Submitted Electronically via Regulations.gov

March 30, 2026

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

RE: AOPA comments on potential regulatory changes that might be included in a potential upcoming CRUSH proposed rule, as well as other programmatic changes that could be implemented to make CMS more effective in crushing fraud to protect taxpayer dollars

Dear Administrator Oz:

On behalf of the American Orthotic and Prosthetic Association (AOPA), I respectfully submit the following comments in response to CMS' request for information (RFI) on potential regulatory changes that might be included in a potential upcoming CRUSH proposed rule, as well as other programmatic changes that could be implemented to make CMS more effective in crushing fraud to protect taxpayer dollars.

Since 1917, AOPA has been the largest orthotic and prosthetic trade association, consisting of more than 1,800 patient care facilities and suppliers that together manufacture, distribute, design, fabricate, fit, and provide clinical care for patients using orthoses (orthopedic braces) and prostheses (artificial limbs). Each and every day, AOPA and its members strive for a world where orthotic and prosthetic (O&P) care transforms lives. AOPA members understand the importance of integrity and honesty in the provision of high quality O&P clinical care and have witnessed the unfortunate suspicions and mistrust that have recently befallen all providers of this important clinical care because of a relatively small number of bad actors that have used the Medicare orthotic benefit to facilitate intentional and criminal fraud.

AOPA has long supported all efforts to eliminate this fraudulent activity while reducing undue administrative burden on qualified providers whose sole interest lies in the provision of the highest quality, most clinically appropriate O&P care.

AOPA's comments are in alignment with those of our O&P profession partners that, together, make up the Orthotic and Prosthetic Alliance. While those comments will be submitted separately, AOPA would like to reiterate its support for, and contributions to, them as representative of the greater O&P profession.

330 John Carlyle Street, Suite 200, Alexandria, VA 22314
Phone: (571) 431-0876
Fax: (571) 431-0899
info@aopanet.org

American Orthotic & Prosthetic Association

The RFI asks for suggestions on how existing CMS program integrity activities may be implemented to enhance and improve CMS statutory authority to prevent bad actors from engaging in fraud, waste, and abuse. AOPA is pleased to provide the following comments on existing CMS efforts and recommendations on ways to improve them as part of the CRUSH Initiative.

- **Focused use of Medicare supplier enrollment moratoria**
  AOPA understands CMS' decision in February 2026 to take immediate action to stem the continued fraud and abuse that data has indicated is almost exclusively perpetuated by suppliers enrolled in one of the seven provider categories identified during the February 25, 2026 White House press conference. The limited scope and timeline of the current moratorium is an appropriate short-term solution to address the immediate concern. The ability to extend it by six-month increments supports the use of real-time data to determine its effectiveness and continued need.

- **Exploration of additional opportunities to prevent enrollment of fraudulent providers**
  AOPA recommends that CMS consider additional ways to prevent bad actors from enrolling as Medicare DMEPOS suppliers to solve the problem before it begins. Since 2022, CMS has used two enrollment contactors (Novitas and PGBA) to process and facilitate DMEPOS provider enrollment. AOPA recommends that CMS increase its oversight and training of the enrollment contractors to ensure that they are enforcing all applicable licensure and accreditation requirements for enrollment under specific provider types. Improved enrollment screening during the application process may prevent many of the bad actors from establishing a presence as an enrolled provider that allows them to subsequently launch fraudulent schemes.

- **Increased use of prior authorization in the Medicare Fee for Service program**
  Since its inception in 2020, Medicare fee for service prior authorization has continually proven to be an effective and efficient program. It has significantly reduced fraud, waste, and abuse without delaying the provision of clinically appropriate, medically necessary care. Key to this success has been the fact that affirmative prior authorization decisions are not subject to additional medical necessity review once the care is delivered. While prior authorization affirmation remains subject to technical requirements that may result in claim denial, providers and patients may rest assured that once medical necessity has been affirmed through prior authorization, Medicare will process and pay the resulting claim. As of April 13, 2006, Medicare prior authorization is required for 21 O&P codes. AOPA recommends that CMS consider further expansion of Medicare fee for service prior authorization. Requiring the affirmation of medical necessity prior to provision of a Medicare covered item will eliminate significant fraud, waste, and abuse that is being promulgated by bad actors who rely on vulnerabilities in claim edits to receive inappropriate Medicare reimbursement.

