March 30, 2026

Administrator Mehmet Oz
Deputy Administrator Daniel Brillman
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz,

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate the opportunity to comment on this RFI related to CRUSH. MHPA and its member MCOs are grateful for the opportunity to collaborate with CMCS to address these critical issues, and stand ready to partner with CMS, states, and providers in addressing fraud, waste, and abuse (FWA) in the Medicaid program. Ensuring that Medicaid services are of high quality and readily available for those for whom the service is clinically appropriate is of the utmost importance to MHPA and its member plans.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 Medicaid managed care organizations (MCOs) serving nearly 51 million Medicaid enrollees in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid enrollees receive health care through MCOs, and MHPA provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost- effective, and quality health care for Medicaid enrollees.

How MCOs are detecting and combating FWA

As joint funders of Medicaid, both the federal government and states are instrumental in ensuring Medicaid program integrity. As Medicaid's predominant delivery model, Medicaid MCOs play a critical role as partners in detecting and mitigating FWA in the Medicaid program. The interventions described below are in addition to the proactive network contracting oversight, prior authorization, and payment integrity efforts that are standard for nearly all plans subject to state partner approval.

- **Utilization Management (UM)** protects taxpayer dollars through upfront program integrity efforts, including prior authorization, step therapy, and pre-adjudication of claims. Prior authorization enhances patient safety, increases evidence-based care, and reduces overutilization of medically unnecessary or low-value health care services, while

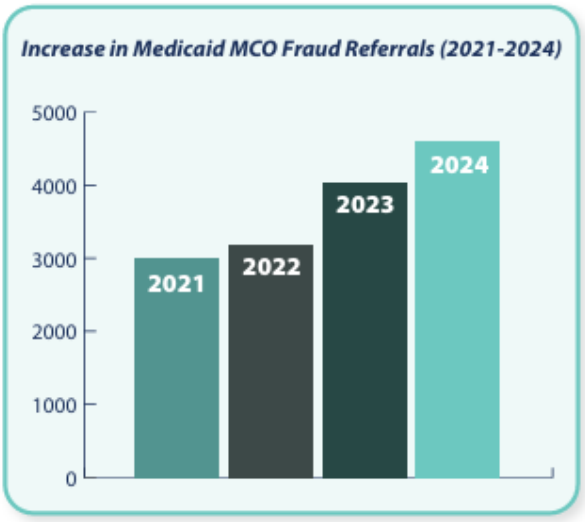
still ensuring access to care. Some states are placing restrictions on UM tools, which can have a deleterious impact on the ability of MCOs to effectively address FWA.

- **Leveraging internal clinical review**, including prior authorization, supports clinically appropriate care. Member plans noted the importance of diagnoses that are provided by qualified clinicians in their respective specialty areas.
- **Screening network providers and employees** verifies whether they are excluded from the Medicaid program by the Department of Health & Human Services (HHS)/Office of Inspector General (OIG) or debarred by federal officials from participating in federal contracts (42 CFR § 438.610). Screening methods include license verification and database checks for criminal history and/or other disqualifying information. Many member plans engage in the best practice of requiring providers to provide up-to-date background checks, fingerprint clearances, and other required documentation to maintain credentialing. A member plan noted they were able to use available staff rosters to screen for staff working for multiple agencies and were able to identify staff reporting a high number of hours per week across multiple agencies. Working with these providers, the plan made more than 100 referrals to the state's Medicaid Fraud Control Unit (MFCU).
- **Formal compliance programs** provide transparency through written policies, procedures, and standards of conduct (42 CFR § 438.608).
- **Monitoring and auditing**, leveraging ongoing systems to detect, assess, and respond to risks allow for early identification and action to address potential issues. Robust monitoring and advanced data analytics, including algorithms and data mining, enable Medicaid MCOs to identify patterns and insights that can prevent payment for extreme quantities of services provided on the same day, medically impossible or unlikely services, and services improperly combined or separated for payment purposes. MCOs also work to ensure payment integrity by reviewing claims to verify billing accuracy. When anomalies are detected, Medicaid MCOs refer potential FWA to the state Medicaid agency and/or MFCUs while initiating rapid review, provider outreach, and/or a pre-payment hold. This data oversight is part of routine analysis of claims and encounter data. MCOs also leverage case managers that monitor service patterns to identify outliers and help protect against FWA.
- **Cross functional structures** are integral to monitoring FWA across the full claims life cycle. Utilizing a multidisciplinary approach allows various departments (e.g., enrollment, network operations, pharmacy) to proactively identify and address FWA in a holistic and efficient framework.
- **Investigation and remediation** processes support quick action once potential issues are identified and enable implementation of corrective actions. MCOs follow compliance reporting requirements and initiate corrective actions, including referrals to the state

OIG, issuance of a refund demand letter, placement of provider on prepayment review, education for the provider, and/or a referral to provider network for consideration of network termination.

