March 30, 2026

Submitted electronically via http://www.regulations.gov

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Re: Request for Information Related to Comprehensive Regulations to Uncover Suspicious Health Care Billing and Provision Practices (CRUSH Initiative), File Code CMS-6098-NC

Dear Secretary Kennedy and Administrator Oz:

On behalf of the National Health Care Anti-Fraud Association (NHCAA), I am writing in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding the development of comprehensive strategies to strengthen program integrity and combat health care fraud, waste, and abuse.

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. NHCAA is unique among associations in that we are a private-public partnership—our members include the nation's most prominent health insurance plans, as well as federal, state, and local government law enforcement and regulatory agencies with responsibility for addressing health care fraud. NHCAA has long counted CMS and the U.S. Department of Health and Human Services, Office of Inspector General (OIG) among its valued partners in safeguarding the integrity of our nation's health care system. In fact, the OIG was instrumental in the founding of NHCAA.

For more than four decades, NHCAA's mission has remained constant: 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. This commitment is unwavering, regardless of whether a patient has private health coverage or is a beneficiary of Medicare, Medicaid, or any other public program.

NHCAA appreciates CMS's leadership in seeking input through this RFI and supports the agency's efforts to enhance its ability to detect, prevent, and respond to fraud. NHCAA's

comments focus on several key themes raised in the RFI, including the need for timely access to actionable information, stronger cross-sector coordination, and the effective use of multi-payer data. CMS's emphasis on improving coordination, leveraging data, and accelerating the identification of suspicious activity is both timely and necessary. CMS's efforts under the CRUSH initiative will be most effective when supported by policies that enable timely, cross-payer information sharing and sustained engagement among public and private partners.

The Evolving Nature of Health Care Fraud

Health care fraud remains a pervasive and costly problem that undermines the integrity of our health care system, drains finite resources, and places patients at risk. While misconduct can take many forms, NHCAA's experience demonstrates that the most significant and harmful schemes are often perpetrated by dishonest providers, organized groups, and even phantom providers operating across multiple payers and jurisdictions. These schemes are frequently sophisticated, highly coordinated, and designed to exploit gaps in oversight and communication, often by overwhelming systems in a short period of time.

Individuals and organizations engaged in fraud routinely take advantage of fragmentation within the health care system—particularly the separation between public programs and private payers—to evade detection. When information is siloed, even well-resourced entities may see only a portion of a broader scheme. Effective fraud prevention and detection therefore depend not only on strong individual program integrity tools, but also on the ability to connect information across participating entities.

The Importance of Private-Public Partnership

Since its inception, NHCAA has been grounded in the principle that strong partnerships between the public and private sectors are essential to effectively combat health care fraud. Our experience as a convener of health plans, law enforcement, and regulatory agencies has consistently demonstrated that far more can be achieved collectively than through isolated efforts.

Building and sustaining trust-based relationships between public agencies and private sector partners is fundamental to these efforts. Effective information exchange requires not only appropriate legal and technical frameworks, but also confidence among participants that shared information will be used responsibly and constructively. CMS is well-positioned to institutionalize this type of engagement across the health care ecosystem.

We encourage CMS to continue prioritizing policies and initiatives that strengthen relationships and collaboration between government entities and private payers, recognizing that these partnerships are indispensable to quickly identifying and addressing schemes that span multiple programs and jurisdictions.

NHCAA has further examined these issues in its white paper, *"Addressing Fraud and Abuse in Medicaid Demands a Collaborative Approach,"* which outlines a set of 12 practices designed to strengthen coordination among state agencies, managed care organizations, and federal partners. The paper reflects NHCAA's experience convening diverse participants to identify practical ways to enhance communication, align processes, and improve collective fraud-fighting efforts. While this work was developed in the context of Medicaid, many of these practices have broader applicability and may inform efforts to strengthen coordination across Medicare, CHIP, and other health care programs. CMS may find these practices instructive as it considers opportunities to enhance coordination across the health care system. To that end, we are submitting our white paper along with this letter, for your consideration.

Information Sharing as Foundational Anti-Fraud Infrastructure

A central lesson from NHCAA's decades of experience is that timely and meaningful information sharing among payers and enforcement entities is one of the most effective tools available to combat health care fraud. NHCAA has long been a leader in providing opportunities for insurer members to share vital and timely information about emerging schemes and open investigations. Payers—whether public or private—who rely solely on their own data and information are inherently limited in their ability to detect complex, multi-payer schemes. Coordinated information exchange, by contrast, enables participants to identify patterns, connect seemingly disparate activities, and intervene more quickly. As reflected in NHCAA's work on collaborative practices in Medicaid, effective information sharing must be supported by clear frameworks, consistent engagement, and shared expectations across participating organizations.

We encourage CMS to prioritize the development and enhancement of mechanisms that facilitate the secure, timely, and actionable exchange of fraud-related information. In particular, CMS should consider:

- Promoting greater alignment in data standards and reporting frameworks to enable more efficient cross-payer analysis;
- Supporting more timely sharing of information related to suspect providers, emerging schemes, and program integrity actions;

- Providing clarity around appropriate information sharing that protects sensitive data while enabling effective cooperation;
- Encouraging ongoing engagement among CMS, its contractors, private payers, and law enforcement partners to ensure that shared information is both useful and actionable; and
- Supporting mechanisms that enable cross-payer visibility into program integrity actions, such as enrollment denials, revocations, and payment suspensions.

Strengthening information sharing is not simply an operational improvement, it is foundational to building a more proactive and coordinated approach to fraud prevention.

Provider Screening and Stopping Fraud at the Point of Entry

Preventing fraudulent actors from entering federal health care programs in the first instance remains one of the most effective program integrity strategies. NHCAA members have found significant success through enhanced provider screening and early detection efforts that focus on identifying risk at the point of entry—often before care is rendered or claims are submitted. These efforts may include strengthened credentialing and verification processes, analysis of relationships between providers, owners, and investors, as well as targeted review of high-risk applicants. While the financial impact of such activities can be difficult to quantify, their value is clear: they help prevent improper payments, disrupt schemes before they take hold, and, most importantly, protect patients from harm.