- **Reduced reliance on "pay and chase" payment models**
  Effective fraud, waste, and abuse schemes rely heavily on the current "pay and chase" model that has been used since the creation of the Medicare program. The sheer volume of claims that must be processed daily make universal pre-payment claim review impossible. Instead, contractors must rely on a complex system of claim level system edits and data analysis to

330 John Carlyle Street, Suite 200, Alexandria, VA 22314
Phone: (571) 431-0876
Fax: (571) 431-0899
info@aopanet.org

identify suspect claims that should be denied or subject to further review. Unfortunately, these systems are not failproof and are easily targeted by criminals intent on defrauding the Medicare program. Pay and chase systems result in claim payments that should not have occurred. By

the time vulnerabilities in the edits are identified by data analysis, the damage has often already occurred, and the bad actors have disappeared into obscurity. AOPA recommends that CMS invest resources into additional technology and training on alternate methods of claim processing that may reduce exposure to fraud, waste, and abuse in Medicare claims processing systems. Artificial intelligence (AI) technology may be particularly useful in creating alternate claim payment pathways that reduce fraud, waste, and abuse while not creating undue administrative burden for legitimate providers who are dedicated to the provision of high quality, clinically appropriate care. While AOPA recommends that CMS explore ways to appropriately use advances in AI technology to support program integrity efforts, we also recommend that CMS maintain a cautious approach regarding when and where to rely on AI technology. While AI technology is rapidly advancing and is continually improving, over-reliance in the wrong circumstances may result in unintended harm to Medicare beneficiaries, especially regarding their ability to access appropriate clinical care necessary to treat their individual medical needs.

The RFI requests comments on ways that CMS can reduce fraud, waste, and abuse among Medicare Advantage programs. AOPA offers the following recommendations in response to this request.

- **Increased CMS oversight of Medicare Advantage contractors**
  Bad actors who have continuously defrauded the Medicare program have learned to capitalize on systemic vulnerabilities in the Medicare program. The exponential expansion of the Medicare Advantage program that has naturally occurred as baby-boomers that are comfortable with managed healthcare become eligible for Medicare has provided criminals with new opportunities to identify and take advantage of oversight challenges when a handful of fee-for-service contractors become hundreds of contractors who service Medicare beneficiaries through Medicare Advantage plans. AOPA recommends that CMS work with its Medicare Advantage contractor partners to develop consistent, repeatable processes that will make it more difficult for bad actors to continue to use the sheer size of the program to their advantage.

- **Improved communication and transparency between CMS and Medicare Advantage contractors**
  The RFI specifically asks for feedback regarding ways CMS can prevent suppliers that have been excluded from the Medicare fee-for service program from simply shifting the focus of their fraudulent activity to the Medicare Advantage program. AOPA believes the ability to stop this shift is essential to the effective reduction of fraud, waste, and abuse. Exclusion from Medicare fee for service should be a disqualifying event for the excluded provider, both for continued participation and for new enrollment in the Medicare Advantage program. Many of the criminals that have been perpetuating DMEPOS fraud for years have been reliant on their ability to shift quickly, whether it is from one product category to another or from fee-for-service to managed care. AOPA recommends that CMS explore ways to improve

transparency between its fee-for-service and managed care contractors that will allow them to share information and data transparently and prevent the continued fraud provision by motivated criminals.

The RFI requests feedback regarding how changes to current rules and regulations that govern solicitation of Medicare and Medicaid beneficiaries may reduce fraud, waste, and abuse. AOPA believes that the current lack of restriction on beneficiary contact may be the largest vulnerability that currently exists. Current regulations only restrict telephone solicitation. This restriction is archaic and does not adequately protect Medicare and Medicaid beneficiaries from all the communications channels through which they are being targeted with empty promises of healthcare solutions taking advantage of their healthcare circumstances to place fraudulent orders for unnecessary or inappropriate interventions. AOPA recommends the following:

- **Explore and evaluate ways to prohibit mass-marketing to Medicare and Medicaid beneficiaries**
  Recent fraud schemes have almost always involved late night television advertising where unwitting beneficiaries are offered services "at little or no cost to you". Whether it is catheters, continuous glucose monitors, or as AOPA is keenly aware of, knee and back braces, beneficiaries are encouraged to call a toll-free number where a call center employee will collect their Medicare or Medicaid information and start the fraudulent billing cycle. If it is not an ad on TV, it is a message on social media, or a messaging app. As technology has made it easier to communicate with the general population, bad actors have found ways to take advantage of the outdated and lax restrictions on beneficiary solicitation. Developing new regulations to prevent inappropriate solicitation of Medicare and Medicaid beneficiaries will eliminate the ability of criminal elements to begin the fraud cycle by preventing them from accessing their intended targets.

