ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

March 30, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
Attention: CMS-9898-NC
P.O. Box 8016, Baltimore, MD 21244-8016

Re: CMS Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), CMS-6098-NC

Dear Administrator Oz:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

ABHW is the national voice for payers managing behavioral health insurance benefits. ABHW member companies provide coverage to 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, our policy work strives to ensure that physical and behavioral health care is integrated and coordinated. ABHW is focused on guaranteeing better outcomes for whole-person care for all individuals and communities.

I. Applied Behavioral Analysis (ABA)

ABHW members recognize the important role Applied Behavior Analysis (ABA) services play in supporting certain individuals with autism spectrum disorder (ASD) when delivered appropriately by qualified clinicians. However, recent oversight activity highlights program integrity concerns associated with rapid growth in ABA utilization across public programs. Multiple audits by the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) have identified substantial improper Medicaid payments tied to ABA services, including at least $56 million in improper payments in Indiana and $18.5 million in Wisconsin due to insufficient documentation, services not meeting program requirements, and services provided by unqualified staff.[1] This federal audit activity continues to identify widespread improper or potentially improper payments

[1] https://oig.hhs.gov/reports/all/2024/indiana-made-at-least-56-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children-diagnosed-with-autism/

across several states, reflecting systemic vulnerabilities in documentation, supervision, and billing practices for ABA services.[2]

Health plans have similarly observed rapid growth in provider participation and high-intensity service patterns without clear evidence of patient functional improvement. They have witnessed firsthand the recurring fraud, waste, and abuse risks from inadequate clinical documentation, excessive treatment hours, billing practices that limit auditability (such as bulk or lump-sum billing), and services delivered without sufficient clinical supervision. In some markets, a notable share of services reflects limited or no supervision in line with accepted standards of care.

These challenges are compounded by the lack of (1) nationally consistent credentialing requirements, (2) standardized medical necessity criteria, and (3) clearly defined service parameters across states. These gaps hinder effective oversight and result in uneven program integrity protections.

ABHW encourages federal and state policymakers to strengthen program integrity safeguards for ABA services while preserving access to clinically appropriate care. In particular, CMS should establish nationally consistent, evidence-based coverage parameters for ABA services, including clear guardrails for treatment intensity, frequency, duration, and documentation. Diagnostic evaluations should be conducted using a validated evidence-based tool, and treatment plans should include measurable goals, demonstrate functional progress, and be subject to periodic reassessment to confirm ongoing medical necessity. CMS should also reinforce credentialing and supervision standards by requiring appropriate Board-Certified Behavior Analyst (BCBA) oversight, ensuring technician-level transparency through individual National Provider Identifiers (NPIs), and defining minimum supervision expectations.

Taken together, these steps would promote more consistent oversight, improve accountability, and help ensure that ABA services are delivered in a manner that supports patient outcomes while maintaining program integrity and long-term affordability.

II. SUD Residential Treatment Facilities

ABHW members also remain concerned about persistent fraud, waste, and abuse within certain segments of the SUD treatment system, particularly among some residential treatment providers. Federal and state enforcement actions have identified troubling practices, including patient brokering schemes, kickbacks for referrals, and billing for medically unnecessary services or services that were not actually delivered.[3] For example, federal prosecutors have brought numerous cases involving addiction treatment facilities that paid illegal kickbacks to recruiters in exchange

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[2] https://oig.hhs.gov/reports/all/2026/colorado-made-at-least-778-million-in-improper-fee-for-service-medicaid-payments-for-applied-behavior-analysis-provided-to-children; https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-audit-finds-maine-made-at-least-456-million-in-improper-medicaid-payments-for-autism-services

[3] https://www.justice.gov/archives/opa/pr/national-enforcement-action-results-78-individuals-charged-25b-health-care-fraud

for patient referrals or otherwise exploited individuals seeking treatment.[4] Enforcement actions continue to reveal significant fraud schemes involving patient brokering and illegal referral payments in the addiction treatment sector.

ABHW supports targeted program integrity efforts that address fraudulent and abusive actors while preserving access to legitimate, high-quality treatment programs. Policymakers should continue strengthening oversight mechanisms, including licensing and accreditation standards, transparency in referral and ownership relationships, and data-driven monitoring of billing and utilization patterns.

ABHW advocates for the following to address fraud and abuse in SUD Residential Treatment Facilities:

- **Ensure all facilities are licensed and fully accredited to provide SUD services.**
- **Identify, disseminate, and adopt quality standards, best practices, and model policies to ensure the appropriate level of care and treatment for patients.**
- **Examine fraudulent administrative and billing practices of these facilities.**

We encourage CMS to more clearly delineate the range of residential services and levels of care to support consistent oversight and program integrity. In particular, we recommend that CMS formally recognize the American Society of Addiction Medicine (ASAM) Levels of Care (LOC) framework as a standardized reference point and, building on that framework, establish corresponding quality standards and best practices tailored to each level. A more structured approach would help distinguish between clinically intensive services and lower-acuity supportive settings, reducing ambiguity that can contribute to inappropriate billing, fraud, or misaligned expectations.

We also recommend that CMS explicitly acknowledge the distinctions across the spectrum of residential settings, for example, between sub-acute residential detoxification and clinically managed treatment programs, and longer-term recovery residences or "group homes," which typically provide supportive housing rather than clinical treatment. Clarifying these differences is critical to ensure that coverage, reimbursement, and oversight are aligned with the clinical intensity and purpose of the service, while preserving access to the full continuum of care.

Additionally, CMS should work with states to have visibility into ownership structures, affiliated entities, and NPIs, particularly where there is a history of fraudulent or abusive conduct. Federal and state regulators should also coordinate to prevent entities subject to license revocation, criminal investigation, or civil fraud actions from re-entering the system under new corporate structures. Strengthening data sharing among CMS, Exchanges, health plans and issuers, and law enforcement, while maintaining appropriate beneficiary protections, is critical to disrupt these schemes.

At the same time, program integrity efforts should be balanced with policies that support access to evidence-based SUD treatment across the full continuum of care, including outpatient and

[4] https://www.justice.gov/archives/opa/pr/california-addiction-treatment-facility-operator-convicted-paying-nearly-29m-illegal

community-based services that improve long-term recovery outcomes. The vast majority of providers deliver high-quality, good-faith care. Strengthening front-end verification, provider accountability, and transparency can deter bad actors without limiting access to necessary treatment.

Thank you for the opportunity to provide feedback on this RFI. We are committed to engaging with CMS and other partners to find opportunities to improve behavioral health outcomes for all individuals. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO