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Centers for Medicare & Medicaid Services
Department of Health and Human Services

Via: Electronic Mail

Re: CMS–6098–NC, RIN 0938–AV97, Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

To Whom It May Concern:

On behalf of the National State Auditors Association (NSAA), representing state audit officials nationwide, we appreciate the opportunity to provide input on the above-referenced Request for Information. We commend the Centers for Medicare & Medicaid Services (CMS) for its continued commitment to strengthening program integrity and for seeking stakeholder feedback on strategies to combat fraud, waste, and abuse across Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace.

The National State Auditors Association (NSAA) is an affiliate of the National Association of State Auditors, Comptrollers and Treasurers (NASACT) dedicated to uniting state auditors by encouraging and providing opportunities for the free exchange of information and ideas between auditors at the state, federal, and local levels.

The following comments reflect our observations and recommendations based on the experience of our member offices across multiple states. We look forward to engaging with your office in more detail as CMS explores efforts to reduce fraud, waste, and abuse.

Program Integrity Enhancements

CMS has an opportunity to strengthen program integrity through improved coordination, oversight, and enforcement mechanisms.

Enhanced coordination across federal and state entities is critical. States would benefit from improved information sharing, including access to additional federal databases and tools that allow for cross-state comparisons of provider and beneficiary data.

Strengthening national-level visibility, such as expanding databases of known fraud patterns or sanctioned individuals, would further support these efforts. An example of this is our members' work with HHS-OIG. Some of our members are using data from three sources: their state, neighboring states, and federal data to identify situations where individuals are concurrently enrolled in multiple state Medicaid plans. Working together to

reduce concurrent enrollments is critical to protecting both state and federal funds from waste.

Outside of the concurrent enrollment example, states maintain separate connections to multiple federal data sources to verify eligibility and other program requirements. Because most eligibility factors, aside from state residency, rely on federally maintained data, a centralized system would reduce administrative complexity and improve consistency while supporting states in identifying bad actors.

One state also suggested requiring the use of Office of Motor Vehicles (OMV)-equivalent driver's license data to identify beneficiaries who move out of a state. Most states' OMV-equivalent agencies participate in an interstate compact to share data when residents move between states. While the usability of the data differs from state to state, it is an example of leveraging existing information to improve program integrity.

Eligibility and Provider Oversight

In discussions among our members, Eligibility has consistently been the primary area of concern with the Medicaid program. Eligibility determination processes represent a significant area of risk and would benefit from additional federal clarity and strengthened controls. State audits have identified concerns related to insufficient verification procedures, overreliance on automated processes, and inconsistent handling of eligibility alerts.

CMS guidance would benefit from increased specificity. For example, vague regulatory concepts - such as "reasonable compatibility" in eligibility determinations - have led to inconsistent application across states and increased risk of improper payments. This highlights the need for clearer federal expectations to ensure consistent and accurate implementation.

CMS should pursue regulatory changes that strengthen oversight of eligibility functions performed by state-based exchanges. The Compliance Supplement for the Medicaid program does not currently direct state auditors to test verifications performed by these exchanges, despite their significant role. For example, in one state, the exchange determined eligibility for approximately 75% of Medicaid beneficiaries during fiscal year 2025 and is also responsible for CHIP eligibility determinations. This represents a substantial volume of determinations without assurance that verifications were performed correctly.

CMS should address the contradiction between two federal requirements. Title 2 CFR Part 200.515 requires auditors to report questioned costs for statewide single audit findings. However, under Section 1903(u) of the Social Security Act and Title 42 CFR Part 431, Subpart Q, states are required to return recoveries based on eligibility errors only when identified through the Payment Error Rate Measurement (PERM) program. This lessened



emphasis on questioned costs could lead state Medicaid agencies to not take aggressive action to remedy issues that caused questioned costs identified in Single Audits.

Enhancing requirements for verification plans, clarifying expectations for resolving eligibility alerts, and strengthening controls around passive renewals and presumptive eligibility should also be prioritized. Increased emphasis on staffing adequacy and specialization for eligibility determinations could further improve accuracy and reduce risk.

CMS could also strengthen oversight of contractors and program integrity partners by increasing incentives for participation and ensuring more consistent engagement. For example, states have raised concerns regarding limited participation and capacity among Unified Program Integrity Contractors (UPICs) and Recovery Audit Contractors (RACs), which can hinder timely investigation and recovery efforts. CMS should consider adding minimum use standards to Title 42 CFR Part 455, Subpart F to prevent underutilization of RACs.

Provider oversight could be strengthened through more frequent enrollment validation, clearer ownership disclosure requirements, and enhanced mechanisms to track providers across state lines. Expanding tools such as preclusion lists or establishing national tracking mechanisms would help prevent providers from re-entering the system in different states after sanctions.

