Comprehensive Medicaid Integrity Plan

for Fiscal Years 2019 – 2023

Executive Summary

Section 1936(d) of the Social Security Act directs the Secretary of Health and Human Services (HHS) to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. This Comprehensive Medicaid Integrity Plan sets forth the strategy of the Centers for Medicare & Medicaid Services (CMS) to safeguard the integrity of the Medicaid program during federal fiscal years (FYs) 2019–2023.[1] Building upon our existing program integrity efforts, this 5-year Plan includes the new and enhanced Medicaid program integrity initiatives that CMS announced in the Medicaid Program Integrity Strategy that was released in June 2018.[2]

This 5-year period is projected to be one of continued growth in Medicaid enrollment and rapid growth in federal and state investment. Over FYs 2019–2023, Medicaid enrollment is projected to increase by 6 percent, while total Medicaid expenditures are projected to grow to $777 billion in FY 2023, an increase of nearly 25 percent. Over $98 billion of this projected $153.7 billion increase would be paid from the federal Treasury.[3] Because the federal government will pay at least 90 percent of the cost of the expansion of Medicaid coverage to newly eligible, low-income adults during this time period,[4] program integrity challenges for participating state Medicaid programs and CMS will remain at the forefront of program administration and oversight.

Medicaid is a federal-state partnership, and that partnership is central to the program's success. CMS provides states with guidance to use in meeting statutory and regulatory requirements, technical assistance including tools and data, federal matching funds for their expenditures, and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual programs through activities including setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. State Medicaid programs and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse.

This Comprehensive Medicaid Integrity Plan is shaped by the following themes:

- *Patients First:* CMS's overarching strategy is built upon the goal of putting patients first because fraud, waste, and abuse not only result in loss of program funds but can directly harm beneficiaries when Medicaid is billed for unnecessary or undelivered services.

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[1] This 5-year plan reflects information as of December 31, 2019. This plan was developed by CMS during calendar years 2018 and 2019, and thus does not reflect the temporary flexibilities in CMS operations necessitated by the public health emergency due to the 2019 Novel Coronavirus Disease (COVID-19). This plan includes the ability for CMS and states to adapt and adjust strategies as the Medicaid program integrity environment changes over time. CMS will continue to communicate with stakeholders about the COVID-19 flexibilities as they affect any activities described in this plan.

[2] CMS announces initiatives to strengthen Medicaid program integrity, press release, June 26, 2018.

[3] CMS, National Health Expenditure Projections 2018-2027, February 2019.

[4] Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

- *Federal-State Partnership:* Medicaid program integrity efforts can only succeed when CMS and states work in partnership. To facilitate and improve the federal-state partnership, CMS is adjusting its Medicaid oversight in ways that are more mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk.

- *Flexibility, Accountability, and Integrity* are the three key principles that ground CMS's vision for transforming the Medicaid program. CMS applies these principles in its program integrity work to achieve: (1) greater flexibility in program integrity approaches to empower individual states to create innovative programs; (2) stronger accountability for cost-effective program integrity outcomes and reducing improper payments; and (3) enhanced program integrity, employing new and evolving initiatives to work in partnership with states.

This Comprehensive Medicaid Integrity Plan is designed to strengthen the ability of the federal-state partnership to safeguard the integrity of the Medicaid program. The execution of this Plan will improve the ability of state Medicaid agencies and CMS to leverage program data to detect and prevent improper payments, which will strengthen the ability of state Medicaid agencies to safeguard state and federal Medicaid dollars from misuse for fraud, waste, and abuse. These efforts will expand the capacity of CMS to protect the integrity of the Medicaid program together with states and to manage risk in the administration of federal grants to states.

To hold states accountable for Medicaid eligibility and payment integrity, CMS will assess the effectiveness of states' claims payment and beneficiary eligibility processes by:

- Revising the measurement of Medicaid beneficiary eligibility improper payment rates, pursuant to updated regulations; [5]

- Implementing a restructured Medicaid Eligibility Quality Control (MEQC) program, pursuant to updated regulations; [6]

- Measuring the performance of states' beneficiary eligibility systems and processes in making timely and accurate determinations; and

- Conducting strategic audits of high-risk states' beneficiary eligibility determinations in the newly eligible adult expansion group, where a greater share of federal taxpayer dollars is at risk.

To assess the performance of states' efforts to safeguard program integrity, CMS will:

- Add program integrity measures to the Medicaid and Children's Health Insurance Program (CHIP) scorecard;

- Expand state program integrity reviews to additional states for high-risk areas, including managed care, personal care services, and responses to the opioid crisis; and

- Work more closely with states as they develop and implement corrective actions to reduce improper payments.

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[5] 82 FR 31158, July 5, 2017.
[6] Ibid.

To improve fiscal accountability for Medicaid expenditures, CMS will bring a stronger program integrity focus to oversight of federal grants to states through:

- Enhanced reviews of quarterly Medicaid expenditure claiming;
- Closer collaboration with independent state auditors to follow-up on findings from the single audit for Medicaid;[7] and
- Proposed improvements to the regulatory framework to require more transparency in supplemental payment reporting and reduce questionable financing mechanisms.

To help states meet the unique program integrity challenges of Medicaid managed care, CMS will:

- Provide updated guidance, technical assistance, and educational support to ensure that states comply with new managed care program integrity requirements that protect both beneficiaries and Medicaid funds;
- Conduct reviews of managed care contracts and actuarial reviews of capitation rates to ensure compliance with required safeguards in the new rules; and
- Conduct examinations of managed care plans' financial reporting focused on medical loss ratios and rate setting to verify whether plans' expenditures for providing health care services have been reported accurately and support capitation rates set in plans' contracts with states.

To enhance sharing of claims data, analytics, and audit capabilities, CMS will:

- Enhance systems and procedures for sharing appropriate Medicare data with states;
- Improve the quality and completeness of Medicaid claims data reported to CMS through the Transformed Medicaid Statistical Information System (T-MSIS) to conduct program integrity analytics;
- Share algorithms with and provide data analytic and audit support to states to improve detection of Medicaid fraud, waste, abuse, and other improper payments; and
- Work with states to strengthen the functionality of their claims payment systems and fully implement required prepayment safeguards.

To ensure that states fully implement required prevention strategies in provider enrollment, CMS will assist states with their provider screening activities through:

- Expanded and improved databases and data exchanges for provider screening;
- Updated sub-regulatory guidance and individualized, onsite technical assistance; and
- CMS tools and services to reduce the state burden of required provider screening and revalidation.

To provide educational and technical assistance to support and strengthen states' program integrity safeguards, CMS will:

- Expand and update training to enhance the qualifications of state program integrity staff;
- Provide further opportunities for states and CMS to share noteworthy practices, discuss emerging trends, and strengthen collaboration among state and federal stakeholders;

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[7] State single audits are performed under the requirements of Office of Management and Budget Circular A-133.

- Provide technical assistance to states that integrates focused staff training, previous and current onsite assessments, and follow-up support tailored to each state's needs to help identify program integrity vulnerabilities and implement effective mitigation strategies;

- Educate providers to promote awareness of program integrity issues and reduce billing and documentation errors to avoid the subsequent burden of audits and appeals;

- Provide educational materials to help states ensure that beneficiaries provide accurate and up-to-date information on circumstances that may affect eligibility; and

- Provide technical assistance to states to improve safeguards in their Home and Community Based Services programs to implement required electronic visit verification, ensure proper billing and payment, and improve strategies to prevent incidents of abuse, neglect, and exploitation.

This Plan is informed by our review of past and current program integrity efforts by CMS and its state partners. It is also informed by recommendations made by the HHS Office of Inspector General, the Government Accountability Office, the Medicaid and CHIP Payment and Access Commission, the National Association of Medicaid Directors, and ongoing feedback and engagement of the Medicaid Fraud and Abuse Technical Advisory Group.[8] Moving forward, we will continue our efforts to work productively with these partners to identify and resolve program integrity issues in the Medicaid program.

CMS will report on the progress made in implementing the program integrity initiatives presented in this Plan in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

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[8] In addition to recommendations in reports by these organizations, this comprehensive plan was developed in consultation with the United States Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the HHS Inspector General, and state officials with responsibility for controlling provider fraud, waste, and abuse under Medicaid, as required by Section 1936(d) of the Social Security Act. The Medicaid Fraud and Abuse Technical Advisory Group has been working with CMS since 1997 and includes state program integrity directors representing every CMS region.

