COMPREHENSIVE REGULATIONS TO UNCOVER SUSPICIOUS HEALTHCARE (CRUSH) RFI

UNITED COUNCIL ON WELFARE FRAUD

RESPONSE TO CMS-6098-NC

MARCH 30, 2026

The United Council on Welfare Fraud (UCOWF) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information on potential regulatory changes that could make CMS more effective in "crushing fraud" to protect taxpayer dollars and strengthen program integrity.

UCOWF is the only national professional organization solely focused on the prevention, detection, prosecution, and recovery of fraud in government public assistance programs. Our members are the boots on the ground, the first responders to these issues – from the county, state, and federal levels. **For over half a century, UCOWF has been at the forefront of "crushing fraud" in all recipient/beneficiary government assistance programs.** We remain dedicated to our mission of improving professional investigation outcomes and processes through our Certified Welfare Fraud Investigator certification/accreditation. Our annual training conferences brings in investigators from all corners of the United States and Territories. It is because of our unique perspectives and insights that UCOWF has been asked to testify in front of Congress on several occasions, including recent Farm Bill and DOGE hearings.[1] The majority of our members work in county and state agencies administering benefits to individuals, including Medicaid – these firsthand experiences are reflected in this response.

We appreciate the opportunity to provide CMS with feedback from our subject matter experts who strive day in and day out to provide effective and efficient stewardship of taxpayer funded programs and safeguarding safety-net programs from fraudsters seeking to obtain services and benefits for which they are not entitled.

Last week, UCOWF was asked to provide Congress with legislative solutions to address fraud, waste, abuse, and improper payments in all public assistance programs. A copy of this response is available on our website at https://www.ucowf.net/assets/pdf/UCOWF+Response+to+Budget+RFI+on+FWA+Legislation_17March2026.

Drawing from our past publications, testimony, and subject matter expertise, our responses to the CMS "CRUSH" RFI relating to beneficiaries are as follows:

A) MODIFICATIONS TO PROGRAM INTEGRITY REQUIREMENTS

1. *Are there ways in which CMS could better use existing statutory authorities to expeditiously prevent bad actors from engaging in fraud, waste, and abuse?*

UCOWF RESPONSE: Yes. CMS can use existing statutory authorities more assertively and consistently to prevent beneficiary fraud at the front end and during beneficiary redeterminations, such as:

- **Enforce existing verification authorities (42 Part 435)** – Fully utilize §435.948 - §435.956 to require verification through federal and state data sources rather than relying on self-attestation where discrepancies exist. The over-reliance of self-attestation is a significant factor in fraud and overpayments. Narrow the use of "reasonable compatibility" when data conflicts are present, require resolution before approval. Cease the practice and recommendations defaulting to an applicant's "word" when data exists with discrepancies in reported eligibility factors.
- **Strengthen use of Asset Verification Systems (Section 1940, SSA)** – Enforce mandatory AVS/AFI use for all non-MAGI populations and apply required FMAP consequences for noncompliance. Currently, the State of Arizona does not check for a portion of their Medicaid non-MAGI beneficiaries, despite the Medicaid Extenders Act of 2019 required penalty application. Similarly, California was able to cease testing all Aged, Blind, and Disabled Medicaid beneficiaries for two years without CMS enforcing the FMAP penalties. Now the State of Illinois now has a bill to eliminate AVS testing. Requiring State Medicaid Agencies (SMAs) to follow the law and enforcing it will eliminate waste in the program designed for low-

[1] "The War on Waste: Stamping out the Scourge of Improper Payments and Fraud," Feb. 12, 2025 testimony.

income/low-resource lawful residents. CMS should prohibit waivers or State Plan Amendments that bypass asset testing and federal law.

The largest contributor to fraud, waste, and abuse in Medicaid is the reliance on self-attestation.

