National
MLTSS
Health Plan Association

November 2026

Recommendations to Improve MCPAR Reporting and Analysis

Dear Center for Medicaid and CHIP Services (CMCS) staff,

The National MLTSS Health Plan Association (MLTSS Association) greatly appreciates CMCS staff speaking with the Association about CMS's review of Managed Care Program Annual Reports (MCPAR) data. We understand that CMS is especially interested in using MCPAR data to help quantify Fraud, Waste, and Abuse (FWA) detection and oversight efforts. We also recognize that CMS has identified data inconsistencies in MCPAR data – including in data related to dental and MLTSS plans.

Background

While we share CMS's interest in better understanding the data variation in MCPAR, it is important to first account for differences in state requirements and the operational processes that generate the report data. Medicaid managed care organizations (MCOs) operate under individual state contracts. As a result, program integrity definitions, reporting thresholds, and program design can vary substantially across states and MCO contracts. Moreover, states diverge on how they define elements of the MCPAR itself. For instance, a state may require reporting of "suspected" fraud cases versus only "known" cases. States also differ in reporting requirements. For example, one state may require an MCO to report virtually every fraud referral received, while another may allow the MCO to conduct an initial review and report only matters warranting a Special Investigative Unit (SIU) investigation.

Differences in program design also contribute to variation in results reported in the MCPAR, such as in long-term services and supports (LTSS) programs. For example, LTSS programs frequently require strict prior authorization, with MCO reviews completed before services are rendered. This front-end review can reduce waste, denials, and disputes that would otherwise surface later in the process. These programmatic design differences, separate from any difference in program integrity rigor, illustrate why cross-program and cross-state comparisons require caution.

Differing state approaches can also produce very different referral and investigation counts even when underlying activity is similar. HHS-OIG has documented significant state variation in fraud referral thresholds, timing, contractual requirements, and related processes.

There are several MCPAR elements that make comparability difficult due to various factors.

- **Overpayments/recoveries:** Results depend on definitions, state requirements, and where in the payment integrity lifecycle amounts become reportable. Effective prepayment controls can also reduce downstream overpayments and recoveries, so lower recoveries do not necessarily indicate weaker program integrity performance.

- **Investigations:** Counts can vary based on case-opening criteria, reporting requirements, investigation complexity, and closure practices.
- **Staffing:** FTE counts may not capture actual capabilities because MCOs often use centralized SIU, analytics, clinical audit, payment integrity, and vendor resources across markets.
- **Longitudinal trends:** Changes over time in state definitions, thresholds, recovery requirements, or contract provisions can cause MCPAR values to change even when underlying activity or MCO performance has not.

Recommendations

As CMS has identified data inconsistencies in existing MCPAR data reporting, we strongly support CMS working with states, and health plans as applicable, to address these inconsistencies before using the data for trend analyses or managed care oversight. To address existing comparability and consistency issues in MCPAR data reporting we put forth the following recommendations for CMS:

Improving Comparability and Consistency of MCPAR Data:

1. **Update the MCPAR data dictionary to establish common definitions for MCPAR reporting elements including:**
    - Referrals
    - Investigations
    - Overpayments and recoveries
    - Credible allegations of fraud
    - Reporting thresholds and timelines
    - Payment suspension and deconflictions
    - Treatment of centralized/shared resources

    We recommend that CMS also expand this data dictionary to address distinctions in program integrity data reporting, including:
    - When a matter becomes an open investigation and distinguishing between preliminary reviews, analytics-generated leads, and formal SIU investigations;
    - When an investigation is considered resolved, including whether resolution means administrative closure, investigative completion or another specific event;
    - Establishing the counting unit, such as Provider, investigation/case or claim, and address matters spanning multiple reporting periods;
    - Distinguishing referrals to state Medicaid program integrity units from referrals to Medicaid Fraud Control Units (MFCUs), including direct referrals and whether referrals are counted when submitted or accepted;

- Accounting for state contractual or regulatory requirements that may require a matter to be opened, recorded or reported even when it would not independently meet the plan's ordinary investigative threshold

CMS could also provide a plan-facing request template that uses MCPAR's exact definitions that states could use to solicit data from plans. This would improve consistency across states and reduce burden for plans that operate in multiple states.

2. **Require states to document and share their MCPAR reporting methodologies with health plans including a clear mapping between the source report, the applicable MCPAR field and any state adjustments or calculations.** States have flexibility in how they report on their MCPAR data. For example, some states pull information for MCPAR from existing reports, some states ask managed care plans for data for specific elements, and some states rely on a mixture of both methods. In some cases, MCOs have reported a lack of awareness of the state's MCPAR reporting methodologies, while other plans have reported data to states without receiving feedback. This inconsistency makes it difficult for managed care plans to know where a state's MCPAR data came from, which in turn makes it difficult to rectify any data inconsistencies.

