

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted at <http://www.regulations.gov>

Re: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), [91 Fed. Reg. 9803 \(Feb. 27, 2026\)](#)
CMS-6098-NC

March 30, 2026

Dear CMS Colleagues:

The Center for Medicare Advocacy and the National Committee to Preserve Social Security and Medicare submit the following comments on CMS-6098-NC. We are limiting our comments to the first issue, Modifications to Program Integrity Requirements, and nursing homes.

The Center for Medicare Advocacy (Center) is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on our experiences talking with and representing Medicare beneficiaries and their families and advocates.

The National Committee to Preserve Social Security and Medicare (NCPSSM) is a membership-based, nonpartisan, Washington-based advocacy group founded in 1982 to protect and strengthen federal retirement benefits. It lobbies Congress, educates the public, and advocates against cuts to Medicare and Social Security for current and future generations.

Comments

The Center and NCPSSM make the following comments in response to A. Modification to Program Integrity Requirements, with respect to nursing homes.

Question 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?

Question 4: What changes could CMS or its contractors make to existing processes to promote their ability to effectively deter fraud, waste, and abuse and promote payment accuracy and efficiency, including by more expeditiously gathering actionable information?

CMA and NCPSSM make two recommendations in response to these questions.

1. CMA and NCPSSM recommend that the Centers for Medicare & Medicaid Services (CMS) **enforce longstanding regulations that address related party business dealings by skilled nursing facilities.**

Skilled nursing facilities (SNFs) frequently buy goods and services from businesses. Since [September 30, 1986](#), federal regulations at [42 C.F.R. §§413.17\(c\)\(2\), 413.17\(d\)\(1\)\(iv\)](#) have permitted SNFs to do business with “related parties” (defined at [42 C.F.R. §413.17\(b\)](#) as businesses with common ownership or control). However, if SNFs do business with related parties, the regulations expressly provide that the costs of services or supplies provided by the related parties must not exceed the price of comparable services or supplies purchased elsewhere in the open market. [42 C.F.R. §413.17\(d\)\(1\)\(iv\)](#). The Inspector General found that this requirement is not enforced and has never been enforced.

At present, as the HHS Office of Inspector General reported in *Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs*, [A-07-21-02836](#) (Dec. 2024), nursing homes spend more than 40% of their Medicare payments on related party businesses that they own or control. However, CMS’s Medicare Administrative Contractors do not review costs reports that are annually submitted by SNFs to determine whether they comply with related party requirements. The result is widespread noncompliance and SNFs’ receiving millions of dollars of overpayments from the Medicare program.

The Inspector General selected a non-statistical sample of 14 SNFs representing “a variety of geographic locations, sizes, ownership characteristics (i.e., recent ownership changes, type of ownership, chain organizations, affiliations with private equity companies), and CMS quality ratings” and evaluated one cost report for each one. The Inspector General found that seven of the 14 SNFs “did not properly adjust some of their related-party costs to Medicare-allowable costs as required, which resulted in \$1,703,734 in overstated costs” – an average of \$243,390 for each facility. Specifically, the Inspector General found that the seven SNFs’ overstatements totaling \$1,703,734 consisted of:

- “a total of \$857,169 in overstated costs from undisclosed related parties for which profits were not removed at all,
- “a total of \$763,835 in overstated costs from disclosed related parties for which profits were not removed at all, and
- “a total of \$82,730 in overstated costs for which profits were not correctly adjusted.

The total amount of overpayments to SNFs for paying inflated prices to companies they own is clearly enormous.

Related party transactions matter because SNF owners and operators who make inflated payments to companies they own and control are diverting Medicare reimbursement from resident care to excessive private profit. The results of SNFs diverting millions of dollars of public reimbursement are poor care, suffering, and death of residents, as documented in numerous reports and cases.

CMS must implement the Inspector General’s recommendations to CMS, including its first recommendation, ““require MACs to include, as part of the normal desk review or audit process,

a review of reporting and disclosure of related-party costs.” CMS must enforce the decades-old requirement that SNFs receive market rates for services they purchase from companies they own and control.