The provider screening provisions strengthened under the Affordable Care Act have been instrumental in advancing these efforts. CMS's recent use of its statutory authority to impose a six-month nationwide moratorium on the enrollment of certain DMEPOS suppliers further illustrates the importance of initiative-taking, data-driven, and risk-based approaches to preventing fraud at the point of entry. This action, taken in response to identified program integrity vulnerabilities, reflects a broader shift toward front-end safeguards designed to reduce improper payments before they occur. Continued attention to these types of preventive tools will be critical to CMS's broader fraud prevention strategy.

NHCAA also recognizes that certain sectors of the health care system continue to present elevated fraud risks, including Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), as well as laboratory, genetic, and molecular diagnostic testing. These areas have historically been vulnerable to complex and rapidly evolving schemes, often involving coordinated activity across multiple providers and payers. NHCAA's insurer members devote significant resources to addressing fraud in these sectors and have

developed and implemented some of the field's more innovative and data-driven approaches to detecting and preventing improper billing and abusive practices. These efforts further underscore the importance of sharing insights, identifying emerging patterns, and fostering coordination across partners to stay ahead of evolving risks.

NHCAA also commends CMS for its recent decision to publicly release data on revoked Medicare providers and suppliers. The "Revoked Medicare Providers and Suppliers" dataset represents an important step forward in enhancing transparency and equipping both public and private partners with actionable information. By making this data—including provider identifiers, revocation authorities, and re-enrollment bar periods—available and regularly updated, CMS has created a valuable resource that can help payers, regulators, and others more effectively identify risk, prevent improper payments, and strengthen program integrity efforts. Continued expansion of such data-sharing initiatives will further enhance collective efforts to combat health care fraud and abuse.

Adequate Investment and Identifying Opportunities for Efficiencies are Essential

The Office of the Actuary in the Centers for Medicare & Medicaid Services projects $5.94 trillion in national health expenditures for 2026, including $1.3 trillion for Medicare and $1.1 trillion for Medicaid. To protect this enormous outlay that underpins the well-being of Americans, adequate, respective investment in program integrity efforts is essential for sustaining and strengthening anti-fraud activities. NHCAA insurer members, particularly those operating Medicaid plans across multiple states, must dedicate significant staff time and resources to meeting varied and often duplicative state-specific reporting requirements. While these reporting obligations serve important oversight functions, the lack of standardization across states creates administrative inefficiencies that divert resources away from core detection and prevention activities. Greater alignment and standardization of Medicaid program integrity reporting requirements would yield substantial efficiencies, allowing plans to redirect time, funding, and personnel toward more effective anti-fraud work.

The Role of Advanced Analytics and Artificial Intelligence

CMS's RFI appropriately highlights the growing role of advanced analytics and artificial intelligence (AI) in strengthening program integrity. NHCAA recognizes that AI and related technologies hold significant promise in enhancing the ability of both public and private participants to detect anomalous billing patterns, identify emerging schemes, and act more quickly on actionable information. At the same time, these technologies are increasingly being leveraged by those seeking to perpetrate more sophisticated and scalable fraud.

As CMS considers the role of AI in future program integrity efforts, it is important to recognize that the effectiveness of these tools is fundamentally dependent on the quality, completeness, and accessibility of underlying data. AI-driven solutions are most effective when informed by comprehensive, cross-payer datasets and supported by appropriate information-sharing frameworks. Policies that promote responsible data exchange, strengthen coordination among participants, and ensure transparency in how data is used will be critical to maximizing the benefits of AI while mitigating associated risks. NHCAA's members, including many organizations at the forefront of developing advanced analytic tools, stand ready to support CMS in these efforts.

Protecting Beneficiaries from Fraud and Medical Identity Theft

CMS's RFI appropriately highlights concerns regarding Medicare beneficiaries being subjected to unsolicited outreach by individuals seeking to obtain personally identifiable information for fraudulent purposes. NHCAA agrees that medical identity theft and the exploitation of seniors and other vulnerable populations represent serious and persistent threats. These schemes not only result in financial losses but also place beneficiaries at risk of compromised medical records, inappropriate care, and broader harm.

NHCAA recognizes and strongly supports the important work of the Senior Medicare Patrol (SMP) program, which has for decades played a critical role in educating beneficiaries about how to detect, prevent, and report fraud. SMP serves as a valuable partner in empowering beneficiaries to safeguard their personal information and recognize suspicious activity. Continued investment in and support for SMP will be essential to strengthening these efforts and expanding beneficiary awareness.

NHCAA also supports CMS's existing prohibition on unsolicited telephone contact by DMEPOS suppliers and agrees that consideration should be given to extending similar protections to other categories of providers and suppliers, where appropriate. Limiting unsolicited outreach can help reduce opportunities for fraudulent schemes, while reinforcing broader program integrity efforts. At the same time, any such policies should be carefully designed to preserve appropriate and legitimate communications between providers and patients.

Leveraging the Healthcare Fraud Prevention Partnership (HFPP)

NHCAA recognizes the Healthcare Fraud Prevention Partnership (HFPP) as an important example of private-public partnership and a platform with significant potential to enhance

program integrity efforts. The HFPP is uniquely positioned to bring together claims data from multiple payers, offering a broader and more comprehensive view of health care billing and utilization patterns than any single entity can achieve independently.

The greatest value of the HFPP lies in its ability to aggregate and analyze cross-payer claims data to identify emerging fraud schemes, detect aberrant billing patterns, and generate actionable insights that can be shared with participating entities—including identifying patterns that may not be visible within a single payer's dataset. We encourage CMS to continue strengthening and focusing the HFPP's efforts in this area.

Conclusion

NHCAA appreciates CMS's commitment to strengthening program integrity and its recognition of the importance of engagement across the health care system in shaping future policy. As CMS considers next steps, we encourage the agency to emphasize collaboration, build trust among participating entities, and enhance information sharing across the health care system.

Health care fraud is a complex and evolving challenge that cannot be addressed by any single entity acting alone. By prioritizing private-public partnerships and enabling more effective information exchange, CMS can significantly enhance its ability to detect, prevent, and respond to fraud—thereby protecting patients and preserving the integrity of our nation's health care programs.

We appreciate the opportunity to provide these comments and would welcome the opportunity to further engage with CMS on these important issues. Please do not hesitate to contact us if we can be of assistance.