- **Ensure the provision of appropriate clinical care for DMEPOS that require custom fitting and/or custom fabrication**
  AOPA recommends that CMS take steps to ensure that DMEPOS services that require custom fitting and/or custom fabrication are only provided by suppliers who are appropriately educated and credentialed to provide the clinical care necessary to facilitate the proper fit and function of the item. This is especially relevant for custom fitted and custom fabricated orthoses. As outlined in the separate comments submitted by the Orthotic and Prosthetic Alliance, a current statute exists that restricts the provision of custom fitted and custom fabricated orthoses to only qualified providers as defined in section 427 of the Benefits Improvement and Protection Act (BIPA) of 2000. AOPA recommends that CMS promulgate regulations to implement this already existing law.

In addition to the comments above that address specific sections of the RFI, AOPA would like to offer the following additional recommendations regarding ways that CMS can promulgate meaningful regulations to implement the stated goals of the CRUSH initiative.

330 John Carlyle Street, Suite 200, Alexandria, VA 22314
Phone: (571) 431-0876
Fax: (571) 431-0899
info@aopanet.org

- **Continue to build productive and collaborative relationships with representatives of the DMEPOS provider community**
  AOPA is just one of several trade associations that represent the DMEPOS provider community, but we are extremely proud of the collaborative relationships with CMS and its contractors that have continuously paid dividends in reducing fraud, waste and abuse. AOPA worked directly with CMS program integrity staff to ensure successful implantation of Medicare prior authorization for select orthoses and prostheses. With AOPA's input, CMS created a pathway to allow for provision of medically necessary orthoses without prior authorization when there was an emergent need for immediate provision of the orthosis to avoid irreparable harm to the health or well-being of the patient. This pathway emphasized the provision of appropriate clinical care but also included safeguards that prevented unnecessary exposure to fraud, waste, and abuse. AOPA has also served for more than ten years on each of the four DME MAC Administrative Councils which facilitates crucial dialogue between the DME MAC contractors and DMEPOS industry representatives. The DME MAC Advisory Councils allow for open and honest dialogue and creates opportunity for crucial two-way communication that has often included information regarding new fraud, waste, and abuse schemes that otherwise may have gone unnoticed.

- **Consider the impact of CMS programs that may unintentionally contribute to increased fraud, waste, and abuse**
  AOPA recommends that CMS consider the potential impact of new programs on fraud, waste, and abuse. One example of a recently announced program that may inadvertently contribute to addition fraud, waste, and abuse is the remote item delivery (RID) program that has been discussed as an integral part of the 2028 DMEPOS competitive bidding program. While limiting the number of awarded contracts to a small number of providers who will rely on mail-order delivery of selected product categories may seem to inherently limit fraud, waste, and abuse, it may actually lead to poor clinical outcomes where no clinical care is included in the delivery of selected orthoses. While this is more likely to result in waste rather than fraud and abuse, it still represents an unintended consequence of a well-intended program.

- **Consider utilizing existing pathways to help fight waste, fraud, and abuse**
  AOPA recommends that CMS review and consider supporting passage of H.R. 4475/S. 2393-The Medicare Orthotic and Prosthetic Patient Centered Care Act. Two of the three provisions of the bill would have a direct impact on the reduction of waste, fraud, and abuse in the Medicare program. One provision would prohibit the drop-shipping of Medicare covered custom fitted and custom fabricated orthoses. Ensuring that custom fitted and custom fabricated are delivered with the clinical care necessary for them to function properly would greatly reduce the opportunity for bad actors to simply ship multiple braces to a patient's home with little to no instruction on how to properly use them. Another provision of the legislation would ensure that Medicare beneficiaries could receive off-the-shelf orthoses from the orthotists and prosthetists with whom they are receiving care by extending current competitive bidding exemptions for physicians and therapists to certified orthotists and prosthetists. Expanding these exemptions would allow patients to receive truly holistic care from trusted

330 John Carlyle Street, Suite 200, Alexandria, VA 22314
Phone: (571) 431-0876
Fax: (571) 431-0899
info@aopanet.org

providers without having to rely on unknown and potentially unscrupulous providers for their OTS orthosis. Expanding the existing exemptions would not result in additional cost to the Medicare program as exempted providers are reimbursed at the same rates established through the competitive bid program.

AOPA appreciates the opportunity to submit its comments and recommendations in response to the Request for Information and looks forward to continuing to be a trusted and valued partner to CMS and its contractors.

Sincerely,

Teri Kuffel, JD
Executive Director

330 John Carlyle Street, Suite 200, Alexandria, VA 22314
Phone: (571) 431-0876
Fax: (571) 431-0899
info@aopanet.org