Self-attestation (also known as self-certification or the "honor system") is the practice of accepting an applicant's statement as true, without the need or attempt to verify the information. The reliance on self-attestation in government programs, where applicants simply declare their eligibility without rigorous verification, has emerged as a profound national security vulnerability, enabling widespread fraud and billions in improper payments that undermine public trust and fiscal integrity. UCOWF acknowledges that there may be situations in which a program must accept a client's statement – but they should only be after independent verifications attempts have not returned information that can confirm or refute program eligibility. Yet regulations about Medicaid beneficiary fraud are nearly non-existent.

CMS regulations implemented the Affordable Care Act went so far as to mandate states must accept self-attestation in beneficiary applications and redeterminations, a significant factor in the explosive growth (and expense) of the program. President Trump's first Fraud Task Force hearing even called out the use of this practice – while White House Deputy Chief of Staff Stephen Miller attributed this problem to "blue states," the practice is actually carried out in all states due to current regulations and CMS guidance:

- 42 CFR 435.603(h)(3) – This provision properly refers to future income or household-size changes being verified, including by self-attestation, but only when reasonably compatible with other electronic data obtained by the agency. That is a narrower and more defensible use of self-attestation than the broader attestation authority found elsewhere in Part 435. This is **good** policy - self-attestation should **only** be used when electronic data checks are unable to provide any information. UCOWF supports limited use of self-attestation only when authoritative electronic data are unavailable or inconclusive, and only with follow-up corroboration where material eligibility factors remain unresolved.
- 42 CFR 435.945(a) – **This is the core problem CMS should address**. It allows states, except where law requires other procedures such as for citizenship and immigration status, to accept attestation of information needed to determine Medicaid eligibility without requiring further information or documentation. CMS codified this approach in its 2012 ACA eligibility rule, relying on broad ACA and Medicaid Act authorities rather than a specific congressional directive to authorize self-attestation in this exact form. The regulation states (emphasis added):

  > "Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual."

  This only served to codify and expand an "honor system" self-attestation friendly framework that created an environment that enabled fraud, waste, and abuse to thrive. CMS should now revise this regulation to restore stronger front-end verification and program integrity safeguards.
- Other references requiring states use self-attestation can be found in 42 CFR Part 435 and Part 457.

3. *Are there existing requirements or policies, including those issued through regulations, memoranda, administrative orders, sub-regulatory guidance documents, or policy statements that could be altered to increase CMS' ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace®?*

UCOWF RESPONSE: Yes. UCOWF has written four letters and spoken directly with CMS leadership regarding the now-rescinded SMD #24-005 memo, "Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions."

CMS's December 5, 2024, memorandum created substantial confusion by signaling to states that beneficiary fraud recoveries and related sanctions were largely impermissible, even in cases involving criminal convictions, intentional misrepresentation, ineligible enrollment, or other eligibility-related fraud identified by state investigators. The rescission of SMD #24-005 was necessary, but it was not sufficient to cure the operational damage. The memo discouraged states from pursuing beneficiary fraud recoveries, disrupted long-standing state and county fraud-investigation practices, and created uncertainty about whether agencies could pursue administrative recoveries, referrals, and other lawful enforcement actions. The memo also threatened states with fiscal penalties for taking such actions.

UCOWF has consistently warned that this confusion has chilled enforcement and weakened Medicaid program integrity. That problem persists, despite the memo's rescission. CMS should now use both regulation and sub-regulatory guidance to make clear that beneficiary fraud investigations, recoveries, and enforcement actions remain lawful and necessary when supported by facts and due process. Regulations are needed to close the underlying policy gaps, and guidance is needed to restore operational clarity so that state and county agencies can act quickly, consistently, and confidently to protect Medicaid integrity.

Absent both clear regulations and formal guidance, states will remain vulnerable to uncertainty, uneven enforcement, and continued erosion of Medicaid program integrity.

B) ENHANCED IDENTITY PROOFING AND OWNERSHIP REQUIREMENTS

The questions from CMS again focus on providers. However, CMS must also address and require stronger beneficiary identity verifications.

