The Disability and Aging Collaborative &

CCD
CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

March 30, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-6098-NC

Re: Centers for Medicare & Medicaid Services Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098-NC)

The 107 undersigned members of CCD's Long-Term Services and Supports (LTSS), Rights, Health, and Developmental Disabilities, Autism and Family Support Task Forces and the Disability and Aging Collaborative (DAC) and allies appreciate the opportunity to respond to the "Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare."[1]

CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. DAC is a coalition of approximately 60 national and state organizations that work together to advance long-term services and supports policy at the federal level. Formed in 2009, the DAC was one of the first coordinated efforts to bring together disability, aging, and labor organizations.

We have limited our response below to Section K: Medicaid and CHIP.

[1] 91 Fed. Reg. 9803–06 (Feb. 27, 2026).

Section K: Medicaid and CHIP

1. Is there any way that CMS should better leverage or expand its statutory or regulatory programs integrity oversight?

Access to long-term care is becoming more essential than ever as the United States undergoes profound demographic change. More than 10,000 people daily are turning 65 while an estimated one in four adults have a disability.[2] Today, 8.4 million people rely on Medicaid for the home and community-based services (HCBS) that provide these essential supports, enabling older adults to live in the homes they worked their entire lives for, adults with disabilities to be in their communities instead of nursing facilities, and children with disabilities to grow up at home with their parents and loved ones, instead of in pediatric nursing institutions.[3] The vast majority of people – including 94 percent of older adults and 90 percent of people with disabilities – want to live and age in their own homes and communities. Most people with disabilities and older adults who need community-based supports do not have an alternative insurance option to help pay for them. Medicare has a very limited benefit mostly focused on short-term rehabilitation. Private health insurance options rarely cover long-term care and private long-term care insurance is prohibitively expensive with high denial rates. Thus, Medicaid plays an especially critical role in this landscape as the nation's largest, and often sole, payer of long-term services and supports that low-income older adults and people with disabilities rely on.

Medicaid HCBS is a group of services delivered via section 1915(c) or 1115 waiver programs and through various state plan authorities, including the Community First Choice 1915(k) option and section 1915(i) state plan amendments. HCBS programs vary by state and targeted population and may include services such as personal care assistance to help individuals with functional limitations perform daily activities like bathing, dressing, eating, and mobility; transition services to help people leave institutional settings and establish community-based living; employment supports; intensive community-based mental health services; transportation support; and

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[2] Census Bureau, *2020 Census Will Help Policymakers Prepare for the Incoming Wave of Aging Boomers*, https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html (last visited Mar. 30, 2026); Centers for Disease Control and Prevention, *Disability Impacts All of Us Infographic*, https://www.cdc.gov/disability-and-health/articles-documents/disability-impacts-all-of-us-infographic.html (last visited Mar. 24, 2026).

[3] Alexandra Carpenter *et al*., Mathematica, *Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid Long-Term Services and Supports Users and Expenditures*, *2023* (October 17, 2025).

habilitation services. For example, individuals with disabilities and older adults rely on personal care services and other kinds of HCBS to:

- Help an older parent return to living independently after a hospitalization for a stroke or fall;
- Enable a grandparent with dementia to stay at home while getting support for cooking, taking medication, moving around the home, and transportation for medical appointments;
- Provide daytime or nighttime nursing care to a child with complex medical needs that require continuous monitoring and fast intervention, so parents can have relief without worrying about their child's safety;
- Support a working-age adult with intellectual and developmental disabilities to secure and maintain their employment;
- Help an adult with significant mental health needs avoid unnecessary hospitalization and maintain stable housing, employment, and meaningful relationships in the community.

These supports allow millions of people to live independently, avoid unnecessary institutionalization, and remain connected to their families and communities. As the aging population grows and disability needs remain high, strengthening HCBS is one of the most effective ways to promote autonomy and dignity while ensuring that long-term care remains both accessible and sustainable.

The undersigned organizations are deeply concerned about the Centers for Medicare & Medicaid Services' (CMS) recent actions. Individuals with disabilities and older adults rely on many of the Medicaid services that CMS is targeting in its actions in Minnesota, as well as many of the services that CMS has flagged for investigation in New York, Maine, California, and Florida. When funding for such services is wholesale suspended or frozen, as it has been in Minnesota, Medicaid enrollees are ultimately harmed, not protected.[4]

Broad restrictions on funding services risk cutting off access to essential services for populations who already face significant barriers to care. CMS should instead rely on targeted, data-driven oversight strategies that identify misuse without undermining the

[4] *See Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act*, 91 Fed. Reg. 1539 (Jan. 14, 2026); See Letter from Dorothy Ferguson, Dir., Div. of Fin. Operations W., Ctr. for Medicaid & CHIP Servs., to John Connolly, State Medicaid Dir., Minn. Dep't of Hum. Servs., (Feb. 25, 2026), https://www.documentcloud.org/documents/27420090-cms-medicaiddeferral-letter-q4-2025/.

health and stability of those who rely on Medicaid. When oversight efforts focus primarily on beneficiaries rather than on the complex financial practices of large corporate providers, people with disabilities and older adults bear the brunt of the harm. Even when beneficiaries are not the focus, it is CMS's responsibility to act carefully to ensure that beneficiaries are not collaterally harmed by enforcement actions. Effective oversight must therefore prioritize corporate accountability and financial transparency to ensure that public funds are used to support the care and independence of older adults and people with disabilities, and that crucial programs like Medicaid HCBS remain available.

