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March 27, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Oz:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to provide comments in response to the CMS-6098-NC request for information. The Medicare and Medicaid programs are essential insurers in New York, serving as the largest payers for healthcare and long-term care services and supports in the state. As such, HANYS members are deeply invested in the integrity of the Medicare and Medicaid programs.

New York's hospitals and health systems have long championed and promoted responsible stewardship of and compliance with federal and state regulations. Our members conduct regular audits and ongoing monitoring, often engaging with outside experts to ensure full compliance with state and federal laws. Additionally, the New York State Office of Medicaid Inspector General reviews all Medicaid providers on a rolling five-year basis.

Against this backdrop of long-standing and layered oversight, HANYS is well-positioned to offer feedback on areas where CMS may consider action to better serve patients and taxpayers, while highlighting where existing controls are already effective in ensuring program integrity.

A. Modifications to Program Integrity Requirements – Medicare Advantage

Enrollment in Medicare Advantage continues to grow, with more than 2.1 million New Yorkers now enrolled in an MA plan. This growth trend shows no signs of slowing down; the Congressional Budget Office projects total MA enrollment will reach 64% of all Medicare beneficiaries by 2033.

Despite the growth of the program, CMS oversight and enforcement of MA plans has historically been limited. This has allowed MA plans to engage in continued, systemic policy violations with minimal consequence, and has left providers and patients with limited recourse.

Due to this lack of accountability, MA plans continue to use more restrictive clinical criteria than fee-for-service (or traditional) Medicare when reviewing prior authorization requests, leading to unnecessary and costly payment denials. A recent Joint Economic Committee report found that MA plan behavior led to over \$13.5 billion¹ in overpayments in Part B premiums annually. The same report found that since 2016, MA overpayments have added an estimated \$82 billion to Part B premiums, affecting not just MA enrollees, but traditional Medicare enrollees, state and federal government, and taxpayers nationwide.

Recognizing the extent to which MA plans have failed to meet the expectations of their members and have contributed to unnecessary care delays and wasteful administrative costs, HANYS recommends CMS take actions in the areas below:

Clarify and enhance CMS oversight MA plans are required to adhere to Medicare fee-for-service coverage policies and cannot impose more restrictive medical necessity criteria. Nevertheless, MA plans continue to deviate substantially from Medicare FFS coverage, utilization management and reimbursement policies. This impacts patient access and care, which results in MA enrollees experiencing vastly different healthcare encounters from those of their peers in Medicare FFS.

CMS oversight is extremely important not only to understand the challenges providers face when interacting with MA plans, but also to ensure that MA plans change their behavior and comply with CMS requirements. Providers have struggled to understand when CMS has the authority to conduct oversight versus when it does not and have found it difficult to engage CMS on these issues. Moreover, many of these disputes do not involve contractual terms, but instead involve evidence related to abusive plan practices that delay access to care and add unnecessary cost to the system. In those instances, there is no reason for CMS not to intervene.

The RFI also explores establishing regulatory requirements to allow MA plans to suspend payments to providers and suppliers in an effort to address fraud. However, given the persistent challenges that CMS already faces in ensuring MA plans comply with its regulations, extending payment suspension authority to MA plans, particularly by mirroring the processes set forth in [42 CFR 405.371](#), would be extremely problematic and likely lead to greater confusion.

Unlike Medicare FFS, MA plans already exercise broad discretion through utilization management, prior authorization and post-payment review processes, often with limited transparency and inconsistent adherence to CMS coverage and payment rules. **Granting MA plans additional authority to unilaterally suspend payments would materially increase the risk of inappropriate payment interruptions**, particularly absent robust safeguards, timely notice requirements and meaningful appeal rights for providers.

Recommendation: HANYS recommends that CMS explicitly clarify its oversight abilities related to mitigating poor behaviors from MA plans. HANYS strongly urges CMS to establish stiffer enforcement mechanisms and meaningful penalties for MA plan non-compliance with existing regulations, rather than establish a new regulatory framework for these plans.

