Request for Information (RFI) - Fraud Defense Contracts

RFI Questions - Response Form

RESPONDENT INFORMATION

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The Centers for Medicare & Medicaid Services (CMS) works diligently to crush fraud in federal health care programs, including Medicare and Medicaid. A cornerstone of CMS' program integrity (PI) strategy is focused on using advanced analytics and other investigative techniques to identify potentially problematic actors and stopping them in their tracks. CMS has traditionally contracted with private entities to bolster our investigative capabilities and take appropriate administrative action, including imposing payment suspensions, revoking Medicare billing privileges, and referring potential fraud cases to states and appropriate law enforcement entities. Through this Request for Information (RFI), we are seeking creative ideas and solutions as to how a contractor might best address the draft Statement of Objectives (SOO). The draft SOO reflects the direction of the proposed future operating model, including a greater CMS role in lead development, prioritization, and direction of investigations. We encourage commenters to recommend innovative approaches for accomplishing the objectives within that framework and to identify where the framework creates risk. Within that framework, responses should not be constrained by traditional policies and processes, such as those in the current Unified Program Integrity Contractor (UPIC) Statements of Work or the Medicare Program Integrity Manual. We have also developed a list of specific questions for which we are seeking input; however, all ideas are welcome.

*Each question appears on its own page. Type your response in the box below the question. Responses are limited to **4,000 characters (including spaces)**; text will scroll within the box if it exceeds the visible area.*

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 1

1. What defines a successful PI model in 2026 and beyond? Provide examples of activities, technology, or other innovations that should be included in a new PI model focused on crushing fraud. How is this different or similar to the traditional investigative roles of the UPICs and predecessor contractors, such as the Zone Program Integrity Contractors (ZPICs)?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should explicitly address beneficiary eligibility and identity fraud in its future Medicaid program integrity strategy and issue affirmative guidance to the state and county investigators responsible for this work. Expanding contractor analytics and provider enforcement does not resolve the gap identified in UCOWF's March 30, 2026 CRUSH response. This still applies to contract services, similar to other programs allowing third party support, such as USDA's SNAP program - see 7 CFR 272.4(g).

A successful program integrity model must prevent fraudulent enrollment and payment, identify the responsible actor, and assign each actionable lead to an agency with the authority and resources to resolve it. CMS cannot credibly describe a model as comprehensive while leaving beneficiary eligibility fraud, including stolen and synthetic identity schemes, without an explicit operational framework. Even the PARIS 2.0 initiative is modeled on pay-and-chase that wastes taxpayer funds, enables fraud/waste, and is inconsistent with HHS OIG and GAO Fraud Framework models.

CMS should issue a Medicaid Beneficiary Program Integrity Framework; require states, through appropriate authority, to identify their responsible investigative units, staffing, referral procedures, and reporting; and support identity proofing, independent eligibility verification, and interstate and cross-program matching before improper payments occur. Controls should cover enrollment and renewal, including managed care capitation paid before any medical claim is submitted.

The Marketplace demonstrates the importance of enrollment controls. CMS reported that on August 31, 2026, it canceled approximately 315,000 unauthorized enrollments covering more than 760,000 individuals and expected approximately $2.2 billion in advance premium tax credits to be returned. These were confirmed unauthorized enrollments; CMS's announcement did not establish that every case involved identity theft or a synthetic identity. UCOWF members see this every day, especially in aligned safety net social programs (Integrated Eligibility Systems that include Medicaid) where fraud is identified, offenders sanctioned, and taxpayer funds recovered... except in Medicaid. The lesson for Medicaid is to verify identity and enrollment authorization before payment and investigate suspected manipulation wherever it occurs in beneficiary applications administered by SMAs.
- See https://www.cms.gov/newsroom/fact-sheets/federal-marketplace-ffe-sbe-fp-anti-fraud-actions

UCOWF's March 30, 2026 CRUSH response explained that state and county public assistance investigators perform a distinct function that provider-focused contractors and MFCUs do not replace (and for which MFCUs cannot). Rescinding SMD 24-005 was necessary, but rescission alone did not provide affirmative guidance on investigations, permissible recoveries, referrals, and due process. This RFI continues to omit that dedicated state investigative function.

Success should include verified losses prevented, timely and lawful eligibility corrections, defensible referrals, sustained actions, and recovery where authorized. Provider-focused payment controls remain necessary, but they cannot by themselves resolve fraudulent beneficiary enrollment.

The UCOWF CRUSH response can be found at:
https://www.ucowf.net/assets/pdf/UCOWF+Response+to+CMS+CRUSH+RFI+CMS-6098-NC+30March2026/

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 2

2. CMS is considering centralizing some compliance-related tasks currently assigned to the individual PI contractors. What impacts (positive, negative, and risks) will the approach have on the PI contractors supporting payment suspensions, revocations, law enforcement referrals, etc.?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Centralized administrative support can improve consistency, reduce duplicate requests and churn, and standardize evidence packages. It can also delay urgent action, separate investigators from local evidence, and create a single bottleneck if CMS does not establish decision deadlines and escalation procedures.