Sincerely,

Louis Saccoccio
Chief Executive Officer

Enclosure: "Addressing Fraud and Abuse in Medicaid Demands a Collaborative Approach: NHCAA Collaborative Practices for Anti-Fraud Success in Medicaid Managed Care"

NHCAA
National Health Care Anti-Fraud Association®

Addressing Fraud and Abuse in Medicaid Demands a Collaborative Approach: NHCAA Collaborative Practices for Anti-Fraud Success in Medicaid Managed Care

February 2020

Background

An estimated 73 million people depended upon the Medicaid program for their health care coverage in 2018.[1] That year, health expenditures for Medicaid exceeded $597 billion, with Federal spending accounting for $371 billion and the States contributing $226 billion.[2] By 2027, spending for Medicaid is projected to reach a staggering $992 billion and will cover nearly 83 million individuals.[3]

Medicaid is our nation's largest health program as measured by enrollment and is only second to Medicare in terms of expenditures. Since 2003, the Government Accountability Office (GAO) has repeatedly designated Medicaid a "high risk program," including it on the GAO's biennial High Risk List.[4] The GAO designates government programs and operations as high risk based primarily on their vulnerabilities to fraud, waste, and abuse. The national Medicaid improper payment rate, as reported by the U.S. Department of Health and Human Services (HHS) for 2018, was 9.8% percent or $36.25 billion.[5]

It is relevant to note that an improper payment does not necessarily indicate fraud or abuse. It is also important to recognize the corresponding requirement to promptly report MCOs' identification and recovery of overpayments. 42 CFR § 438.608(a)(2) (MCOs must promptly report to the State all overpayments identified and recovered, specifying the overpayments due to potential fraud.) Also, Medicaid overpayments are required to be returned no later than 60 days after identification. 42 CFR § 438.608(c)(3), 438.600(a)(2); 42 U.S.C. §1320a-7k(d).

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[1] National Health Expenditure Accounts (NHEA), Historical, Office of the Actuary, Centers for Medicare & Medicaid Services. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html
[2] Ibid.
[3] National Health Expenditure Accounts (NHEA), Projected, Office of the Actuary, Centers for Medicare & Medicaid Services, Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.htm
[4] U.S. Government Accountability Office (GAO), High Risk List. Retrieved from https://www.gao.gov/highrisk/overview
[5] PaymentAccuracy.gov, Department of Health and Human Services, Medicaid. Retrieved from https://paymentaccuracy.gov/the-numbers/

The enactment of the Patient Protection and Affordable Care Act (ACA) in 2010 is perhaps the most consequential act over the last decade for Medicaid. The law includes several provisions that altered the Medicaid program; most notably, the significant expansion of the program that includes federal matching funds for the States. The law expanded Medicaid eligibility to individuals under age 65 with incomes below 133% of the Federal Poverty Level (effectively 138% of the FPL).

In a significant June 2012 ruling,[6] the U.S. Supreme Court struck down the ACA provision that would have eliminated all federal Medicaid funding to states that chose not to comply with the expansion of Medicaid. The Court concluded that states choosing not to comply would not risk losing their existing funding. As of January 2020, 36 states and the District of Columbia have expanded their Medicaid programs in accordance with the ACA,[7] resulting in more than 17 million additional people with Medicaid coverage.

Considering how enormously important Medicaid is to those it serves and its substantial impact on government budgets and taxpayers, it is of critical importance to ensure the integrity of the program. Additionally, protecting Medicaid beneficiaries from the physical and emotional harm that can result from fraud must be a priority.

Medicaid Managed Care

When Medicaid was first established, it employed a fee-for-service (FFS) payment structure where health care providers are compensated for each service they provide. Some of these fee-for-service arrangements began to change as states explored payment reforms and health care delivery system changes, and looked to managed care as an alternative.

Managed care delivery systems grew rapidly in the Medicaid program during the 1990s. Today, managed care penetration varies considerably by state, as do the types of payment and delivery system models states have adopted. While not all state Medicaid programs contract with managed care plans, a large and growing majority do.[8] According to the Kaiser Family Foundation, there were 277 comprehensive risk-based managed care organizations (MCOs) in operation across 38 states and

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[6] National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., Syllabus, Supreme Court of the United States, decided June 28, 2012, Retrieved from https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf
[7] Status of State Action on the Medicaid Expansion Decision, State Health Facts, Health Reform, Medicaid and Health Reform, Kaiser Family Foundation. Retrieved from http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/
[8] Henry J. Kaiser Family Foundation, State Health Facts, Medicaid Managed Care Tracker. Retrieved from https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/

the District of Columbia as of March 2019.[9] Some states considered to be "Medicaid managed care states" utilize alternative risk-based models (most often involving a capitated payment system) such as coordinated care organizations (CCO), health insuring organizations (HIO), and accountable care organizations (ACO).

Through their contracts with the states, Medicaid MCOs are required to "implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse."[10] Specifically, contracts must require MCOs to establish "procedures and a system with dedicated staff" devoted to compliance issues, and contracts must also include a provision requiring the "prompt referral of any potential fraud, waste or abuse that the MCO [...] identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit."[11] In practice, MCOs have a special investigations unit, or SIU, that is tasked with fraud prevention, detection, investigation and reporting responsibilities.

Medicaid Managed Care Regulations

In 2016, the Centers for Medicare and Medicaid Services (CMS) published a final rule[12] that adopted significant amendments to the Medicaid managed care regulations. The rule made significant revisions to Title 42 CFR Part 438 (hereinafter "Part 438")[13] to modernize the Medicaid managed care regulations. A few highlights of Part 438 include the following requirements that States must ensure are in place:

- MCOs must have appropriate health information systems and abide by data, information and documentation reporting requirements. Part 438.242 and 438.604;
- MCOs and their subcontractors must keep records for at least 10 years. Part 438.3(u);
- MCO subcontract relationships and delegation obligations are delineated, including agreements by others to comply with all applicable Medicaid laws, regulations, guidance and contract provisions. Part 438.230;

[9] Henry J. Kaiser Family Foundation, State Health Facts, Medicaid MCO Enrollment by Plan and Parent Firm, March 2019. Retrieved from https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-march-2019/

[10] 42 CFR 438.608, Program integrity requirements under the contract. Section (a) Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. Retrieved from https://gov.ecfr.io/cgi-bin/text-idx?SID=feeca32d38468745178951794288fbbe&mc=true&node=se42.4.438_1608&rgn=div8

[11] Ibid.