Upcoding: Unsupported risk-adjusted payments have been a major cause of improper reimbursement within the MA program. CMS risk-adjusts payments to MA plans by using beneficiaries' diagnoses to pay higher capitated payments for sicker patients. Some MA plans exploit this upcoding policy to make beneficiaries appear sicker to receive higher payments from Medicare.

¹ U.S. Congress Joint Economic Committee. (March 10, 2026) JEC Brief Finds Medicare Advantage Overpayments Causing Increased Premiums for All Seniors. <https://www.jec.senate.gov/public/index.cfm/republicans/2026/3/jec-brief-finds-medicare-advantage-overpayments-causing-increased-premiums-for-all-seniors>

An October 2024 OIG report² raised significant concerns about the extent to which MA plans maximized their risk-adjusted payments by inappropriately leveraging chart reviews and health risk assessments to receive higher payments. Unfortunately, this behavior continues today, as was seen by a Department of Justice settlement earlier this month with Aetna over violating the *False Claims Act* for continued upcoding.³

With a chart review, the MA plan retrospectively reviews beneficiary medical records to identify diagnoses not originally submitted to the MA companies, thereby increasing reported risk scores and payments. In addition, the Medicare Payment Advisory Commission has long recommended requiring MA plans to use two years of diagnosis data. MedPAC has noted that it would improve the accuracy of diagnostic information, reduce year-to-year variation in documentation and result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment.

Recommendation: CMS should end the use of subjective chart reviews and health risk assessments by MA plans for assigning diagnoses. CMS must validate diagnoses reported only on in-home HRAs and HRA-linked chart reviews to ensure that MA plans are not wrongfully “upcoding.”

Post-acute care: Institutional PAC providers, including inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals and home health agencies, play a vital role for recovering Medicare beneficiaries — whether in FFS or MA. However, inadequate MA plan networks of PAC providers create significant barriers for patients who require this specialized level of care.

Beyond network adequacy challenges for PAC providers, MA plans’ prior authorization processes frequently delay or prevent timely transitions to post-acute settings. As a result, hospitals are increasingly forced to retain patients whose acute care needs have been met but who would be more appropriately treated in a non-hospital setting. In effect, hospitals are serving as long-term destinations rather than transitional points of care.

Although CMS implemented welcome PAC-related changes in the CY 2024 final rule, inappropriate prior authorization denials for PAC continue unabated, perpetuating delays in care and contributing to inefficiencies across the healthcare system.

Recommendation: CMS should conduct more frequent and targeted audits of MA delays and denials for PAC services, including the criteria being applied to evaluate admissions for facility-based PAC services and the rationale for denials. CMS must also ensure that inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals and home health aides are explicitly added to MA network adequacy requirements, and that standards are adopted to ensure there is a sufficient number and type of each PAC facility in MA networks.

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

CMS proposed shortening the Medicare Part A and B claims filing window for certain high-risk items and services from one year to 90 to 180 calendar days. HANYS strongly opposes this change as it would pose significant challenges for New York hospitals and providers nationwide by increasing claim denials, heightening administrative burden, creating obstacles for complex cases, complicating retroactive eligibility processes and limiting the time available to correct errors.

² HHS Office of Inspector General. (Oct. 21, 2024) Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions
<https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions>

³ U.S. Department of Justice. (March 11, 2026) Aetna Agrees to Pay \$117.7 Million to Resolve False Claims Act Allegations
<https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations>

Higher denials and revenue loss: A reduced filing window increases the likelihood of automatic denials and limits opportunities to correct claims. Many hospitals, particularly those treating complex, high-acuity patients, require the full one-year window to complete documentation, coding and interdisciplinary reviews. A compressed window leaves insufficient time to resolve clinical questions, obtain external records or address payer coordination issues.

