Texas Hospital Association

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March 30, 2026

The Honorable Mehmet Oz, M.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6098-NC
P.O. Box 8013
Baltimore, MD 21244-8013

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

Dear Doctor Oz:

On behalf of our more than 460 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association (THA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) Request for Information (RFI).

1. Texas Hospitals are Partners in CRUSH (General Comments)

Fraud, waste and abuse are intolerable. They undermine the objectives of Medicare, Medicaid and the health insurance marketplace, and threaten health care access for patients these programs serve. We share CMS's goal of improving program integrity and eliminating fraud, waste and abuse from government health care payments.

Hospitals take seriously their responsibility to comply with all laws and regulations. Our industry's goal is always to follow the expectations of state and federal partners as they exercise broad authority to safeguard public health care program integrity. Our shared responsibility to steward taxpayer-funded health care resources is best achieved when regulators give clear guidance on the "rules of the road," apply those rules fairly and consistently, and prevent misunderstandings by being accessible to regulated providers. CRUSH is an opportunity for CMS to reinforce and adapt these practices.

CRUSH also provides an opportunity to remedy wasteful or abusive practices that disrupt the Texas hospital payment environment and increase costs. Given significant volatility ahead related to H.R. 1, we will highlight opportunities for CMS to reduce instability in government payments. This will help Texas hospitals better withstand payment contractions in the years ahead.

CMS must exercise tight control over fraud, waste and abuse risks, but at the same time must avoid curtailing permissible practices. Doing so can rapidly destabilize payment and jeopardize patient access. It is important that federal actions arising from CRUSH are not passed along as increased friction for good actors, who comprise the vast majority of providers in Medicare, Medicaid and

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marketplace qualified health plan networks. We urge CMS to refrain from implicitly or explicitly targeting permissible practices as fraud, waste or abuse. CMS should avoid overstepping Congressional directives as it evaluates measures within its authority to curb fraud, waste and abuse.

Finally, Texas's Medicaid program stands out among peers as one of the least hospitable in the nation to fraud, waste and abuse, particularly in supplemental payments. CMS's CRUSH RFI gives an opportunity to highlight replicable features of Texas' program. As CMS weighs Medicaid reforms under CRUSH, it should make use of the example Texas provides.

2. Payer Friction is a Recurrent Source of Abuse and Waste (Responds to Sections A and K)

In Sections A and K, CMS solicits stakeholder feedback on ways to use CMS's existing statutory authorities or provide increased authority to prevent fraud, waste and abuse.

The resources hospitals expend fighting inappropriate denials, resolving disputes and pursuing escalation tactics to secure payment on appropriate care is a source of waste in Medicare and Medicaid. CMS should continue to act assertively to reduce these wasteful and abusive practices by payers. Doing so will reduce the overall cost of care.

Medicare Advantage Organizations Misuse Prior Authorization & Utilization Review. In recent years, THA has consistently informed CMS on the misuse of utilization review, specifically prior authorization, by Medicare Advantage organizations (MAOs).[1] Texas hospitals treat a high number of Medicare Advantage (MA) beneficiaries as compared to other states in the US. In 2024, 54% of Texas' Medicare beneficiaries were enrolled in MA versus 46% in traditional Medicare.[2]

A recent U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) report concluded MAOs consistently interrupted beneficiaries' access before and after care was delivered through (1) inappropriate denial of medically necessary services or (2) retroactive denials of payments to providers for care already delivered and initially paid. The OIG found that 13% of prior authorization denials and 18% of payment denials met Medicare coverage criteria and should have been granted and approved.[3]

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[1] See THA letter dated February 13, 2022 in response to CMS' 2024 Policy and Technical Changes to the Medicare Advantage program, et.al. proposed rulemaking.
[2] KFF. (2024). Health care in Texas. https://www.kff.org/interactive/election-state-fact-sheets/texas (see Figure 4).
[3] U.S. Department of Health and Human Services Office of Inspector General. (2022). Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

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While we applaud CMS' efforts to strengthen oversight and compliance of MAOs in this area through recent rulemaking in 2024 and 2025, it is vital that CMS does not relax this pressure.

