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July 24, 2015

The Honorable Sylvia Mathews Burwell , HHS Secretary
The Honorable Andrew M. Slavitt, CMS Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: File Code CMS-2390-P

Dear Secretary Burwell and Administrator Slavitt:

On behalf of the National Health Care Anti-Fraud Association (NHCAA), I am writing in response to the proposed rule published in the June 1 issue of the *Federal Register* with file code CMS-2390-P, relating to Medicaid managed care and the Children's Health Insurance Program (CHIP).

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. We are unique among associations in that we are a private-public partnership—our members comprise the nation's most prominent health insurance plans as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud which participate in NHCAA as law enforcement liaisons.

NHCAA's mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission is the same regardless of whether a patient has private health coverage through an employer or as an individual, or is a beneficiary of Medicare, Medicaid, or any other public program.

On a national level, fraud infects and undermines our nation's health care system and is a drain on finite resources. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more annually. It is a serious and costly problem that affects every patient and every taxpayer. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm — unfortunate and insidious side effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and certainly it is not victimless.

It is from this perspective that NHCAA offers its comments. Overall, NHCAA fully supports the program integrity requirements included in the proposed rule. Our specific comments follow:

Medical Loss Ratio Requirement

When the Department of Health & Human Services (HHS) promulgated regulations to put into effect the Medical Loss Ratio (MLR) requirements of the Affordable Care Act (ACA) for health insurers, NHCAA argued throughout the rulemaking process that the anti-fraud efforts of health insurers are unequivocally "activities that improve health care quality." Despite NHCAA's position, the final MLR rule that became effective on January 3, 2012, while making some allowance for claims payment recoveries, specifically excluded "fraud prevention activities" from the list of quality improvement activities. Nevertheless, NHCAA continues to believe that insurer activities devoted to anti-fraud efforts—regardless of whether they are categorized as recoveries, savings or prevention—are activities that improve health care quality and therefore should be included as such for the MLR calculation.

The Medicaid managed care proposed rule now being considered would establish standards for calculating and reporting Medical Loss Ratio (MLR) under Medicaid managed care, with a federal

minimum MLR of 85 percent. (States would have the discretion to establish a higher MLR.) We recognize that the rule generally follows similar standards currently in place for calculating MLR for private plans, with some adjustments based upon the unique aspects of delivering services through Medicaid managed care.

The proposed rule states that CMS wants to encourage Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) to "build and sustain a program integrity infrastructure that has strong prevention activities as well as robust processes for the detection, referral and recovery of improper payments, including potential fraud, waste and abuse." Consistent with this goal, the proposed rule includes expenditures related to fraud prevention for Medicaid plans in the numerator, although limited to .5 percent of a Medicaid plan's premium revenues. So, while anti-fraud activities continue to be excluded from the category of "activities that improve health care quality," NHCAA strongly supports the decision to acknowledge the importance of fraud prevention by permitting it to be included as part of the MLR numerator. We also appreciate CMS's discussion of the parameters of what constitutes prevention-related expenditures and the emphasis given to the use of advanced anti-fraud technologies such as data analytics and the application of predictive or other sophisticated algorithms.

The MLR rule currently in place for private insurers serves to disincentive plans from investing in cutting-edge solutions such as predictive modeling and data analytics. NHCAA encourages HHS to extend the same methodology CMS proposes for Medicaid to the MLR rules currently in place for private health insurers and Medicare Advantage plans.

Compliance Program Requirements

Regulation currently applicable to Medicaid managed care plans lists seven standard elements of a basic compliance program that MCOs and PIHPs are required to have. This rule proposes to expand upon those elements, offering greater detail and laying out additional requirements. In addition, the compliance plan requirements would now be applicable to PAHPs as well. NHCAA is in agreement with providing additional detail and specificity because it offers greater guidance for health plans about the expectations of CMS with regard to program integrity. We also have the following specific comments:

- Rules currently in place for Medicaid managed care require that plans designate a compliance officer and a compliance committee that are accountable to senior management. The proposed Medicaid rule would require the compliance officer (CO) to "report directly to the Chief Executive Officer and the board of directors." NHCAA supports the effort to ensure that the compliance officer has ready access to plan leadership and believes that requiring the CO to report both to the CEO and Board will help ensure that compliance concerns are acknowledged and addressed. The proposed rule also gives greater weight to the required compliance committee by establishing a "Regulatory Compliance Committee on the board of directors and at the senior management level." Again, we support this proposed change that aims to enhance program integrity.

- The proposed Medicaid rule would require "dedicated staff" for internal monitoring and auditing of compliance risks and states that this internal monitoring system shall include coordination with law enforcement on suspected criminal acts (such as provider fraud) that are identified. We support these requirements, but note that the current Medicare Advantage (MA) rule does not specify that there must be staff specifically dedicated to monitoring and auditing

compliance risks, and it does not include the requirement to coordinate with law enforcement. CMS asserts in the proposed Medicaid rule that revisions and additions to the compliance program requirements are intended to better align Medicaid with Medicare Advantage. Health insurers often participate in both Medicare and Medicaid programs, so NHCAA believes it's sensible to try and make the compliance program requirements of the two programs more consistent. Therefore, NHCAA recommends that CMS consider additional changes to further align the two sets of regulations that establish compliance program requirements.

- There are several other new program integrity requirements included in the proposed rule, some of which implement additional reporting obligations by the plan to the state. For example, a requirement that a plan must promptly notify the state when it receives information about specified changes in an enrollee's circumstances that may affect Medicaid eligibility (i.e. residence change, income change, death). Another is a proposed requirement that a plan must promptly notify the state when it receives information about a provider's circumstances that may affect the provider's eligibility to participate in Medicaid managed care. And finally, a requirement that a plan promptly refer potential fraud, waste or abuse (FWA) to the state Medicaid program integrity unit or potential fraud to the State Medicaid Fraud Control Unit. While additional reporting obligations would require that plans expend more resources to meet them, NHCAA supports these proposed requirements because they will help combat fraud, waste and abuse.