Current federal Medicaid regulations expressly require states only verify beneficiary citizenship or immigration status. They also require that an applicant be a state resident, but residency verification is comparatively soft and may rely on self-attestation unless the state chooses to verify or has conflicting information. Part 435 does not contain a clear, general requirement that states perform robust identity proofing of the person applying before enrollment. Strengthening existing rules can address this gap.

This regulatory gap weakens program integrity and creates an environment ripe for fraud, waste, and abuse. Identity verification is distinct from citizenship/immigration status verification (which has stricter rules under the Deficit Reduction Act of 2005, PL 109-171).

CMS can better use existing authority by closing the regulatory gap around beneficiary identity verification. Medicaid regulations do not require a meaningful identity-proofing standard to ensure the applicant is who he or she claims to be. In practice, this leaves states free to approve coverage based on attestation and limited data checks, creating a clear vulnerability for beneficiary fraud. CMS should require states to verify identity using authoritative electronic data sources at enrollment and renewal.

CMS does not mandate a single nationwide list of acceptable identity documents for Medicaid applicants. Instead, states have flexibility, often following standards aligned with federal guidance (e.g., 42 CFR 435.945 - 435.952 for verification generally, and citizenship/identity rules at 42 CFR 435.406, and 435.407). **Many states accept self-attestation for identity** with electronic verification, and paper documents are requested **only if needed for resolution – yet the documents are not authenticated.**

The impact of this gray area in healthcare is what enabled the largest healthcare fraud case in the nation's history – a $14.6 billion dollar scheme by Russian nationals using stolen PII from Americans to falsely enroll beneficiaries and then bill for fraudulent services.

K) MEDICAID AND CHIP

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

UCOWF RESPONSE: Yes. See prior responses regarding the regulatory gap in beneficiary fraud (and the rescinded SMD #24-005), identity verification standards, and regulations on self-attestation.

2. *In order to strengthen program integrity oversight of provider enrollment, should CMS require that states require their high-risk providers to revalidate more frequently than every 5 years, and if so, how frequently?*

UCOWF RESPONSE: Yes. Either require annual revalidations or institute continuous monitoring for new and high-risk providers.

4. *What tools or guidance can CMS give to states to enhance program integrity in the Medicaid and CHIP managed care and fee-for-service programs?*

UCOWF RESPONSE: See prior comments regarding beneficiary fraud and the rescinded SMD #24-005.

8. *What data and information should states report to CMS to ensure that fraud, waste, and abuse is being identified, investigated, and resolved?*

UCOWF RESPONSE: Under 42 CFR 455.17, SMA's must report provider fraud investigative information. There is no parallel mandatory case-level reporting requirement in beneficiary fraud in current rules. To strengthen identification, investigation, and resolution of fraud/waste/abuse, additional mandatory elements that could be added to the required quarterly report could include:

- Beneficiary fraud investigations and outcomes, like USDA's FNS-366B report. Include the number, whether pre-issuance or post-issuance, referral rates to MFCU/law enforcement, number of open investigations, and dollars identified. As many states maintain Integrated Eligibility Systems, the State agency responsible for beneficiary investigations and the number of investigators should be noted.
- Beneficiary and Provider overpayment claims established and collected, like USDA's FNS-209 report. Include the number of claims and dollar values, the amount retained by the State, and what is to be paid back to the federal government.

L) STATE SPECIFIC MEDICAID AND CHIP QUESTIONS

1. *What statutory or regulatory changes are needed to strengthen states' ability to effectively reduce fraud, waste, and abuse in Medicaid and CHIP?*

UCOWF RESPONSE: See prior comments regarding SMD #24-005 and regulatory gaps on beneficiaries. While federal overpayments are considered federal debt and require collection, the Treasury Offset Program does not include Medicaid. Sanctions and disqualifications (lockouts) for those committing beneficiary fraud provide penalties (with due process) would strengthen program integrity. CMS could operate a system similar to USDA's Electronic Disqualified Recipient System (eDRS) where states upload individuals who have been proven to have committed SNAP fraud. States are required to check eDRS prior to enrolling SNAP applicants, reducing fraud, waste, and abuse in food assistance.