Our members advise that MA plans are "slow-walking" or denying prior authorizations under the cover of decision timelines required by CMS-0057-F[4]. Some are issuing denials due to the plan's own inability to meet the decision timeframes; other MAOs are treating the 72-hour maximum as a minimum waiting period and saying they are unable to give authorization for any post-acute care sooner than the 72 hours allowed for urgent requests. When MAOs misuse utilization review methods, they create bottlenecks in patient throughput and pass the denied cost of care onto the provider. Hospitals must offset those stranded costs with other revenue to stay afloat. Cost-shifting to private insurance offered by Texas employers and third-party payors is a direct result.

Last month, HHS OIG issued an Industry Segment-Specific Compliance Guidance (ICPG) for MAO use to ensure compliance with all Part C laws and regulations. Most notably, the OIG identified "access to care" as a risk area for compliance within the MA program. The OIG specifically notes that MAO compliance programs should "evaluate whether utilization management tools, such as prior authorization, could inappropriately limit or impede access to medically necessary covered services and consider drafting policies and procedures to guard against these risks." [5]

CMS should use all program integrity and enforcement tools at its disposal to ensure that MAOs are complying with regulations, such as establishing a utilization management committee and auditing the use of artificial intelligence in making or recommending prior authorization and other coverage decisions.[6] With the issuance of the ICPG, no excuse remains for non-compliance by MAOs in ensuring sufficient beneficiary access to care. CMS should consider a review of current Part C regulations to determine whether any of the HHS OIG recommendations from the ICPG can strengthen existing rules.

Misapplication of Reimbursement Principles and Coverage Requirements: Reduced Payment is Not Coverage. THA also encourages CMS to reconsider its interpretation of its statutory obligations to ensure that MAOs are complying with federal law to provide beneficiaries with basic benefits that are afforded Medicare beneficiaries under Parts A and B. Last year, THA became aware that one MAO changed their reimbursement policy for inpatient hospital admissions that cross two-midnights. CMS informed THA that since the MAO is providing for some nonzero "automatic payment" the existence of that "payment" means the issue is a hospital-MAO contractual dispute. CMS noted that the non-interference clause prevents CMS from policing this type of policy. CMS did promise to monitor implementation and evaluate whether additional action or guidance may be

[4] Centers for Medicare and Medicaid Services. (2024). Fact sheet: CMS interoperability and prior authorization final rule CMS-0057-F. https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-prior-authorization-final-rule-cms-0057-f
[5] U.S. Health and Human Services Office of Inspector General. (February 2026). Medicare Advantage Industry Segment-Specific Compliance Program Guidance. https://oig.hhs.gov/compliance/ma-icpg/ (see page 13).
[6] Ibid. (see page 14); see also 42 C.F.R. §422.137.

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warranted to ensure compliance with inpatient coverage criteria requirements under Part C. We urge CMS to keep its promise. CMS should audit and review all new unilateral coverage policies adopted by MAOs to ensure compliance with federal law.

According to CMS, as long as an MAO pays any amount for a health care service or supply, that payment meets the MAO's coverage obligations to beneficiaries. CMS's interpretation may not be tenable as a matter of access. Hospitals bear all of the financial risk when an MAO automatically reduces initial payment (and thus, coverage) through unilateral policy updates, especially when hospitals are prohibited from billing Medicare beneficiaries any amounts that are more than the MAO's cost-sharing obligation.

The non-interference clause only prohibits CMS from mandating that an MAO adopt "a particular price structure for payment under such a plan."[7] It does not prohibit CMS from prohibiting unilateral policy changes during a contract term that could impact the provision or access to health care services by a Medicare beneficiary. Such a prohibition would not require a particular price structure for payment. It would instead ensure that a beneficiary's access to services is not impeded by unilateral policies. We encourage CMS to explore innovative and flexible interpretations of the non-interference clause, specifically that the non-interference clause only prohibits CMS involvement in very narrow and specific actions with respect to payment.

