



March 30, 2026

Dr. Mehmet Oz
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20001

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

Dear Administrator Oz:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH). ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP believes that reducing and preventing fraudulent activities in public health care programs is essential to protecting the integrity of these programs and their beneficiaries. However, it is important to emphasize that measures to prevent and address fraud should not interfere with physicians' ability to provide proper medical care. Often, physicians who comply with the rules and follow proper procedures report that enforcement activities create an onerous burden for their practices and that these activities create an atmosphere where physicians believe that all their behavior is suspect. This undermines efficient medical care and places patients at risk from interference with the medical decision-making process.

Another important point worth emphasizing is that fraud enforcement efforts should attempt to avoid wide-ranging corrective policies. For example, in early 2026, the Administration announced that Medicaid funds would be withheld from Minnesota's Medicaid program over concerns of fraud and noncompliance with federal statutes. However, the measure was not directed at specific instances of fraud but rather at a broad category of health care services determined to be "high-risk." While certain services paid for by the Medicaid program do carry a higher risk for fraud relative to others, withholding payment for an entire group of services unfairly punishes physicians who comply with the rules and risks harming patients by diminishing access to care. This policy to implement a wide-ranging corrective strategy should be reexamined to determine how affected patients may continue to receive necessary care.

With reference to Medicaid, it is important to understand what the true extent of waste, fraud, and abuse actually is across the program. Using data from the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG), the following table provides a general estimate:

Table 1. FY 2024 Medicaid Fraud Control Unit (MFCU) Statistical Chart, Summary

State	Total Investigations ¹	Total Convictions	Total Recoveries ²	Total Medicaid Expenditures ³	Recovery Share of Total Expenditures
Alabama	36	0	\$482,403	\$8,402,246,395	0.01%
Alaska	188	3	\$239,448	\$2,903,998,205	0.01%
Arizona	256	41	\$74,611,716	\$20,388,207,470	0.37%
Arkansas	186	35	\$3,114,223	\$8,313,192,411	0.04%
California	1,089	48	\$583,830,457	\$157,098,115,172	0.37%
Colorado	293	1	\$3,914,483	\$14,674,282,245	0.03%
Connecticut	159	15	\$6,463,994	\$11,295,095,591	0.06%
Delaware	256	14	\$10,781,129	\$3,340,013,477	0.32%
D.C.	68	10	\$18,228,184	\$4,371,805,614	0.42%
Florida	677	58	\$76,220,595	\$35,906,458,788	0.21%
Georgia	428	6	\$86,841,411	\$15,577,343,261	0.56%
Hawaii	481	0	\$10,341	\$3,235,615,999	0.00%
Idaho	188	3	\$1,146,717	\$4,050,629,368	0.03%
Illinois	467	38	\$1,861,478	\$33,747,393,898	0.01%
Indiana	979	54	\$3,292,363	\$20,020,602,077	0.02%
Iowa	279	25	\$2,216,804	\$8,873,891,969	0.02%
Kansas	166	21	\$146,968	\$5,412,711,075	0.00%
Kentucky	242	18	\$30,378,270	\$18,302,226,947	0.17%
Louisiana	529	41	\$63,582,816	\$17,179,873,718	0.37%
Maine	58	7	\$236,304	\$4,731,878,956	0.00%
Maryland	374	13	\$18,897,116	\$18,454,924,113	0.10%
Massachusetts	616	13	\$19,795,696	\$26,192,755,044	0.08%
Michigan	489	13	\$4,767,762	\$25,357,658,261	0.02%
Minnesota	220	36	\$16,672,513	\$19,328,609,948	0.09%
Mississippi	370	33	\$9,254,550	\$7,356,967,378	0.13%
Missouri	392	36	\$5,148,281	\$16,445,334,330	0.03%
Montana	56	7	\$11,539,344	\$2,504,417,999	0.46%
Nebraska	83	4	\$1,340,796	\$3,839,619,333	0.03%
Nevada	325	30	\$7,108,542	\$6,175,562,821	0.12%
New Hampshire	70	7	\$143,542	\$2,621,947,677	0.01%
New Jersey	159	21	\$9,820,192	\$24,217,228,219	0.04%
New Mexico	353	2	\$88,381	\$8,490,310,931	0.00%
New York	510	19	\$59,913,805	\$98,177,794,119	0.06%
North Carolina	369	5	\$21,021,953	\$30,213,413,903	0.07%
North Dakota	71	0	\$160,715	\$1,526,106,243	0.01%
Ohio	1,010	129	\$17,106,841	\$35,202,561,948	0.05%
Oklahoma	442	15	\$711,121	\$9,324,676,370	0.01%
Oregon	92	14	\$5,199,569	\$16,993,042,692	0.03%
Pennsylvania	720	74	\$11,325,616	\$44,432,259,542	0.03%
Puerto Rico	73	7	\$1,446,349	\$4,892,795,357	0.03%
Rhode Island	134	2	\$168,007	\$3,724,826,196	0.00%
South Carolina	181	40	\$11,869,014	\$10,239,545,186	0.12%
South Dakota	145	8	\$1,056,789	\$1,600,448,228	0.07%
Tennessee	209	26	\$26,749,052	\$14,345,332,011	0.19%
Texas	723	78	\$111,800,769	\$49,398,376,058	0.23%
U.S. Virgin Islands	15	1	\$235,085	\$138,552,427	0.17%
Utah	144	17	\$3,995,368	\$5,104,329,509	0.08%
Vermont	95	18	\$583,668	\$2,336,362,561	0.02%
Virginia	299	16	\$4,796,455	\$22,354,412,784	0.02%
Washington	499	19	\$4,244,633	\$21,318,488,278	0.02%
West Virginia	214	5	\$12,505,242	\$5,110,871,376	0.24%
Wisconsin	154	5	\$236,162	\$12,770,801,034	0.00%
Wyoming	57	0	\$767,644	\$830,736,672	0.09%
Total	16,688	1,151	\$1,368,070,676	\$948,846,651,184	0.14%