Under Section 1634 of the Social Security Act, states can opt to allow and accept Social Security Administration's SSI determinations to confer eligibility in Medicaid non-MAGI (Aged, Blind, and Disabled). Intending to streamline application processes for eligible households, this state option has resulted in massive fraud and waste being extended to Medicaid.

The core problem is that SSA's SSI resource review is not as complete as the downstream Medicaid consequence assumes. SSA OIG found in September 2024 that SSA does not verify liquid resources when applicants or recipients allege (self-attest) they have less than $400 in financial accounts and estimated that this practice led to about 198,960 recipients receiving $718 million in SSI payments for which they were ineligible. Yet the audit did not factor in Medicaid payments, pushing the fraud/waste into tens of billions yearly. The same audit estimated about 800,140 applicants/recipients under-reported financial accounts by $100 or more, with 219,640 failing to report all their financial accounts.

That is not a small technical defect. SSA's own oversight materials show that financial accounts are a major driver of SSI improper payments: SSA OIG reported that overpayments related to financial accounts averaged about $1.5 billion annually from FY 2018 through FY 2022. Separately, SSA OIG reported that SSI overpayments in FY 2022 exceeded $4.6 billion, or about 8 percent of SSI payments that year.

Since 1634 States automatically piggyback Medicaid on SSI, those improper payments automatically flow into Medicaid eligibility. This is why the loophole matters – a federal SSI determination based on the "honor system" and an incomplete/ un-checked asset verification can become a state Medicaid determination and overpayment without the State even performing its own check. **In fact, when States were required to conduct the post-COVID-19 PHE Medicaid "unwinding," the 35 State Medicaid Agencies did not conduct redeterminations on any of the estimated 7.5 million 1634 Medicaid enrollees**. The lack of regular Medicaid renewal decisions must be addressed more frequently than once every 6 years (SSI timeframes).

Section 1634 should not allow a state to outsource the eligibility determination that triggers Medicaid when the federal feeder program did not fully verify eligibility and countable assets. In addition, when SSA accepts SSI applicant self-certification/ attestation and do not verify assets, allowing States to use the 1634 means they are in violation of the law and Congressional mandate that all States verify assets in non-MAGI Medicaid. This also confers federal matching withholding penalties to the States – which they avoid through 1634.

Without such a fix, improper SSI awards can automatically become improper Medicaid enrollments, and because the initial eligibility call was made upstream by SSA, states are left with weaker tools to prevent, prove,

and remedy the problem. CMS can address this in clarifying rule promulgation or request Congress to statutorily fix the 1634 Loophole.

2. *What regulatory or administrative changes could CMS make to empower states to-- (a) pursue bad actors; and (b) better coordinate program integrity efforts with the federal government, law enforcement, and other states?*
UCOWF RESPONSE: See prior comments regarding beneficiary fraud and the rescinded SMD #24-005.

3. *What data or tools would facilitate state program integrity activities?*
UCOWF RESPONSE: See prior comments regarding a CMS eDRS. In addition, creation of a Medicaid Beneficiary Fraud Framework, similar to the USDA SNAP Fraud Framework, would create a uniform guidance on document on best practices regarding detection, investigation, enforcement, and recovery of overpayments.

4. *Would further use of federal databases, such as Do Not Pay (DNP), or non-federal databases provide states with more complete information to move further away from a pay-and-chase model and towards pre-pay review?*
UCOWF RESPONSE: Yes. Additional databases include access to federal Income Tax Returns to corroborate household income and composition. UCOWF cautions that federal databases come with requirements burdensome to state/county administration – including requirements to independently (manually) verify the information. State and private sector databases may be considered "Verified Upon Receipt" and allow swifter decisions when confirming beneficiary provided eligibility information or properly flag conflicting information that can prevent fraud prior to enrollment.