[12] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27497 (May 6, 2016). Federal Register: The Daily Journal of the United States. Web. 6 May 2016. Retrieved from https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

[13] 42 CFR Part 438, Managed Care. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8

- Contracts must contain delineated program integrity requirements including as to subcontractors and as to compliance programs. Part 438.608;
- Contracts require a "Provision for the prompt referral of any potential fraud, waste or abuse that the MCO, PIHP or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit." Part 438.608(a)(7);
- State Medicaid enrollment and screening is required for network providers that will receive Medicaid money directly or indirectly to order, refer or render covered services for an MCO's enrollees in a State's Medicaid program. Part 438.602(b)(1);
- Certifications must be executed by the MCO's CEO or CFO, or an individual who reports directly to either the CEO or CFO with delegated authority to sign. The CEO or CFO remains "ultimately responsible for the certification" executed by the designee. Part 438.606(a). The Certification applies to documentation and information as well as data submitted by the MCO. The Certification content must attest that it is "based on best information, knowledge and belief, the data documentation and information specified in 438.604 is accurate, complete, and truthful." Part 438.606(b);
- Contracts must include a section as to the "treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to providers" wherein states can specify treatment of recoveries due to overpayments. Significantly, this provision does not afford discretion or "apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations." Part 438.608(d)(iv). This can include cases brought based on a reverse false claims theory where overpayments have not been returned within 60 days.

2018 GAO and HHS-OIG Reports

In June 2018, the GAO released a Medicaid study entitled "Actions Needed to Mitigate Billions in Improper Payment and Program Integrity Risks"[14] which, among other things, discussed managed care. The GAO emphasized the need to improve data reporting and for CMS to ensure that Medicaid data is timely, complete and comparable from all states, and useful for program oversight. The GAO stated that "Regarding managed care payments which were nearly half (or $280 billion) of Medicaid spending in fiscal year 2017, GAO has found that the full extent of program risk due to overpayments and unallowable costs is unknown." (cover page to Study). The GAO referenced the importance of retaining the Part 438 requirement of states arranging for an independent audit of the data submitted by MCOs at least once every 3 years (Part 438.602(e)).

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[14] Government Accountability Office. (2017). MEDICAID: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks. (GAO-18-598T). https://www.gao.gov/assets/700/692821.pdf

In July 2018, the United States Department of Health and Human Services, Office of Inspector General (HHS-OIG) published a report titled "Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse"[15] (OEI-02-15-00260) (hereinafter, "the OIG report"). It examines the program integrity challenges that exist in Medicaid managed care. This report was based on 2015 data along with interviews of MCO and State Medicaid officials conducted in May and June of 2017.

The OIG report made eight recommendations to the Centers for Medicare and Medicaid Services (CMS), suggesting ways to improve efforts to protect Medicaid and ensure that taxpayer dollars are spent appropriately. The report called for CMS to emphasize the identification and sharing of "best practices" with regard to anti-fraud efforts in Medicaid. Notably, one of the recommendations called on CMS to identify and share best practices to provide assistance to the States to help facilitate improvement of communication and coordination between MCOs and state-level program integrity entities (i.e. Medicaid Program Integrity Units, Medicaid Fraud Control Units, State Offices of Inspector General, state auditors, etc.).

Prompted, in part, by the 2016 CMS final Medicaid managed care rule and the OIG report, several NHCAA members that operate as Medicaid managed care organizations (MCOs) expressed interest in convening a group to discuss the challenges of fraud and abuse in Medicaid and to examine collaborative practices that could improve communication and coordination among Medicaid anti-fraud partners. As a result, over the span of several months, following the publication of the OIG report, NHCAA conducted discussions with many of the interested parties to explore the possibility of their assisting NHCAA in developing a set of anti-fraud collaborative practices in Medicaid managed care. With more than three decades of experience facilitating private-public partnerships and collaboration, NHCAA was ideally positioned to bring MCOs and state and Federal partners together to explore ways to improve and expand private-public collaboration under Medicaid, thereby increasing the effectiveness of their collective anti-fraud efforts.[16]

NHCAA's discussions led to the launch of the NHCAA Collaborative Medicaid Fraud Work Group. The group met in-person on April 3rd, May 30th and August 1st of 2019. Along with NHCAA staff, Medicaid partners attending these meetings included individuals from Medicaid MCOs, two state Medicaid

[15] U.S. Department of Health and Human Services, Office of Inspector General. (2018, July). Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse. (Report (OEI-02-15-00260). Retrieved from https://oig.hhs.gov/oei/reports/oei-02-15-00260.asp

[16] The National Health Care Anti-Fraud Association was founded in 1985 as a private-public partnership against health care fraud with a mission 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. NHCAA's role as a private-public partnership makes it unique among associations. NHCAA's 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.

Fraud Control Units (MFCUs), two state Medicaid Program Integrity (MPI) offices or units, the Center for Program Integrity at the Centers for Medicare and Medicaid Services (CMS-CPI), the Office of the Inspector General at the Department of Health and Human Services (HHS-OIG), one board member of the National Association for Medicaid Program Integrity (NAMPI), and one representative from the National Association of Medicaid Fraud Control Units (NAMFCU).

The objectives of the Work Group were:

- To increase private-public cooperation and collaboration to improve Medicaid managed care fraud, waste and abuse enforcement;
- To develop a better working understanding of how Medicaid MCOs address fraud, waste and abuse and what they are accomplishing;
- To determine how MCO fraud detection and prevention efforts can be utilized by government partners to increase enforcement efforts; and
- To identify and recommend collaborative practices for several aspects of Medicaid anti-fraud efforts—including private-public information sharing—that promote effective coordination and efficiency.

The Work Group proceeded under the premise that the development and adoption of sound collaborative practices by entities responsible for addressing fraud and abuse in state Medicaid programs could enhance program integrity efforts and improve communication and collaboration among Medicaid anti-fraud partners. Over the course of the three in-person meetings, the participants engaged in thoughtful discussions and provided invaluable insight and direction to NHCAA. Following each meeting, drafts of the collaborative practices along with background information and explanatory comments were provided to the Work Group participants for review and comment.

The resulting "NHCAA Collaborative Practices for Anti-Fraud Success in Medicaid Managed Care" are set out below. These Collaborative Practices are the work of NHCAA and do not necessarily reflect the official policy position of any individual, MCO, MFCU, MPI, Medicaid Agency or other organizational participant in the process.

