Comprehensive Medicaid Integrity Plan

FOR FISCAL YEARS 2024 – 2028

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Executive Summary

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 (referred to in this document as "CMIP" or "Plan") sets forth the Centers for Medicare & Medicaid Services (CMS) strategy for working with states to safeguard the integrity of Medicaid and the Children's Health Insurance Program (CHIP) during fiscal years (FYs) 2024–2028.[1]

The FY 2024-2028 CMIP contains many initiatives that are highlighted in five key areas necessary for Medicaid program integrity oversight:

1. **Medicaid Managed Care Oversight.** Medicaid managed care oversight is a critical priority for CMS as state Medicaid programs continue to expand the use of managed care delivery systems. Maintaining robust, effective oversight of Medicaid managed care will allow CMS to address emerging risks to program dollars and beneficiaries.
2. **Access to Care and Program Sustainability.** Responsible stewardship of Medicaid and CHIP includes ensuring that beneficiaries have appropriate access to covered services. Fundamental to that access is the appropriate determination of Medicaid or CHIP eligibility. CMS is engaged in several initiatives aimed to improve the Medicaid and CHIP eligibility determination processes, ensuring accurate redetermination of current beneficiaries eligibility, and that the eligibility of individuals newly applying for Medicaid and CHIP benefits is correctly determined.
3. **High-Risk Vulnerabilities.** To help target oversight activities, CMS uses risk-based approaches to prioritize and evaluate appropriate mitigations to implement based on the vulnerability that exists. Risk-based approaches are key to responsible stewardship and accountability because they focus efforts on high-risk states, providers, managed care plans (MCPs), and program areas to maximize a return on investment, while reducing the burden on good actors. Recent high-risk vulnerabilities include Medicaid managed care and proper eligibility determinations.
4. **Data Sharing and Collaboration**. Data sharing and other collaborative efforts further CMS's goals of enhancing the federal-state partnership, ensuring equity in Medicaid and CHIP, and pursuing innovative solutions to program vulnerabilities. CMS has implemented several data sharing and collaborative opportunities to provide a holistic view of nationwide Medicaid and CHIP data and ensure all state

[1]This 5-year plan reflects information as of September 2024. 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 changes in COVID-19 flexibilities unwinding as they affect any activities described in this plan.

partners have access to critical information when overseeing their programs.

5. **Education and Technical Assistance**. CMS provides education and technical assistance to support and strengthen state program integrity activities, including providing technical assistance to help states identify vulnerabilities and implement appropriate mitigation strategies.

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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Introduction

Medicaid and CHIP provide free or low-cost health coverage to millions of people including low-income adults, children, pregnant women, the elderly adults, and people with disabilities. Section 1936(d) of the Act directs the Secretary of 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.[2] Building on prior strategies, goals, and program enhancements, this Plan sets forth the CMS most recent strategy for working with states to safeguard the integrity of Medicaid and CHIP during FYs 2024–2028; a five-year period that is projected to be one of continued growth in Medicaid federal and state spending while CMS and states continue to address the impacts of the COVID-19 Public Health Emergency (PHE).

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.[3] Because Medicaid is a federal-state partnership, state Medicaid agencies and CMS share mutual obligations and accountability for the integrity of the program, including the development of program safeguards necessary to ensure proper and appropriate use of federal and state dollars. States provide the first line of defense against fraud, waste, and abuse in the Medicaid program and, in accordance with federal laws and guidance, establish eligibility standards and enrollment of beneficiaries, screen and enroll providers, establish payment policies, contracts with managed care plans (MCPs),[4] and process claims for items and services furnished to Medicaid beneficiaries enrolled in Medicaid fee-for-service programs. In addition to providing federal funding to support each state's Medicaid program, CMS also provides states with regulatory requirements and other guidance on federal Medicaid requirements; education and technical assistance, including tools and data; program assessment and feedback; and federal resources for strengthening their program integrity capacities.

The FY 2024 - 2028 CMIP is divided among four main themes that track CMS' strategic plan:[5]

1. ***Protect Programs:*** CMS' primary program integrity goal is to protect the Medicaid program's sustainability for future generations by being a responsible steward of public funds and ensuring accountability of all stakeholders across the Medicaid program. By using risk-based approaches, CMS can target high-risk states, providers, and program areas to ensure compliance with federal requirements and protect beneficiaries from harm.
2. ***Engage State Partners:*** Effective Medicaid program integrity efforts require CMS and states to work in close partnership. CMS engages its state partners throughout the

[2] Comprehensive Medicaid Integrity Plan for FYs 2019-2023 (December 31, 2019).
[3] Dodaro, Gene L. (GAO), Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks, Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs, GAO-18-598T (June 27, 2018) and GAO, High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas, GAO-23-106203 (April 20, 2023).
[4] The term 'managed care plans' includes managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case management (PCCM), and PCCM entities, as applicable.
[5] CMS Strategic Plan.

program integrity development and implementation process, while being mindful of the uniqueness of each state's enrollment, demographics, delivery systems, and level of risk.