5. *What successful strategies have certain states implemented that others can replicate as best practices?*
UCOWF RESPONSE: See response to question #M-15.

9. *What incentives could be put in place for states to proactively engage in program integrity efforts, and what new penalties might be necessary to address non-compliance by states?*
UCOWF RESPONSE: UCOWF recommends enhanced FMAP funding for states beneficiary fraud administration and establishment of an annual Medicaid Beneficiary Fraud Framework grant for states. CMS can also enforce FMAP penalties for states failing to institute program requirements (such as required income and asset verifications).

M) STATE SPECIFIC MEDICAID AND CHIP QUESTIONS

15. *How could CMS better detect and mitigate improper dual enrollment in Medicaid/CHIP and subsidized Exchange plans?*
UCOWF RESPONSE: CMS should move dual-enrollment prevention to the front end. The most effective approach is a pre-issuance, interstate and cross-program matching system that checks Medicaid, CHIP, and subsidized Exchange applications against current enrollment data before coverage is approved, not months later after capitation payments or subsidies have already been made. CMS's own analysis found that 2024 enrollment data reflected 2.8 million people potentially enrolled in multiple Medicaid/CHIP programs or simultaneously in Medicaid/CHIP and a subsidized Exchange plan, with an estimated $14 billion in annual waste. The February 2025 PARIS match identified 3,218,150 individuals receiving benefits 6,685,958 times across states.

UCOWF has made the same point in SNAP: Congress and agencies should favor front-end, interstate matching that prevents duplicate participation before payment, rather than relying primarily on post-issuance recovery.

CMS should learn from the limits of older pay-and-chase models. Mississippi's National Accuracy Clearinghouse successfully demonstrated that dual enrollment can be identified and enrolled in real-time prior to benefit issuance, instead of a quarterly SSN-only matching PARIS model.

HHS OIG found capitation payments for 208,254 concurrently enrolled beneficiaries in August 2019 and 327,497 in August 2020, and an October 2024 Oregon audit found the state paid about $445 million for individuals enrolled in Oregon and one or more other states at the same time from 2019 to 2022. Congress has already recognized the need for modernization. The One Big Beautiful Bill Act requires a new monthly multi-state system for Medicaid, and CMS should build that system to detect duplicate enrollment across Medicaid, CHIP, and subsidized Exchange coverage before benefits are issued, using strong identity resolution, residency validation, and timely state reporting.

IN CLOSING

Medicaid is one of the largest federal programs, with annual expenditures exceeding $800 billion, yet a glaring program-integrity gap: the deficiencies in federal regulations and guidance in addressing Medicaid beneficiary fraud or establishing clear enforcement and recovery authorities for improper payments caused by beneficiaries. While federal law establishes extensive oversight for providers - through Medicaid Fraud Control Units, provider exclusions, and civil penalties - there is no comparable regulatory framework governing beneficiary fraud, sanctions, or overpayment recovery.

This glaring legislative gap was brought into sharp focus by the Centers for Medicare & Medicaid Services (CMS) issuance of SMD 24-005. UCOWF believes that CMS can remedy these issues in regulations and guidance.

The impact and need to address these issues are not theoretical – CMS estimates that Medicaid improper payments totaled approximately $37.39 billion in FY 2025, with eligibility documentation failures accounting for the majority of the errors.

SNAP, TANF, Social Security, and even Unemployment Insurance all contain statutory frameworks allowing fraud sanctions and overpayment recoveries – Medicaid should be brought into alignment with those programs.

It is our hope that UCOWF's response provide actionable solutions for CMS to improve Medicaid program integrity, restore public trust, provide effective oversight and stewardship of taxpayer funds, and help "crush fraud." We cannot win the war on fraud without the implementation of these recommendations.