2. CMA and NCPSSM recommend that **CMS reinstate the off-cycle Medicare revalidation process for nursing homes.**

In a December 11, 2025 notice in *MLN Connects*, [Skilled Nursing Facilities: January 1 Revalidation Deadline Indefinitely Suspended](#), CMS indefinitely suspended the off-cycle revalidation deadline of January 1, 2025. The requirement was put in place on October 11, 2024, when CMS issued a revised Medicare enrollment application process for institutional providers, including a new attachment that required all skilled nursing facilities (SNFs) to complete an **off-cycle revalidation** process between October and December 2024. The deadline was extended three times before CMS indefinitely suspended it in December 2025.

In final rules published November 17, 2023 implementing §6101 of the Affordable Care Act, [“Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities; Medicare Providers’ and Suppliers’ Disclosure of Private Equity Companies and Real Estate Investment Trusts,”](#) 88 Fed. Reg. 80141, CMS explained the need for more public information about ownership of nursing homes by private equity and similar owners:

Reports have circulated that nursing facility quality has declined under private equity and similar owners. For example, in February 2021 the National Bureau of Economic Research (NBER) published an analysis titled “Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes.” The report stated: “Our estimates show that private equity (PE) ownership increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11% [citing Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, [“Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,”](#) 2021, p. i.]. A November 2021 analysis published in the Journal of the American Medical Association contained similar findings concerning PEC-owned nursing facilities. Titled “Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents,” the report stated that PECs seek annual returns of 20% or more; with this pressure to generate high short-term profits, private-equity-owned nursing homes might reduce staffing, services, supplies, or equipment, which could adversely affect quality of care. [citing Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., *JAMA Health Forum*, November 19, 2021]. The analysis concluded that: (1) private equity acquisition of nursing facilities was associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions; and (2) per the study’s findings, more stringent oversight and reporting on private equity ownership of nursing homes may be warranted. [citing Braun]. The previously mentioned concerns about nursing home ownership are not limited to PECs. Other types of private ownership, such as REITs, have generated similar concerns.

88 Fed. Reg., 80144.

Reinstating the off-cycle revalidation process would enable CMS to gather actionable information expeditiously and “to expeditiously prevent bad actors from engaging in fraud, waste, and abuse.”

Question 2: Are there ways to modify provider enrollment (including revocation), medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility to expeditiously prevent bad actors from engaging in fraud, waste, and abuse?

CMA and NCPSSM have two recommendations in response to this question.

1. CMA and NCPSSM recommend that **CMS (1) develop federal standards for certification of SNFs and nursing facilities and (2) prohibit certification for operators with a history of providing poor care.**

At present, CMS essentially takes the position that state licensure is a sufficient basis for certification and imposes only two minimal conditions for certification (disclosing ownership interests and having a quality assessment and assurance committee).

The Nursing Home Reform Law (42 U.S.C. §§1395i-3(f)(1), 1396r(f)(1), Medicare and Medicaid, respectively) defines as the Secretary’s “duty and responsibility . . . to assure that the requirements governing skilled nursing facilities . . . , and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.” Setting appropriate standards of care, enforcing them, and spending public money appropriately are three distinct, but complementary, responsibilities that give the Secretary broad and comprehensive authority to set federal standards for certification and to prohibit certification of operators with poor records.

Law Professor Nina Kohn demonstrates in [“Using What We Have: How Existing Legal Authorities Can Help Fix American’s Nursing Home Crisis,”](#) 65 *Wm. & Mary L. Rev.* 127 (2023) (full article available through link) that CMS should use the longstanding statutory authority at 42 U.S.C. §§1395i-3(d)(1)(A), 1396r(d)(1)(A), 1395i-3(f)(5), 1396r(f)(5) and the provisions quoted above “to steer public funds away from nursing homes owned or operated by entities with a history of abuse and neglect” and “to deny certification to facilities that are governed or managed by entities that have shown they are unlikely to administer them in a way that will provide residents with the required quality of care.” Article pages 143, 145. She concludes:

Denying certification to facilities owned or operated by entities with a history of endangering residents is therefore consistent with the Secretary’s statutory mandate to refrain from certifying facilities that are not administered in a way that enables them to provide residents with high-quality care.

Id. 146.