Furthermore, once a claim is denied for timely filing, hospitals have no pathway to appeal, resulting in permanent revenue loss for services that were medically necessary and appropriately delivered. As those denials increase, hospitals are forced to devote substantial resources to internal auditing and claim reprocessing, driving up costs while diverting staff time from direct patient care.

Greater administrative burden: A shortened deadline will cause hospitals to face intense pressure to accelerate coding and billing cycles, causing staff burnout and increased administrative costs. Compressing these tasks into a 90- to 180-day window increases the risk of errors, staff burnout and turnover among administrative and clinical staff.

Hospitals would likely need to hire additional billing and coding personnel or invest in costly process automation tools to meet shortened timeframes — expenses that are especially challenging due to rising costs for drugs, labor and supplies. These increased costs would reduce resources available for patient care, quality improvement and strategic investments.

Shorter deadlines reduce the time available to identify and correct technical claim errors including minor coding adjustments, missing documentation, enrollment mismatches and coordination-of-benefits updates. These issues are often not discovered until later in internal audit cycles or after receiving updated information from clinicians or other payers.

Barriers for complex cases: Many complex, long-stay and high-severity patients routinely require documentation that extends beyond 180 days, especially when external providers, long-term care facilities or family representatives must supply records or clarifications. For cases involving complications, transfers or prolonged hospitalizations, the clinical course may not even be fully resolved within 90 to 180 days. Therefore, shorter deadlines would penalize hospitals that treat the sickest patients. Facilities specializing in trauma, oncology, transplant, behavioral health and multi-morbidity elderly patients would be disproportionately affected, as these cases inherently require more time to complete accurate and compliant billing.

Retroactive eligibility complications: Shorter filing deadlines would significantly limit the hospital's ability to bill patients whose eligibility is determined retroactively, particularly those transitioning from commercial coverage or Medicaid. Under the current one-year filing window, hospitals can update and resubmit claims once Medicare coverage is established. However, a 90- to 180-day deadline would undermine this process, leaving hospitals unable to bill Medicare for services provided months earlier when coverage was not yet confirmed. This would shift costs to hospitals or patients and increase uncompensated care in a manner inconsistent with Medicare's intent.

Without adequate time to make corrections, hospitals are more likely to lose payment for otherwise valid claims. This change would penalize providers for technical, non-substantive errors rather than advancing CMS' goal of curbing true fraud and abuse. Maintaining the one-year window ensures that Medicare receives accurate claims and supports proper program integrity.

Recommendation: For these reasons, HANYS strongly urges CMS to maintain the current one-year Medicare claims filing deadline.

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

HANYS and our member hospitals and health systems appreciate the potential of artificial intelligence in addressing ongoing concerns with coding oversight and hospital billing. However, the use of AI in health insurance utilization review is largely unregulated at the national level, effectively creating a “wild west” in how AI is used to approve, deny or delay care.

A 2024 survey of physicians by the American Medical Association found that more than 60% of healthcare providers believe that the growing reliance on AI algorithms is increasing prior authorization denials. These increased denials negatively impact patient care, place undue burden on providers and add unnecessary costs to the healthcare system.

Recommendation: Any data sources used by AI models should be transparent and subject to strict regulations and any final adverse determinations must be made only by a clinical peer reviewer.

K. Medicaid and CHIP

Medicaid is the largest single source of healthcare coverage in the United States.⁴ Over 76 million people are enrolled in Medicaid and the Children’s Health Insurance Program nationwide, covering nearly one in five Americans.⁵ Given the scope of the program nationwide, Medicaid provides critical resources to hospitals and health systems.

Yet Medicaid rates have long been substantially lower than the true cost of delivering care. This makes it difficult for many providers to cover their costs. Hospitals are the nation’s 24/7 healthcare safety net, obligated by law to treat all patients regardless of ability to pay. Challenges with financial solvency continue to plague hospitals in areas with high Medicaid coverage, both urban and rural. Since 2005, nearly 200 rural hospitals nationwide have completely or partially closed, and more than 400 are at risk of closure.⁶ For those facilities that have not yet closed, many have shuttered chemotherapy services, obstetrics or psychiatric care. These closures force patients to travel longer distances to receive care and ultimately drive up the cost of care for patients.

