Comprehensive Medicaid Integrity Plan

Fiscal Years 2014 - 2018

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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 2014–2018.

The implementation of the Affordable Care Act over the next five years will result in an expansion of Medicaid enrollment and an increase in the federal investment in the program. The Congressional Budget Office (CBO) projects that over federal fiscal years 2014 – 2018, Medicaid enrollment will expand by a total of 14 million beneficiaries and federal Medicaid spending will increase by a total of $119 billion over five years.[1] This Comprehensive Plan represents the CMS strategy to improve existing program integrity efforts as well as implement new initiatives to safeguard expanded coverage and financial investment in the Medicaid program.

Medicaid is a federal-state partnership, and that partnership is central to the program's success. CMS provides states with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, federal match for their expenditures, and other resources. CMS carries out its obligations to states while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk. States fund their share of the program, and, within federal and state guidelines, operate their individual programs, including setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. State Medicaid programs and CMS share responsibility for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible individuals and are not diverted into fraud, waste, or abuse.

This 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 diversion into fraud, waste, and abuse. These efforts will expand the capacity of CMS to protect the integrity of the Medicaid program and to manage risk in the administration of federal grants to states.

To increase the ability of state Medicaid agencies and CMS to leverage program data to protect Medicaid from fraud, waste, and abuse, CMS will:
- Improve the quality and consistency of Medicaid data reported to CMS;
- Increase state Medicaid agency access to Medicare program integrity data; and
- Improve the analysis of Medicaid program data to identify potential fraud, waste, and abuse.

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[1] CBO, Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf

To build the capacity of state Medicaid agencies to prevent and detect fraud, waste, and abuse against the Medicaid program, CMS will:
- Streamline CMS assessment of state Medicaid program integrity activities;
- Support state oversight of program integrity in Medicaid managed care;
- Provide technical assistance to state Medicaid agencies with respect to data analysis; and
- Expand training of state staff through the Medicaid Integrity Institute.

To expand the capacity of CMS to protect Medicaid program integrity and to manage risk in the administration of federal grants to states, CMS will:
- Eliminate duplication of efforts by integrating Medicare and Medicaid audits and investigations;
- Improve financial accountability for Medicaid managed care organizations;
- Improve safeguards for Medicaid fee-for-service claims;
- Expand reporting and controls for provider rate setting;
- Enhance beneficiary eligibility safeguards;
- Improve the accuracy of state claiming and grant management;
- Execute safeguard strategies for new forms of payment and new delivery systems; and
- Revise measurement of error rates to align with program changes.

This Plan is informed by our evaluation 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 Children's Health Insurance Program (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.[2] 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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[2] 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.

Introduction

The Government Accountability Office (GAO) has identified the Medicaid program as high risk due to its size ($400 billion annually), growth, diversity of programs, and concerns about the adequacy of fiscal oversight.[3] State Medicaid programs and CMS share accountability for the integrity of the Medicaid program and for program safeguards necessary to ensure proper use of both federal and state dollars. As a federal-state partnership, the Medicaid program presents program integrity challenges and opportunities that are distinct from the Medicare program. States are the first line of defense against fraud, waste, and abuse in their Medicaid programs as they 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 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 safeguarding the integrity of the Medicaid program during federal fiscal years (FFY) 2014–2018.

This 5-fiscal year period is projected to be one of rapid growth in Medicaid enrollment and in federal investment. The Congressional Budget Office (CBO) projects that over fiscal years (FYs) 2014 – 2018, Medicaid enrollment will expand by a total of 14 million beneficiaries and federal Medicaid spending will increase by a total of $119 billion over five years.[4] Over 90 percent of the total increase of 14 million beneficiaries over this 5-year period is due to the expansion of Medicaid coverage to low-income adults under the Affordable Care Act, P.L. 111-148.[5] This historic expansion of coverage will bring new program integrity challenges for participating state Medicaid programs and for CMS.

