our health care system at risk, jeopardize the health of individuals across our state and nation, and harm our economy. Our state Medicaid agency and Governor have both detailed these impacts in Colorado. We urge CMS to reverse course, support these crucial programs, and avoid weakening them further with the imposition of burdensome regulations and new administrative requirements for consumer, providers, and states. We welcome the opportunity to work with you toward these goals.

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Thank you for the opportunity to provide input through this request for information. We appreciate your consideration of our comments. If you have any questions, please contact Kyle Rojas Legleiter, The Colorado Health Foundation Senior Director of Policy Advocacy, at klegleiter@coloradohealth.org or (303) 953-3618.

Sincerely,

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