CMS should also consider implementing regulatory changes to strengthen oversight of providers with confirmed improper claims or significant overpayments. For example, requiring periodic provider audits and shortening re-enrollment periods would enhance monitoring and reduce future improper claims. A standard five-year re-enrollment cycle may be too long for providers with a history of improper payments.

Leveraging Data

The use of data and technology is central to advancing program integrity efforts. CMS should consider establishing minimum data analytics standards and expanding the use of predictive analytics at the national level. Leveraging systems such as the Transformed Medicaid Statistical Information System (T-MSIS) could identify patterns of fraud across states that could significantly improve detection and prevention.

States would benefit from access to real-time or near-real-time data, improved system integration, and tools that generate alerts for abnormal billing patterns or eligibility anomalies. CMS could also support states by providing technical assistance, implementation guidance, and funding to modernize legacy systems and adopt advanced analytics tools.

CMS may also wish to consider the benefits of common data analytics software across states or creating a centralized technology clearinghouse of approved analytics tools,



including descriptions of capabilities and use cases. A shared analytics environment would allow states to securely upload data and run standardized fraud detection models. Additionally, model algorithms and analytic templates could be developed to identify high-risk providers, unusual billing patterns, and eligibility anomalies.

Expanding access to federal databases, including Do Not Pay (DNP), could help shift states from a "pay-and-chase" model to a more proactive pre-payment review approach. Enhanced data integration would allow states to verify eligibility, identify duplicate enrollments, and detect high-risk providers before payments are issued. Currently, utilizing Do Not Pay requires states to each enter into agreements separately with the Department of Treasury. Our members have discussed the possibility of a single agreement between the Federal government and all states which would encourage broader use of DNP by states.

However, access alone is insufficient. CMS should consider requiring the use of certain data sources and providing guidance on how to effectively integrate and act on results. States have noted that data tools are most effective when paired with clear expectations, adequate staffing, and timely follow-up processes.

Money Follows the Person

CMS should include Money Follows the Person (MFP) Demonstration Program (Assistance Listing 93.791) in Part 4 of the Compliance Supplement. Established by the Deficit Reduction Act of 2005 and implemented beginning in 2007, the MFP program is administered by approximately forty states and often qualifies as a Type A program. This is especially important given the significant federal investment over the last two decades.

Guidance, Training, and Best Practices

CMS can further support states by providing clearer guidance, expanded training opportunities, and mechanisms for sharing best practices. A multi-tiered approach including webinars, hands-on training, technical assistance, and implementation toolkits would help states adopt modern technologies and strengthen program integrity efforts.

CMS should issue management decision letters that provide actionable guidance, rather than brief responses that do not support resolution.

Training is a key mechanism to ensure stakeholders remain current on strategies to combat fraud, waste, and abuse. A strong example is the NASACT Medicaid Training Summit, a partnership between NASACT and the U.S. Department of Health and Human Services (HHS). This training includes sessions from both state and federal Medicaid auditors and is designed for auditors at all experience levels. Between 200 and 300 attendees representing state and territorial auditors, CPA firms, state Medicaid staff, and the federal government attend this virtual training held around the beginning of April each

year. This training has been essential to spreading the word on the success of states working together and with HHS-OIG to identify instances of concurrent enrollment.

CMS should also consider publishing summaries of common fraud schemes, emerging risks, and effective mitigation strategies. This would demonstrate CMS's commitment to program integrity and enhance partnerships with other entities that provide Medicaid oversight.

CMS may wish to require states to report and publish information related to fraud recoveries, program performance, and managed care outcomes to improve transparency and strengthen program integrity. Increased transparency can enhance accountability and support oversight efforts. Additionally, CMS should consider sharing the results of its reviews of state-based exchanges with state auditors to assist with their risk assessments.

Incentives and Accountability

States face resource constraints that can limit proactive investments in program integrity. CMS should consider providing financial incentives - such as enhanced federal matching rates, grant funding for additional audits, or performance-based rewards tied to reductions in improper payments.

Allowing states to retain a portion of recovered funds could further incentivize investment in fraud prevention. At the same time, clear accountability standards and strengthened oversight remain essential to ensure consistent compliance.

Conclusion

We appreciate the opportunity to provide these comments. We believe that clearer guidance, stronger oversight, improved data sharing, and expanded use of analytics will significantly enhance efforts to prevent and detect fraud, waste, and abuse.

NSAA looks forward to a continued collaboration with CMS to support these important objectives.

Sincerely,

Pat McCarthy
President, NSAA
State Auditor, Washington