   CMS could require states to document or obtain CMS pre-approval of their MCPAR data collection methodology before collecting data from plans. This would provide a mechanism to document state-to-state variation in data collection, while preserving state flexibility to design methodologies suited to their managed care programs.

3. **Provide technical assistance to states and plans for MCPAR reporting, especially when there are changes made to reporting definitions, specifications, or validation requirements.** Beyond more detailed federal guidance on how terms are defined, CMS could provide technical assistance to states on the operational steps required for compiling data for MCPAR reporting. Since states collect most MCPAR data from plans, we would encourage CMS to include plan staff in their technical assistance efforts, or to hold plan-specific technical assistance sessions. Also, since LTSS programs have their own unique reporting challenges, such as tracking appeals from people using LTSS, LTSS quality measures, and handling D-SNP and integrated-care populations, providing targeted technical assistance to MLTSS states and plans would address specific LTSS components of MCPAR reporting.

   CMS technical assistance should include operational examples demonstrating how common Medicaid investigative situations should be reported, including:

   - An investigative action required to be opened or reported under a state contract;
   - An investigation spanning multiple reporting years;
   - A government referral made while an investigation remains open;
   - Multiple actions or outcomes associated with one investigation; and

- Shared enterprise SIU staff working across Medicaid and other lines of business.

4. **Provide MCOs the opportunity, and a reasonable timeframe, to review and correct MCPAR reports before they are sent to CMS.** Currently, states report their MCPAR data directly to CMS and health plans do not have visibility into what is being reported. Allowing health plans to review and correct these reports before they are sent to CMS may prevent data inconsistencies in the final data. We are aware of at least one state that has recently established a workgroup that includes MCO representatives to examine the state's MCPAR data. We support this type of collaboration and believe CMS should encourage this type of engagement between states and MCOs more broadly. It may be helpful for CMS to establish a defined review period of at least 30 business days, a process for resolving discrepancies found in the data, and a mechanism for correcting information after submission if additional errors are identified, that states can implement.

   Additionally, CMS now sends states standardized feedback on data quality. We encourage states to pass the relevant plan-level findings on to plans so they can adjust their processes before the next report.

<u>Expanding MCPAR Reporting for More Comprehensive FWA Insights.</u>

We understand that states have many competing priorities and that working with health plans to accurately report the existing MCPAR data may take considerable time and effort. We believe that getting this data collection right should be a top priority for states, with support from CMS. However, as states, health plans, and CMS work to resolve MCPAR data quality issues, we believe there are also opportunities to gain more comprehensive program integrity insights from this data reporting. There may also be opportunities for CMS to work with states to eliminate other state reporting requirements that may be duplicative to the MCPAR reporting, lessening the administrative burden on states.

Below, we offer some recommendations to take MCPAR reporting further:

1. **Add MCPAR program integrity question descriptions to more accurately portray fraud detection actions.** Pairing MCPAR numerical results with a short narrative would help to provide important context for what program integrity elements actually represent. States and plans also handle different aspects of program integrity. States handle provider enrollment and screening, and many handle fraud referrals and payment suspensions. Making clear in MCPAR reporting which party is best positioned or ultimately responsible for the execution of each element would more accurately portray program integrity performance. Including a short narrative explanation from states and health plans about how contractual and regulatory requirements influence reported results would also add clarity to MCPAR reporting.

2. **Update overpayment reporting elements to better capture program integrity actions.** By reporting more granular information on overpayments, CMS will have higher quality data with which to monitor state and plan performance. CMS could consider asking states to split overpayment reporting into stages: amounts identified, amounts recovered, and amounts still pending. States could also report overpayments by source of detection (e.g., health plan, state audit, Medicaid fraud control unit). We also recommend that prepayment cost avoidance be reported separately from post-payment recoveries, and the methodology should also distinguish amounts identified from amounts actually recovered, to avoid treating estimated cost avoidance as equivalent to recovered dollars. States should also be able to report on when overpayments cannot be recovered (ex: if the provider's practice has closed, or in the case of pharmacy overpayments, which cannot be recouped). These changes would portray a more accurate picture of how plan fraud detection activities are functioning.

The MLTSS Association greatly appreciates the opportunity to provide these recommendations to strengthen CMS analysis of MCPAR data and welcomes the opportunity to continue to collaborate with CMS on this critical issue.

If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,



Mary Kaschak

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