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Introduction

Medicaid provided health care for an estimated 75.2 million Americans, including many of the nation's most vulnerable citizens, at a combined federal and state estimated cost of over $623 billion in federal fiscal year (FY) 2019.[9] The Government Accountability Office (GAO) has included Medicaid on its list of high-risk programs since 2003, acknowledging that the size, complexity, and diversity of Medicaid make the program particularly challenging to oversee at the federal level.[10] State Medicaid agencies and the Centers for Medicare & Medicaid Services (CMS) share mutual obligations and accountability for the integrity of the Medicaid program and for the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars. States provide the first line of defense against fraud, waste, and abuse in their Medicaid programs as they enroll beneficiaries, screen and enroll providers, establish payment policies, contract with managed care entities, process claims, and pay for services furnished to Medicaid beneficiaries. CMS provides states with guidance on federal Medicaid policies, education and technical assistance, program assessment and feedback, and federal resources for strengthening their program integrity capacities.

Section 1936(d) of the Social Security Act (the Act) directs the Secretary of Health and Human Services (HHS) to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. This Comprehensive Medicaid Integrity Plan sets forth the CMS strategy for working with states to safeguard the integrity of the Medicaid program during FYs 2019–2023.

This 5-year period is projected to be one of continued growth in Medicaid enrollment and rapid growth in federal and state investment. Over FYs 2019–2023, Medicaid enrollment is projected to increase by 6 percent, while total Medicaid expenditures are projected to grow to $777 billion in FY 2023, an increase of nearly 25 percent. Over $98 billion of this projected $153.7 billion increase would be paid from the federal Treasury.[11] Because the federal government will pay at least 90 percent of the cost of the expansion of Medicaid coverage to newly eligible, low-income adults under the Patient Protection and Affordable Care Act during this time period, program integrity challenges for participating state Medicaid programs and CMS will remain at the forefront of program administration and oversight.

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[9] CMS, National Health Expenditure Projections 2018-2027, February 2019, (Tables 16 and 17).

[10] Dodaro, Gene L. (GAO), Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks, (GAO-18-598T), Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, June 27, 2018.

[11] CMS, National Health Expenditure Projections 2018-2027, February 2019. From FY 2019 to FY 2023, total Medicaid enrollment is projected to increase from 75.2 million to 79.6 million, while total Medicaid expenditures are projected to grow from $623 billion to $777 billion (Tables 16 and 17).

This Comprehensive Medicaid Integrity Plan is shaped by broad CMS goals and by our vision for transforming the Medicaid program, grounded in three key principles: greater flexibility, stronger accountability, and enhanced program integrity.[12] In pursuit of its goals and vision, CMS recognizes the responsibility of state and federal program integrity efforts to both protect beneficiaries and to ensure that taxpayer dollars are spent only on allowable items and services. CMS's goals and vision are reflected in the following themes echoed throughout the plans described in this document:

- *Patients First:* CMS's overarching strategy is built upon the goal of putting patients first.[13] Accordingly, program integrity efforts must prioritize patients and access to care because fraudulent, wasteful, and abusive activities not only result in loss of program funds but can directly harm beneficiaries. Physicians who inappropriately prescribe prescription drugs to increase their billings may be placing their patients at medical risk. Personal Care Attendants who are inadequately screened or qualified may expose beneficiaries in their own homes to risks of harm from substandard or undelivered services, theft, neglect, or abuse.[14] Similarly, if a dental clinic performs unnecessary procedures on children to generate revenue, the children's health is at risk. Using screening procedures to prevent enrollment of fraudulent providers, and identifying and quickly removing those who have already enrolled, prevents Medicaid payment for substandard care that can harm beneficiaries.

- *Federal-State Partnership:* Medicaid program integrity efforts can only succeed when CMS and states work in partnership and both parties uphold their responsibilities. States operate their individual programs within federal and state guidelines by setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, and claiming expenditures. CMS has obligations under federal law with respect to oversight, support and assistance, auditing, and education. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers. Successfully delivering cost-effective health care to many of America's most vulnerable citizens depends on developing and strengthening effective federal-state partnerships.

- *Greater Flexibility:* CMS is increasing its flexibility in program integrity approaches and its responsiveness to states' needs to empower individual states to create innovative programs that best address the unique program integrity challenges that each state faces. CMS is adjusting its Medicaid oversight in ways that are more mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk. CMS's interaction with states in Medicaid program integrity continues to evolve toward a more collaborative relationship where states are better able to identify priority areas, allowing CMS to provide support and facilitate sharing of states' best practices. As examples, this Plan highlights initiatives focused on state flexibility in developing MEQC pilots, voluntary state technical assistance, provider enrollment data compare and data exchange services, centralized provider screening, and targeted provider education.

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[12] Verma, Seema, CMS's Efforts to Fight Medicaid Fraud and Overpayments, Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, August 21, 2018.

[13] CMS Annual Financial Report for FY 2017, November 2017.

[14] CMS, Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services, February 2018.

- *Stronger Accountability:* Allowing states greater flexibility in program integrity approaches must be balanced by greater accountability for cost-effective program integrity outcomes. Accordingly, CMS will hold states accountable for implementing effective program integrity efforts and reducing improper payments. CMS launched the first Medicaid and Children's Health Insurance Program (CHIP) Scorecard in June 2018 to increase public transparency and accountability about the Medicaid and CHIP programs' administration and outcomes. To hold states accountable across key areas of program integrity, CMS will identify measures of state performance on selected program integrity activities for the Medicaid and CHIP Scorecard. This Plan also describes CMS initiatives to hold states accountable in key areas, such as the accuracy of beneficiary eligibility determinations, state claiming of federal funds, and oversight of managed care contracts and rate setting. While CMS will hold states accountable, we will also provide more support and assistance than ever before to help states meet high program integrity standards. Throughout this Plan, we outline numerous efforts through which CMS will provide guidance, training and education, data, technical assistance, and other support to help states comply with federal statutes and regulations designed to strengthen the integrity of the Medicaid program and meet the challenges states face in safeguarding Medicaid beneficiaries and taxpayer dollars.

- *Enhanced Program Integrity:* This Plan in its entirety presents CMS's new and evolving initiatives to work in partnership with states to strengthen Medicaid program integrity at both state and federal levels. Building upon our existing program integrity efforts, CMS announced several new and enhanced Medicaid program integrity initiatives in June 2018 that are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net.[15] Examples of these new initiatives include increased oversight of beneficiary eligibility determinations, stronger audits of state claims for federal matching funds and managed care plans' medical loss ratios, and increased sharing of quality claims data and robust analytic tools.

This Plan is informed by our review of past and current program integrity efforts by CMS and its state partners. It is also informed by recommendations made by the HHS Office of Inspector General (OIG), the GAO, the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association of Medicaid Directors (NAMD), and ongoing feedback and engagement of the Medicaid Fraud and Abuse Technical Advisory Group. CMS has implemented improvements to address past recommendations and feedback from these stakeholders, and will address additional recommendations and feedback from these stakeholders as part of this 5-year Plan.

Informed by these considerations, this Plan sets a path for CMS and its state partners to improve Medicaid program integrity going forward into FYs 2019–2023. Inherent in this Plan is also the flexibility for CMS and states to adapt and adjust strategies as the Medicaid program integrity environment changes over time. This Plan will enable CMS and states to better protect federal and state Medicaid funds from fraud, waste, and abuse; improve accountability by providers and managed care plans to the program and its beneficiaries; and mitigate the risks associated with expanded federal grants to states.

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[15] CMS announces initiatives to strengthen Medicaid program integrity, press release, June 26, 2018.

Comprehensive Medicaid Integrity Plan for Fiscal Years 2019–2023

1. Assess the Effectiveness of State Program Integrity Activities

CMS promotes state accountability by assessing the effectiveness of states' efforts to safeguard Medicaid dollars, identifying vulnerabilities in their processes, and monitoring their corrective actions. Regarding payment outcomes, CMS assesses the integrity of Medicaid payments by measuring improper payment rates due to eligibility determination errors, and payment errors from Fee-For-Service (FFS) and managed care capitation claims. CMS also classifies the types of errors and their impact, and states use this information to develop corrective action plans that CMS reviews and monitors. CMS also visits state Medicaid agencies and reviews the effectiveness of their processes for safeguarding Medicaid program integrity. The following sections describe CMS's plans to assess states' performance on protecting their Medicaid programs from fraud, waste, abuse, and other improper payments. Some of the initiatives below were announced in the Medicaid Program Integrity Strategy in June 2018.

In addition, as a broad measure of state performance, CMS developed the Medicaid and CHIP Scorecard to increase public transparency and accountability regarding state outcomes and administration of their programs. We also describe plans to expand the current Medicaid and CHIP Scorecard to include measures of state performance on selected program integrity activities.