This Plan addresses these new requirements as well as ongoing Medicaid program integrity issues. It is informed by our evaluation 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. In keeping with recommendations by these stakeholders, CMS has already implemented improvements as well as discontinued activities that have not proven cost-effective.[6] Additional recommendations by these stakeholders will be implemented as part of this 5-year Plan.

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[3] GAO, High-Risk Series: An Update. GAO-13-283, Feb. 2013, http://www.gao.gov/highrisk/medicaid_program/why_did_study.
[4] CBO, Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline,
http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.
[5] Ibid. The adult enrollment is projected to increase by 13 million from FY 2014 to FY 2018.
[6] CMS discontinued three Medicaid program integrity activities during the last three years that had not proven to be cost-effective. First, in February 2011, CMS stopped assigning audits to Audit Medicaid Integrity Contractors (MICs) based solely on data from the Medicaid Statistical Information System (MSIS). Second, CMS decided not to renew the contracts for the Review

This Plan is shaped by six broad considerations:

- First, under the Affordable Care Act, the Medicaid program will be transformed over the next five years. Medicaid eligibility for most non-disabled, non-elderly populations will be simplified and streamlined. At state option and largely at federal expense, Medicaid coverage of low-income adults will increase significantly. This enrollment growth, in turn, will create demand for additional providers to meet the health and long-term care needs of Medicaid beneficiaries. Medicaid long-term care services and supports will increasingly be provided in the community rather than in nursing facilities. And states will continue to expand their reliance on managed care arrangements in order to provide acute care services and long-term care services and supports to program beneficiaries. In combination, these trends will result in significant growth in the Medicaid population overall, in Medicaid managed care enrollment, and in federal Medicaid spending. In addition, as CMS and states develop new health care delivery and payment models, management controls must help ensure that we accomplish our intended goals without creating inappropriate incentives for or vulnerabilities to fraud, waste, and abuse.

- Second, the harm created by fraud, waste, and abuse against the Medicaid program is not limited to state and federal funds. Fraud, waste, and abuse can also directly harm beneficiaries. Physicians who inappropriately prescribe prescription drugs to increase their billings may be placing their patients at medical risk. If a nursing facility, in order to maximize profits, does not maintain adequate staffing or nutrition, the residents will be at great risk. Similarly, if a dental clinic performs unnecessary procedures on children in order to generate revenue, the children's health is at risk. Keeping fraudulent providers out of the Medicaid program in the first place, and identifying them quickly if they do enroll, prevents Medicaid payment for substandard care that puts beneficiaries in harm's way.

- Third, Medicaid program integrity efforts can only succeed when the federal government works in partnership with states. States fund their share of the program, and, within federal and state guidelines, operate their individual programs by setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. CMS has obligations under federal law with respect to oversight, support and assistance, auditing, and education. CMS carries out its obligations to states while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk. 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.

MICs as they expired over the period from August 2012 to May 2013. Finally, in early FY 2013, CMS indefinitely suspended the State Program Integrity Assessment (SPIA), an annual activity to collect state Medicaid program integrity data.

- Fourth, the focus of CMS program integrity efforts in Medicaid is shifting beyond the traditional emphasis on "pay and chase" to prevention of costs due to fraud, waste, or abuse. Operational experience has taught us that Medicaid funds improperly paid to fraudulent providers are very difficult to recover. Program integrity policy, as reflected in the Affordable Care Act, now emphasizes keeping bad actors out of Medicaid through risk-based provider screening, periodic revalidation of provider enrollment, and temporary suspension of payments while credible allegations of fraud are under investigation by law enforcement. To improve oversight of providers participating in Medicaid, program integrity policy at both the federal and state level will increasingly rely upon sophisticated analysis of claims and utilization data.