CMS should centralize common support while preserving direct operational relationships with state and county beneficiary program integrity units. Any centralized model must explicitly route suspected eligibility and identity fraud to the responsible state unit. Routing all Medicaid fraud to an MFCU is not a sufficient design: federal matching funds generally do not support MFCU investigations of beneficiary eligibility fraud unless the case also involves conspiracy with a provider. Expecting law enforcement officers in agencies dedicated to serving and protecting their separate jurisdictions to investigate hundreds of thousands of fraudulent beneficiary eligibility cases without CMS funding is a futile mission at best and a threat to public safety without added dedicated staff and funds.

CMS should track both the receipt and accepted ownership of each referral. A referral that is rejected, misrouted, or left unassigned should trigger reassignment, not be counted as a completed integrity outcome.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 2a

2a. Medical Review (MR) - how should CMS distinguish MR performed in support of fraud investigations from compliance-focused MR, and what type and level of MR capability should remain with PI contractors? How should investigative MR, including targeted prepayment and post-payment reviews, be scoped to produce reliable findings without unnecessary review volume?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Medical review should answer defined clinical or billing questions needed to establish the facts of a suspected scheme. Investigative review should remain available to the case team, with qualified clinical support, documented sampling methods where used, and an explanation of how findings support the proposed action. Routine compliance review can be organized separately when that does not disrupt active investigations.

Beneficiary eligibility and identity fraud require different expertise. Medical review cannot establish whether an applicant concealed income or assets, misrepresented residence, used a stolen identity, or fabricated an identity. CMS should fund and measure that investigative work separately rather than assume clinical review covers all Medicaid fraud risks.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 2b

2b. Requests for information and requests for assistance from law enforcement and other partners - should CMS centralize this work, with whom, and what would be gained or lost in responsiveness and investigative value?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should centralize request logging, secure records exchange, standardized data production, and national coordination within a state model led by SMA's that upload to an CMS-accountable intake function. Investigators should retain direct contact with the requesting agency and the state or county unit responsible for the underlying matter. A central contractor may support intake, but CMS should retain responsibility for disclosure policy, prioritization, and unresolved jurisdictional issues.

The system should distinguish provider fraud, beneficiary eligibility fraud, identity theft, and mixed schemes. Standalone eligibility allegations should reach the designated state beneficiary investigative unit, with criminal referral to appropriate law enforcement when required. MFCUs should receive matters within their purview - relevant provider conspiracies.

Centralization can improve tracking and cross-state visibility. It will lose investigative value if it substitutes generic data responses for case consultation, obscures local evidence, or requires every communication to pass through a national queue.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 2c

2c. Site Verifications - should site verifications be centralized or performed by a separate contractor, and how should CMS coordinate them with PI contractor onsite activities?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Provider site verification may be centralized or performed by a separate contractor if investigators can request targeted visits, communicate case-specific concerns, and obtain timely records, photographs, and findings suitable for evidentiary use. Routine enrollment verification should be distinguished from visits supporting an active investigation, and duplicate visits should be avoided.

Provider site verification does not address beneficiary identity or eligibility. Where a lawful beneficiary investigation requires field verification, CMS should recognize the role of state and county investigators and their applicable access, privacy, and evidentiary requirements. A provider inspection contract should not be represented as a substitute for that capability. See the UCOWF CRUSH RFI response referenced in Q1.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 2d

2d. What other current functions performed by PI contractors could be centralized to allow the PI contractors to focus on crushing fraud?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Potential candidates include routine records retrieval, secure evidence storage, standardized data extracts, common training, referral tracking, administrative quality review, and shared identity-resolution services. Centralization should be tested against turnaround time, evidentiary quality, and the burden imposed on investigators.

CMS should retain accountable policy leadership and preserve local investigative judgment. Shared services must be available to designated state and county beneficiary investigators, not only federal contractors and provider-fraud entities. An efficiency initiative that excludes those investigators would institutionalize the same gap identified in UCOWF's CRUSH response.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 3

3. What are the advantages and disadvantages of specialty contractors for specific provider types for national functions?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Specialty contractors can provide expertise in complex provider billing, ownership arrangements, and recurring national schemes. Risks include fragmented accountability, duplicated investigations, inconsistent evidence standards, and failure to see a scheme spanning multiple provider types or programs.

CMS should require shared case identifiers, cross-contractor coordination, and a named lead for each scheme. It should also establish a distinct capability for enrollment, identity, and eligibility analysis that supports designated state investigators. Organizing every specialty around provider type leaves application fraud outside the model, even where fraudulent enrollment generates ongoing capitation payments.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 4

4. What jurisdictional structure and office or field presence would best support timely and effective investigations under the proposed PI model, including cases that may cross geographic boundaries?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

A national coordination function should support state-based investigative ownership and regional field capacity. Each state should identify its Medicaid beneficiary program integrity contact and any county or other public assistance units acting on its behalf. Written agreements should establish jurisdiction, evidence sharing, criminal referral procedures, and responsibility for administrative eligibility action.