1.1. Eligibility and Payment Integrity

Historically, CMS has measured improper payment rates in states' beneficiary eligibility determinations through the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs. Statutory changes to Medicaid and CHIP eligibility processes required states to implement a new methodology for eligibility determinations by updating their eligibility processes and systems, and required CMS to update the PERM and MEQC programs. As a result, for FYs 2015 through 2018, CMS did not conduct the eligibility measurement component of the PERM program or operate the MEQC program, while CMS developed new regulations to update both programs. During the pause of the PERM program's eligibility measurement component, CMS required all states to implement Medicaid and CHIP Eligibility Review Pilots to ensure effective oversight and monitoring of Medicaid and CHIP eligibility determinations.[16] Based on the pilots, CMS updated the PERM eligibility measurement methodology and restructured the MEQC program to reduce redundancies between the two programs in a final rule published on July 5, 2017.[17] CMS's updated PERM and MEQC programs are described in this section.

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[16] FY2014-FY2017 Medicaid and CHIP Eligibility Review Pilots.
[17] 82 FR 31158, July 5, 2017.

Revise Measurement of Eligibility Improper Payment Rates

To comply with the Improper Payments Information Act of 2002, CMS developed the PERM program, which calculates improper payment rates for three components of the Medicaid program and CHIP—FFS payments, managed care capitation payments, and beneficiary eligibility determinations. The PERM reviews take place on a rotating cycle with one-third of states being reviewed each year.

CMS reported an updated national eligibility improper payment rate for FY 2019, based on the revised eligibility measurement methodology in the updated PERM regulation issued in July 2017.[18] All states will be reviewed under the new eligibility methodology by FY 2021.

The July 2017 final rule also implemented policy and operational improvements to the PERM program that will reduce state burden, improve program integrity, and promote state accountability. Changes being implemented for the PERM program include:

- Eligibility Review Responsibility: A federal contractor will conduct PERM eligibility reviews with support from each state. Previously, states were required to conduct eligibility reviews and report the results to CMS.

- Federal Improper Payments: Improper payments will be cited if the federal share amount is incorrect (even if the total amount is correct). Previously, improper payments were only cited based on the total amount (i.e., combined federal and state share). This change will allow CMS to measure improper federal payments due to state placement of an individual in an incorrect eligibility category that results in the incorrect Federal Medical Assistance Percentage (FMAP) being claimed.

- Corrective Action: States will continue to implement Corrective Action Plans (CAPs) for all errors and deficiencies found during the PERM review. However, there will be more stringent requirements added for states that have consecutive PERM eligibility improper payment rates over the 3 percent national standard.

- Disallowances: Potential disallowances under section 1903(u) of the Act will be applicable for eligibility reviews conducted during PERM years in cases where a state's eligibility improper payment rate exceeds the 3 percent national standard, beginning in FY 2022. CMS can pursue disallowances if a state does not demonstrate a good faith effort to meet the 3 percent threshold, which is defined under current regulations as meeting PERM CAP and MEQC pilot requirements.[19]

Implement a Restructured MEQC Program

Since 1978, the MEQC program has involved state reviews of Medicaid and CHIP eligibility determinations to ensure they were made correctly. In the final rule issued in July 2017, CMS restructured the MEQC program into an ongoing series of pilots that states are required to conduct during the two off-years between their triennial PERM

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[18] HHS, FY 2019 Agency Financial Report, Section 3, November 2019.
[19] 42 CFR 431.1010.

review years. This change will reduce redundancies between the MEQC and PERM programs and ensure continuous oversight of state eligibility determinations. States have great flexibility in developing their MEQC pilots and may focus their reviews of individuals found eligible on state-specific vulnerabilities or error prone areas to identify the causes of erroneous determinations of eligibility. However, CMS may impose more stringent MEQC review requirements of individuals found eligible in states that have consecutive PERM eligibility improper payment rates over 3 percent. In addition, states are required to devote part of their MEQC pilots to reviews of improper denials or terminations, which are not addressed through PERM reviews.

For cases where individuals were erroneously determined eligible, states are also required to assess the financial implications of the errors during the 3-month period after the erroneous eligibility date. States will be required to return the federal share of any such overpayments made as a result of these erroneous eligibility determinations through their quarterly expenditure reports.

On August 30, 2018, CMS issued the first part of the revised MEQC program guidance, which explains the overall MEQC requirements and describes the MEQC pilot planning documents that each state must develop following the end of its respective PERM review year.[20] The second part of the guidance, which covers the specifications for MEQC case-level reports and CAPs, will be released in the third quarter of FY 2020.

The restructured MEQC program is an important tool in CMS's effort to reduce improper payments and ensure that Medicaid and CHIP benefits are available only to those who truly qualify for them. The MEQC pilots not only provide a vehicle for states to review and address erroneous eligibility determinations that contribute to the PERM improper payment rate, but also require states to systematically review improper denials and terminations that may prevent truly eligible persons from accessing Medicaid and CHIP benefits.

CMS Oversight of Beneficiary Eligibility Determination

CMS monitors the accuracy of state eligibility determinations through a number of mechanisms, including regular review and analysis of states' data regarding application and renewal processing, as well as technical assistance provided to states if potential issues are identified. CMS also reviews verification plans, which outline state processes and procedures for verifying eligibility, including use of data sources.

Many states have now implemented a wide range of new requirements into their processes for eligibility determinations because of updated statutory and regulatory requirements. These changes were intended to produce more standardized, simplified, computerized, data-driven processes for determining Medicaid eligibility. CMS is currently working with states that have not fully implemented all eligibility systems requirements to bring their systems into compliance, and ensure that these systems are making timely and accurate eligibility determinations.

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[20] CMS, Medicaid Eligibility Quality Control (MEQC) Sub-Regulatory Guidance, effective October 22, 2018.

In addition, CMS is developing a new, outcomes-based systems certification process to enable CMS to use test data, key performance indicators, and metrics to measure the performance of eligibility systems on an ongoing basis. This will allow CMS to identify and help remediate any systems issues related to eligibility determinations. CMS is also enhancing state accountability by tying system performance to enhanced federal funding for maintenance and operations of these systems.

CMS will be testing the results of these new systems and procedures to ensure that accurate determinations are being made and renewals are processed appropriately.

Audits of Beneficiary Eligibility Determinations

Correctly determining beneficiary eligibility is vital to the accuracy of Medicaid payments. This is particularly true for the newly eligible adult group, where a greater share of federal taxpayer dollars is at risk. To ensure compliance with the eligibility determination requirements for the newly eligible adult group, CMS began new eligibility audits in FY 2019 in several states, including those where the HHS-OIG previously identified vulnerabilities in the states' eligibility systems and processes, as well as states deemed high risk due to recent Medicaid expansion actions or other state audit findings.[21,22]

The HHS-OIG's reviews of Medicaid expansion eligibility determinations in New York, Kentucky, and California found that these states did not always comply with federal and state requirements to verify applicants' eligibility criteria, and estimated that across these three states, approximately $655 million in federal Medicaid payments were made on behalf of 413,349 ineligible beneficiaries.[23] CMS audits in these three high-risk states are focusing on whether beneficiaries were appropriately found eligible for the newly eligible adult group, whether services for those beneficiaries were assessed the correct FMAP, and whether findings from previous HHS-OIG reports on Medicaid eligibility determinations have been addressed by these states. CMS is also calculating the amounts inappropriately paid, if any, to the states due to improper eligibility determinations. In addition, the audits assess how states have progressed in ensuring that the eligibility and enrollment systems accurately verify applicant information with appropriate data sources and in maintaining documentation to support eligibility determinations.

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[21] HHS-OIG, Kentucky Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries, A-04-15-08044, May 2017; Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance With Federal and State Requirements, A-04-16-08047, August 2017; New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries, A-02-15-01015, January 2018; California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, A-09-16-02023, February 2018; California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, A-09-17-02002, December 2018.

[22] Louisiana Department of Health, Medicaid Eligibility: Wage Verification Process of the Expansion Population, November 8, 2018; Medicaid Eligibility: Modified Adjusted Gross Income Determination Process, December 12, 2018.

[23] Ritchie, Brian P. (HHS-OIG), Medicaid Fraud and Overpayments: Problems and Solutions, Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, June 27, 2018.

CMS does not currently have statutory authority to recoup overpayments for eligibility errors that are identified through these audits. To address this issue, CMS included a legislative proposal in the FY 2020 President's Budget that would expand extrapolation and disallowance authority for eligibility audits conducted outside of the PERM program.[24]

CMS also plans to continue these audits to include other states based on a risk analysis informed by issues noted during the review of State Plan Amendments for expansion approval; findings from other review programs, such as the PERM and MEQC programs; audits conducted by other entities, such as the HHS-OIG, GAO, and/or state auditors; and other sources.