- Fifth, the work of CMS to safeguard the integrity of the Medicaid program encompasses a broad spectrum of cooperative activities throughout the agency. The Center for Medicaid and CHIP Services (CMCS) is accountable for setting broad program policy, approving state plans and waivers, and carrying out program and financial management activities related to grant-making with the states. The Center for Program Integrity (CPI) is responsible for implementation of the Medicaid Integrity Program established under the Deficit Reduction Act of 2005 and the Medicaid program integrity authorities in the Affordable Care Act. The Office of Financial Management is responsible for the measurement and annual reporting of Medicaid payment error rates through the Payment Error Rate Measurement program. The Consortium for Medicaid & Children's Health Operations serves as the regional focal point for CMS interactions with states, territories, and local governments relating to Medicaid and the Children's Health Insurance Program (CHIP), including coordination of program integrity efforts. Finally, to improve care coordination for Medicare-Medicaid enrollees and eliminate cost-shifting between the Medicare and Medicaid programs and among related health care providers, the Affordable Care Act created the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) within CMS.

- Finally, program integrity efforts in Medicare have considerable potential to strengthen program integrity in Medicaid, and vice versa. Over 8 million Americans – seniors and younger persons with disabilities – are dually eligible for both Medicare and Medicaid. A substantial number of hospitals, nursing facilities, pharmacies, physicians, and other providers participate in both Medicare and Medicaid, as do many managed care companies. This overlap of beneficiaries, providers, and plans creates opportunities to safeguard both programs from fraud, waste, and abuse through the use of data analysis, coordinated audits, and collaboration among state and federal law enforcement agencies in investigations and prosecutions. State Medicaid programs can benefit from CMS's capacity to analyze Medicare data, as well as from the investigative resources of CMS Medicare contractors. At the same time, when state Medicaid agencies uncover fraudulent, wasteful, or abusive activity in their programs, this information can benefit Medicare program integrity work.

Informed by these considerations, this Plan sets a path for CMS and its state partners to improve Medicaid program integrity going forward into FY 2014 – FY 2018. The Plan will enable CMS and states to better protect federal and state Medicaid funds from fraud, waste, and abuse, to

improve accountability by providers and managed care plans to the program and its beneficiaries, and to mitigate the risks associated with expanded federal grants to states.

Comprehensive Medicaid Integrity Plan for FFYs 2014-2018

1. *Improve Medicaid program data and expand its use in safeguarding program integrity*

1.1. Improve the quality and consistency of Medicaid data reported to CMS

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. Section 4735 of the Balanced Budget Act of 1997 requires states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration.

From March 2011 to June 2012, CMS worked closely with 12 pilot states and other stakeholders to refine and enhance the Medicaid Statistical Information System (MSIS) data set. The result of this effort is the Transformed Medicaid Statistical Information System (T-MSIS), which encompasses the data set produced in the daily operation of the Medicaid program, including fee-for-service (FFS) claims, encounters performed under managed care arrangements, beneficiary eligibility and demographic information, and provider enrollment data. Though states will transition to T-MSIS at different points in time, all states are expected to submit timely T-MSIS data to CMS by July 1, 2014.

As states migrate from MSIS to submitting T-MSIS data sets, CMS will review and approve T-MSIS data submissions to ensure the state is accurately transforming state records into the T-MSIS format. In addition, CMS will position technical assistance to states to provide subject matter expertise in correcting erroneous data. T-MSIS implementation encompasses a higher standard of data integrity as its foundation whereby automated edit rules are applied to ensure state submissions meet established expectations for timeliness, robustness, and data integrity. Moving forward, CMS will continue to monitor, evaluate, and improve the quality and consistency of states' data by continuing to enhance and refine data validation and quality systems edits.

In future years, T-MSIS will be the foundation of a robust state and national analytic data infrastructure that includes data elements necessary for program integrity data mining and audit functions. T-MSIS data will, among other things, enhance the ability of states and CMS to observe trends or patterns indicating potential fraud, waste, and abuse in the program so that they can be prevented or mitigated. States will be able to analyze their own program data along with other information in the CMS data repositories, including Medicare data, in order to identify potential anomalies for further investigation. In addition, T-MSIS data will

support a host of improved program and financial management tools for the analysis of enrollments, encounters, claims, expenditures, delivery systems, and beneficiary outcomes.[7]

1.2. Increase state Medicaid agency access to Medicare program integrity data

Over 8 million Americans are dually enrolled in both Medicare and Medicaid, 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 targeting, conserve resources, and increase success rates.

The Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act limit the types of Medicare data that CMS may release and how the requesting entity may use such data. Working within these requirements, CMS is taking a number of steps to improve state access to Medicare data.

CMS maintains the Fraud Investigation Database (FID), which contains information on investigations, cases, and payment suspensions pertaining to Medicare providers. The database contains numerous searchable fields that can assist states in identifying problem providers who are enrolled in both Medicare and Medicaid, and to identify fraudulent or abusive schemes that Medicare is investigating and may affect state Medicaid programs. All states can request and gain access to the FID, and CMS has conducted webinar training for states on its use.

Section 6501 of the Affordable Care Act requires states to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other Medicaid State plan. To implement this provision, CMS published the final rule on February 2, 2011,[8] provided guidance to states on the reciprocal termination requirement in informational bulletins,[9] and instituted a centralized process to enable states to share information on terminated providers and to download information on Medicare terminations on January 1, 2011. In December 2013, CMS developed and launched an enhanced collection, storage, and delivery process for Medicaid termination notifications. States have been instructed to report all "for cause" Medicaid terminations that have exhausted their state appeal rights to CMS, which reviews each case for a potential Medicare revocation as defined in CFR 424.535. The new system will store all state-submitted terminations as well as all Medicare revocations. CMS will finalize these steps in FY 2014 and work with the

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[7] Transformed Medicaid Statistical Information System (T-MSIS) Data (SMD# 13-004), August 23, 2013, available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf.

[8] 76 Fed. Reg. 5862

[9] CPI-CMCS Informational Bulletin, CPI-B 11-05, May 31, 2011, available at: http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf and CPI-CMCS Informational Bulletin, CPI-B 12-02, January 20, 2012, available at: http://www medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-20-12.pdf.

states to enhance collaboration, improve reporting, and create transparency through this process.

Section 6401 of the Affordable Care Act established a landmark provision for the alignment of procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. The federal regulation at 42 CFR 455.410 allows states to rely on Medicare for provider screening and enrollment decisions. To facilitate real-time exchange of information from Medicare to state Medicaid programs, CMS has been providing states with training and direct access to the Medicare provider enrollment system known as PECOS (Provider Enrollment, Chain, and Ownership System) since April 2012. This system enables states to review all current and historic information on each Medicare provider and supplier, including a National Provider Identifier, Taxpayer Identification Number, and legal business name. To increase efficiency and accessibility for states, CMS has been creating a regular data extract of key Medicare enrollment information since January 2013. This data extract reduces the need for manual review of individual records within PECOS and allowed states to systematically evaluate information and better prioritize workload. In 2014, CMS will further improve states' access to Medicare enrollment data by increasing the information available in the data extracts, and by enhancing PECOS based on feedback from state users engaged in screening of providers for Medicaid.

CMS administers the Medicare-Medicaid Data Match (Medi-Medi) program, through which the CMS Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs) collaborate with state Medicaid agencies to generate leads for fraud and abuse investigations. The leads are developed by matching Medicare and Medicaid data at the provider and beneficiary level. If the analysis of the matched claims data indicates potential Medicare fraud, waste, or abuse, the ZPIC/PSC investigates; if the analysis indicates potential Medicaid fraud, waste, or abuse, the ZPIC/PSC refers the case to the state Medicaid agency for disposition. State participation is voluntary; as of January 2014, 21 states[10] have joined the Medi-Medi program, representing over 66 percent of Medicaid spending. Several additional states have expressed interest in the Medi-Medi program, and CMS intends to work with these states and encourage additional states to participate in 2014 and beyond. In addition, the availability of T-MSIS data at the national level beginning in July 2014 (section 1.1) will provide CMS, its program integrity contractors, and state Medicaid agencies with a national data source of Medicaid claims that can eventually be matched with Medicare claims to identify duplicate payments and aberrant billing and utilization patterns.