Strong CMS Oversight of Medicare Advantage is Key Due to Lack of Enforcement by State Governments. Due to federal pre-emption laws and jurisprudence, state oversight of MA plans and MAOs is limited. States agencies and state legislatures are largely unable to pass laws or adopt regulations to monitor compliance by MAOs. As a result, providers are reliant on federal lawmakers and CMS to ensure that MAOs abide by federal law. CMS should consider whether it is feasible or permissible for CMS to authorize state governments to have a hand in regulating MA – for example, sanctioning fraudulent and misleading MAO marketing in local communities.

States Need Tools to Reduce Misuse of Utilization Management in Medicaid Managed Care. Today, 97% of Texas' Medicaid beneficiaries are enrolled in managed care.[8] Ensuring Medicaid managed care enrollees have comparable access to medically necessary care as other insured patients is a key administrative responsibility of state Medicaid agencies. A recent OIG audit found that in some cases, Medicaid beneficiaries are prevented from accessing covered services because of Medicaid managed care organization (MCO) misuse and overuse of utilization management practices, including prior authorization denials.[9]

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[7] Section 1854(a)(6)(B)(iii).
[8] Texas Health & Human Services Commission. (2024). Texas Medicaid and CHIP Reference Guide, 15th ed.
[9] U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicaid-managed-care/

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In the seven Texas Medicaid MCOs sampled, OIG found high variance in prior authorization denial rates, including one plan that denied prior authorization requests at a rate nearly three times the national average (Table 1). OIG also noted Texas does not offer external medical reviews as an option for enrollees when MCOs uphold a prior authorization denial at the first level of appeal.

Table 1: Prior Authorization Request Denial Rates, Select Texas Medicaid MCOs

MCO	Enrollment	Denial Rate
Molina Healthcare of Texas, Inc.	178,509	34.2%
Amerigroup Texas, Inc.	593,798	17.0%
Amerigroup Insurance Co.	150,159	14.6%
Superior Health Plan	838,407	13.0%
NATIONAL AVERAGE		*12.5%*
United Healthcare Community Plan of TX	296,898	10.9%
Aetna Better Health of Texas	75,617	10.0%
Aetna Parkland Community Health Plan, Inc.	154,219	6.4%

Source: U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

We recommend CMS consider ways to support state Medicaid agencies in enhancing managed care accountability including (1) enhancing reviews of prior authorization denial rates; (2) delivering technical assistance, corrective action plans, or monetary penalties when warranted; (3) establishing a requirement for external medical reviews; and (4) further examining how Managed Care Program Annual Reports submitted by states can facilitate these efforts.

CMS should also use its oversight of Medicaid MCOs to improve transparency, speed and clarity of Medicaid prior authorizations to adhere to CMS-0057-F. The rule requires Medicaid managed care plans to publicly report the percentage of standard prior authorization requests approved, denied or approved after appeal. Medicaid MCOs must also adhere to the minimum response times for prior authorization requests and to provide a specific reason for all denied requests.

The Medicaid and CHIP Payment Advisory Commission's (MACPAC) June 2026 report to Congress is expected to contain recommendations on (1) state and federal tools for ensuring MCO accountability and (2) automation in Medicaid prior authorization. We urge CMS to study the recommendations for potential state guidance and new requirements.

3. Texas Medicaid is a Replicable Model for Supplemental Payment Transparency and Lean Program Administration (Responds to Sections K and L)

Texas runs one of the country's most efficient Medicaid programs. In 2022, federal Medicaid funding to Texas equaled 113% of the total cost of mandatory benefits in Texas, the leanest ratio of any state

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and about half the national average of 208%.[10] Texas avoids spending overruns by implementing strict eligibility criteria focused on core Medicaid populations. Texas did not expand Medicaid eligibility under the Affordable Care Act.