1.2. *Review of State Program Integrity Activities*

As part of our ongoing partnership with states, CMS reviews the effectiveness of states' activities to prevent and reduce losses due to fraud and other improper payments resulting from waste, abuse, or billing errors. Based on these reviews, CMS provides feedback and guidance to help states improve their program integrity performance by making specific recommendations and working with states to ensure that corrective actions are completed.

State Program Integrity Reviews

State Medicaid programs are required to have a fraud detection and investigation program that meets minimal federal standards. CMS conducts focused reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, and personal care services.[25] Focused program integrity reviews include onsite state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. In FY 2019 and beyond, CMS will continue to conduct focused reviews of high-risk program integrity areas, such as managed care and personal care services in selected states.

In addition to the focused reviews, CMS also conducts desk reviews of states' program integrity activities to increase the number of states and topics that are assessed each year. Desk reviews help both CMS and states track the progress of states' corrective actions, evaluate states' compliance with program integrity regulations, and highlight noteworthy practices to share with other states.

From FY 2016 through 2018, CMS completed desk reviews of the status of states' PERM CAPs related to Medicaid FFS and managed care claims payment errors, states' completion of corrective actions from previous program integrity reviews, terminated providers that should no longer be billing Medicaid, and compliance with Medicaid Recovery Audit Contractor requirements. Also in FY 2018, CMS began conducting desk reviews of states' preparedness to respond to the opioid crisis by gathering

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[24] HHS, FY 2020 President's Budget in Brief, pages 91-92.
[25] State Program Integrity Reviews.

information on states' current programs, delivery systems, policies, and/or noteworthy practices to address this national public health emergency.

During the next 5 years, CMS will continue to conduct desk reviews related to states' responses to the opioid crisis, PERM CAPs, and completion of corrective actions from previous program integrity reviews. Additional areas for future desk reviews may include terminated providers that should no longer be billing Medicaid and compliance with Medicaid payment suspension requirements.

Corrective Actions to Reduce Payment Errors

Through the PERM improper payment rate measurement process, CMS identifies and classifies types of errors and shares this information with each state. States then analyze the findings to determine the root causes for payment errors, which is a necessary step in the development and implementation of effective state CAPs to reduce improper payments.

In an intensive effort to solve the root causes of payment errors, CMS will interact more closely than ever with states to provide support and technical assistance to states as they develop and implement CAPs, and CMS will monitor and evaluate their effectiveness. CMS will work directly with states to help identify vulnerabilities and overcome barriers that prevent resolution of identified deficiencies with the goal of eliminating repeat findings.

Along with increased support, CMS will hold states accountable for reducing their improper payment rates. CMS requires states to meet more stringent requirements if they have consecutive PERM eligibility improper payment rates exceeding the 3 percent national standard per section 1903(u) of the Act. Under current regulations, CMS will pursue disallowances for states that fail to demonstrate a good faith effort by satisfying PERM CAP and MEQC pilot requirements. In addition, CMS is exploring policy and legislative changes to expand extrapolation and disallowance authority for eligibility audits conducted both as a part of and separate from the PERM program.[26]

1.3. *Add Program Integrity Measures to the Medicaid and CHIP Scorecard*

To increase public transparency and accountability about the Medicaid and CHIP programs' administration and outcomes, CMS launched the first Medicaid and CHIP Scorecard in June 2018. The Scorecard includes measures reported by states, as well as federally reported measures in three areas: state health system performance, state administrative accountability, and federal administrative accountability.[27]

To hold states accountable across key areas of program integrity, CMS will identify measures of state performance on selected program integrity activities for inclusion in the Medicaid and CHIP Scorecard, as announced in the Medicaid Program Integrity

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[26] HHS, FY 2020 President's Budget in Brief, pages 91-95.
[27] Medicaid & CHIP Scorecard.

Strategy. For example, in the November 2019 update to the Scorecard, CMS added measures based on state initiation of collaborative investigations with their Unified Program Integrity Contractors and state participation in the Healthcare Fraud Prevention Partnership at any level.[28] In the future, as more data become available, CMS intends to add other measures to the Scorecard, including performance data derived from improper payment drivers. CMS may add or replace areas of emphasis as improved program integrity measures are developed.

2. Improve Medicaid Fiscal Accountability

CMS regards the fiscal integrity of the Medicaid program to be a top priority. We will conduct oversight of states' Medicaid expenditures through reviews and audits of state claiming on quarterly expenditure reports and through review of findings from states' single audits. CMS further recognizes that almost half of Medicaid expenditures are for services delivered through managed care. We will be taking steps to ensure that states comply with new managed care regulations that protect both beneficiaries and Medicaid funds, review managed care contracts and capitation rates, and conduct reviews of managed care plans' reported medical loss ratios (MLRs) and rate setting.

2.1. *Accuracy of State Claiming of Federal Funds*

CMS will bring a stronger program integrity focus to its oversight of state claiming of federal Medicaid funds through action on several fronts—enhanced reviews and audits of state expenditure claims, an improved regulatory framework, and closer collaboration with state auditors that are independent of state Medicaid agencies.

State Quarterly Expenditure Reviews

States submit quarterly expenditures that represent their reported outlays during the preceding quarter (including any adjustments within a 2-year timely filing window). CMS financial management staff carefully review these expenditures to ensure that they are claimed in accordance with federal laws, regulations, and policy guidance. If CMS determines that an expenditure is questionable or not adequately documented, approval of the expenditure is deferred; if adequate explanation and additional supporting documentation cannot be provided, the expenditure is disallowed. States must ensure that their expenditure reporting is accurate, supported, and reflects compliance with all federal rules.

CMS will bring an increased program integrity focus to our financial management review activities by ensuring proper claiming for expenditures for newly eligible individuals (those expenditures eligible for an enhanced FMAP), ensuring proper financing of state share where required (especially with respect to Certified Public Expenditures, intergovernmental transfers, and provider taxes and donations), and examining disproportionate share hospital payments. In addition, CMS will conduct audits that follow up on findings of state-to-federal cost shifting in HHS-OIG and GAO

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[28] Measures of State Administrative Accountability in the November 2019 update to the Medicaid & CHIP Scorecard.

reports and Department of Justice investigations of improper state claiming of federal Medicaid funds.

Medicaid Fiscal Accountability Regulations

CMS is proposing improvements to the regulatory framework for Medicaid fiscal accountability to better track how states fund their share of Medicaid expenditures, and thus better ensure that federal taxpayers do not fund a disproportionate share of Medicaid. These improvements are set forth in the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P) to strengthen the transparency and oversight of Medicaid supplemental payments by requiring states to report more complete and timely provider-level data on supplemental payments (including the financing of such payments), clarify Medicaid financing definitions, and close loopholes to address financing of Medicaid state share through impermissible uses of health care-related taxes and provider-related donations.[29]

Single Audits for Medicaid

GAO has reported that state auditors—with responsibility for their state's single audits—are uniquely qualified and positioned to partner with CMS in its oversight of Medicaid.[30] A state's single audit includes an organization-wide audit of the Medicaid program in which the auditor samples program and management practices to determine whether the state has complied with federal statutes, regulations, and the terms and conditions of federal awards that may have a direct and material effect on the Medicaid program.[31] Shortly before the beginning of FY 2019, CMS began working more closely with state auditors and revising the Single Audit Compliance Supplement for Medicaid, which identifies the objectives and compliance requirements to be audited due to their direct and material effect on the success of the Medicaid program. Going forward, CMS will continue to review the single audit reports, findings, and recommendations for Medicaid and issuing decisions, monitoring, and following-up on corrective actions to ensure findings are resolved and recommendations are implemented.

2.2. *Medicaid Managed Care*

Managed care organizations received over $182 billion of federal Medicaid dollars in 2016, almost half of federal Medicaid spending.[32] State Medicaid programs continue transitioning from fee-for-service to managed care delivery systems to provide for the delivery of covered health and long-term services to their members. Managed care poses unique oversight and program integrity challenges. To help address these challenges, CMS continues to engage stakeholders, including states, managed care

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[29] 84 FR 63722, November 18, 2019; 2019 Medicaid Fiscal Accountability Regulation (MFAR), Fact Sheet, November 12, 2019.
[30] Dodaro, Gene L. (GAO), Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity, (GAO-18-687T), Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, August 21, 2018.
[31] State single audits are performed under the requirements of Office of Management and Budget Circular A-133.
[32] CMS, 2017 Actuarial Report on the Financial Outlook for Medicaid.

organizations, and Medicaid Fraud Control Units, to share promising practices and other information that will help strengthen program integrity efforts in Medicaid managed care. CMS has taken steps to improve accountability by state agencies, managed care plans, and providers to mitigate the risks associated with Medicaid managed care contracts.