Currently, state Medicaid agencies may access Medicare Part A, Part B, and Part D claims data for care coordination of dually eligible Medicare and Medicaid beneficiaries, but not for program integrity purposes. CMS is currently establishing a process to expand state use of Medicare claims data for dually eligible beneficiaries to include Medicaid program integrity.

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[10] As of January 2014, the 21 Medi-Medi states are Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa, Michigan, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, Utah, and Wyoming.

In September 2012, CMS launched the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership for sharing information related to health care fraud, waste, and abuse. The HFPP includes representatives from Medicare, state Medicaid programs, state law enforcement, and private plans and associations. Partnership members voluntarily collaborate and share data and strategies for detecting and preventing health care fraud, waste, and abuse.   States participating in the HFPP include Arizona, Illinois, Iowa, Kansas, Ohio, New York, Massachusetts, and Vermont, and CMS is evaluating ways that additional states and Medicaid-oriented partners can benefit from and contribute to the partnership. In 2014, CMS will complete the public notification of the new information collection activity as required by Paperwork Reduction Act of 1995 that will enable the expansion of data sharing partners in the HFPP.

1.3. Improve the analysis of Medicaid program data to identify potential fraud, waste, and abuse

CMS is a national leader in the use of predictive analytics to identify program integrity vulnerabilities. The CMS Fraud Prevention System (FPS) streams all Medicare Part A and Part B claims prior to payment, running each claim against multiple algorithms that identify patterns of fraud, waste, and abuse. Alerts are created when the FPS identifies claims and other data that suggest aberrant billing. The FPS then consolidates alerts on a specific provider and adds background information to provide context to the alerts raised. The leads with the highest potential for fraud, waste, or abuse are investigated by the ZPICs/PSCs. Information generated by the FPS is also used to take administrative action against high-risk providers in order to protect the Medicare program, including revocation of billing privileges, implementation of auto-denial and prepayment review edits, and suspension of payments. The FPS began operations on June 30, 2011, and overcame the inherent up-front costs of the first year of implementation to produce a positive return on investment.[11]

Although Medicaid is organized and administered differently than Medicare, there are opportunities to transfer the FPS techniques, such as predictive analytics, for identifying program integrity risks in Medicare to states for use in protecting their Medicaid programs from fraud, waste, and abuse. Several state Medicaid programs are already in the process of incorporating predictive analytics into their program integrity efforts. Congress has also shown interest in the potential of predictive analytics to prevent fraud, waste, and abuse against the Medicaid program. In the Small Business Jobs Act of 2010, Congress required CMS to report, by March 2015, on the feasibility, cost-effectiveness, and technical assistance necessary for expanding the use of predictive analytics technologies for identifying and preventing improper payments in Medicaid and CHIP.

As a Center for Excellence in implementing predictive modeling technology, CMS will share its expertise with state Medicaid programs to facilitate the application of predictive analytics to Medicaid and CHIP in accordance with the Small Business Jobs Act. CMS has begun to provide general technical assistance packages for states that are considering procurement of

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[11] CMS, *Report to Congress: Fraud Prevention System First Implementation Year*, September 2012, available at: http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf.

predictive analytics technology. CMS will also provide targeted technical assistance and training to states that are implementing predictive analytics technology. Finally, we will explore the feasibility and utility of bi-directionally sharing algorithms with states that have implemented predictive analytics programs.

As an additional step to expand the use of predictive analytics technologies to Medicaid and CHIP, CMS will take action to incorporate T-MSIS data, as it is received from states, into both Medicaid-specific and multi-program analytics. Over time, CMS's analytic infrastructure will provide states, CMS, and other stakeholders the ability to observe trends or patterns indicating potential fraud, waste, and abuse in the program so we can prevent or mitigate the impact of these activities. To facilitate sharing of potential fraud trends among stakeholders, CMS will promote regular communication with state Medicaid program integrity units, as well as more frequent communications with federal law enforcement partners.