Communication and Collaboration

Protecting patients and safeguarding the Medicaid program are priorities shared by all Medicaid anti-fraud partners. They pursue these priorities by working to keep fraud out of the program while striving to create efficiencies that enable more tax dollars to be spent on the provision of health care to beneficiaries rather than being lost to fraud.

NHCAA has no doubt that, collectively, all partners with an interest or responsibility in protecting Medicaid from fraud do their best. However, some of them may be doing their best in isolation. Medicaid anti-fraud partners cannot work in isolation and expect to be successful in detecting and preventing health care fraud.

Our best opportunity to more effectively address fraud in Medicaid is to focus on enhancing private-public partnerships while continuously identifying and implementing efficiencies. Communication and collaboration among anti-fraud partners is the thread that runs through each of the NHCAA recommended Collaborative Practices, and are the most critical factors in the successful detection, prevention, investigation, and prosecution of health care fraud.

It was the consensus view of the Work Group that many of the challenges facing anti-fraud partners in Medicaid managed care can be met, or at least mitigated, by the development of collaborative relationships and consistent, routine communication among the parties to the extent the government entities are able to legally share information, and decide in their discretion to do so. NHCAA recognizes and appreciates the legal restrictions that our government partners must follow when conducting fraud investigations. Some of these restrictions include limitations on the information that can be shared with MCOs and others outside the government. However, when appropriate, effective partnerships, strong communication, and relationships built on trust and common goals, allow partners to be more effective and better able to utilize their collective resources to combat fraud.

Adoption of the Collaborative Practices

Some states already follow one or more of these Collaborative Practices. Additionally, the manner and degree to which each state partner can implement these Collaborative Practices likely will vary. For instance, as of March 2019, the number of Medicaid MCOs operating in a given state program varied widely, from as many as 24 to as few as 1. Moreover, state contract language with MCOs varies, as do state statutes, regulations and policies addressing Medicaid, all of which must nevertheless comply with the Part 438 requirements. In this regard, implementation or adoption of the

Collaborative Practices is situational, in that it may not be practicable for a state partner to adopt one or more of the Collaborative Practices. State partners should consider adoption in a manner that is flexible and applicable to each state's operations and consistent with the Part 438 amendments. At a minimum, NHCAA hopes that the Collaborative Practices will be used as a resource by state partners in situations where adoption of each Collaborative Practice is not possible.

Nevertheless, despite the variations among state Medicaid programs, NHCAA is confident that these Collaborative Practices address topics of common interest for state anti-fraud partners, and that their flexible adoption will significantly enhance the success of anti-fraud efforts in Medicaid. Therefore, NHCAA encourages that the Collaborative Practices, to the extent possible, be adopted by state Medicaid agencies and their Program Integrity Units, Fraud Control Units, and Medicaid MCOs. It also is the hope of NHCAA that all Medicaid anti-fraud partners express support for the Collaborative Practices in a manner consistent with their respective authorities and processes.

Some suggestions for how Federal and state agencies and associations representing Medicaid anti-fraud partners could encourage support for and adoption of the NHCAA Collaborative Practices include:

- Both the state MFCU and State Medicaid agency are required to enter into a written agreement, such as a memorandum of understanding (MOU), to be reviewed at least every 5 years. The Collaborative Practices could serve as a resource when considering amendments to the MOU.
- State Medicaid agencies could recommend adoption by MPI units and MFCUs and incorporate them as appropriate into MCO Medicaid contracts with the state.
- Through its audit process of state Medicaid programs, CMS can make "observations" when it finds a weakness or room for improvement. These "observations" would not represent a formal finding or requirement, but would be an opportunity for CMS to encourage adoption.
- The Medicaid Integrity Institute (MII)—developed to meet the training and education needs of state Medicaid Program Integrity employees—regularly considers suggestions for enhancing its course offerings. NHCAA believes that consideration should be given to incorporating the NHCAA Collaborative Practices into relevant course materials. Additionally, to the extent feasible, MII should consider the collaborative value of inviting Medicaid MCOs to participate in relevant programs.
- Through their respective policy review processes, NAMPI and NAMFCU could support and encourage adoption by their members.

The cooperation envisioned by the NHCAA Collaborative Practices holds promise for yielding positive results for prevention, investigations, recoveries, and enforcement actions. These in turn factor into

lowering medical costs by halting spending attributable to fraud, and ultimately translates into savings for taxpayers as well as for Federal and state budgets.

With billions of dollars lost every year, detecting, preventing, and prosecuting fraud requires focused attention, compliance with regulations, statutes, policies and contracts, and a commitment to innovative solutions. There is no silver bullet for ridding the Medicaid program of fraud, but NHCAA believes that a successful anti-fraud program and strategy must be multi-faceted, and the adoption of the following recommended Collaborative Practices can have a positive impact on the success of anti-fraud efforts in Medicaid.

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NHCAA Collaborative Practices for Anti-Fraud Success in Medicaid Managed Care

February 2020

Premise: Success in detecting, preventing, investigating and prosecuting health care fraud in Medicaid is enhanced when public and private anti-fraud partners are committed to common goals, effectively communicate, build relationships and establish trust, leading to meaningful collaboration and efficient utilization of resources.

1. Hold Regular Meetings of Medicaid Anti-Fraud Partners
2. Ensure Coordination between MPIs and MFCUs
3. MCOs Must Report Provider Network Changes and Encounter Data
4. Employ the Use of Data Analytics
5. Communicate Data Analytic Activities and Capabilities
6. Share Data Analytic Information
7. Institute a Case Coordination Process
8. Communicate Investigation Status
9. Recognize Preventive Measures
10. Identify and Address Disincentives That Impact Recoveries
11. Streamline MCO Reporting Requirements
12. Evaluate Standardized Reporting

NOTE: These Collaborative Practices are offered with the understanding that they incorporate the sharing restrictions placed on the government and the retention of governmental discretion in sharing and communicating data analytic information, case coordination matters and investigative status information.

Collaborative Practice #1: Hold Regular Meetings of Medicaid Anti-Fraud Partners

Regularly scheduled, state-specific meetings should be implemented that bring together public and private Medicaid anti-fraud partners to communicate, collaborate and build meaningful working relationships. (While ideally these meetings would be in-person, other formats that utilize technology could be effective.) At a minimum, these meetings would include the state Medicaid Program Integrity (MPI) Unit, the state Medicaid Fraud Control Unit (MFCU), and Medicaid MCOs operating in the state. Other Federal and state entities may be included as appropriate.