2. **How can CMS better prevent, identify, and address Medicaid and CHIP fraud, waste, and abuse in the context of individuals who do not have satisfactory immigration status for full Medicaid or CHIP benefits who are accessing services inappropriately?**

CMS does not need to take additional steps to prevent, identify, or address fraud regarding individuals' immigration status. Per statute, citizenship and immigration status is already subject to stringent verification requirements, requiring that an individual's status is confirmed by the Department of Homeland Security - either through real-time verification via SAVE or through additional manual verification. There is no evidence to suggest that these existing procedures are inadequate or that systemic fraud regarding immigration status is occurring. In our experience, the more common problem is that individuals who *do* have satisfactory immigration status are incorrectly found ineligible--because of data limitations in SAVE and/or the complexity of programming immigrant eligibility rules into state eligibility systems. CMS should focus its resources on ensuring that eligible individuals have access to the coverage to which they are entitled.

3. **How can CMS help states to better prevent, identify, and address Medicaid and CHIP fraud, waste, and abuse related to service areas that have been identified has high risk for fraud in certain states, such as the following: housing stabilization services; behavioral health services; personal care assistance (PCA) services; nonemergency medical transportation?**

Categorically identifying HCBS services as "high risk" is misleading. Increased enrollment in a particular program, increased spending on HCBS, or an increased number of direct care workers alone or in combination may be reflective of trends that have nothing to do with program integrity. HCBS spending has been increasing across the country as a direct result of decades of work by families, people with disabilities, and older adults who want to live, work, and age with dignity in their own homes and communities, alongside bipartisan federal and state efforts to rebalance funding to

HCBS from institutional care. Simply put, more people are enrolled in Medicaid HCBS and fewer people are relying on more expensive institutional care.

To the extent any service in specific states and localities are identified as “high risk,” the appropriate response is not to preemptively cut off federal funding, but rather to collaborate with community members, protect access to services, and address individual issues precisely rather than take actions that destabilize the program at large.

Conclusion

Thank you for the opportunity to provide a response to this Request for Information. If you have any questions or concerns, please feel free to contact Jennifer Lav at lav@healthlaw.org or Gelia Selassie at gselassie@justiceinaging.org.

Sincerely,

National Organizations

Access Ready Inc.
ADAPT National
American Association for Geriatric Psychiatry
American Association on Heath and Disability
American Music Therapy Association
American Therapeutic Recreation Association
Angelman Syndrome Foundation
Autism Society of America
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Care in Action
Caring Across Generations
Center for Health and Social Care Integration at Rush
Center for Medicare Advocacy
Center for Public Representation
CenterLink
Coalition on Human Needs
Community Catalyst
Congregation of Our Lady of Charity of the Good Shepherd, U.S. Region
Disability Belongs
Disability Rights Education and Defense Fund (DREDF)
Diverse Elders Coalition (DEC)
Doctors for America
Easterseals, Inc.
Epilepsy Foundation of America

Families USA
Family Values @ Work
Family Voices National
Grassroots Project/Get On Board
Justice in Aging
Lakeshore Foundation
Little Lobbyists
Medicare Rights Center
Mental Health Transformation Alliance (MHTA)
Mindfreedom International
MomsRising
Muscular Dystrophy Association
National Advocacy Center of the Sisters of the Good Shepherd
National Association of Councils on Developmental Disabilities
National Association of Social Workers (NASW)
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Disability Rights Network (NDRN)
National Domestic Workers Alliance
National Down Syndrome Congress
National Health Care for the Homeless Council
National Health Law Program
National Respite Coalition
National Women's Law Center
PHI
Public Advocacy for Kids (PAK)
Rogan's List
SAGE
Service Employees International Union
TechTonic Justice
The Arc of the US
The Myalgic Encephalomyelitis Action Network (#MEAction)
United Church of Christ
United Spinal Association
United States International Council on Disabilities
Voices of Health Care Action
Well Spouse Association
Wise

<u>Regional, State, and Local Organizations</u>

ADAPT of Texas
Boston Center for Independent Living
Center for Elder Law & Justice

Coalition of Texans with Disabilities
Colorado Consumer Health Initiative
Colorado Cross-Disability Coalition
Community Employment Alliance
Detroit Disability Power
Direct Advocacy & Resource Center
Disability Law Center
Disability Law Center of Utah
Disability Rights Connecticut
Disability Rights Iowa
Disability Rights Mississippi
Disability Rights New Jersey
Disability Rights New Mexico
Disability Rights North Carolina
Disability Rights Pennsylvania
Disability Rights South Carolina
Disability Rights Washington
Disability Rights Wisconsin
Hawaii Disability Rights Center
Health & Medicine Policy Research Group
Health Law Advocates
LeadingAge California
Massachusetts Law Reform Institute
Maternal and Child Health Access
Max Higbee Center
New Disabled South
Parkview Services
PAVE
Pennsylvania Immigration Coalition
Personal Attendant Coalition of Texas
SACRI (Senior Agenda Coalition of RI)
SCIboston
Serving at-risk families everywhere, Inc.
Southeast KS Independent Living (SKIL) Resource Center
Spokane Disability Collaborative
Supporting Illinois Brothers and Sisters
Tennessee Justice Center
The Arc of King County
The Arc of Whatcom County
UDW/AFSCME Local 3930
Washington Multicultural Services Link
William E. Morris Institute for Justice