2. *Improve state management capacity to protect Medicaid program integrity*

2.1. Streamline CMS assessment of state Medicaid program integrity activities

State Medicaid programs are required to have a fraud detection and investigation program that meets minimal federal standards. In the past, CMS has conducted comprehensive reviews of each state's Medicaid program integrity activities on a 3-year cycle and has reported findings and recommendations to states. The purpose of these reviews is to ensure state compliance with federal regulations and to assist them in identifying and correcting vulnerabilities in their programs.

In response to state feedback, CMS is streamlining its process for conducting these comprehensive reviews by shifting from an emphasis on regulatory compliance to a more integrative assessment of risk and program vulnerabilities. To achieve that shift, CMS is redesigning its comprehensive review guide to make it less burdensome to complete, more focused on empirical issues, and better able to elicit information that will help CMS meet the technical assistance needs of states.

FFY 2014 will be a transition year in CMS assessment of state program integrity activities. During the redesign of the comprehensive review guide, CMS will not perform comprehensive reviews, but will instead conduct focused reviews of high-risk program integrity areas in selected states, such as Medicaid expansion and managed care. In FFY 2015, CMS intends to resume comprehensive state program integrity reviews on a four-year cycle, using the final redesigned review guide.

CMS will also implement a database to support the process of gathering, storing, and tracking information from the comprehensive state program integrity reviews. This database, to be assembled over the FY 2014 – FY 2018 period, will also contain state technical assistance requests and CMS responses to those requests. The database will provide a single location for CMS to easily extract information on findings, results, and corrective actions related to state reviews.

2.2. Support state oversight of program integrity in Medicaid managed care

State Medicaid programs are increasingly looking to managed care entities (MCEs) to provide covered health and long-term services to Medicaid beneficiaries. MCEs include both managed care organizations (MCOs), which are paid on a capitated basis that puts them at financial risk, as well as primary care case management arrangements, which operate on a fee-for-service basis. Most of the states that have elected to expand their Medicaid programs to cover low-income adults in FY 2014 will be enrolling this newly eligible population in MCOs. Over the FFY 2014 – FFY 2018 period, federal payments for managed care are projected to grow from $92 billion to $141 billion, according to the Congressional Budget Office.[12] To address this rapid expansion in Medicaid managed care, CMS will update guidance to states on Medicaid managed care program integrity issues.

Providing effective support to states in protecting the integrity of their Medicaid managed care programs requires broadening CMS staff expertise beyond FFS program integrity to meet the unique challenges of managed care. As discussed below, new training in the unique challenges of managed care program integrity will be offered to state staff at the Medicaid Integrity Institute. CMS will adapt this curriculum for in-house training of CMS staff as well.

2.3. Provide technical assistance to state Medicaid agencies with respect to data analysis

As discussed in section 1.3, CMS will use its expertise in predictive analytics technologies to assist states in deploying these methods in their Medicaid programs to more effectively identify potential fraud, waste, and abuse. The Small Business Jobs Act of 2010 requires CMS to report, by March 2015, on the feasibility and cost-effectiveness of expanding the use of predictive analytics technologies for identifying and preventing improper payments in Medicaid.

CMS makes general technical assistance available to states in the form of resource materials for the states to consider in procuring new predictive analytics systems—e.g., the CMS-developed Statement of Work for the FPS. In addition, CMS has given states insight into the FPS at training sessions at the Medicaid Integrity Institute (MII) and direct outreach efforts. CMS also provides direct technical assistance to states during the review of Advance Planning Documents submitted by states applying for federal matching funds for the costs of implementing this technology, and will continue to do so. CMS will also provide targeted technical assistance and training to states that are implementing predictive analytics technology. Finally, CMS will explore the feasibility and utility of bi-directionally sharing algorithms with states that have implemented predictive analytics technologies.

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[12] CBO, Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.

2.4. Expand training of state staff through the Medicaid Integrity Institute

CMS provides training to state program integrity staff through the MII at no cost to states in collaboration with the Department of Justice's National Advocacy Center Office of Legal Education in Columbia, South Carolina and through distance learning webinars. 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.