In the 2016 Medicaid managed care final rule,[33] CMS significantly strengthened program integrity standards for states' contracts with managed care organizations and their network service providers. In November 2018, CMS proposed significant regulatory revisions to streamline the 2016 managed care regulatory framework, while maintaining the current regulatory framework for program and fiscal integrity, including provisions related to provider screening and enrollment standards, actuarial soundness, and MLR standards.[34]

Ensure Compliance with the Managed Care Final Rule

CMS has begun releasing guidance to assist states with understanding and implementing the requirements of the 2016 Medicaid managed care final rule. Of paramount importance for Medicaid program integrity are requirements for the screening and enrollment of managed care network providers, for which CMS released updated guidance.[35] In FY 2020, CMS plans to release further guidance on the program integrity requirements of the final rule to include:

- Federal and state roles and responsibilities in the oversight of managed care plans;

- Review of states' program integrity monitoring and reporting requirements;

- Required program integrity provisions in managed care contracts, including verification of services and reporting of overpayments, overpayment recoveries, and potential fraud, waste, abuse;

- Requirements for managed care compliance plans and disclosures;

- Required submission and certification of encounter data and other data to ensure actuarial soundness of capitation rates; and

- Administrative actions available for states to enforce plans' compliance with program requirements.

CMS will work with states to understand the challenges they are facing in implementing the managed care rules, and provide support for states with options to overcome those challenges. To provide effective support to states on implementing the requirements, CMS will continue to offer technical assistance and educational opportunities through courses, webinars, further guidance, and communication with stakeholder groups. There will be courses specifically on the implementation of the managed care rules through the Medicaid Integrity Institute, described below, which will continuously educate state staff on the unique program integrity challenges of Medicaid managed care, while providing

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[33] 81 FR 27497, May 6, 2016.
[34] See Managed Care Guidance regarding Notice of Proposed Rulemaking.
[35] CMS, Medicaid Provider Enrollment Compendium (MPEC), July 2018.

valuable networking opportunities among states to share and discuss challenges and noteworthy practices for program integrity in Medicaid managed care.

To assess state compliance in implementing the managed care rules, CMS will develop measures and monitor state progress on meeting the requirements in the final rule. To hold states accountable for implementing required program integrity safeguards in their managed care programs, CMS will pursue administrative remedies with states that remain non-compliant.

CMS Oversight of Managed Care Contracts

As part of the 2016 Medicaid managed care final rule, CMS clarified rate setting standards to ensure more consistent and accurate financial accountability for Medicaid managed care organizations. States initiate annual contract actions with managed care plans to set the requirements and capitation rates for the beneficiaries assigned to their care. CMS will continue to complete reviews of the contracts and actuarial review of capitation rates to ensure compliance with the new rules. CMS will evaluate areas for in-depth examination by CMS actuaries and audit contractors, and determine whether additional steps are necessary to ensure rates are actuarially sound and support the contract terms to deliver high value, high quality services to enrollees.

CMS has also initiated a process to review and evaluate directed payments through managed care contracts where states are required to evaluate the effectiveness of those payment strategies. CMS will be completing thorough reviews of those payment strategies to determine and identify any areas requiring additional scrutiny to promote value in the delivery of services under Medicaid managed care.

Managed Care Reviews

The 2016 Medicaid managed care final rule strengthens the fiscal integrity in Medicaid and CHIP managed care by requiring more transparency in the managed care rate setting process and adding standards for the calculation and reporting of MLRs and encounter data submissions.

CMS will conduct reviews of Medicaid managed care plans' financial reporting in selected states focused on MLRs and rate setting. The final rule stipulates that states must require managed care plans to submit financial and other data supporting service encounters, the actuarial soundness of capitation rates, and reported MLRs.[36] CMS's reviews will verify whether plans' expenditures for providing health care services have been reported accurately and support capitation rates set in plans' contracts with states. These reviews will also identify any vulnerabilities in the MLR reporting process and determine actions states have taken to reconcile revenues.

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[36] 42 CFR 438.604.

3. Enhance Sharing of Claims Data, Analytics, and Audit Capabilities

Program integrity efforts are considerably enhanced by the sharing of data, analytics, and audit findings across payers. CMS provides states with access to appropriate Medicare data, states submit Medicaid data to CMS, and CMS sponsors the Healthcare Fraud Prevention Partnership for sharing certain health care data among government and private organizations. Through data sharing, non-compliant or fraudulent providers identified in one program can be more rapidly identified in other programs and appropriate administrative actions taken across the health care sector to reduce fraud, waste, abuse, and other improper payments for all payers.

3.1. State Access to Medicare and Other Payers' Data

State Access to Medicare Data

Over 12 million Americans are dually enrolled in Medicare and Medicaid,[37] and providers and managed care plans that serve Medicaid patients often participate in Medicare as well. This overlap means that Medicare program integrity data offers the potential to greatly enhance state Medicaid program integrity efforts. Analyzing both Medicare and Medicaid claims data enables CMS and states to detect duplicate and other improper payments for services billed to both programs. Sharing information among federal and state investigators about aberrant providers or plans can improve the identification of improper billing and optimize investigative resources.

Through the State Data Resource Center (SDRC), state Medicaid agencies may request Medicare data for individuals who are dually enrolled in Medicare and Medicaid to support care coordination and program integrity functions, such as preventing duplicate payments by Medicare and Medicaid. A state Medicaid agency may request Medicare eligibility and enrollment data, Medicare Parts A and B claims, and Part D pharmacy claims. The SDRC provides technical advisors who can help states determine how to use available data based on state priorities for Medicare-Medicaid coordination and program integrity. In addition, the SDRC offers frequent webinars on a variety of topics such as linking Medicare and Medicaid databases and program integrity data requests.

CMS administers the Medicare-Medicaid Data Match (Medi-Medi) program, through which Medicare and Medicaid claims for dually enrolled beneficiaries are matched at the provider and beneficiary level to check for duplications. State participation is voluntary; as of December 2019, 19 states participate in the Medi-Medi program.[38] CMS's Unified Program Integrity Contractors perform analyses of Medicare-Medicaid matched data and collaborate with state Medicaid agencies to conduct investigations and audits, as described in section 3.2.

CMS will also provide states access to Medicare data sources in a data warehouse environment, upon request. These Medicare data sources include Medicare Parts A and

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[37] CMS, MMCO Statistical & Analytic Reports, Annual (Medicare-Medicaid Duals) Enrollment Trends, September 2019.
[38] As of December 2019, the 19 Medi-Medi states are Alabama, Alaska, Arizona, California, Florida, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, West Virginia, and Wyoming.

B claims, Part D pharmacy claims, and Medicare-Medicaid matched data. CMS will reach out to states to inform them of opportunities to access these data sources. In addition to data access, CMS will provide states with guidance on using these data sets and applying advanced analytics. CMS and states will be able to identify duplicate Medicare and Medicaid payments and other types of improper payments for services billed to both programs.

Healthcare Fraud Prevention Partnership

In September 2012, CMS launched the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership that seeks to identify and reduce fraud, waste, and abuse across the health care sector. As of December 2019, the HFPP consisted of 152 total partners, including 19 federal and state law enforcement agencies, 5 additional federal agencies, 72 private plans (including organizations participating in Medicaid managed care), 13 associations, and 43 state and local partners. Partnership members voluntarily contribute claims data through a Trusted Third Party (TTP) and collaborate on strategies for detecting and preventing health care fraud, waste, and abuse.[39] For example, analyses of HFPP data have been successful in identifying fraud schemes and improper billing issues across payers, such as "impossible day" billing, excessive holiday and weekend billing, billing and referring by providers with deactivated National Provider Identifiers, and excessive urine drug testing.

Recently, efforts have been made to promote the HFPP and encourage participation by potential partners that have been traditionally challenging to recruit and engage (e.g., Medicaid agencies and smaller private payers that have limited internal resources). In addition, the TTP has acquired some state Medicaid data to conduct the cross payer studies. As of September 2019, 12 state partners had contributed data to the TTP allowing the TTP to utilize state Medicaid data to conduct cross payer fraud, waste, and abuse studies and provide individual and summary results to each respective state. Over the next 5 years, efforts will focus on performing analytics on areas of concern as identified through the partners and through ongoing data analysis of the cross-payer dataset. This capability will be broadened over this time to include not only professional claims data for individual providers, but also institutional and pharmacy claims from an ever-expanding pool of large and small private payers, state Medicaid agencies, and federal agencies.

