



NATIONAL ASSOCIATION OF STATE OMBUDSMAN PROGRAMS

March 30, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: Response to Request for Information (RFI) – Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) Initiative

Dear Dr. Oz,

As President of the National Association of State Long-Term Care Ombudsman Programs (NASOP) and a State Long-Term Care Ombudsman, I am writing on behalf of our members to comment on the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative announced in early 2026.

NASOP members collectively oversee more than 3 million long-term care licensed resident beds in nursing homes and similar care facilities across every state, the District of Columbia, and U.S. territories. We offer the following comments grounded in direct, frontline experience with the populations this initiative is intended to protect.

Increase Investments in Programs that Identify Fraud, Waste, and Abuse

Long-Term Care Ombudsman Programs (LTCOPs) identify and address problems with fraud, waste, and abuse across the country. We monitor long-term care facilities, develop relationships with residents to hear their concerns, and solve the problem or alert the appropriate regulatory authority.

The Administration can more effectively tackle fraud, waste, and abuse in long-term care spending by strengthening both LTCOPs and Medicaid Fraud Control Units (MFCUs). Increased resources would enhance these programs' oversight capacities. We also urge expanded outreach and education for long term care residents and their family representatives about how to recognize and report fraud, waste, and abuse. These targeted investments would lead to earlier detection, improved accountability, and more effective elimination of improper spending.

Investigate Hidden Profits and Related-Parties Transactions in Private Equity-Owned Nursing Homes

NASOP remains deeply concerned about the lack of transparency regarding profits in private equity owned nursing homes. Although facilities often report narrow operating margins, many shift income, including Medicare and Medicaid funds, to related-party entities through inflated rent, management fees, and payments for services or supplies.

The research evidence on outcomes is unambiguous. A landmark study published in the *Review of Financial Studies* (Gupta et al., 2024) found that private equity-owned nursing homes increased patient mortality by 11%, driven by staffing reductions and declining compliance with care standards — outcomes that represent direct harm to Medicare and Medicaid beneficiaries. A 2024 HHS research brief documented a 12% relative decline in registered nurse hours per resident day and a 14% worsening in deficiency scores at PE-owned facilities compared to other for-profit facilities. These are not abstract financial concerns: they are measurable, documented harms to the very residents these programs serve.

The financial mechanism enabling these outcomes is equally documented. A 2024 *Health Affairs* study found that PE-owned facilities systematically shift revenue to related-party entities through rent, management fees, and staffing contracts — expenses that appear on cost reports as legitimate care costs but flow to affiliated investors rather than direct resident care. Critically, a March 2024 *Health Affairs* analysis found that only one-third of PE investments identified through proprietary investment data appeared in CMS public ownership records. Industry claims that PE ownership affects ‘less than 5%’ of nursing homes are inconsistent with independent research finding 13% ownership rates when complete data are used. CMS cannot police what it cannot see.

Example: In New Jersey, the Long-Term Care Ombudsman is looking into a trend that involves nursing home real estate owners carrying substantial amounts of debt, which leads to understaffing and neglect of the residents. The situation typically begins when a nursing home business changes ownership, or the nursing home is refinanced. The real estate owners obtain a mortgage for significantly more than the property is worth. Often, the mortgages are insured by HUD through the Section 232 program. The owners of the nursing home pay increased rents to cover the real estate owners' debt payments. However, the owners of the real estate and the nursing home business are often the same investors, paying themselves for the nursing home's operating revenues — which are mostly taxpayer dollars — to cover their high debts on the property. Meanwhile, they are allocating fewer dollars to staffing needs and related care costs. The nursing home business cuts nursing home food, activities for residents, building upkeep, and other products or services that promote resident well-being. For one nursing home that changed ownership hands in 2024, the rent payment more than doubled in a single year, and spending on direct care staffing dropped by \$2.7 million. Staffing levels fell from 4.27 nurse staffing hours per resident day in 2023 to 3.04 hours in 2024.

We urge the Administration to increase scrutiny of these related-party transactions and to strengthen accountability for how public funds are used. Greater oversight is essential to

ensure that taxpayer dollars are directed toward resident care rather than excessive corporate profit.

Specifically, NASOP urges CMS to take the following actions:

- Require complete consolidated cost report disclosure of all related-party transactions and condition Medicare/Medicaid participation on full beneficial ownership disclosure at all corporate levels, including PropCo, ManageCo, and StaffCo entities; and
- Cross-reference CMS ownership records against proprietary investment databases and refer material discrepancies to Medicaid Fraud Control Units for review.

Preserve Timely Access to Necessary Care

While NASOP supports the goal of reducing fraud, waste, and abuse, implementation of the CRUSH initiative must not compromise long term care residents' timely access to necessary care. Interruptions or delays in essential services threaten the health and safety of vulnerable individuals and may ultimately increase costs causing hospitalizations, expensive emergency room visits, and other high-acuity care.

We therefore highlight the following concerns related to CRUSH implementation:

1. **Barriers to Patient Care:** Aggressive and imprecise enforcement measures, such as automatic payment suspensions, may inadvertently delay or deny residents the access to essential medical services.
2. **Reductions in Home and Community-Based Services (HCBS):** We are concerned that pulling back on HCBS funds due to “program vulnerabilities” will trap residents in skilled nursing facilities (SNFs) and reduce access to community-based care. Such outcomes will sacrifice Americans' ability to live in the community and will limit utilization of lower cost, in-home care. Research consistently demonstrates that HCBS costs Medicaid between one-third and one-half of comparable nursing facility placement. Restricting HCBS access in the name of fraud prevention will predictably shift beneficiaries into higher-cost institutional settings, increasing — not reducing — total federal expenditure. LTCOPs regularly document residents who wish to return to the community but cannot access HCBS supports; reductions in those services will result in more residents institutionalized against their will, in potential violation of the *Olmstead* mandate.
3. **Obstacles to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS):** The six-month moratorium on new DMEPOS suppliers, risks disrupting the supply chain and impeding access to essential medical items like wheelchairs and hospital beds.
4. **Provider and Ownership Requirements:** Due to ongoing staffing shortages across the country, proposed citizenship, or legal residency requirements for owners, as well as expanded background checks, must be implemented carefully to avoid excluding legitimate providers or disrupting care continuity. Background checks should extend to

beneficial owners at all corporate levels — not only facility operators — to match the anti-fraud intent of CRUSH.

In conclusion, NASOP respectfully requests CMS to: (1) Increase federal funding for the Long Term Care Ombudsman Program and State Medicaid Fraud Units, as core fraud detection and response investment; (2) require full beneficial ownership disclosure and consolidated financial reporting for all Medicare and Medicaid participating facilities; (3) protect HCBS access as the lower-cost, resident-preferred alternative to institutional placement; and (4) ensure that any enforcement actions include robust resident protection protocols to prevent care disruption for the most vulnerable beneficiaries.

Thank you for the opportunity to provide these comments on the CRUSH initiative. NASOP looks forward to continued collaboration with CMS to ensure that anti-fraud efforts strengthen program integrity while protecting access to high-quality care and safeguarding the rights of long-term care residents.

Sincerely,

Patricia Hunter

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Washington State Long-Term Care Ombudsman