- With regard to the phrase "prompt referral of potential fraud, waste or abuse" included in the proposed reporting requirements we suggest adding clarification of what is meant by "potential." Otherwise, state Medicaid programs and Medicaid managed care plans may have differing interpretations about what constitutes "potential" FWA, thus triggering the reporting process. For instance, most health plans operate hotlines and host email boxes to allow

consumers to report suspected FWA. As a matter of practice, health plans typically take some basic investigative steps to look into these reports before concluding that FWA may have occurred. At what point would the state expect the plan to report? Upon receipt of the complaint by the consumer or after the plan has conducted an initial assessment of that complaint? NHCAA suggests that CMS provide more guidance around the term "potential." Such insight could help avoid weakening a well-intended process that, in practice, could yield an unwieldy volume of reporting that offers limited anti-fraud impact. We recommend a clarifying phase such as "after an initial investigation or review indicates that fraud, waste or abuse may have occurred" as a condition to the reporting requirement.

Reporting of Overpayments

The Affordable Care Act (ACA) requires overpayments to be reported and returned within 60 calendar days of their identification with a written explanation of the reason for the overpayment. The proposed Medicaid managed care rule would implement these ACA requirements specifically for MCOs, PIHPs, and PAHPs. In addition, the rule would require plans to have a mechanism in place for network providers to report and return overpayments within 60 calendar days. NHCAA supports these requirements.

Provider Screening

The ACA established several provider screening and enrollment requirements that have clearly enhanced anti-fraud efforts. Under the proposed rule, state Medicaid programs (through their contracts with plans) would now be responsible for screening and enrolling all Medicaid managed care network providers who are not otherwise enrolled with the state. Previously, Medicaid providers that ordered or

referred services only as part of a managed care network were excluded from the screening and enrollment requirements.

This provision does not require Medicaid managed care network providers to render services to Medicaid fee-for-service beneficiaries, only that they be screened for and enrolled in the FFS program.

We understand that states, as well as the HHS Office of Inspector General (OIG), have identified as a vulnerability, a lack of consistency in the application of the provider screening and enrollment provisions applicable to FFS providers in states' managed care programs. We agree with CMS that providers who are unable to enroll in Medicaid FFS could attempt to shift their participation to Medicaid managed care plans to avoid detection. We appreciate also CMS's assertion that this approach will result in administrative and cost efficiencies by eliminating the need for each plan to conduct duplicative screening activities as part of the credentialing process (although plans would not be prohibited from conducting their own additional provider screenings). This approach would also ensure that the provider screening protocols established by the ACA (limited, moderate and high risk provider categories) would apply to all providers that serve Medicaid beneficiaries, whether through FFS or managed care.

This proposed provision is clearly intended to strengthen program integrity and therefore NHCAA is supportive of the requirement. However, as CMS notes, this proposed policy could possibly impact a managed care plan's ability to effectively build and maintain its provider network. It would be vital to ensure that the administrative challenges inherent in the screening, disclosure and enrollment process would not impede a plan's ability to develop and maintain its provider network and ensure network adequacy. Perhaps language could be added to the rule that would allow a plan to add providers to its network on a provisional basis after conducting its own provider screening and credentialing processes,

while awaiting the outcome of the state-led screening and enrollment process. In addition, it would be helpful if the rule were to provide a timeframe in which the state can be expected to complete the screening and enrollment process and then communicate the outcome to the plan.

Suspension of Payments

The suspension of payments provision of the ACA has proven to be an important anti-fraud tool. The proposed Medicaid managed care rule would enable MCOs, PIHPs, and PAHPs to suspend payments to a network provider that is the subject of a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. The state must make the determination that payments be suspended and the plan would then be responsible for promptly taking action to suspend payments once directed to do so by the state. NHCAA supports this provision.

However, it has been the experience of some NHCAA members which operate as Medicaid managed care plans in multiple states that states often interpret and apply differently the Medicaid suspension of payment rule developed in response to the ACA. The rule that defines "credible allegation of fraud" under Medicaid (42.C.F.R. § 455.2) requires that a state verify allegations of fraud and that "Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis." In addition, the existing rule offers several "good cause" exceptions why a state Medicaid agency may decide not to suspend payments. For the proposed Medicaid rule, we recommend that CMS provide additional clarification that could help ensure that states take similar and consistent action with regard to making determinations to suspend payments to network providers under Medicaid managed care.

Subcontractual Relationships and Delegation

CMS proposes new requirements for Medicaid plans that enter into subcontractual arrangements and/or delegate responsibilities that relate directly or indirectly to the performance of a plan's activities or obligations under its contract with the state. One requirement reads, "The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems of the individual or entity, or of the individual's or entity's contractor or subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contract with the State, if the reasonable possibility of fraud is determined to exist by any of these entities." While this provision mirrors somewhat closely one that is applicable under Medicare Advantage, we note that the phrase "if the reasonable possibility of fraud is determined" is an addition to the Medicaid requirement. While possible fraud certainly is an appropriate basis for an audit, we would suggest that a subcontractor should also be subject to an audit for possible waste and abuse. We recommend adding the phrase "or similar risk" to the reasonable possibility of fraud language.

On behalf of the National Health Care Anti-Fraud Association, thank you for this opportunity to comment on CMS's proposed rule aimed at modernizing regulation of Medicaid managed care. We are available for any questions that you may have.

Sincerely,

Louis Saccoccio
Chief Executive Officer