3.2. *Strengthen Medicaid Data Analytics and Audits*

Oversight of a program of the size and scope of Medicaid requires robust, timely, and accurate data to ensure efficient financial and program performance; support policy analysis and ongoing improvement; identify potential fraud, waste, and abuse; and enable data-driven decision-making. CMS has worked with states over the last several years to enhance the Medicaid data that states are required by law to provide to CMS by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS).

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[39] The Trusted Third Party is a federal contractor that aggregates, de-identifies, and secures HFPP partners' contributed data under the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. No partner—public or private—has access to the data of other partners.

T-MSIS provides Medicaid data including FFS claims, encounters performed under managed care arrangements, service utilization and expenditure data, beneficiary eligibility, and provider enrollment data. T-MSIS is the foundation of an improved national analytic data infrastructure to advance reporting on outcomes and enhance the ability to identify potential fraud and other improper payments. As of January 2019, all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands have been submitting monthly T-MSIS data to CMS.[40]

Transformed Medicaid Statistical Information System (T-MSIS) Data Use

CMS continues to monitor ongoing monthly T-MSIS data submissions and strengthen efforts to assess and improve the quality of T-MSIS data. CMS plans to assess, improve, and maintain T-MSIS data quality and expand how we and other stakeholders will begin to make use of T-MSIS data. Continuous T-MSIS data quality review and improvement is an essential and ongoing task, which CMS expects states to maintain as a permanent and ongoing process of their operations.

CMS outlined expectations for states to address T-MSIS data quality issues by identifying 12 top priority items that states were expected to either resolve by February 2019 or submit corrective action plans, followed by additional guidance to states regarding T-MSIS state compliance in March 2019.[41,42] CMS will continue to expand this data quality review from the 12 top priority items to a more comprehensive data quality approach in 2019 to determine priorities and timelines for resolution of new identified data quality issues. For example, CMS plans to add the completeness of prescriber National Provider Identifiers to the future top priority items for T-MSIS data quality and implement an edit to check the accuracy of prescriber identifiers.

As part of the Medicaid Program Integrity Strategy, CMS announced further efforts to address T-MSIS data quality and use, which include validating the quality and completeness of T-MSIS data for program integrity purposes. CMS's ongoing goal is to use advanced analytics and other innovative solutions to both improve T-MSIS 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.

CMS's Unified Program Integrity Contractors and our other program integrity analytics contractors have begun testing T-MSIS data and will submit state-specific reports and recommendations to CMS regarding the use of T-MSIS data for program integrity going forward. As T-MSIS data quality meets required criteria, CMS will incorporate T-MSIS data into both Medicaid-specific and multi-program analytics to allow states, CMS, and

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[40] Transformed-Medicaid Statistical Information System (T-MSIS).

[41] CMS, Transformed-Medicaid Statistical Information System (T-MSIS) (State Health Official Letter #18-008), August 10, 2018. Examples of these 12 top priority items include managed care encounter data, eligibility group coding, duplicate claims, and cross-file linkages.

[42] CMS, T-MSIS State Compliance (CMCS Informational Bulletin), March 18, 2019.

other stakeholders the ability to observe and address trends or patterns indicating potential fraud, waste, and abuse in Medicaid.

States, oversight entities, policy researchers, entrepreneurs, and others are eager to access the T-MSIS data set. To make T-MSIS data available to stakeholders for the first time, CMS released in November 2019 a robust set of research-ready T-MSIS data files and user support materials, including data quality briefs and technical guidance documents. CMS will expand the availability of T-MSIS data in a future release to include annual files containing information on providers and managed care plans.[43] Opening up T-MSIS data to third parties will enable greater collaboration between CMS and states, managed care plans, and other stakeholders to address both the quality and usability of T-MSIS data.

Data Analytics Pilots

CMS remains committed to utilizing advanced analytics and other innovative solutions to both improve Medicaid eligibility and payment data and maximize the potential for the data to be used for program integrity purposes. CMS is a national leader in the use of predictive analytics to identify program integrity vulnerabilities. The CMS Fraud Prevention System (FPS) streams Medicare Part A and Part B claims on a national basis, running each claim against multiple algorithms that identify patterns of fraud, waste, and abuse. Claims may be automatically denied based upon edits, and alerts (or leads) are created for additional investigation when the FPS identifies claims and other data that suggest aberrant billing.

CMS will share its extensive knowledge, gained from analyzing large, complex Medicare data sets, to support states in analyzing Medicaid claims data to identify potential program integrity issues based on state and CMS priorities. CMS anticipates that continuing to work with states to improve the quality of T-MSIS data will enable states and CMS to perform analyses useful for program integrity and program management. Through forums, such as the Medicaid Integrity Institute, CMS will share FPS algorithms and provide data analytic support as necessary to assist states with their program integrity efforts.

Unified Program Integrity Contractors

Previously, CMS used several different contractors to carry out program integrity responsibilities in Medicare and Medicaid throughout the nation. To improve efficiency and coordination of federal data analysis and audit/investigation work within each region, CMS developed a Unified Program Integrity Contractor (UPIC) strategy. Under this strategy, Medicare, Medicaid, and Medi-Medi audit and investigation work at the federal level is consolidated into a single contractor within a defined multi-state area, which complements audit and investigation efforts by states.

Working with states, regional UPICs perform data analysis and conduct investigations and audits using Medicaid data, as well as Medicare-Medicaid matched data discussed

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[43] Medicaid and CHIP T-MSIS Analytic Files Data Release, Fact Sheet, November 7, 2019.

below. In collaboration with states, the UPICs conduct proactive Medicaid data analysis, investigations, and audits of all types of Medicaid providers and report identified overpayments to states for recovery. The UPICs work closely with states to ensure their work aligns with state priorities. The most common collaborative audits have been conducted in the areas of hospice services, Medicaid credit balances, and emergency services to non-citizens. Moving forward, we expect that managed care, opioids, and hospice will continue to be areas of focus for the UPICs in their collaborative work with states.

For services to beneficiaries dually enrolled in both Medicare and Medicaid, UPICs work with Medicare-Medicaid matched data and collaborate with state Medicaid agencies to generate leads for fraud and abuse investigations. If the analysis of the matched claims data indicates potential fraud, waste, or abuse in Medicare, the UPIC investigates; if the analysis indicates potential fraud, waste, or abuse in Medicaid, the UPIC works with the state to determine whether the UPIC or state will investigate.

3.3. *Strengthen States' Claims Payment Systems*

Federal and state governments have invested heavily in the development and operations of Medicaid claims processing and information retrieval systems that engage in high volume transactions. In 2016, CMS released an update to the Medicaid Management Information System certification process in the form of the Medicaid Enterprise Certification Toolkit 2.0 to ensure a more comprehensive analysis of CMS-funded state systems functionality. Moving forward, CMS is focused on increasing accountability and state flexibility by creating an outcomes-based oversight model to state systems certification. This approach will focus on producing timely and accurate claims payment results, properly screening and enrolling providers, member management, and comprehensive data analytics and reporting capabilities including timely and accurate submissions of required federal reporting such as T-MSIS data.

An important required prepayment safeguard is the National Correct Coding Initiative (NCCI), a CMS program of medical claim coding policies and prepayment edits, originally implemented in the Medicare program to promote correct claim coding and control improper coding that leads to inappropriate payments of Part B claims. Section 1903(r) of the Act requires CMS to notify states of which NCCI methodologies are compatible with Medicaid claims, and requires states to use these methodologies to prevent payment of improperly coded claims.

To assist states in implementing NCCI prepayment methodologies, CMS provides states with NCCI edit files, technical policy and guidance manuals, and technical assistance. Experts from CMS and its NCCI contractor are available to states through the NCCI mailbox and monthly teleconference calls to provide updates and address specific questions and issues of concern. CMS continues to work with individual states to provide direct technical assistance on correctly and completely implementing NCCI edits. Beginning in FY 2020, CMS will work with states to update information about their NCCI implementation status. CMS has issued technical guidance to assist states in

making consistent and robust estimates of their NCCI cost savings.[44] Although not required, these cost savings may be used to better monitor the effectiveness of Medicaid NCCI implementation within the states.

4. Provide CMS Services to Strengthen States' Program Integrity Activities

Through our partnership with states, CMS provides extensive support to strengthen states' provider screening and enrollment activities, train state program integrity staff at the Medicaid Integrity Institute, educate providers and beneficiaries to increase compliance and awareness of Medicaid integrity issues, and offer technical assistance on a wide range of program integrity issues. CMS will expand our services to states over the next 5 years to reduce state burden in complying with federal regulations designed to strengthen the integrity of the Medicaid program and build state capacity to prevent and detect fraud, waste, and abuse.