Building on the success of the MII to date, CMS is expanding the reach of MII's educational mission by increasing the number of courses and distance learning opportunities. This expansion will enable CMS to provide training to additional state Medicaid agency staff on emerging program integrity challenges and opportunities over the next five years. This training will include identifying and mitigating program integrity risks in Medicaid managed care as well as the use of predictive analytics technologies in both a fee-for-service and managed care context.

3. ***Improve Federal management capacity to protect Medicaid program integrity***

3.1. Eliminate duplication by integrating Medicare and Medicaid audits and investigations

Currently, CMS uses several different contractors to carry out program integrity responsibilities in Medicare and Medicaid throughout the nation. Regional ZPICs/PSCs perform data analysis and conduct investigations of potential fraud, waste, and abuse in the Medicare Program. The ZPICs/PSCs also conduct Medi-Medi data matching activities discussed in section 1.2, above. In collaboration with states, Audit Medicaid Integrity Contractors (MICs) conduct post-payment audits of all types of Medicaid providers and report identified overpayments to states for recovery.

To improve efficiency and coordination of federal data analysis and audit/investigation work within each region, CMS is developing a Unified Program Integrity Contractor (UPIC) strategy. Under this strategy, Medicare and Medicaid program integrity audit and investigation work at the federal level will be consolidated into a single contractor within a defined multi-state area, which will complement audit and investigation efforts by states. This contractor will conduct Medicare, Medicaid, and Medi-Medi investigations and audits within designated geographic jurisdictions. In July 2013, CMS released a Request for Information and conducted an Industry Day targeted at gathering information from the vendor community on possible requirements for combining Medicare and Medicaid program integrity functions. CMS expects to implement the UPIC strategy beginning with initial contract awards in FY 2015 with additional transitions to occur in subsequent fiscal years.

3.2. Improve financial accountability of 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. States set and negotiate those rates, as well as establish expectations and standards for other aspects of plan financial

performance and service delivery (including program integrity, network adequacy, quality, and outcomes), in accordance with both federal and state requirements. CMS approval of these contracts is required. We will be conducting more detailed reviews of these contracts, identifying areas for in-depth examination by CMS actuaries and audit contractors, and determining whether additional steps are necessary to ensure rates are efficient and support the necessary contract terms to deliver high value, high quality services to enrollees.

3.3. Improve safeguards for Medicaid fee-for-service claims

Federal and state governments have invested heavily in the development and operations of claims systems that engage in high volume transactions. Proper adjudication of these transactions is dependent on technical designs and investments, implementation of effective claims edits and predictive modeling approaches, efficient suspense resolution procedures, proper use of payment suspension authorities, and referral and information sharing practices. CMS will be expanding our assessment of these systems and operations to ensure that our investments are producing timely and accurate claims payment results, processing State Plan Amendments implementing required safeguards (such as the National Correct Coding Initiative), and supporting new investments (such as those in predictive modeling) that can help detect claims anomalies and relationships of interest.

3.4. Expand reporting and controls for provider rate-setting

States are responsible for establishing payment methodologies for providers, within federal rules which establish upper payment limits (UPLs). CMS issued a State Medicaid Director (SMD) letter on March 18, 2013[13] that outlined requirements for state submission of UPL tests on an annual basis beginning in 2013. We will be working with states to implement these new reporting requirements, provide appropriate feedback and guidance as we receive the new annual tests, and validate underlying documentation and financial information to ensure that all states are in compliance with UPL requirements.

3.5. Enhance beneficiary eligibility safeguards

States are now implementing wide-ranging new requirements on their business processes and procedures for eligibility determinations. These changes, required by the Affordable Care Act, will result in a more standardized, simplified, computerized, data-driven process for determining eligibility for the Medicaid program. We will be testing the results of these new systems and procedures to ensure that accurate determinations are being made and renewals are processed appropriately.