Texas operates ten different supplemental and directed Medicaid hospital payments under various federal authorities, funded nearly 100% with intergovernmental transfers (IGTs) and local provider assessments. Texas' philosophy is to ensure comprehensive health care services to Medicaid-eligible Texans regardless of the organizational structure of the hospital that happens to serve a community. For this reason, Texas' public and private hospitals all are financially encouraged to shoulder safety net responsibilities. Broad-based local assessments on private hospitals, meaningful Medicaid fee-for-service and managed care payment enhancements, and an uncompensated charity care pool all backstop comprehensive care to low-income Texans. The ratio of Medicaid charges to total charges differs by just four percentage points between public and private Texas hospitals,[11] evidence that Texas maintains a safety net where every hospital does their part.

Texas provides a replicable framework for state fiscal transparency and oversight. Because Texas has long relied on complex local Medicaid supplemental payment financing mechanisms, the state legislature and Medicaid agency constructed robust lines of sight into those mechanisms as well as the payments they support. Thanks to these efforts, Texas' payments are not hospitable to fraud, waste and abuse.

Existing Medicaid Disproportionate Share Hospital (DSH) safeguards are also working as intended. Hospital-specific limits and mandatory DSH audits provide meaningful guardrails that ensure payments cannot exceed a hospital's actual costs. Texas also employs methods to ensure that the uncompensated care pool and DSH payments are not duplicating payment on the same costs. These protections for program integrity function well and there is no obvious need for additional broad restrictions.

Texas Leads on Transparency in Medicaid Nonfederal Share Financing. Texas stands out as a national leader in Medicaid financing transparency. Every dollar that passes through the program is accounted for and publicly reported. In its June 2024 report to Congress, MACPAC recognized Texas' progress on financing transparency, holding up the Texas Medicaid agency's practice to report provider-level financing data "in a standard way that could be a model for other states." [12]

[10] Pope, C. (2024). Slowing optional Medicaid spending growth. Manhattan Institute. https://manhattan.institute/article/slowing-optional-medicaid-spending-growth
[11] American Hospital Survey/Texas Department of State Health Services Annual Survey of Hospitals. (2024).
[12] Medicaid and CHIP Payment Advisory Commission (MACPAC). (June 2024). Report to Congress on Medicaid and CHIP. Chapter 1: Improving the Transparency of Medicaid and CHIP Financing. https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-WEB-508.pdf

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Texas Health and Human Services Commission (HHSC) operates a robust local funding (LF) team[13] that tracks every local nonfederal share dollar generated through a provider assessment, IGT or certified public expenditure. Through regular surveys of local governmental entities, in-depth permissibility reviews, and annual public reports of nonfederal share sources disaggregated to the provider- and program-level, Texas has demonstrated accountability and rigor that should serve as a model for transparency reform. Statutory language authorizing Texas HHSC to operate LF can be found in the General Appropriations Act, Health and Human Services Commission Rider 14.[14] Rules governing the LF review and reporting processes can be found in the Texas Administrative Code.[15]

The MACPAC report considered whether enhanced federal match could be appropriate for state oversight activities. We recommend CMS create a new pathway for Texas and other states to access enhanced federal match (75-90% Federal Medical Assistance Percentage (FMAP)) should they wish to invest in transparency and oversight and allow those dollars to fund staff. Texas did not apply for enhanced FMAP for Medicaid enterprise systems (MES) because the MES match is not available to fund staff, which was the primary expense.

Texas has operated longstanding, permissible financing mechanisms that have withstood significant scrutiny. The state's local provider assessments have been in place since 2013 and have been reviewed and upheld on two separate occasions in federal district court. Against this backdrop, we caution against CMS targeting permissible financing structures under the guise of fraud, waste or abuse. Reframing lawful arrangements as problematic undermines states that have invested in compliance and transparency.