4.1. Provider Screening and Enrollment

Fundamental to CMS's strategy for reducing improper payments in all government health care programs is that prevention measures are far more cost-effective than pay-and-chase methods. Emphasizing prevention rather than pay-and-chase strategies also minimizes the potential burden of routine post-payment audits to honest providers. Because providers of health care services and supplies are positioned to bill and receive taxpayer funds from health care programs, the most effective methods of preventing improper payments are to screen out bad actors based on records of past actions. Effective methods to prevent *future* improper payments include imposing administrative sanctions against those who repeatedly bill for unnecessary services, terminating the participation of those proven recalcitrant in rectifying improper and wasteful billing practices, and referring cases of suspected fraud to law enforcement for investigation and prosecution.

The following sections describe improved services that CMS will provide to states to assist with their provider enrollment activities—the exchange of data related to provider screening and terminations, guidance and technical assistance to support states' enrollment work, as well as tools and services to perform provider screening.

Provider Screening Data Sources

CMS has significantly expanded data sources available to states for provider screening and enrollment over the past few years and continues to enhance the usability of these data sources through ongoing work with state partners. By the end of FY 2018, CMS completed transitioning state access to these databases to a new online portal, the Data Exchange (DEX) system, to provide states with enhanced data formats and an improved user interface. DEX allows CMS to share federal data with the Medicaid programs of every state, which in turn use DEX to share terminated Medicaid and CHIP provider information with CMS and other states. By March 2019, all 50 states and Puerto Rico obtained access to DEX.

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[44] CMS, NCCI MUE and PTP Edit Savings Guidance for State Medicaid Agencies, November 2019.

CMS will continue to work with states to ensure adoption of the DEX system and to determine the need for future enhancements that may benefit states. DEX provides enhanced functionality for the exchange of the following types of data for provider screening and enrollment:

- Provider Terminations: States must deny or terminate the enrollment of any provider that is terminated for cause under Medicare or under the Medicaid program or CHIP of any other state.[45] DEX provides third generation enhancements to CMS's centralized online mechanism for sharing reciprocal Medicare and Medicaid/CHIP provider termination data, which was initiated in FY 2011.

- Death Master File: DEX provides states with access to the Social Security Administration's Death Master File (DMF), which states are required to check as part of provider screening and revalidation to ensure that identities of deceased providers are not used fraudulently to bill Medicaid. Complete access to the DMF was previously available to states only through a paid subscription, which some states had identified as a challenge.

- Provider Enrollment, Chain and Ownership System (PECOS): To provide state access to key Medicare provider enrollment information, CMS has provided states with training and direct access to the Medicare provider enrollment system known as PECOS since 2012, regular data extracts from PECOS since 2013, and enhanced usability to assist states' Medicaid provider screening since 2014. These improved PECOS data extracts are now available to states to download through DEX.

- Medicare Exclusion Database (MED) Extracts: CMS also provides states with access through DEX to the MED, which contains the HHS-OIG's data regarding individuals and entities excluded from federally funded health care programs, which states are required to check as part of Medicaid provider screening and revalidation.

Provider Enrollment: Guidance and Technical Assistance

To help states strengthen their provider screening and enrollment processes, CMS has significantly enhanced guidance and technical assistance to states. As part of this ongoing effort, CMS will update guidance and expand these services to additional states over the next few years through the following activities:

- CMS published the first edition of the Medicaid Provider Enrollment Compendium (MPEC) in March 2016—a culmination of sub-regulatory guidance to assist states in the implementation of provider screening and enrollment requirements. CMS has provided updates each year, including additional guidance to assist states in applying new screening and enrollment requirements to Medicaid managed care network providers. CMS will complete and publish a broader update to the MPEC in early 2020.

- To provide direct, individualized technical assistance to states in strengthening their provider screening and enrollment processes to meet federal requirements,

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[45] 42 CFR 455.416, based on Section 1902(a)(39) of the Social Security Act.

CMS conducts onsite visits and follow-up by both CMS provider enrollment experts and a State Assessment contractor. CMS experts have assessed state compliance with requirements and worked to reduce state burden by helping states leverage Medicare screening and enrollment data through site visits to 15 states by the end of FY 2019. CMS re-procured its State Assessment contractor in FY 2018 to assist with ongoing state technical assistance and process improvements related to provider screening and enrollment. By the end of FY 2019, the State Assessment contractor had visited 17 states to assess compliance with requirements, conduct a gap analysis, and develop strategic blueprints to help states improve processes. CMS will expand its work by providing assistance to additional states until all states have had the opportunity to meet.

- Going forward, CMS will also continue monthly calls with states to understand challenges or barriers states currently face, to facilitate the exchange of noteworthy practices among states, and to respond to questions regarding guidance or other provider enrollment issues. CMS has also dedicated an additional monthly call focused entirely on provider enrollment and screening issues in Medicaid managed care.

Screening Medicaid Providers

Some states have faced challenges implementing the required activities to comply fully with enhanced provider screening requirements. As a result, non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments since FY 2014.[46] To reduce the burden of conducting screening for new enrollments and revalidation of Medicaid providers, CMS allows states to use provider screening results from Medicare, CHIP, or other State Medicaid agencies. In addition, CMS will make the following tools and services available to assist states in meeting provider screening requirements:

- CMS currently offers a data compare service for provider screening that allows a state to rely on Medicare's screening in lieu of conducting state screening. This service reduces state burden, particularly for provider revalidation, because it allows states to remove dually enrolled providers from their revalidation workload. Using the data compare service, a state provides a list of Medicaid providers to CMS and then CMS returns information indicating for which providers the state can rely on Medicare's screening. As of June 2019, 26 states and territories had participated in the data compare service. CMS will continue to work with states on an ongoing basis to promote the advantages of the data compare service to work toward the goal of expanding use of the service to all states.

- As part of the Medicaid Program Integrity Strategy, CMS will pilot a centralized process to screen Medicaid-only providers on behalf of states on an opt-in basis, similar to the current process in place for Medicare. The purpose of this effort is to explore whether centralization of Medicaid provider screening can reduce state and provider burden, better ensure providers are screened appropriately based on categories of risk, and address a major source of improper payments. CMS has

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[46] HHS, [FY 2019 Agency Financial Report, Section 3](#), November 2019, page 216.

recruited two states, Iowa and Missouri, and began screening their Medicaid-only providers through databases for valid licenses, criminal background checks, and the federal Treasury's Do Not Pay portal in late FY 2019. CMS will evaluate the results and impact of the pilot and assess the value of expanding the service to more states in the future.

4.2. Education and Technical Assistance

CMS provides educational and technical assistance to support and strengthen states' program integrity activities through training of state program integrity staff at the Medicaid Integrity Institute, provider and beneficiary education, and technical assistance to help states identify vulnerabilities and implement mitigation strategies.

Medicaid Integrity Institute

Since 2008, CMS has offered training to state program integrity staff at no cost to states in collaboration with the Department of Justice's National Advocacy Center, Office of Legal Education in Columbia, South Carolina. The Medicaid Integrity Institute (MII) provides both classroom training and distance learning webinars to enhance the professional qualifications of state Medicaid integrity staff across the nation. The MII offers a program of courses and examinations for the Certified Program Integrity Professional designation, which is recognized by the American Association of Professional Coders and the National Health Care Anti-Fraud Association. Courses at the MII also provide opportunities to discuss emerging trends, support new initiatives, and strengthen collaboration among state and federal partners.

CMS will update and expand MII training for state program integrity staff to meet new state challenges and federal priorities. New course content will be developed such as improved use of data exchanges to address beneficiary eligibility fraud; fiscal responsibility in financial management practices and expenditure reporting; new state and plan responsibilities under the Medicaid managed care final rule; complete implementation of provider screening, disclosure, and enrollment requirements; and improved investigative skills training. These course offerings will teach new concepts and skills, while building existing knowledge to support identifying and mitigating Medicaid program integrity risks. CMS will take steps to integrate MII training more closely with follow-up technical assistance when state staff return to their respective agencies to facilitate applying lessons learned at MII to solving problems at the state level.

CMS will also be updating and expanding distance learning opportunities to extend the MII's reach to train even more state program integrity staff on a wider range of content areas. Distance learning will offer additional opportunities for Medicaid agency staff to address and discuss new program integrity challenges as they arise over the next 5 years.