3.6. Improve accuracy of state claiming and grant management

States submit quarterly expenditures that represent their reported outlays during the preceding quarter (including any adjustments within a two-year timely filing window). CMS

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[13] Federal and State Oversight of Medicaid Expenditures (SMD# 13-003), March 18, 2013, available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

financial management staff carefully review these expenditures before final approval is made. If CMS determines that an expenditure is questionable or is not adequately documented, approval is deferred; if adequate explanation and additional supporting documentation cannot be provided, a disallowance is issued. States must ensure that their expenditure reporting is accurate and supported, and reflects compliance with all federal rules. We will focus our financial management review activities on ensuring proper claiming for expenditures for newly eligible individuals (those expenditures eligible for 100% Federal Medical Assistance Percentage), 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 payments.

3.7. Execute safeguard strategies for new forms of payment and delivery systems

As CMS and states develop new health care delivery and payment models, management controls must help ensure that we accomplish our intended goals without creating inappropriate incentives or vulnerabilities to fraud, waste, and abuse. CMS is working with states, providers, and other stakeholders to test approaches to improve access and quality of care, while reducing cost and burden in the health care system. These new models include Accountable Care Organizations, medical homes, and initiatives focused on Medicare-Medicaid dual enrollees. As part of these developments, CMS will create frameworks to protect the federal resources that are invested in these service delivery reforms. Although we are in the early stages of developing the necessary methods of oversight and safeguards, developing these frameworks will be a priority for CMS during the next five years.

3.8. Revise measurement of error rates to align with program changes

To comply with the Improper Payments Information Act of 2002, CMS developed the Payment Error Rate Measurement (PERM) program, which calculates error rates for three aspects of the Medicaid and CHIP programs—fee-for-service and managed care payments, and program eligibility. Findings from federal reviews of FFS and managed care payments are combined with state eligibility determination review findings to yield national Medicaid and CHIP program error rates. The PERM reviews take place on a rotating cycle with one third of states being reviewed each year.

The Affordable Care Act created significant changes to Medicaid and CHIP eligibility applicable to all states regardless of their decision to expand Medicaid to low-income adults, including use of Modified Adjusted Gross Income methodologies for income determinations and household composition and use of the Federal Data Services Hub for access to federal verification sources. To accommodate these changes, states are updating their eligibility processes and systems; the current methodologies for measuring eligibility accuracy under PERM need to be updated as well. In light of these factors, CMS is implementing an interim change in methodology for conducting Medicaid and CHIP eligibility reviews under PERM for FYs 2014 - 2016. Instead of the current PERM eligibility review, all states will participate in Medicaid and CHIP Eligibility Review Pilots.

The 50-state Medicaid and CHIP Eligibility Review Pilots will use targeted measurements to: (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors. The Pilots will also provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS's approach to rulemaking that it will undertake prior to the resumption of the PERM eligibility measurement component in FY 2017.

Closing Remarks

To meet the program integrity challenges of the transformation and expansion of Medicaid, CMS will implement the strategies outlined in this Plan to more effectively work with states to safeguard federal and state Medicaid funds, while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk. Over the next 5 years, Medicaid funds will provide health care for a growing population of vulnerable children and adults, reaching an average monthly enrollment of 71 million by FY 2018.[14]

CMS will continue to work with Congress and the states to develop flexible strategies and initiatives to more effectively promote Medicaid program integrity and safeguard taxpayer dollars. CMS will use the new authorities and resources provided by Congress in the Affordable Care Act to shift beyond traditional "pay and chase" practices to prevention of improper payment. Accordingly, CMS will work with states to keep bad actors out of Medicaid through risk-based provider screening, periodic revalidation of enrollment of all providers, and temporary suspension of payments while credible allegations of fraud are under investigation.

The key strategies described in this Plan strengthen the federal-state partnership in Medicaid program integrity by improving our ability to effectively share and analyze Medicare and Medicaid data between CMS and states, and building states' capacities to safeguard their Medicaid programs through assessment, training, and technical assistance in critical program areas such as managed care. Through the execution of this Plan, CMS will manage the risks associated with administration of federal grants to states, improve oversight of financial accountability for managed care and provider rate setting, and develop program integrity controls to safeguard new health care delivery and payment models.

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

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[14] CBO, Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.