Cross-state schemes need a designated lead and a common evidence plan. No case should disappear because a contractor’s geographic boundary differs from the location of the applicant, provider, stolen identity, or payment. CMS should provide national matching and coordination while preserving state authority over eligibility determinations and applicable enforcement processes. The current PARIS model in ineffective.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 5

5. Where do handoffs among PI contractors, Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), the Supplemental Medical Review Contractor (SMRC), and other CMS contractors delay or weaken administrative actions? How should responsibilities be redrawn under the proposed PI model?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

UCOWF does not offer contractor-specific operational findings about MAC, RAC, SMRC, or PI contractor handoffs. CMS should require an evidence-based inventory of delays, including repeated records requests, rejected referrals, competing case ownership, time to compete investigations, and elapsed time awaiting government decisions.

From the beneficiary perspective, the critical handoff is often missing altogether: a contractor identifies an enrollment anomaly but NO designated state beneficiary investigator receives and resolves it. CMS should require a documented referral pathway, acceptance acknowledgment, assigned owner, action deadline, and final disposition. Referral to law enforcement or an MFCU (in provider collusion cases as they cannot investigate beneficiaries) should not automatically close the administrative eligibility issue.

Critical to handoffs are activities occurring pre-enrollment, and those that occur post-enrollment. Examples of post eligibility involving contractors could include billing anomalies to the same client, residential address mismatches for services continually out of state, and duplicate participation matches in the PARIS system. Any and all work potentially impacting eligibility should be routed to those state beneficiary eligibility fraud control units. Any case involving beneficiary fraud, even post-enrollment, should be sent to the state beneficiary eligibility investigators as this information often prevents recertification/re-enrollment (e.g. beneficiary not living in the state paying capitation rates).

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 6

6. Should investigations involving Medicare Advantage (Part C) and Part D be integrated with fee-for-service investigations or remain with a separate contractor? What capabilities do Part C and Part D investigations require that fee-for-service investigations do not?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should preserve cross-program investigative visibility whether Part C and Part D work is integrated or separately contracted. Specialized capabilities include enrollment and disenrollment analysis, plan payment and risk-adjustment analysis, prescription-event review, and examination of relationships among plans, intermediaries, providers, and beneficiaries.

UCOWF's principal concern is that organizational separation must not hide identity misuse or inappropriate enrollment across Medicare, Medicaid, CHIP, and subsidized Exchange coverage. Suspected dual-eligible enrollment manipulation should be routed to the responsible state beneficiary investigative unit. A match across programs is a lead for review, not by itself proof of an improper enrollment.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 7

7. If CMS takes a greater role in lead development, prioritization, and direction of investigations, what decision timelines, data and systems access, and approvals must CMS commit to so that contractors can meet their performance standards?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should establish written service levels for lead acceptance, assignment, data access, investigative approvals, and proposed actions. Urgent matters involving ongoing loss, identity exploitation, or threatened evidence should receive expedited review. CMS should maintain an escalation contact and separately record time awaiting CMS, state, contractor, or law-enforcement action.

Contractors need timely access to authorized enrollment, eligibility, payment, and identity-related information, with sufficient provenance to support review. State beneficiary investigators need equivalent access appropriate to their responsibilities. Performance standards should not penalize contractors for documented government delays or encourage them to bypass required approvals.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 8

8. How should CMS transition in-flight investigations, active payment suspensions, open law enforcement matters, and case files to the new model without losing cases or institutional knowledge? What transition timeline is realistic?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require a reconciled inventory of every active matter, pending action, referral, deadline, evidence location, and responsible official before transition. Incoming and outgoing teams should conduct joint reviews of high-risk cases, preserve access and audit histories, and obtain acceptance from the receiving case owner. Pending state beneficiary referrals must be included.

UCOWF recommends a phased transition with a defined overlap period and readiness gates rather than an unsupported universal completion date. CMS should determine the timeline from actual caseload, system migration, staffing, and legal deadlines. A case should not be considered transferred until the receiving team has usable evidence and confirmed responsibility.

No transition in beneficiary eligibility investigations is necessary if CMS would acknowledge the state/county investigator roles and provide SMAs with guidance as investigators are currently and actively working these cases.

INVESTIGATIVE WORK AND OPERATING MODEL • QUESTION 9

9. What investigator, clinical, and data science qualifications should CMS require of PI contractor staff, and how do those requirements affect pricing and the ability to staff quickly?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require demonstrated investigative competence, evidence handling, interview skills, report writing, and familiarity with the relevant program and legal process. Clinical reviewers and data scientists should meet role-specific professional qualifications and demonstrate that their work can withstand independent review.

For beneficiary matters, teams need experience in public assistance eligibility, identity theft, synthetic identities, income and resource verification, integrated eligibility systems, administrative hearings, and criminal referrals. The UCOWF Certified Welfare Fraud Investigator credential or comparable documented expertise should be recognized. CMS should consult state and county investigators when developing competency standards.

Specialized qualifications affect staffing time and cost. CMS should permit qualified multidisciplinary teams, supervised training, and surge rosters without treating provider claims experience as a substitute for beneficiary eligibility expertise.