Comments:

- This practice of regularly scheduled meetings of Medicaid partners is fundamental. NHCAA recognizes that confidentiality requirements impose limitations on the ability of MPIs and MFCUs to share certain information. Where government partners are able to share information, it will meaningfully enhance communication and collaboration with one another, and will encourage an environment of trust where the implementation of additional collaborative practices is more easily attainable.
- On March 22, 2019, HHS-OIG published a final rule[17] that makes revisions to State Medicaid Fraud Control Unit Rule and State Medicaid Program Integrity Rule. In the section devoted to public comments and OIG responses, the OIG offered the following statement about including MCOs in meetings: *"We also believe it is a best practice that the Unit or State program integrity officials collaborate with the MCO SIUs and that SIU officials attend regular meetings on referral issues. However, we are also mindful that States should have the discretion to define the relationship with MCOs within the confines of existing law and regulation."*
- Establishing a successful meeting process demands commitment by the partners and it can take time to build trust. Be aware that staff turnover is an unavoidable reality which creates challenges that can undermine the process.
- Topics for discussion in these meetings should be solicited from all included partners and could consist of the following: anti-fraud strategies; fraud trends and emerging schemes; the sharing of investigative insight, information, and data; and state expectations for its contracted MCOs.
- Next steps, takeaways and any decision, directive or obligation resulting from partner meetings should be documented in writing, particularly if there are changes to which MCOs must adhere. Ideally, these changes would be enumerated in a dated memo to the affected MCO(s) to ensure compliance, understanding and accountability.

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[17] Medicaid; Revisions to State Medicaid Fraud Control Unit Rules, 84 Fed. Reg. 10700-01 (March 22, 2019). Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-03-22/pdf/2019-05362.pdf.

- In addition to convening regularly scheduled meetings of all Medicaid partners in a state, each partner—whether it be the state agency, MPI unit, MFCU, or an MCO, should devote time and energy on targeted relationship building with other individual partners.

Collaborative Practice #2: Ensure Coordination between MPIs and MFCUs

Regular and routine coordination between MPIs and MFCUs should be a goal for every state program. This coordination will help to ensure consistent information flow between these key state entities, as well as the consistent flow of information and guidance, when appropriate, to program MCOs.

Comments:

- Medicaid agencies and MFCUs are separate and distinct entities, but are required to enter into a written agreement that establishes a practice of regular meetings or communication between the two entities. Regulation requires them to establish procedures for how they will coordinate their efforts.[18] However, the Medicaid agency does not have authority to review the activities of the MFCU, or to review or overrule a referral of suspected criminal violations to an appropriate prosecuting authority. 42 CFR § 1007.9.
- The states' Medicaid Program Integrity (MPI) offices conduct preliminary investigations[19] regarding potential Medicaid fraud (that is not the result of a whistleblower qui tam filing, or independent MFCU or federal investigation). Findings of a preliminary investigation determine whether there is a credible allegation of fraud and a full fraud investigation is warranted. Where a full fraud investigation of a provider is warranted, the state MPI is obligated to refer the matter to the state's MFCU.[20] MFCUs may also investigate any potential fraud referred directly to the MFCU or based on their own independent investigations. Federal regulation requires that state contracts with MCOs contain a provision requiring the "prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit." Part 438.608(a)(7). (This referral requirement is more stringent than the "suspected" fraud referral standard.) These obligations necessitate a strong working relationship between the state MPI and MFCU.

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[18] Medicaid; Revisions to State Medicaid Fraud Control Unit Rules, 84 Fed. Reg. 10700-01 (March 22, 2019). Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-03-22/pdf/2019-05362.pdf

[19] 42 CFR, § 455.14. Preliminary Investigation. Retrieved from https://www.ecfr.gov/cgi-bin/text-idx?SID=7031e4ccd8171f584c9fc102cfc1f85a&mc=true&node=se42.4.455_114&rgn=div8

[20] 42 CFR, § 455.15. Full Investigation. Retrieved from https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7031e4ccd8171f584c9fc102cfc1f85a&mc=true&r=SECTION&n=se42.4.455_115

Collaborative Practice #3: MCOs Must Report Provider Network Changes and Encounter Data

Pursuant to 42 CFR Part 438, MCOs must report, consistent with requirements established by the State, information regarding any potential provider fraud or abuse. This should include reporting providers who are terminated from the network (whether or not for cause), whose contracts have not been renewed, who voluntarily leave the network, or whose circumstances may impact the provider's eligibility to participate in Medicaid. Complete, accurate and timely encounter data consistent and in standardized ASC X12N 837 and NCPDP formats are required by Part 438.242, and other actions such as the collection of overpayments from providers.

Comments:

- The Part 438 amendments require Medicaid agencies to require MCOs to report when a provider suspected of fraud or abuse is terminated not for cause, is removed from the network because of nonrenewal of the provider contract, or voluntarily leaves the network, in addition to when the provider is terminated for cause. MCOs are also required to report other actions such as the collection of overpayments from providers.
- The states are required to have MCOs certify encounter data in a complete, accurate, and timely manner.
- MCOs are required to submit encounter data in standardized ASC X12N 837 and NCPDP Formats as required by Part 438.242 and to report matters involving MCO actions against providers.
- Data fields should include the actual amounts paid by MCOs to providers, including those payment methods using a Value Based Payment methodology.

Collaborative Practice #4: Employ the Use of Data Analytics

To the extent that it is not otherwise prohibited by law, each Medicaid partner—MPIs, MFCUs, and MCOs—should utilize proactive data analytical tools as a key part of its anti-fraud efforts.

Comments:

- In one of its recommendations, the OIG report stresses the importance of both MCOs and states employing proactive data analysis to identify cases of fraud and abuse and to improve the quality of referrals made by MCOs to the states.
- Federal regulations identify the "circumstances of permissible data mining" that MFCUs can conduct as well as the process for obtaining approval to utilize data mining as an investigative tool. 42 CFR 1007.20. As of January 15, 2020, twenty states have OIG approval to data mine.[21]
- In addition to traditional claims edits, proactive data analytics could include anomaly detection, predictive analytics, and social network analysis.