CMS should revise current regulations involving enrollment in the Medicare program, 42 C.F.R. §424.510(d); denial of enrollment in the Medicare program, 42 C.F.R. §424.530; revocation of enrollment in the Medicare program, 42 C.F.R. §424.535; and deactivation of Medicare billing privileges, 42 C.F.R. §424.540, to reflect new requirements for SNFs, described above, that prohibit Medicare participation by and reimbursement for operators with facilities that provide poor care.

Sigi Ris, [“CPI Director: Outdated Regs Keep Admin From Blocking Bad Actors From Entering CMS Programs,”](#) *Inside Health Policy* (Mar. 23, 2026).

2. CMA and NCPSSM recommend that **CMS require SNFs to submit audited Medicare cost reports and that CMS conduct audits of a sample of them.**

As noted above, Medicare cost reports receive little if any scrutiny by federal regulators, resulting in the submission of cost reports that are blank, incomplete, or inaccurate. The National Consumer Voice for Quality Long-Term Care, [Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions](#) (2023). Requiring facilities to have (and submit for federal review and audit) cost reports that have been audited by a certified accounting firm would improve the facilities’ accountability for their reports’ accuracy. The government should also audit a sample of cost reports (both a random sample and cost reports that appear most problematic) and enforce existing requirements that identify costs that can be charged to the Medicare program. Charlene Harrington and Toby S. Edelman, “Private Equity and Nursing Home Care: What Policies Can Be Adopted to Address the Growing Problems?” *Public Policy & Aging Report*, 2023, 33, 44-48 (Apr. 2023).

Question 6: A core component of crushing fraud to protect taxpayer dollars is transparency to the Americans we serve about CMS’ program integrity undertakings. How can CMS improve its transparency about its oversight and enforcement activities?

CMA and NCPSSM have one recommendation in response to this question: that **CMS improve transparency in three important nursing home areas: enforcement of care standards, risk-based survey, and antipsychotic drugs.**

First, CMS needs to produce and make public an annual report about **nursing home enforcement** activities, reporting, at the least, how many facilities CMS sanctions by state and nationwide, the types of penalties imposed, information compiled by chain, and information about the Special Focus Facility program, which imposes stepped up oversight and enforcement at 66 facilities nationwide with the poorest records. At present, CMS posts enforcement actions solely on the *Care Compare* website and the information is reported on a facility-by-facility basis. *Care Compare* also provides no way to evaluate how the penalty at a specific facility compares with penalties imposed across a state.

Additional enforcement information needs to disclose on *Care Compare* whether a facility is part of a chain that is subject to a three-year Corporate Integrity Agreement with the HHS Office of Inspector General. Consumers have no information about the Inspector General’s enforcement activities against a particular chain.

Second, CMS has provided no information about the **risk-based survey** process that was cryptically announced in April 2024. In a brief statement, CMS said it was testing a risk-based survey approach that would provide a “more focused” and shorter survey in facilities providing high quality care. No information has ever been provided about the test – how many facilities the risk-based survey process was used in and with what results, how the facilities were selected, how the process worked, and more. As CMS now plans to implement the process in as many as 10% of the nursing homes nationwide, starting possibly as early as this summer, the public needs information about the risk-based survey and how it will operate.

Third, CMS conducted approximately 40 surveys focused on nursing homes’ administration of **antipsychotic drugs** to nursing home residents. CMS has never reported its findings.

The HHS Inspector General recently released an Issue Brief [Nursing Homes Inappropriately Diagnosed Residents with Schizophrenia to Mask the Misuse of Antipsychotic Drugs, OEI-02-23-00201 \(Mar. 2026\)](#) that examined the 40 facilities. The Inspector General’s shocking findings reflected nursing homes admitting that they added schizophrenia diagnoses to resident assessments solely in order to remove those residents from public reporting requirements so that they would have higher star ratings in CMS’s Five-Star Quality Rating System, as publicly reported on *Care Compare*. The Inspector General found that some companies had explicit policies requiring nurses to add schizophrenia diagnoses to residents’ records and that some medical directors made inappropriate and unjustified schizophrenia diagnoses in order to justify prescribing antipsychotic drugs.

The Inspector General recommended that CMS release the findings from its 40 surveys and CMS refused. Transparency is necessary for families of residents to be able to monitor activities in nursing homes and help their friends and relatives receive appropriate care.

Thank you for the opportunity to submit comments.

Sincerely,



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