- **Training** comprised of regular instruction for senior leaders and staff on federal and state standards supports program integrity efforts.

A recent OIG report found that Medicaid MCOs have steadily increased their fraud referrals each year, rising from just under 3,000 fraud referrals in 2021 to more than 4,600 in 2024.



Recommendations to Address FWA

We commend CMS for its decisive action to combat FWA in the Medicaid program, including its proactive outreach for stakeholder recommendations through this RFI. While we are strongly encouraged by federal and state efforts, we encourage CMS to take steps to further empower Medicaid MCOs to detect, stop, and recover fraud faster by removing procedural obstacles, standardizing reporting, improving data sharing, and aligning incentives for prevention.

Recommended areas for programmatic changes that will further empower MCOs to effectively fight FWA are as follows:

1. **Allow proactive processes** that enable MCOs to intervene in potential FWA.
    a. Allow MCOs to initiate temporary payment suspensions and prepayment reviews based on credible allegations of fraud, particularly where patterns of behavior are already documented across programs, eliminating waiting periods to allow for rapid interventions.
    b. Establishment of time-limited exceptions to prompt-pay requirements for claims under active investigations for FWA and short-term waiver of network-adequacy requirements when an MCO terminates a provider for fraud, allowing time to recruit a high-quality replacement.

c. CMS should consider a potential framework for prepayment claims review allowances based on the foundational legal framework found in use by the State of North Carolina's Department of Health and Human Services (see NC G.S. § 108C-7). CMS should require a framework which allows MCOs to conduct data-driven prepay reviews across all CMS-overseen programs, without pre-approval requirements or arbitrary time limits allowing oversight until billing issues are fully resolved. This would allow resources to be focused on detection and prevention over correction.
d. CMS should support states by proactively providing guidance that will streamline implementation of the Medicaid provisions of the Working Families Tax Cut (WFTC) Legislation, including community engagement requirements and the increased frequency of redeterminations. This guidance will not only promote program integrity by reducing administrative burden and ensuring accurate implementation but will also ensure eligible enrollees continue to access coverage.

2. **Standardize program integrity reporting** to eliminate state variation.
    a. CMS should consider exercising its existing oversight authority under 42 U.S.C. § 1396a(a)(4) and 42 U.S.C. § 1396u-6, and pursuant to 42 CFR Part 455, Subparts A and E, to require states to adopt uniform program integrity standards.
    b. Establish a standardized reporting framework for all states, including consistent overpayment reporting requirements, recovery timelines, and a common data definition set and formatting guidelines, as well as cross program taxonomy for FWA.
        i. Create a single portal submission process for regulatory reporting related to Special Investigations Unit (SIU) case investigations, and data-sharing framework that enables cross state fraud detection and pattern detection for emerging schemes.
        ii. Standardized reporting should also include reporting templates and response protocols that will reduce administrative burden and improve information sharing, as well as enable more comprehensive anti-fraud analytics.
    c. CMS should require states to report detailed data on fraud referrals, investigation outcomes, overpayment recoveries and prepayment savings or payment suspension for Medicaid and CHIP. Further analysis should also be linked to MFCU timelines, acceptance rates and outcomes against the referrals reported to CMS and submitted by Managed Care SIUs through regulatory reporting requirements.

3. **Require expanded data driven oversight**, including claims analytics, cross state and cross plan data sharing, and outlier detection to identify fraud patterns early. Enhancing data sharing infrastructure will reduce the siloed nature of current oversight.

Analytics

a. CMS should encourage the adoption of front-end risk scoring methodologies, looking beyond individual claim-level data and include cyber-tracking, banking information cross-references to identify unrelated NPIs with the same banking information, link analysis and business affiliation mapping.
b. Implement at the base level a strong feature-first algorithmic foundation that emphasizes specific, interpretable billing characteristics indicative of FWA. These features should include both provider-level signals and network/graph-based indicators, with features incorporating peer group normalization to ensure providers are evaluated relative to comparable peers. Example features include compromised ID billing ratios, patient acuity levels that are atypically low for the services billed, and elevated rates of cross-billing among otherwise unrelated providers. With a sufficiently rich set of features, providers can be risk-scored using unsupervised outlier detection methods (e.g., an isolation forest). As investigations confirm whether flagged providers are legitimate or fraudulent, these outcomes can feed into a supervised machine-learning feedback loop that continuously improves detection accuracy. The analytical framework should be tightly integrated with operational functions, particularly claims processing and investigative teams, so that high-risk activity can be acted upon quickly, deterring fraudulent payments. In practice, an approach that has all of the following is recommended: (1) a feature layer, (2) a detection layer, (3) a learning layer, and (4) an operational layer. Additional elements can further enhance the value of this system, such as using industry-wide datasets (claims, network, etc.)
c. Integrate standardized predictive data analytics and data validation tools across programs, including Medicaid and other coverage sources to identify patterns, outliers, and inconsistencies that may not be visible within a single program. Aggregating data across federal programs will help prevent bad actors and improper payments from migrating across programs and state lines.
d. Implement multi-pass coordination of benefit (COB) recovery models, which improve identification of claims where another payer may be responsible for payment.

Increased oversight

e. Targeted provider education linked to anomaly detection, enabling early intervention where unusual billing patterns emerge, supporting improved compliance.
f. Embed program integrity oversight within state operations, ensuring continuous monitoring and alignment between policy, compliance, and day-to-day program administration.
g. Establish standards for enhanced oversight of service tracking to support payment integrity initiatives.
    i. A CMS implemented threshold for enhanced monitoring. For example, in cases of large percentage increases in fee schedules, implement enhanced monitoring. Provide an opportunity for plans to escalate large increases to the state level with a formal mechanism for investigation.
    ii. Permit statistically valid audit sampling and extrapolation for increased efficiency and accountability for providers.
    iii. Examine claims and billing for matching signatures and appropriate clinical documentation.

Standardized Data Sharing

h. Create standard mechanisms for timely, bidirectional data and information sharing state-to-state and between states and MCOs.
    i. CMS should partner with states to disseminate information directly through recurrent quarterly trainings or by leveraging the National Healthcare Anti-Fraud Association to present information. CMS should also consider partnering with National Association of Medicaid Fraud Control Units (NAMFCU), the Healthcare Fraud Prevention Partnership (HFPP) or the National Association for Medicaid Program Integrity (NAMPI) to disseminate key findings, learnings and strategies around early detection capabilities.
    ii. Include providers flagged for FWA and movement of enrollment between states to ensure all parties have access to the same critical intelligence.

4. **Establish reinforced, evidenced-based provider credentialing** and supervision guidelines, as well as greater standardization of provider enrollment screening processes across states.
    a. Expand use of federal and supplemental data sources, such as Do Not Pay (DNP), and other databases to support more proactive identification of high-risk providers. CMS should also develop another centralized, cross-state mechanism to support states with more complete information to act appropriately prior to payment.

   b. Integration with and timely updates to Death Masterfile database, Treasury Offset Program, and other exclusion lists would help to mitigate payments to fraudulent individuals and providers.
   c. Reinforce that provider practice areas delivering Medicaid-funded services have National Provider Identifiers (NPI) and enroll as rendering providers to allow verification of credentials and enforce supervision rules.
      i. States may vary in which services they allow non-clinicians to provide; each state should address how these staff are appropriately trained.
      ii. Enhance validation at the time of NPI issuance and revalidation, such as location verification and ownership transparency to reduce the need for retrospective investigations and limit program exposure to known or repeat bad actors.
   d. For certain high risk provider types, CMS should require recertification annually, and for those moderate risk provider types every other year to ensure changes in ownership, location, and compliance status are captured in a timely manner.
   e. CMS should publish periodic enforcement dashboards via electronic communication or otherwise make accessible details of provider revocations and law enforcement arrests and mitigation steps.

5. **Encourage investment in anti-fraud measures** by allowing MCOs to include fraud prevention expenses in the numerator of the Medical Loss Ratio (MLR).
   a. Regulations currently do not allow Medicaid MCOs to include pre-payment fraud-prevention costs in the numerator of the MLR calculation.
   b. Allowing fraud-prevention efforts to be treated similarly to quality-improvement initiatives or post-payment fraud-reduction programs would incentivize additional investments in initiatives that stop fraud before it occurs.

6. **Incentivize states** to proactively engage in program integrity efforts by offering additional enhanced funding for states that exceed program integrity performance benchmarks.

Overall, MCOs play a critical role as partners in detecting and mitigating FWA in the Medicaid program. Building on federal requirements and working with state partners to establish faster, proactive interventions that reduce administrative burden through shared, data-driven insights and increased standardization across states will safeguard program integrity while protecting enrollees.

We thank CMS for their consideration of MHPA's feedback on this RFI and for their efforts to address this critical issue.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Senior Vice President, Government Relations, Policy and Advocacy