Collaborative Practice #5: Communicate Data Analytic Activities and Capabilities

Consistent with any law enforcement or proprietary restrictions, each partner should communicate the scope of its data analytic activities to other partners so that there is a statewide understanding of the data analytical activities and capabilities of each partner.

Comments:

- Establishing a baseline of the data analytical capabilities of the Medicaid anti-fraud partners in the state would provide a better understanding of the strengths and weaknesses of the partners' collective ability to detect and prevent fraud and abuse.
- Partner communication with MFCUs and MPIs concerning data analytic activities and capabilities underscores the importance of working together to identify and address fraud, waste and abuse, while helping establish data analytic expectations among peers. Most Medicaid MCOs employ the use of fraud detection software that generates reports, performs peer comparisons, and identifies high utilizers of CPT codes.

[21] Data Mining Applications, OIG Approvals of Data Mining Applications, Retrieved from https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/data-mining.asp

Collaborative Practice #6: Share Data Analytic Information

Consistent with any law enforcement or proprietary restrictions, statewide protocols agreed to by state Medicaid partners for the sharing of the anti-fraud information developed from anti-fraud data analytics should be established.

Comments:

- Promoting coordination among partners in the cross-use of available data analytics for anti-fraud purposes is crucial to anti-fraud success. Medicaid partners should strive to share algorithms (nonproprietary) employed for anti-fraud purposes, especially focusing on high-risk areas.
- In a state with multiple Medicaid MCOs, plans typically lack access to data from across the Medicaid program in that state. Here, the state has a valuable role to play in establishing expectations and parameters around data sharing; standardizing data fields and the definition of terms; and identifying successful analytics that can be applied broadly across the program.
- These expectations and parameters could be documented in a MOU or information sharing agreement among all the partners. The NHCAA Member Organization information sharing agreement could be used as a model.

Collaborative Practice #7: Institute a Case Coordination Process

Consistent with law enforcement or proprietary restrictions, MPIs, MFCUs, and other relevant state regulatory and law enforcement agencies should implement a case coordination process that allows for a collective and comprehensive review of referred cases with the goal of trying to quickly and efficiently identify those cases warranting MPI administrative or MCO contractual action, versus those needing further law enforcement review. For those cases needing further law enforcement review, the process should set flexible timeframes for the investigative phases; and identify next steps and tasks to be taken by each partner. As appropriate, MCOs should be permitted to provide input regarding cases they have referred. Case Coordination is also enhanced when there are timely responses to MFCU/MPI requests for MCO data, information or assistance.

Comments:

- Beginning in 2018, the CMS Center for Program Integrity (CPI) and HHS Office of Inspector General (OIG) began a formal major case coordination process. Through this process, decisions are made about what action should be pursued in alleged fraud cases, ranging from administrative remedies to further investigation by law enforcement with the goal of a criminal indictment. The concept is to apply the right tool, at the right time, in the right order, based only on conduct. This process serves as an example for this collaborative practice.
- NHCAA recommends that states and their Medicaid partners develop a case coordination process that works for their state, based upon the laws, rules, policies, enforcement opportunities and other tools that exist. The process should identify the cases better suited for administrative/contractual action versus those that need further law enforcement review. Not all provider payment issues require criminal indictment or other legal or administrative action by a government partner. For instance, because of the provider contracts they maintain, Medicaid MCOs can apply tools such as terminating or suspending a provider from its network, placing a provider on pre-payment review, implementing withholds or furnishing provider education. Part 438.608(a)(4) requires MCOs to report provider terminations to the state, and within the parameters of applicable law, MCOs should also notify other MCOs when it terminates providers. For a major case coordination process to be optimally effective, all Medicaid partners should have an understanding of the breadth of the tools, remedies and capabilities each partner brings to the table.

Collaborative Practice #8: Communicate Investigation Status

A process should be instituted that provides for routine communication between state Medicaid authorities (Medicaid agency, MPI, and/or MFCU) and partner MCOs, under established timeframes, concerning the status of an investigation or other action regarding a case referred to the state by the MCO as per state requirements. In cases where further administrative or other alternative action by the MCO to mitigate financial losses would no longer adversely impact an investigation or other state action, the MCO should be so informed in a timely manner and permitted to take such action.

Comments:

- There will be limits as to what information can be shared by states or MFCUs due to court orders, court sealed cases, statutory and regulatory confidentiality requirements, and law enforcement discretion to keep some information confidential because of particular case needs. This includes, but is not limited to, the need to protect the safety of witnesses and law enforcement personnel, and to protect the integrity of law enforcement investigations. MCOs should also not take any action to investigate, resolve or bring a legal action while the referral is pending.
- Depending on its complexity, the investigation of a case referred by an MCO to the state can often take an extended period to complete. In some states, there is a period of time following a referral where the MCO, and perhaps the state MPI office as well, are expected to "stand down" from any administrative or other actions, including recovery of overpayments. During this "stand down" period the provider involved may continue to commit the conduct under investigation, causing financial loss to the Medicaid program and MCO, without the MCO being able to take mitigating action for risk of compromising the ongoing investigation. This type of situation is unavoidable in some cases. However, the situation can be improved upon by providing the MCO with routine, periodic updates as to the status of the investigation; and by informing the MCO in a timely manner when the status of the case allows the MCO to take mitigating action to prevent further losses.
- A regulatory process exists that requires the state agency to request, on a quarterly basis, a certification from the MFCU that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the payment suspension. The Medicaid Agency Fraud Detection and Investigation Program rule[22] and the State Medicaid Fraud Control Units rule[23] both address this.

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[22] Medicaid Agency Fraud Detection and Investigation Program; Suspension of payments in cases of fraud; Referrals to the Medicaid fraud control unit. 42 CFR §455.23(d)(3)(i-ii). Retrieved from https://gov.ecfr.io/cgi-bin/ECFR?page=browse

[23] State Medicaid Fraud Control Units; Relationship and agreement between Unit and Medicaid agency. 42 CFR §1007.9(f)-(h). Retrieved from https://gov.ecfr.io/cgi-bin/ECFR?page=browse

Collaborative Practice #9: Recognize Preventive Measures

Measures designed to prevent fraud before it occurs should be part of every MCO's anti-fraud program. Correspondingly, states should recognize and account for, as appropriate, the impact of anti-fraud preventive measures used by MCOs when evaluating the effectiveness of overall MCO anti-fraud efforts. In addition to comprehensive utilization management, such measures may include, but are not limited to: pre-payment authorizations and reviews; provider screening to prevent potentially fraudulent providers from network participation or to remove such providers from participation; and advanced data analytics such as predictive modeling and social network mapping. The quality of referrals made to MFCUs and MPIs is also an important measure.