MEDICAID PROGRAM INTEGRITY • QUESTION 10

10. What concerns or benefits arise from separating Medicare and Medicaid lead development and investigations, including the effect of reduced cross-program data visibility? What did the unified UPIC model gain or lose compared with separate Medicare and Medicaid contractors, and what evidence supports that view?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Separate Medicare and Medicaid teams can improve attention to different statutes, state systems, and payment arrangements. Separation can also obscure shared identities, common actors, and schemes moving across programs. CMS should maintain authorized cross-program data visibility and case coordination regardless of contracting structure.

UCOWF does not assert a comparative performance finding about UPICs and predecessor arrangements without supporting evaluation data. CMS should compare timeliness, sustained findings, documented prevention, and referral outcomes before selecting a structure.

For Medicaid, the essential improvement is explicit recognition of state and county beneficiary investigators. A unified contract that omits them is not comprehensive; separate contracts that share actionable evidence and assign beneficiary cases can be more effective.

MEDICAID PROGRAM INTEGRITY • QUESTION 11

11. The draft SOO focuses on Medicare PI. CMS is considering the future Medicaid PI strategy and is interested in feedback on the following to frame an effective approach:

Please respond to items 11a-11e on the following pages.

MEDICAID PROGRAM INTEGRITY • QUESTION 11a

11a. What functions should the CMS PI contractor perform and which functions should be led by CMS, State Medicaid Agencies (SMAs), Medicaid Fraud Control Units (MFCUs), etc.?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should lead policy, establish national standards, oversee performance, provide shared data services, provide national and state metric results, and issue affirmative guidance on beneficiary program integrity. It should resolve the uncertainty identified in UCOWF's CRUSH response concerning investigations, referrals, permissible recovery, capitation losses, and due process following rescission of SMD 24-005. A procurement cannot substitute for that policy work.

SMAs should remain accountable for eligibility decisions and designate the state or county public assistance investigative units responsible for suspected beneficiary eligibility fraud. Those units should develop application and renewal fraud cases, verify identity and material eligibility facts, investigate discrepancies, document intent where relevant, calculate supported losses, and prepare administrative or criminal referrals within their authority. Contractors should supply analytics, identity resolution, document examination, evidence development, and technical assistance within their assigned scope. They should refer actionable beneficiary leads to the designated state unit and support resolution. They should not independently terminate eligibility, impose sanctions, or create recovery authority.

MFCUs should perform their authorized functions. Under 42 CFR 1007.19(e)(5), federal matching funds are unavailable for investigating or prosecuting beneficiary eligibility fraud unless the suspected cases also involve conspiracy with a provider. Appropriate law enforcement agencies can investigate criminal beneficiary fraud, and 42 CFR 455.15(b) requires referral when there is reason to believe a beneficiary has defrauded Medicaid. These roles do not supply the missing day-to-day state eligibility investigative function.

CMS should require clear case ownership and fund adequate state capacity through available authorities, while seeking additional authority where necessary. Neither a contractor referral nor a prosecutorial declination resolves whether enrollment and payments remain proper.

MEDICAID PROGRAM INTEGRITY • QUESTION 11b

11b. What is most important to maximize effective coordination among CMS PI contractors, CMS, SMAs, MFCUs, law enforcement?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Effective coordination starts with identifying the actual beneficiary investigators. CMS should expressly include state and county public assistance investigative units in governance, training, data-sharing agreements, and case coordination, rather than assume that naming the SMA, MFCU, and law enforcement reaches every necessary participant. In reality, they do not.

Each state should maintain a responsibility matrix, designated contacts, shared case identifiers, referral acceptance procedures, urgency standards, and disposition reporting. Agreements should preserve evidence, prevent interference with criminal matters, and permit lawful administrative action when criminal prosecution is not pursued.

CMS should also issue the beneficiary program integrity guidance requested in UCOWF's CRUSH response. Agencies cannot coordinate consistently when they lack a common understanding of authorized investigations, recoveries, and administrative remedies.

MEDICAID PROGRAM INTEGRITY • QUESTION 11c

11c. What contractor capabilities should CMS solicit to effectively investigate fraud and abuse involving Medicaid managed care organizations, providers, subcontractors, and encounter data?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Contractors should be able to reconcile eligibility and enrollment records with member-month capitation payments, encounter data, provider claims, subcontractor arrangements, and payment adjustments. They should detect duplicate identities, unauthorized enrollment, suspicious enrollment concentrations, and relationships among applicants, intermediaries, plans, and providers.

Capability should include identity resolution, document authenticity review, network analysis, and reconstruction of enrollment changes with source records and audit logs. Suspected synthetic identities require corroboration; a single mismatch is not proof of fraud.

A lack of encounters does not mean there was no financial loss where capitation was paid, nor does it independently establish fraud. Contractors should develop supported leads, identify any contractual recoupment options, and refer beneficiary eligibility findings to designated state investigators. Recovery from a plan and recovery from an individual require separate legal analysis and must not be conflated.

MEDICAID PROGRAM INTEGRITY • QUESTION 11d

11d. What role should contractors have in identifying, recommending, developing, or supporting Medicaid administrative actions? Which actions require SMA involvement or approval?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Contractors should identify facts, preserve evidence, quantify supported payment exposure, and prepare recommendations for review by the legally responsible agency. They may support notices, hearings, appeals, and referrals, but should not make final governmental decisions affecting eligibility or impose beneficiary penalties on their own.