In the recent Working Families Tax Cut Act (WFTCA), Congress directed CMS toward specific, targeted reforms it determined would improve Medicaid program integrity (e.g., tax uniformity waiver requirements, codifying budget neutrality in waiver programs and reductions in duplicate enrollments). The WFTCA does not contemplate or authorize CMS to pursue broader crackdowns on financing structures that have long been permitted. Furthermore, following the Supreme Court's *Loper Bright* decision,[16] CMS no longer has latitude to act on broad interpretations or assumptions about Congressional intent. It must adhere to the statute as written.

Texas' Transparent Public Documentation of Provider-level Supplemental Payments is Ample and Growing. Texas publicly furnishes current and historical payment files, methods and calculations on all ten of its supplemental and directed payments. This includes provider-level payment data.

[13] Texas Health & Human Services Commission. (2026). Local Funding. https://pfd.hhs.texas.gov/local-funding
[14] Eighty-ninth Texas Legislature, Regular Session General Appropriations Act. https://lbb.texas.gov/Documents/GAA/General_Appropriations_Act_2026_2027.pdf
[15] Texas Administrative Code Title 1, Part 15, Chapter 355, Subchapter L.
[16] *Loper Bright Enterprises v. Raimondo*, 603 U. S. 369 (2024), 144 S. Ct. 2244 (2024).

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Coupled with the reporting requirements on provider-level nonfederal share financing, these data permit analysis of both *gross* Medicaid provider payments made to providers and the *net* payments realized after subtracting the provider's cost of contributing to the nonfederal share. This provides a more expansive and granular view of Medicaid financing and facilitates public accountability.

Texas has enhanced transparency further through managed care contracting. As of 2025, Texas adopted uniform contract language[17] requiring managed care organizations to separately identify base payment amounts from directed payment amounts in all paper and electronic remittances to providers, as well as in all managed care encounter data submitted to the state. This ensures that both the state and providers have accurate data on payments received. The hospital industry advocated for this change because we believe the public has an interest in understanding what portion of directed payment funding is reaching providers as payments for care, and what portion is retained by managed care organizations (MCOs).

Unlike many states, Texas does not use separate payment terms. Instead, it incorporates directed payments into risk-based capitation. This practice will soon become required nationwide by the CMS Medicaid and CHIP Managed Care final rule (CMS-2439-F). We think CMS and other states may find this contracting approach valuable. In a utilization-dependent risk-based arrangement the expected dollar value of a directed payment (less taxes and fees MCOs withhold) only reaches the provider if enrollees use care. When states eliminate separate payment terms, they may not be able to make information available on the amount of directed payment funds that MCOs pay providers unless the necessary encounter reporting exists.

Public Hospital IGT is Permissible Financing, and Texas Does Not Use IGT to Drive Differential Public and Private Provider Payment. We take issue with recent assertions — including those in Paragon's "The Local Loop" report[18] — that public hospital IGT represent a form of Medicaid "money laundering." To the extent the CRUSH RFI probes assertions made in this report, we reiterate: public hospital IGT is a permissible and legitimate source of Medicaid financing, *not* a loophole.

Local governments can contribute up to 60% of a state's non-federal share based on Congress's deliberate construction of Section 1902(a)(2) of the Social Security Act. Given the uncontested practice of states funding supplemental Medicaid payments to governmental health care providers with IGTs from those same providers, CMS should not bend to assertions that the states' use of these IGT funding arrangements is unauthorized or improper. CMS has already prevented public hospitals

[17] Texas Health & Human Services Commission. (2026). Uniform Managed Care Contract Section 8.1.4.8.11. https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

[18] Medrano C, Blase B, and Piper K. (December 2025). The Local Loop: How States Turn Medicaid into a Government Provider Payday Scheme. https://paragoninstitute.org/medicaid/the-local-loop-how-states-turn-medicaid-into-a-government-provider-payday-scheme/?nab=0

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from recycling Medicaid payments as IGT by returning them to states.[19] This targeted intervention is meaningfully different from critics' suggestion that providers who receive enhanced Medicaid payments ought to be barred from supplying any IGT that funds those payments. And because Texas' public and private hospitals all shoulder significant safety net responsibilities, Texas does not use public hospital IGT in a manner that could be credibly described as advantaging public providers over private ones.