Onsite Technical Assistance and Training

CMS carries out the mandates of the Medicaid Integrity Program, established under the Deficit Reduction Act of 2005, which include providing effective support and assistance

to states in their efforts to combat Medicaid provider fraud and abuse.[47] To continue fulfilling this responsibility, CMS will engage a new contractor to obtain an updated and deeper assessment of each state's current processes for implementing Medicaid program integrity. This new initiative will expand our existing support activities by providing technical assistance that integrates focused staff training on program integrity safeguards at the MII, previous and current onsite assessments, and follow-up technical assistance and training tailored to each state's needs.

The contractor will conduct site visits to identify vulnerabilities and gaps in each state's program integrity safeguards, develop an individualized strategic blueprint for each state agency to follow to achieve needed improvements, and develop educational materials and provide in-person (live) training to assist each state in meeting the identified objectives to strengthen their program integrity processes. Through this contract, CMS will provide state Medicaid agencies with tools and opportunities to enhance their knowledge of program integrity safeguards and with technical assistance to help overcome barriers and challenges they face in safeguarding their programs.

Provider Education

Most providers do not commit fraud, but some providers may exhibit recurrent billing and coding errors. This can result in payment delays due to denied payments and appeals. Provider education informs providers of common errors in their billing practices and provides education to help reduce errors, as well as the delays and subsequent burden that can occur due to these errors.

Targeted Probe and Educate (TPE) and Comparative Billing Reports (CBRs) are provider education tools administered by CMS for Medicare providers. These two programs can serve as models for state Medicaid programs as part of their program integrity efforts. Under a TPE strategy, reviewers sample a small number of claims for each provider, identify specific billing and/or documentation issues, and provide focused education. For CBRs, data-driven reports are disseminated to providers with aberrant billing or coding patterns to inform them how their billing for specific services differs from their state and national peers, after which they are invited to attend an educational webinar.

As part of the Medicaid Program Integrity Strategy, CMS will pilot a provider education service for TPE and CBRs with a few select states to provide education and data-driven reports and feedback to providers. The purpose is to help states identify common billing errors, improve provider billing behavior, reduce errors, and avoid escalation to audits. CMS will evaluate the results of the pilot and potentially expand these provider education services to additional states.

Online Resources for Provider and Beneficiary Education

CMS makes educational toolkits available to states on the Medicaid Program Integrity Education website, a repository of resources designed to educate providers,

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[47] 42 U.S.C. 1396u-6. Medicaid Integrity Program.

beneficiaries, and other stakeholders on awareness and noteworthy practices regarding Medicaid fraud, waste, and abuse. CMS plans to update and expand the toolkits available on the website to enhance provider and beneficiary education on an array of current program integrity topics, including but not limited to the following areas:

- Beneficiary Responsibilities: State Medicaid agencies have requested additional methods and resources for addressing beneficiary eligibility fraud, especially with regard to individuals who knowingly and willfully fail to report material income increases that would make them ineligible to continue receiving Medicaid benefits. CMS will expand online toolkits available for states to use in educating beneficiaries about their responsibilities to report changes in circumstances that may affect eligibility, penalties for knowingly and willfully misrepresenting facts to obtain or continue Medicaid or CHIP benefits, and how to report potential fraud.

- Documentation of services: CMS will act to reduce the impact of documentation-related improper payments by updating and expanding education for providers on maintaining proper documentation of billed services. Documentation errors due to providers represented over 90 percent of the total projected improper payments in Medicaid FFS medical review for 2017.[48]

- Managed Care: Due to the continued rise in Medicaid coverage under managed care, CMS will develop additional guidance materials to educate Medicaid managed care plans and network providers on their responsibilities under the 2016 Medicaid managed care final rule.

- Non-Emergency Medical Transportation (NEMT): State Medicaid agencies have identified NEMT as a service where enhanced provider and beneficiary education could significantly reduce improper Medicaid payments. CMS will develop more extensive toolkits to inform both providers and beneficiaries on the proper use of Medicaid transportation services and on practices to prevent and report fraud, waste, and abuse of NEMT services.

- New Provider Education: CMS plans to revise current educational materials and feature new documents to educate providers on areas such as types of fraud, federal penalties for health care fraud, resources for reporting fraud, and beneficiary identity theft.

Ultimately, the education website provides an opportunity to promote awareness of program integrity issues among Medicaid providers and beneficiaries and engage them in continuous education, contributing to a reduction in fraud and increase in knowledge that will have positive outcomes on Medicaid program integrity.

Fiscal and Beneficiary Safeguards in Home and Community Based Services

To address program integrity concerns in Home and Community Based Services (HCBS), CMS has launched several initiatives on fiscal oversight and on health and safety protections for beneficiaries.

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[48] CMS, 2017 Medicaid & CHIP Supplemental Improper Payment Data, November 2017, (Table S9).

To ensure that billing for specific home services is supported by proper documentation, CMS is supporting states in their implementation of Electronic Visit Verification (EVV) systems, as required by the 21st Century Cures Act (P.L. 114-255). All states must incorporate functional EVV systems for Personal Care Services no later than January 1, 2020 and for Home Health Care services no later than January 1, 2023, unless states have received approval from CMS for an additional 12-month delay. CMS is collaborating with its contractors to provide EVV education, training, and technical assistance to states to ensure they are successful in initiating this fiscal integrity control, and that EVV is linked directly to states' billing and/or payment through pre- or post-payment audits. CMS and its contractors are also implementing EVV Learning Collaborative meetings for states, CMS, and other stakeholders to collaborate and openly discuss policy guidance and noteworthy practices. In addition, the FY 2020 President's Budget includes an administrative proposal to require states to assign unique identifiers to Medicaid personal care attendants that would be listed on claims along with dates that attendants performed the billed services.[49]

To improve oversight of rate setting and financial reporting, CMS is also working with contractors to ensure proper billing and payment in HCBS waiver and state plan programs through activities such as conducting reviews and analyses of rate methodology and providing technical assistance and training to states.

Maintaining critical beneficiary protections is an important pillar of Medicaid program integrity, and as such, we are committed to partnering with states to safeguard against incidents of beneficiary abuse, neglect, or exploitation. To improve incident reporting and effective action, CMS is in the process of developing a national survey to monitor the status of incident management systems across the nation. The survey is intended to identify methods and promising practices for identifying, reporting, tracking, and resolving incidents of abuse, neglect, and exploitation. In addition, recognizing that the minority of providers who exhibit fraudulent, wasteful, or abusive billing practices likely pose a higher risk of committing abuse, neglect, or exploitation of beneficiaries, the survey will capture states' methods for monitoring the health and safety of Medicaid participants who receive services from providers who exhibit abusive billing behavior. CMS will develop recommendations based on findings and noteworthy practices from that survey as well as broader technical assistance trainings.

To help states triage health and welfare issues and identify risks of beneficiary abuse or neglect, CMS has engaged another contractor to work individually with states to improve their health and welfare systems by evaluating operations and assessing compliance with required oversight of HCBS settings, including in group homes and assisted living programs. To accomplish this work, CMS plans to conduct a site visit to every state during the 3-year period from FY 2019 to FY 2021. Technical assistance to states will be geared toward improved strategies to prevent abuse, neglect, and exploitation as well as improved state oversight of providers and beneficiaries in the delivery of HCBS.

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[49] HHS, FY 2020 President's Budget in Brief, page 95.

Conclusion

CMS has set forth its Comprehensive Medicaid Integrity Plan for FYs 2019–2023 to employ both new and evolving initiatives to enhance Medicaid program integrity as we share accountability with states to ensure proper and appropriate use of federal and state dollars. CMS will implement the strategies outlined in this Plan to work more closely than ever with our state partners. Together, we will work to strengthen claims payment and beneficiary eligibility processes; ensure full implementation of required prevention strategies in provider enrollment, claims prepayment safeguards, and Medicaid managed care contracts; improve fiscal accountability for Medicaid expenditures; and enhance sharing of claims data, analytics, and audit capabilities.

Mindful of the uniqueness of each state Medicaid program, CMS is responding to states' needs by increasing its flexibility in program integrity approaches to empower individual states to create innovative programs that best address the program integrity challenges that each state faces. CMS balances the greater flexibility afforded to states with enhanced transparency and accountability for cost-effective program outcomes in improving health and safety for Medicaid beneficiaries as well as reducing improper payments. CMS will continue to work with states to develop flexible strategies and initiatives to more effectively promote Medicaid program integrity and safeguard taxpayer dollars.

CMS believes that this comprehensive strategy to address the financial risks associated with the Medicaid program will provide CMS and the states with the tools and flexibility needed to meet the challenges of Medicaid program integrity over the next 5 years. CMS looks forward to continuing to improve our efforts to combat Medicaid fraud, waste, and abuse in partnership with state agencies, NAMD, and federal stakeholders in HHS-OIG, GAO, MACPAC, and other HHS agencies.