SMA involvement is essential for eligibility determinations and redeterminations, enrollment corrections, managed care payment adjustments, and state Medicaid administrative actions within the agency's authority. Authorized state or county investigators should develop beneficiary fraud findings; appropriate officials should approve any recovery, civil action, or criminal referral under applicable law.

CMS should issue written guidance distinguishing correction of eligibility from a fraud penalty, and distinguishing recovery from a plan from recovery against a beneficiary. The rescission of SMD 24-005 did not itself create new sanctions, disqualification periods, or a general right to collect capitation losses from individuals. CMS should identify existing lawful remedies and pursue regulatory or legislative changes where authority is insufficient under the recognition that state and county agencies administering beneficiary eligibility already fulfill this role - despite the lack of guidance relating to Medicaid. Current regulations are nearly non-existent.

UCOWF supports an enforceable beneficiary fraud framework with notice, an opportunity to contest evidence, and fair hearings. Contractors cannot cure the absence of that framework by generating more provider-focused referrals.

MEDICAID PROGRAM INTEGRITY • QUESTION 11e

11e. What measures would best assess contractor performance in Medicaid without creating incentives for unnecessary investigations, referrals, or administrative actions?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should measure verified losses prevented, timely resolution of substantiated leads, evidentiary completeness, sustained administrative findings, supported recoveries, and correction of recurring vulnerabilities. Beneficiary and provider outcomes should be reported separately, with identification of the agency responsible for each action.

Measures should include the share of beneficiary leads accepted by a designated investigative unit, time to resolution, substantiation rates, false positives, reversals, and the treatment of identity-theft victims. Criminal declinations should be distinguished from unsupported allegations and lawful administrative resolutions.

CMS should not reward the volume of alerts, referrals, disenrollments, or alleged savings. Savings methodology should identify the period, baseline, assumptions, and offsets and prevent double counting among contractors, states, and law enforcement. All of these metrics should be publicly posted by state and then by contractor to ensure full transparency.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 12

12. What tools, data sources, analytics, artificial intelligence (AI), modeling, structured query language (SQL)/query methods, open-source intelligence (OSINT), or workflow technologies should CMS use for lead development and investigations? Which capabilities are not currently available through CMS systems that could improve quality or efficiency?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should support authoritative federal and state verification sources, appropriately validated commercial data, enrollment histories, payment records, and secure cross-program matching. Tools should address identity proofing, stolen and synthetic identities, residence, income, assets where applicable, deceased persons, and duplicate participation. Access should follow applicable legal authority and security requirements.

CMS should establish NIST-aligned identity-proofing requirements appropriate to the transaction and population, with accessible alternatives and human review. Digital controls should include account authentication, device and application-pattern analysis, and detection of automated or coordinated submissions. Uploaded documents should be checked for authenticity and signs of manipulation, including AI-assisted fabrication, without treating an automated score as conclusive and allowing beneficiaries due process in administrative hearings to refute denials or disenrollments.

UCOWF's CRUSH response recommended stronger independent verification, front-end matching, and a beneficiary fraud framework. CMS should assess which capabilities are missing in each state and provide shared services and funding, rather than assume every state already possesses them. Few SMAs include any reference to beneficiary program integrity, eligibility fraud, or steps agencies take to recover overpayments of state capitation rates or services provided as a result of a false application let alone due process protections for applicants that should follow other programs (such as SNAP).

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 13

13. How should CMS govern contractor use of AI and analytics, including explainability, human review before any action is taken, and validation of model accuracy? Who should own the models, tools, and work products developed under the contract, and how should CMS ensure they remain portable at contract end?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require documented model purpose, data provenance, validation, error measurement, audit logs, and explanations that investigators can test against source evidence. Human review should precede adverse action. Models should distinguish identity victims, data errors, unresolved discrepancies, and evidence of intentional misrepresentation.

Contracts should provide government access and portability for case records, evidence, model documentation, and government-funded work products sufficient for continuity and independent review. Pre-existing commercial intellectual property and licensing rights should be addressed expressly. A vendor’s proprietary score must not become the only evidence supporting an eligibility or enforcement decision.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 14

14. Based on your experience with fraud and abuse complaint and referral intake, what complaint and referral sources should CMS consider as part of a centralized intake process? What volume and format considerations should CMS account for, and what types of submissions typically require rerouting? What intake gatekeeping, routing, and immediate-escalation criteria would you recommend?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Central intake should accept referrals from beneficiaries and identity-theft victims, eligibility workers, state and county fraud units, MCO special investigation units, providers, auditors, contractors, and law enforcement. Submissions should support structured data and attachments while allowing reports from people who cannot use a digital portal.

Intake should identify program, allegation, relevant identities, potential losses, urgency, evidence, and possible conflicts with existing investigations. It should route beneficiary eligibility fraud to the designated state investigative unit and provider matters to the appropriate provider-fraud channel. Reports involving organized identity theft or continuing large losses should receive immediate assessment.

CMS should estimate staffing from actual volumes and document rejection and rerouting reasons. An incomplete citizen complaint should prompt proportionate follow-up rather than automatic dismissal.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 15

15. How should CMS associate, aggregate, and prioritize repeated complaints or referrals involving the same provider, beneficiary, or scheme over time?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should use persistent case identifiers and validated entity resolution to associate related complaints across time, states, and programs. Links may include identities, addresses, contact information, devices, authorized representatives, providers, or other relevant relationships, subject to lawful access.

Repeated allegations should be assessed for independence and corroboration so that duplicate submissions do not artificially inflate risk. Investigators should distinguish the person whose identity was misused from the actor who submitted the application. Prioritization should consider reliability, ongoing financial exposure, harm to identity victims, organized activity, and the opportunity to prevent further loss.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 16

16. What improvements could expedite law enforcement vetting while ensuring all relevant subjects are vetted?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should use standardized vetting packages, secure electronic exchange, designated agency contacts, and urgency-based response targets. Packages should identify known subjects, aliases, related entities, program involvement, and proposed investigative steps sufficiently to detect conflicts without unnecessary disclosure. Vetting must reach the agency with relevant jurisdiction. Standalone beneficiary eligibility cases should not sit in an MFCU queue simply because they involve Medicaid. CMS should establish a coordinated pathway involving the state beneficiary investigative unit and appropriate law enforcement, consistent with 42 CFR 455.15.

A decision not to pursue criminal charges should be recorded and communicated. It should not automatically prevent lawful eligibility correction or other authorized administrative action, subject to any justified coordination needs.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 17

17. How should contractor proactive data analysis, conducted as capacity allows and with CMS approval, be governed, tracked, and evaluated, including Fraud Prevention System (FPS) access, CMS review, source attribution, and contractor credit?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should predefine approved analytic objectives, data access, methods, review requirements, and criteria for opening investigations. Contractor proposals should record the hypothesis, sources, validation, likely affected programs, and the next investigative step. FPS access should be tied to assigned responsibilities and applicable safeguards.

Credit should reflect a validated contribution to an outcome, with controls against duplicate claims by multiple contractors or agencies. Analysis should include enrollment and capitation risks as well as claims. CMS should not leave proactive beneficiary identity and eligibility detection solely to spare contractor capacity; it should establish a planned and resourced capability with state investigative partners.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 18

18. What level of information sharing, and what mechanisms, would enable more timely exchange of investigative information among the contractors, CMS, SMAs, MFCUs, law enforcement, and other partners while complying with applicable privacy, security, and disclosure requirements?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should enable timely, secure exchange of relevant enrollment, eligibility, identity, payment, and investigative information among authorized partners. This should expressly include state and county beneficiary program integrity units. Shared case references, role-based access, audit logs, agreed data definitions, and secure interfaces can reduce repeated requests and fragmented evidence.

Agreements should specify permissible uses, redisclosure limits, retention, source restrictions, and procedures for protecting active investigations. CMS should clarify lawful sharing pathways and identify changes needed where existing restrictions impede justified work. A general appeal to privacy should not substitute for identifying the actual authority and permitted mechanism for sharing.

LEAD DEVELOPMENT, INTAKE, AND TECHNOLOGY • QUESTION 19

19. How should investigative findings feed back into prepayment edits, provider enrollment screening, and policy changes so that identified vulnerabilities are closed?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Each substantiated scheme should produce a documented review of the control failure that allowed it. CMS should assign an owner, corrective action, implementation deadline, and test of effectiveness. Feedback should reach provider enrollment and payment systems and also beneficiary application, renewal, identity-proofing, and duplicate-enrollment controls.

For example, a verified pattern of manipulated application documents should trigger improved authenticity checks and staff guidance. An enrollment-related capitation loss should trigger review of identity and eligibility controls before the next payment cycle, consistent with legal requirements. CMS should use recurring findings to update its beneficiary fraud guidance and identify necessary rulemaking or legislation.

PERFORMANCE, QUALITY, AND OUTCOMES • QUESTION 20

20. What outcome-based measures should CMS use to evaluate contractor performance, including quality, timeliness, adherence to CMS direction, preventable financial loss, and downstream investigative, administrative, and enforcement outcomes? How should CMS define and measure a successful investigation, particularly when contractors are directed to prioritize actions such as payment suspensions, revocations, exclusion referrals to OIG, or law enforcement referrals?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

A successful investigation reaches a supported disposition and produces an appropriate, lawful result. That result may be prevention of an improper payment, correction of eligibility, a sustained administrative action, an accepted criminal referral, recovery under applicable authority, or a documented finding that clears an allegation.

CMS should measure quality, time to government decision and implementation, validated financial effect, and prevention of recurrence. For directed provider actions, it should assess whether the evidence satisfied the relevant standard and whether recommendations survived review. For beneficiary matters, it should separately track state acceptance, investigative findings, eligibility resolution, identity-victim protection, and authorized recovery.

CMS should distinguish estimated exposure, established overpayments, actual collections, and prospective prevention. Referral counts and gross proposed savings are insufficient measures of success.

PERFORMANCE, QUALITY, AND OUTCOMES • QUESTION 21

21. What barriers currently delay or undermine payment suspensions, revocations, exclusion referrals to OIG, or other actions, and what changes should CMS implement to improve timeliness and quality?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should evaluate delays caused by incomplete evidence, unclear approval authority, unavailable data, repetitive review, and unresolved interagency ownership. Corrective steps should include standard evidence requirements, designated decision officials, tracking of pending approvals, and escalation for ongoing loss.

For beneficiary eligibility fraud, UCOWF has identified a more basic barrier: uncertainty about the permitted administrative response after rescission of SMD 24-005. CMS should issue affirmative guidance explaining existing authorities and limits, including eligibility corrections, criminal referrals, and legally available recovery mechanisms. Where new fraud sanctions or recovery powers require legislation, CMS should identify and seek that authority.

Faster provider suspensions and revocations will not resolve this separate enrollment-fraud problem.

PERFORMANCE, QUALITY, AND OUTCOMES • QUESTION 22

22. What metrics should CMS use to ensure consistent, complete, and defensible administrative actions and law enforcement referral packages?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require quality review of the identity of the responsible actor, applicable authority, relevant elements and evidentiary standard, source provenance, chronology, interviews, supporting and contrary evidence, loss calculations, and required notices and review rights. Criminal referral packages and administrative recommendations should be assessed against their distinct legal requirements.

Metrics should include first-review completeness; return-for-correction rates and reasons; time from substantiation to referral and acceptance; sustained findings; appeal reversals; documented resolution of contrary evidence; and the percentage of beneficiary cases with a confirmed receiving agency and final disposition. The USDA tracks similar metrics in the FNS-366b form submitted quarterly by SNAP agencies that CMS could use as referential guide in beneficiary cases.

Beneficiary packages should identify the material eligibility factor, relevant application or renewal statement, independent verification, evidence of knowledge or intent where required, and program-specific losses. Capitation, claims, subsidies, recoveries, and avoided payments must be separately identified to prevent double counting. Identity-theft victims must be distinguished from perpetrators.

CMS should count a referral as received only after acknowledgment, and as resolved only after a documented disposition. A package sent to an agency that cannot take the case is not a successful enforcement outcome.

PERFORMANCE, QUALITY, AND OUTCOMES • QUESTION 23

23. How should CMS plan for and execute surge capabilities and/or shifts in investigative priorities?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should establish prequalified surge teams, secure onboarding, priority-based workload reassignment, and written activation and demobilization procedures. Planning should cover organized identity attacks, sudden enrollment anomalies, and multistate schemes as well as provider billing fraud.

State beneficiary investigative capacity should be included in surge planning. CMS should offer technical assistance and available funding, preserve ownership of existing cases, and define how urgent leads will move from contractors to state decision makers. Surge output should be judged by verified resolutions and prevention, not by the number of alerts generated.

PERFORMANCE, QUALITY, AND OUTCOMES • QUESTION 24

24. How should the PI model limit false positives and unnecessary provider burden, and how should CMS protect beneficiary access to care when a provider is suspended or revoked?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require corroboration, source validation, qualified human review, and an opportunity to resolve discrepancies before adverse action, consistent with governing rules. It should monitor false positives and reversals and distinguish intentional fraud from administrative error, legitimate overlap, or identity theft.

Provider actions should include plans for continuity of necessary care and accurate communication with affected beneficiaries. Identity-theft victims should receive assistance correcting records and securing accounts. Investigators should avoid labeling every person associated with an unauthorized enrollment as a fraud perpetrator. Strong beneficiary integrity controls protect both taxpayer funds and people whose identities are exploited.

FIXED-PRICE CONTRACTING • QUESTION 25

25. In accordance with E.O. 14402, Promoting Efficiency, Accountability, and Performance in Federal Contracting, CMS seeks to identify opportunities to award contracts on a fixed-price basis. To that end, please provide information on the following:

Please respond to items 25a-25c on the following pages.

FIXED-PRICE CONTRACTING • QUESTION 25a

25a. Based on the draft SOO, please identify opportunities to create fixed-price, fixed unit price, or hybrid pricing structures and explain your assumptions. What information (workload volume, data and systems access, service level agreements, etc.) would be needed?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

UCOWF offers program-integrity considerations rather than vendor pricing. Defined deliverables such as training, standardized data services, routine records production, and quality reviews may support fixed-price or fixed-unit structures. Complex investigations may require a hybrid structure that accounts for uncertainty and case complexity.

CMS should disclose historical workload, case mix, data availability, expected service levels, state coordination requirements, surge expectations, and government approval dependencies. Costs for supporting state beneficiary investigations should be explicit. An acquisition should not appear less expensive merely because eligibility and identity fraud work has been left out of scope.

FIXED-PRICE CONTRACTING • QUESTION 25b

25b. What performance standards and incentives should be considered to ensure quality and timely outcomes?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Standards should reward timely, complete, accurate work; supported dispositions; sustained actions; validated prevention; and successful correction of recurring vulnerabilities. CMS should distinguish contractor-controlled performance from time awaiting government action or essential third-party evidence.

Incentives should be subject to independent quality review, adjustments for reversals and duplicate savings claims, and monitoring for distorted case selection. CMS should not pay bonuses simply for increasing referrals, disenrollments, or proposed recoveries. Beneficiary cases should receive credit for supported administrative resolution and protection of identity victims, even when criminal prosecution is not pursued.

FIXED-PRICE CONTRACTING • QUESTION 25c

25c. Which tasks in the draft SOO are not well suited to fixed-price contracting, and why? How should fixed unit pricing or performance-based incentives be structured so that they do not reward the volume of investigations, referrals, or administrative actions over their quality?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Open-ended organized-fraud investigations, litigation support, major data reconstruction, emergency surges, and matters dependent on unpredictable third-party cooperation are difficult to price as uniform fixed tasks. Rigid pricing can encourage premature closure or avoidance of complex cases.

Where unit pricing is used, units should reflect defined, quality-reviewed deliverables and reasonable complexity bands. Payment should not depend on finding fraud or imposing an adverse action. Hybrid arrangements should preserve incentives for careful investigations and complete evidence, including evidence that disproves an allegation. CMS should monitor whether pricing systematically discourages beneficiary eligibility investigations.

COMPETITION AND CONFLICTS OF INTEREST • QUESTION 26

26. What barriers keep nontraditional vendors, such as commercial special investigations unit (SIU) and analytics firms, from competing for PI work, and how should CMS structure the acquisition to broaden competition?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Open-ended organized-fraud investigations, litigation support, major data reconstruction, emergency surges, and matters dependent on unpredictable third-party cooperation are difficult to price as uniform fixed tasks. Rigid pricing can encourage premature closure or avoidance of complex cases.

Where unit pricing is used, units should reflect defined, quality-reviewed deliverables and reasonable complexity bands. Payment should not depend on finding fraud or imposing an adverse action. Hybrid arrangements should preserve incentives for careful investigations and complete evidence, including evidence that disproves an allegation. CMS should monitor whether pricing systematically discourages beneficiary eligibility investigations.

COMPETITION AND CONFLICTS OF INTEREST • QUESTION 27

27. How should CMS identify and mitigate organizational conflicts of interest for firms that also have health plan, provider, or other CMS contractor business?

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

CMS should require disclosure of relevant plan, provider, subcontractor, data-supplier, and related-party relationships at award and throughout performance. Mitigation should address financial interests, access to competitors' information, and the risk that a contractor evaluates its own systems or prior work.

Measures may include independent review, restricted assignments, information barriers, recusal, or exclusion where a conflict cannot be adequately mitigated. CMS should retain case-assignment authority and audit mitigation compliance. Enrollment and identity vendors should also disclose relationships that could influence their findings or product recommendations.

STRUCTURED FEEDBACK / COMMENTS ON THE DRAFT STATEMENT OF OBJECTIVES • QUESTION 28

28. Please provide comments, feedback, and recommendations on the draft SOO. Information should be organized by page number and task area to facilitate a review of the information.

Response - character limit: 4,000 characters (including spaces). Text scrolls if longer.

Across the SOO: CMS should issue the affirmative beneficiary program integrity guidance requested in UCOWF's CRUSH response. Rescission of SMD 24-005 did not establish a complete operating framework, nor have any beneficiary fraud regulations been proposed by HHS/CMS. Modernizing provider-fraud contracts while continuing to leave beneficiary investigators without clear guidance and support preserves a major vulnerability. Likewise, the barriers to recovering overpayments from fraudulent beneficiary applications as well as the requirement that States pay the full amount of a beneficiary fraud overpayment, even when no collection activity has occurred, is a real impediment to program integrity. States cannot afford to reimburse CMS on identified losses without a recovery preceding the repayment.

Page 1, Sections I and II: The SOO expressly focuses on Medicare. CMS should either add a clearly authorized Medicaid scope or issue a parallel Medicaid framework and procurement. Neither approach should omit beneficiary eligibility and identity fraud. Add designated state and county beneficiary investigative units to the operating model.

Pages 1–2, Section II: Add supported referral of suspected fraudulent enrollment, stolen or synthetic identities, material eligibility misrepresentations, and improper duplicate participation to the responsible state unit. Require accepted ownership and disposition tracking. Beneficiary interviews about provider billing are not a substitute for investigating beneficiary eligibility.

Page 2, Sections III and IV: Name state beneficiary investigative units as operational partners. Preserve their referrals, evidence, and pending actions during transitions. Include enrollment risks in CMS lead-generation priorities.

Pages 3–4, Objective 1: Require relevant eligibility and identity expertise and lawful access to enrollment and capitation records. Do not relegate proactive beneficiary detection to work undertaken only as capacity allows.
Pages 4–5, Objective 2: Distinguish contractor evidence support from state decisions. Include lawful eligibility corrections, supported loss calculations, appropriate criminal referrals, and authorized recovery support. Explain the MFCU funding limitation for standalone beneficiary eligibility cases.

Page 5, Objective 3: Require findings to inform application and renewal controls, identity proofing, independent verification, and cross-program matching. Track whether identified vulnerabilities were corrected.
Pages 5–6, Section VI: Specify decision authority, evidence and data-sharing requirements, due process, and escalation for unassigned cases. Recognize that a contract cannot create beneficiary sanctions or recovery authority.