Recognizing this shortfall in payment and the need to maintain services in communities, states have long employed different financing mechanisms to better support providers who treat Medicaid patients. Supportive funding mechanisms like State Directed Payments, which require managed care plans to pay healthcare providers specific rates or use a specific methodology, have played an important role in helping rural and urban safety net hospitals stay solvent, ensuring underserved communities can continue to access care nearby.

SDP models already include multiple safeguards to maintain program integrity. For example, SDPs are built into managed care capitation rates and as such, CMS requires that states ensure these payments are actuarially sound and produce reasonable, appropriate and attainable provider rates. In addition, states must submit an annual evaluation plan for each SDP to demonstrate adequacy in meeting program quality goals as a condition of CMS renewal.

Congress has also recognized hospital challenges due to uncompensated care and Medicaid payment shortfalls with the introduction of Disproportionate Share Hospital payments, which assist

⁴ American Hospital Association. (March 2026) Medicaid Hospital Payment Basics. <https://www.aha.org/fact-sheets/2026-03-02-fact-sheet-medicaid-hospital-payment-basics>

⁵ HHS. (November 2025) November 2025 Medicaid & CHIP Enrollment Data Highlights <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/november-2025-medicaid-chip-enrollment-data-highlights>

⁶ The Commonwealth Fund (Feb. 9, 2026) Why Rural Hospitals Are Facing a Funding Crisis – and How It Could Get Worse. <https://www.commonwealthfund.org/publications/explainer/2026/feb/why-rural-hospitals-face-funding-crisis-how-it-could-get-worse>

hospitals nationwide in defraying ever-growing costs and losses. As the cost to deliver care keeps rising, this supportive funding mechanism is more critical now than ever.

Like SDPs, the Medicaid DSH program includes robust federal and state safeguards. States must adhere to federal rules governing hospital qualification criteria, annual state DSH allotments, hospital-specific payment limits, mandatory annual state reports and independently certified audits. Additionally, the New York State Office of the Medicaid Inspector General monitors hospital-specific DSH caps.

Beyond the supportive funding mechanisms, Medicaid-related intergovernmental transfers are a critical tool many states use to finance their Medicaid programs. IGTs are already strongly regulated by federal law and CMS guidance and must be approved by CMS through a state plan amendment, with quarterly and annual expenditure reports submitted to CMS and ongoing monitoring by the Office of the Inspector General.

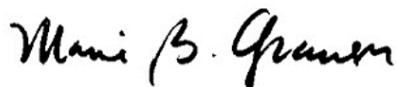
In addition to federal regulatory requirements, New York state's OMIG conducts its own auditing of Medicaid-related IGTs. Oversight also includes protections for proper accounting and receipts for IGT transfers and accurate reporting in county financial statements, as required by the Office of the New York State Comptroller, to ensure transparency and compliance with federal reporting requirements.

Taken together, these existing safeguards demonstrate that comprehensive oversight is already embedded across these mechanisms, ensuring transparency and accountability while supporting CMS' broader goals of improving access and quality of care.

Recommendation: HANYS appreciates CMS' recognition of the critical importance of Medicaid supportive funding and financing mechanisms to ensure adequate access to hospital service for all – regardless of ability to pay. HANYS urges CMS to consider the robust federal and state oversight already in place for these mechanisms and cautions against imposing additional administrative requirements, which would offer limited incremental value and risk diverting resources from care.

HANYS appreciates the opportunity to comment on this Request for Information and urges CMS to incorporate these suggestions into any forthcoming final rule. If you have questions, please contact Cristina Batt, senior vice president, federal relations, at 202.488.1272 or cbatt@hanys.org.

Sincerely,



Marie B. Grause, RN, JD
President