CMS Can Reduce Waste by Minimizing Medicaid Payment Delays. CMS staff are managing a substantial backlog of pending preprints and amendments. States are not always receiving timely approvals needed to prevent interruption in payment. Untimely CMS approvals are a genuine source of administrative waste: for example, a delayed preprint approval saves no money for the federal government, but it forces MCOs to reprocess claims, requires hospitals to expend resources reconciling payment, and has in some cases resulted in litigation.

A parallel problem has occurred when Congress fails to address Medicaid DSH cuts timely. Texas' early DSH advances were reduced due to CMS not allowing Texas to draw a prorated allotment during partial postponement of cuts. As with state directed payment (SDP) delays, a lapse in DSH saves nothing, but forces hospitals to financially reorganize, take on debt, or pursue other measures to weather interruptions. The burden falls hardest on rural hospitals least equipped to absorb sudden payment uncertainty.

One solution would be for CMS to develop and release subregulatory guidance that expands on regulatory expectations for SDP approval in 42 CFR § 438.6(b). Greater transparency about CMS's review standards would help states submit stronger, more consistent applications, reduce the volume of back-and-forth, and ultimately accelerate the approval process.

Texas Medicaid Verifies the Satisfactory Immigration Status of All Enrollees with the Department of Homeland Security. Texas only permits emergency Medicaid reimbursement for patients with unsatisfactory status in accordance with Section 1903(v) of the Social Security Act. Responsive to CMS's updated interpretation of Section 1903(v) issued in State Medicaid Director Letter SMD #25-003[20], Texas does not enroll aliens ineligible for full Medicaid benefits in Medicaid managed care.

4. State Provider Enrollment Systems Constrain Revalidation Frequency (Responds to Section K)

[19]Centers for Medicare and Medicaid Services. (2007). CMS-2258-FC Cost Limits for Governmentally-Operated Providers. https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/Electronic-Comments-on-CMS-Regulations-Items/CMS1201400

[20] Centers for Medicare and Medicaid Services. (September 2025). State Medicaid Director Letter SMD #25-003. https://www.medicaid.gov/federal-policy-guidance/downloads/smd25003.pdf

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In Section K, CMS contemplates requiring high-risk providers to revalidate their Medicaid and CHIP enrollment more frequently than every five years.

We recommend caution on this proposal. A source of waste in Texas' Medicaid program has been the poor technical performance of the state's provider enrollment and management system (PEMS) platform. PEMS has been unstable and beset with technical performance issues for the past several years. Medicaid provider enrollment and revalidation have been significantly delayed for thousands of providers as a result. As of October 2025, 36,000 Texas Medicaid providers were given extended time to complete revalidations and 7,200 providers given second extensions. Prior to the extensions, providers were facing disenrollments and lengthy payment lapses even as they worked in good faith to revalidate on time. Rural hospitals describe PEMS as "slow walking us to closure." Some large Texas hospital systems employ half a dozen FTEs dedicated to solely to revalidating their Medicaid providers. Undoubtedly, these resources could be redeployed to better purposes if Texas' Medicaid provider enrollment system performed to a high standard.

Texas HHSC and its contractors are working to clear an improvement backlog of 160 areas of technical need in PEMS. To help address the ongoing issues, the Texas legislature appropriated $23 million for the upcoming biennium to support HHSC's improvement efforts.

Given the recent experience of Texas Medicaid providers in PEMS, any effort to compress revalidation timelines without substantial improvement in user experience would be disruptive and likely unworkable across the entire continuum of care. However, if CMS moves forward with this proposal, it should not designate hospitals among the high-risk providers it requires to revalidate more frequently than five years at a time.

Because CMS provides the MES enhanced match for establishment and continuous maintenance of provider enrollment systems, we believe CMS could contribute to reducing waste associated with underperforming enterprise systems by giving states additional tools to streamline their Medicaid provider enrollment systems and promote financial accountability of contractors who build and manage these systems. Put simply: if states implement valuable contracts at enhanced matching rates for provider enrollment but receive a product that falls short of the needs of Medicaid providers, states need to be able to recoup a portion of that investment for the taxpayer.

5. Maintain the 1-year Medicare Parts A&B Claims Filing Deadline (Responds to Section F)

In Section F, CMS contemplates reducing the one-year Medicare claims filing deadline for high-risk items and services to a period of 90-180 days.

We recommend that CMS maintain the existing one-year deadline for claim submission. If CMS elects to pursue the approach, it should be piloted in narrow and well-defined high-risk categories,

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and should include exceptions for disasters/emergencies, payer-induced delays, complex claims, and out-of-network cases.

Our members noted shortening the submission window could generate technical denials that have nothing to do with fraud. Cross-program churn and retroactive eligibility changes between Medicare and MA are common, eligibility is established or modified retroactively, and coordination of benefits issues can surface beyond the 180-day mark. Out-of-network care presents a similar challenge. When MA plan members seek care outside their network, claims often require manual processing, single case agreements, and extended documentation cycles that exceed 90 to 180 days. Finally, high-acuity inpatient care generates complex billing that requires the full current timeline to ensure claims are complete and accurate before submission.

6. Hospitals Are in Early Stages of Unlocking AI Potential in Coding Oversight and Hospital Billing (Responds to Section G)

In Section G, CMS seeks input from stakeholders about AI solutions that address coding issues related to overpayments, underpayments, and oversight. CMS also seeks input on use of AI to improve accuracy of hospital billing.

AI can materially improve coding accuracy, detect over/underpayments, and streamline hospital billing, but must be paired with guardrails and standardization. Hospitals are gradually expanding their awareness and successful application of these tools. Hospitals are also contending with increasing payer use of AI in managed Medicare and Medicaid that lacks standardization or transparency. With the launch of CMMI's Wasteful and Inappropriate Service Reduction (WISeR), even certain services in traditional Medicare are now subject to automated payment review practices in Texas.

We value the human component of decision making to prevent abuse or overuse of AI. Texas recently passed Senate Bill 815, a THA-supported bill that prevents health insurers from using automated decision systems to issue adverse determinations. MACPAC's June 2026 report to Congress is expected to contain similar recommendations on automation in Medicaid prior authorization, denials or partial denials (down coding), reflecting emerging national consensus that requiring a "human in the loop" is a reasonable safeguard. We urge CMS to study the MACPAC recommendations for potential state guidance and new requirements. We also urge CMS to evaluate the results of WISeR with particular attention to effects of the apparent financial incentive for WISeR contractors to issue denials. Finally, we urge CMS to closely monitor the implementation of laws like Texas now has and consider the role of states as laboratories for approaches to innovating with and regulating AI in coding and billing.

Many vendors are building and refining AI solutions to address coding issues, overpayments, and underpayments. Compliance oversight is likely inherent to the same tools. Underpayments and overpayments can now be detected rapidly by reconciling remittances against standardized

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coverage and contract logic. Technology to "fingerprint" fraud process patterns, recognize how the fraud was perpetrated, and then build agentic bots to look for those patterns is readily available. AI can go deeper, with greater speed, to infer characteristics that would identify fraud patterns. AI excels at pattern identification and recognition.

However, our members foresee greater complexity with use of AI to increase the efficiency and accuracy of hospital billing, which relies on more variables including efficient and accurate clinical documentation. Numerous vendors are innovating in how they apply technology to improve clinical documentation, but this is challenging to demonstrate at scale.

We appreciate the opportunity to comment on the CRUSH RFI. Please reach out to me with any questions.

Sincerely,

/s/

John Hawkins
President & CEO
Texas Hospital Association