Comments:

- Like SIUs operating in the commercial health insurance market, Medicaid plan SIUs no longer focus exclusively on recoveries and "pay and chase" methodology for fighting fraud. Today, MCOs are devoting increased resources on prepayment efforts to detect and stop fraud before the monies are lost. Recoveries no longer represent the sole measure of success for Medicaid plan SIUs. An SIU's return on investment (ROI) also includes, for instance, its work ensuring that services are medically necessary and having claims system edits, smart algorithms, and prepayment blocks in place that are working every day, saving the program precious and finite health care dollars. The value of an MCO's special investigations unit today hinges upon not only potential fraud referrals and recoveries, but fraud and abuse prevention as well.
- An NHCAA member had recent success in proactively denying access to its network by pharmacies that were suspected of fraud, thus preventing and minimizing exposure. Measuring, acknowledging and accounting for the impact of such efforts should be considered a part of Medicaid MCO program integrity effectiveness.
- MCOs are often innovators who develop new anti-fraud tools, strategies and initiatives. To some extent, this can likely be explained because health insurers that participate as Medicaid MCOs often offer other plans and products across various markets—commercial group health insurance, individual market insurance, and Medicare Parts C and D. This range of experience can help an SIU hone its fraud fighting skills and increase quality referrals to MFCUs and MPIs.
- Below is a list of fraud and abuse preventive activities that could be considered when assessing an MCO's program integrity efforts:
  - Comprehensive Utilization Management to determine medical necessity and plan benefits
  - Clinical Pre-Payment Reviews
  - Clinical Prior-Payment Authorizations

- Claim System Pre-Payment Edits and Denials based on CMS and ADA/CPT/HCPCS coding rules
- Base Edits that analyze contract dates, provider and member eligibility
- Duplicate Check Edits against member claims history
- Program Integrity Awareness and proactive Fraud, Waste and Abuse training for providers, members and employees
- Credentialing and Continuous Screening Processes
- Internal Referrals from Claims, Utilization Management, Customer Service, Complaints Grievances and Appeals, Compliance Hotlines
- External Referrals from Members, Hotlines, Agencies, Law Enforcement, Boards, Publications, and NHCAA
- Provider communication, education, and suspensions carried out in response to potential fraud, waste or abuse activity that result in a measurable change in behavior, as well as provider network terminations
- Use of fraud detection software (rules-based, predictive analytics, etc.)
- Pro-Active Data Analysis indicating Outlier Activity
- Utilization Oversight, Education and Monitoring
- Timely referrals to MPIs and MFCUs of potential fraud

- MCOs that seek to have prevention activities valued and considered by the state when evaluating their program integrity efforts should be prepared to provide detail about those prevention activities.

Collaborative Practice #10: Identify and Address Disincentives That Impact Recoveries

States should review existing laws, regulations, policies and MCO contract provisions and requirements relating to the retention of recoveries in Medicaid managed care with the goal of designing policies that incentivize MCOs to increase recoveries, while recognizing that even without financial incentives, MCOs are legally and contractually required to report potential fraud to MPIs and MFCUs.

Comments:

- The OIG recommends that CMS work with the states to identify and share practices about payment-retention policies and incentives to increase recoveries. It recommends that CMS identify states that have incentive policies, such as "finders keepers or other arrangements," and to share that information with other states as a possible way for states to create stronger incentives for MCOs.
- Restitution for MCOs due to fraud and other overpayments differs state to state. Some states will keep all restitution, some will split it, while still others may return it all to the plan. It's notable that in some states MCOs must seek permission to ask for a recovery or restitution (this after the plan has already sought permission to launch an investigation). Moreover, pursuant to Part 438.608(d)(iv), an exception exists relating to sharing False Claims Act recoveries. Recoveries under the False Claims Act and other investigative recoveries by the government, belong to the government, and cannot be negotiated with the MCOs or included as a recovery belonging to the MCO.
- Regulation requires the state MFCU and the state agency to agree to establish procedures by which the MFCU will receive referrals of potential fraud from MCOs.
- As states seek to develop and implement new and innovative policies aimed at incentivizing MCOs to identify and recover overpayments associated with potential Medicaid fraud, assessing the outcomes of those policies over time as compared with the policies' goals should be a part of the process.

Collaborative Practice #11: Streamline MCO Reporting Requirements

Within the parameters identified in Part 438, the state should examine the reporting requirements for Medicaid MCOs to evaluate the value, necessity and timeliness of each reporting requirement. To improve efficiency, reduce unnecessary administrative burden and safeguard finite anti-fraud resources, reporting requirements, reporting forms, and reporting processes should be standardized and streamlined as much as practicable, and where warranted, eliminated. Collaboration also provides an opportunity to identify additional data points to report in order to assist in identifying potential fraud, including those related to value-based payments.

Comments:

- This exercise could help partners develop an appreciation for the reasons behind various reporting requirements and could also shed light on requirements that are lacking in value and utility. Having regular discussions among partners about reporting also can help avoid these requirements from falling victim to a "going through the motions" mentality, resulting in data that is lacking in depth and usefulness. All required data, documents and information should be timely and complete, and MCOs should comply with all requirements. Part 438.608(b).
- The OIG report made a specific recommendation that CMS work with the states to standardize reporting of referrals across all MCOs in the state. (CMS did not concur with this recommendation.)

Collaborative Practice #12: Evaluate Standardized Reporting

As a means toward administrative burden reduction, collectively, state Medicaid agencies should evaluate whether there are state-specific reports that could be transformed into a standard report that can be used uniformly state to state, whether regionally or nationwide.

Comments:

- A number of MCOs contract with Medicaid in multiple states and as a result must comply with the reporting requirements in each of those states. To the extent the information required to be reported is similar in nature but required to be reported on different forms in different formats, it could be more efficient for both the MCO and the states if some reporting could be standardized among the states on a national or regional basis, especially systems that utilize the required X12 and NCPDCP formats.