Source: OIG. Medicaid Fraud Control Units. Accessed at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on 5 March 2026.

¹ Investigations are defined as the total number of open investigations at the end of the fiscal year.

² Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

³ MFCU and Medicaid Expenditures include both State and Federal expenditures.

The extent of waste, fraud, and abuse in the Medicaid program is less than 1.0% for all states and territories using data from MFCU enforcement. This simple analysis suggests that this is not a systematic issue and can largely be explained by a relatively few instances of fraudulent and unscrupulous behavior. If this is the case, directing resources to the enforcement of waste, fraud, and abuse may not be an efficient endeavor and would impose an opportunity cost for improving public health programs elsewhere. Further, current enforcement efforts may be lacking useful investigative tools to protect program integrity. One of these tools includes All-Payer Claims Databases (APCDs) which are centralized repositories for claims information from public and private payers across a state. This may enhance the effectiveness of current enforcement efforts and would provide regulators with a tool to identify emerging patterns of suspicious behavior and develop targeted interventions to mitigate bad actors and any harm to beneficiaries.¹

Artificial Intelligence in Healthcare

HHS has expressed its intention to address new and emerging technologies, including AI, to improve healthcare efficiency and reduce waste, fraud, and abuse. ACP believes that the development, evaluation, and deployment of AI should align with principles of medical ethics and should enhance the patient-physician relationship, physician decision-making, and benefit underserved communities. To further these goals, CMS should prioritize several key measures of successful AI development:

1. Inform patients, physicians, and other clinicians if AI tools are being used to conduct medical decision-making or treatment decisions, whenever possible;
2. Prioritize the privacy and confidentiality of patient and clinician data in the development, evaluation, and deployment of AI models;
3. Establish a continuous improvement mechanism to systematically improve clinical safety, effectiveness of treatments, and health care equity—particularly for medically-underserved populations; and
4. Be cognizant of existing physician workflows and avoid creating new administrative burdens or exacerbating old ones through the integration of new AI systems.

While AI can be a valuable tool for identifying and addressing under- and over-payments in healthcare, it should not replace experienced physician knowledge on payment. Many private payers and hospital facilities are beginning to leverage AI for billing and utilization management activities. While AI may become an indispensable part of these processes, human physicians bring both the technical and tacit knowledge that enhances health care by merging the quantifiable and not-so-easily quantifiable into operations. AI should be viewed as a tool and not as a replacement for genuine medical understanding and experience.

¹ Han A, Janousek C, Noh S. Unveiling Medicaid Fraud and Abuse: The Influence of Price Transparency and State Political Context. *Health Economics, Policy and Law*. 2025:1-18. <https://doi.org/10.1017/S1744133125100157>.

It is important to enforce laws and regulations against fraudulent and unscrupulous activities in public programs, but this should be balanced with the need for beneficiaries to access services, particularly when it comes to health care. Using AI to identify and discontinue fraudulent behaviors can be an indispensable practice to reduce waste and improve efficiency in public health programs, but it should not impede or be regarded as a substitute for the authentic understanding and experience that physicians bring. Enforcement measures should ease the process of combating fraudulent behaviors and trust physicians to provide efficient, high-quality care to their patients. Implementing informed and well-investigated policies can help make public programs a reliable and efficient resource for all Americans.

Thank you for the opportunity to comment on CMS's CRUSH RFI. We look forward to continuing to collaborate with CMS to support and improve the practice of internal medicine. Please contact Brian Outland, PhD, Director of Regulatory Affairs, at boutland@acponline.org with comments or questions about the content of this letter.

Sincerely,

A handwritten signature in blue ink that reads "Leslie F. Algase MD, FACP". The signature is written in a cursive, professional style.

Leslie F. Algase, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians