CMS Medicaid Program Integrity Strategy

Enhanced Medicaid Program Integrity Strategy

The last several years have seen a rapid increase in Medicaid spending driven by several factors, including Medicaid expansion, from $456 billion in 2013 to an estimated $576 billion in 2016. Much of this growth came from the federal share that grew from $263 billion to an estimated $363 billion during the same period. With this historic growth comes an equally growing and urgent responsibility to ensure sound stewardship and oversight of our program resources. As part of CMS's plan to reform Medicaid using the three pillars of flexibility, accountability and integrity, we are announcing a new strategy to ensure we are keeping the Medicaid program sustainable for our future.

While the responsibility for proper payments in Medicaid primarily lies with the states, oversight of the Medicaid program requires a partnership, and CMS plays a significant role in supporting state efforts and increasing state oversight, accountability, and transparency. Because of this responsibility, CMS is announcing new and enhanced initiatives that will create greater transparency in and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states. The initiatives include stronger audit functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules.

CMS's Robust Plan for New or Enhanced Medicaid Program Integrity Initiatives

- **Strengthen the Program Integrity Focus of Audits of State Claiming for Federal Match Funds and Rate Setting** – CMS will begin targeted audits of some states' managed care organization (MCO) financial reporting. Plans have implemented risk mitigation strategies like Medical Loss Ratio; CMS will be checking to make sure claims experience actually matches what plans have been reporting. Audit activities will include review of high-risk vulnerabilities identified by the Government Accountability Office and Office of Inspector General (OIG), as well as other behavior previously found detrimental to the Medicaid program.

- **Conduct New Audits of State Beneficiary Eligibility Determinations** – CMS will initiate audits of state beneficiary eligibility determinations in states previously reviewed by OIG. These audits will include assessment of the impact of changes to state eligibility policy as a result of Medicaid expansion; for example, we will review whether beneficiaries were found eligible for the correct Medicaid eligibility category.

- **Optimize state-provided claims and provider data**: It is an administration priority for CMS to work closely with states to ensure that CMS and oversight bodies have access to the best, most complete and accurate Medicaid data. For the first time, all 50 states, D.C. and Puerto Rico are now submitting data on their programs to the Transformed Medicaid Statistical Information System (TMSIS), and over the course of the coming months CMS will be validating the quality and completeness of the data. CMS's ongoing goal is to use advanced analytics and other innovative solutions to both improve TMSIS data and maximize the potential for program integrity purposes. This will allow CMS to identify instances like a beneficiary receiving more hours of treatment than hours in a day or other flags that necessitate further investigation.

- **Use Data Innovation to Empower States and Conduct Data Analytics Pilots** – CMS will share its extensive knowledge, gained from processing and analyzing large, complex Medicare data sets, to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation.

- **Offer Provider Screening for States on an Opt-In Basis** – CMS will pilot a process to screen Medicaid providers on behalf of states. Centralizing this process will improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of error as measured by the Payment Error Rate Measurement (PERM) program today.

- **Enhanced Data Sharing and Collaboration between CMS and the States.** CMS will work with States to enhance data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. For example, CMS is making the Social Security Administration's Death Master File available for States to support provider enrollment activities.

- **Publicly Report State Performance on the Medicaid Scorecard** – CMS has released a Medicaid scorecard that presents state performance measures related to their Medicaid programs. Future versions of the scorecard will include state program integrity performance measures like PERM, the Medicaid improper payment error rate.

- **Provide Medicaid Provider Education to Reduce Improper Payments** – CMS will strengthen efforts to provide effective Medicaid provider education to reduce aberrant billing, including education focused on comparative billing reports. CMS also will work with states on other provider facing tools and investments we are currently making.

CMS's Existing Initiatives Protect Medicaid

- **Managed Care Rate Reviews** - Beginning in 2014, CMS implemented enhanced review of state capitation rates for coverage of the new expansion population to ensure that capitation rates are consistent with federal requirements and appropriately contain costs. CMS has since expanded that review to all managed care capitation rates and adopted a regulation providing more detailed requirements related to rate setting. All managed care rates are reviewed to ensure that the rates are actuarially sound and based on commonly accepted actuarial principles. Our rate review includes monitoring strategies implemented by states to mitigate rate setting risk, such as MLRs and risk corridors. Based on our review of these strategies states will be paying back an estimated $3.2 billion from the risk-mitigation strategies in 2014 and an estimated $5.5 billion return from those arrangements in 2015. This represents about nine percent of capitation payments for newly eligible adults in 2014 and 2015.

- **Ensure State Compliance with the Medicaid Managed Care Final Rule** – CMS will monitor state implementation of, and enforce compliance with, program integrity safeguards such as (1) reporting overpayments and fraud, and (2) screening and enrolling Medicaid managed care providers.

- **Financial Oversight.** CMS engages in robust financial oversight to ensure that when states ultimately claim for federal match on their expenditures, that federal Medicaid funds are spent lawfully and appropriately. We use specialized accountants and financial management specialists to review state claims each quarter, using trend analyses, environmental scanning and the results

of external audits to find anomalies, and request additional documentation or justifications when necessary. We also engage in state specific reviews, going on-site to review state Medicaid programs to ensure that state expenditures and corresponding claims for federal matching funds are allowable. In Fiscal Year 2017, these efforts resulted in questioning $2.7 billion in Medicaid costs and averting nearly $500 million in questionable reimbursements.

- **Payment Error Rate Measurement (PERM) Reviews** – The PERM program measures improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP) where each state is audited on a rolling three year basis and annually produces national and state-specific improper payment rates for each state Medicaid program. The improper payment rates are based on federal reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. Through the PERM program each state is reviewed once every three years.

- **Medicaid Eligibility Quality Control (MEQC) Program** – The MEQC program uses state-directed reviews in the two off-cycle PERM years to address Medicaid beneficiary eligibility vulnerabilities. MEQC focuses on areas not addressed through PERM reviews and on areas identified as error-prone through the PERM program.

- **Medicaid Provider Screening and Enrollment** – CMS uses multiple tools to assist states with provider screening and enrollment compliance, and allow them to leverage Medicare data and activities. These include the Provider Enrollment, Chain and Ownership System (PECOS), state site visits for technical assistance and education, Medicare data compare services, and the Medicaid Provider Enrollment Compendium (MPEC).

- **State Program Integrity Reviews** – CMS conducts reviews to determine if state policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states' program integrity best practices, and monitor state corrective action plans.

- **Medicaid Integrity Institute (MII)** – CMS's MII provides training and education to more than one thousand state Medicaid PI staff annually. Course topics include provider screening and enrollment, managed care, personal care services, opioids, beneficiary fraud, data analytics, and investigatory techniques.

- **Healthcare Fraud Prevention Partnership (HFPP)** – The HFPP is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations that aims to detect and prevent healthcare fraud through data and information sharing.

- **CMS's Unified Program Integrity Contractors (UPICs)** - CMS's UPICs are contracted entities that perform activities that identify and reduce fraud, waste, and abuse by individuals and entities furnishing items and services under Medicare and Medicaid. The UPICs work closely with states to perform numerous functions to detect, prevent, and deter specific risks and broader vulnerabilities to the integrity of the Medicaid program, including conducting provider investigations and audits.