Member Case Integrity (MCI) Shared Service

Scope, Roles and Operations

What exactly is in scope for the centralized Medicaid fraud unit (e.g., intentional program violations, overpayments, referrals only, full case handling)?

- The Member Case Integrity (MCI) Shared Service will handle the full scope of Medicaid fraud, including receiving referrals, working with the State to determine recoupment amounts and full case handling, including working with judicial districts and District Attorneys throughout the State to pursue prosecutions.
- Federal Medicaid regulations do not allow for Intentional Program Violations, nor do they allow for an "overpayment" amount to be determined without a full investigation. These processes would continue with the Shared Service.

How will fraud referrals be initiated? What is the county worker's role at referral, during the investigation, and at resolution?

- As part of R-07, a new CBMS fraud referral process will be implemented; this allows for any eligibility worker throughout the State to report suspected fraud. The county's role would be limited to referral, though the county may need to provide documentation, or interviews of county staff, for the investigation. The Shared Service would handle the case from referral to final resolution.

Will there be separate investigations (state vs county)?

- No, only Shared Services investigations of Medicaid fraud would be allowable going forward. The county would not be expected to, nor would be reimbursed for, any work related to Medicaid fraud, except referrals to, and cooperation with, the Shared Service.

How will investigators operate statewide—phone only, virtual, or in-person home visits? What will be the expectations around in-person work in distant/rural counties?

- This may look different, depending on the county or region. Some investigators may subcontract with the Shared Service, maintaining a local presence, or some may be hired by the Shared Service and travel required.

Legal Jurisdiction & Prosecution

Who prosecutes these cases—local DAs, Attorney General, something else?

- The Shared Service does not change the judicial process of Medicaid fraud investigations; this would continue per current process. However, the Shared Service would work to build relationships with DAs and judicial districts statewide, which is supported by the R-07 request for Judicial District Liaisons in the Shared Service.

Will DAs accept cases originating from outside investigators? How will jurisdictional challenges be handled when the investigation is centralized but the court is local?

- Most other states have this function centralized at the state, or regionalized, and do not have issues with DAs accepting cases. There is no precedent in federal law that requires only a county-based investigation be accepted in the judicial process. That being said, it will continue to be the decision of DAs of what "threshold" they will accept cases and the Shared Service would work through that process and document the different thresholds for acceptance of cases throughout the State.

Will the centralized unit carry cases all the way through to completion (administrative hearings, IPV determinations, criminal trials) or only investigate and hand off?

- The Shared Service would carry any fraud case through completion, including recoupment of funds from members. The county would only become involved if the case requires testimony and/or documentation from staff. This includes working with DAs and judicial districts on potential prosecutions.

Funding, Incentives and Staffing

Who receives recovered funds and incentives from collection payments (state vs county vs shared)? Will counties continue to receive 50% of certain recoveries, or will that change?

- No, counties would no longer be eligible to receive the percentage of Medicaid recoveries, as is current practice. Since those funds are actually state dollars, they would be re-routed to the Shared Service and reinvested in the Shared Service, under direction from, and with approval from, HCPF.

What is the anticipated time and cost savings to counties, especially those with high Medicaid fraud volume?

- Time and cost savings are realized because counties no longer would have the responsibility to do Medicaid fraud work; it would all be managed by the Shared Service.
- The only requirement for counties would be to partner with the Shared Service on documentation requests and if the prosecution requests testimony or interviews from county staff. The Shared Service would manage that process and work with the county to fulfill those requests.

Will the state provide new funding for the centralized unit's investigative, administrative, and travel costs, or will this be funded by reallocating county administrative funds?

- The Shared Service is fully funded by federal and state dollars only, no county share is required. Additionally, there is no requested change to HCPF's county administration appropriation to implement this Shared Service.

What happens to existing county fraud/program integrity staff—are they retained locally, reassigned to the centralized unit, or repurposed?

- As with the other Shared Services, the county has 3 options for these staff - they can repurpose them for other duties, they can subcontract with the Shared Service or they can be directly hired by the Shared Service

Data, Quality and Value

Do we have statewide data on: 1) How much Medicaid fraud work is currently done; 2) Time spent; and 3) outcomes (overpayments, recoveries, prosecutions)?

- Yes, HCPF has data through 2024 on #1 and #3, through an annual fraud report that counties were required to submit to the State, which was then passed off to the General Assembly. This includes how many active investigations in the year and what the outcomes were for those investigations. Time spent was not a datapoint collected on that report, but we have gained insight to that through other data collections.
- For reference, the annual fraud report was repealed in the last legislative session, so counties are no longer required to report that as of 2025.

How will confidentiality and data sharing be managed across jurisdictions and systems?

- Medicaid data is not owned by the counties; it is State-owned data. Therefore, the Shared Service, acting under contract and supervision of the Shared Service, would have full access to all Medicaid data throughout the state, and confidentiality measures as established by HIPAA and federal/state regulations would be adhered to.

What are the clear measures of success (reduced error rates, higher recoveries, fewer PERM findings, etc.)?

- One clear measure of success that must be implemented to comply with federal regulations is that fraud investigations occur for all counties throughout the state, which is currently not the case.

Is there any consideration of centralizing all fraud work (e.g., SNAP + Medicaid) versus only Medicaid, to avoid fragmentation and duplication?

- CDHS continues to accept county feedback and will determine the appropriate next steps.

Questions?