3. ***Advance Equity:*** CMS works to design, implement, and operationalize policies that support health for all the people served by Medicaid and CHIP, such as by ensuring that individuals remain enrolled when they meet eligibility requirements and have access to covered benefits.
4. ***Drive Innovation:*** CMS drives innovation to tackle health system challenges and emerging program integrity risks, creating a stronger, better Medicaid program.

In addition to CMS' strategic plan, this Plan is informed by past and current program integrity efforts by CMS and its state and federal partners, as well as recommendations made by the HHS Office of Inspector General (OIG), the GAO, the Medicaid and CHIP Payment and Access Commission (MACPAC), and national Medicaid advocacy groups.

Comprehensive Medicaid Integrity Plan for Fiscal Years 2024–2028

1. Medicaid Managed Care Oversight

Medicaid managed care is a critical priority for CMS' program integrity work during FYs 2024–2028. 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. Approximately 67 million individuals were enrolled in a comprehensive, risk-based MCP in 2021, representing 75 percent of the total Medicaid enrollment.[6] This compares with approximately 53 million, or 67 percent, of individuals enrolled in an MCP in 2016.[7]

While managed care may be a preferred method for most states to administer Medicaid benefits, it poses unique oversight and program integrity challenges. CMS regularly engages stakeholders (including states, MCPs, and Medicaid Fraud Control Units (MFCUs)) to share promising practices and other information that will strengthen program integrity efforts in Medicaid managed care, as well as to modernize our program integrity work to address those challenges. In addition, CMS has taken steps to improve accountability by state agencies, MCPs, and providers to mitigate the risks associated with Medicaid managed care plan contracts. For example, in the 2016 Medicaid managed care final rule, CMS significantly strengthened program integrity standards for state contracts with MCPs and their network providers.[8] In a 2020 Medicaid managed care rule, CMS finalized significant regulatory revisions to streamline the requirements under the 2016 managed care regulatory framework to help ensure that state Medicaid agencies are able to work more effectively to design, develop, and implement Medicaid managed care programs that best meet each state's needs and populations.[9] In a 2024 rule, CMS finalized additional regulations on managed care program integrity, including provider incentive payments oversight and overpayment reporting requirements.[10]

For FYs 2024-2028, CMS plans to implement important initiatives that continue to support our oversight role in Medicaid managed care while continuing to look for new ways to monitor and address risks and vulnerabilities as the program integrity landscape changes over time. The following initiatives reflect CMS' Medicaid managed care program integrity strategy for this 5-year period.

[6] CMS, 2021 Medicaid Managed Care Enrollment Summary.
[7] CMS. Medicaid Managed Care Enrollment Report.
[8] CMS-2390-F, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (May 6, 2016).
[9] CMS-2408-F, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (November 13, 2020).
[10] CMS-2439-F, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (May 10, 2024).

1.1 Managed Care Service Utilization and Access to Care Data Analytics

CMS is conducting a cross-component initiative that identifies where data resources may be leveraged to inform Agency-wide efforts around Medicaid managed care program integrity. During FYs 2024–2028, CMS will create a process to monitor access to care and the effectiveness of Medicaid MCPs' program integrity programs efforts, particularly those MCPs that operate nationally or in multiple states. In addition, CMS is analyzing data to compare utilization and access between fee-for-service and managed care arrangements.

1.2 Unified Program Integrity Contractor Medicaid Managed Care Oversight

As part of adapting to a changing program integrity landscape, CMS has developed a new enhanced investigative strategy to better target Medicaid managed care fraud, waste, and abuse. Through the use of its Unified Program Integrity Contractors (UPICs), CMS has initiated Medicaid MCP audits that will enhance CMS' oversight of program integrity activities conducted by MCPs. For FY 2023, CMS initiated audits of 22 MCPs in 5 states. For FYs 2024 – 2028, CMS plans to expand this project to 42 additional states and territories. The final reports for audits initiated in FY 2023 will be issued within the FY 2024-2028 timeframe.

1.3 Medical Loss Ratio Audits

CMS audits Medicaid MCP financial reporting in selected states, focused on annual Medical Loss Ratio (MLR) reporting and MLR remittance calculations.[11] CMS uses a risk-based analysis to identify states and areas for review, considering MLR summary report data from the state, prior discussions with state Medicaid officials, relevant CMS guidance, related CMS MLR auditing experiences, Medicaid audit history, enrollment, and managed care penetration. The primary objectives of the MLR audits are to review state MLR oversight practices, including determining if the annual MLR reports submitted to the state by MCPs adhere to federal requirements and whether the MCPs' annual MLR reporting and minimum MLR remittance calculations were substantiated by the underlying data and supporting documentation. In addition, these audits focus on high-risk areas, that may include:

- Treatment of third-party vendor data
- Treatment of activities that improve health care quality
- Requirements for special contract provisions related to payment, with a particular focus on state directed payments
- Requirements related to provider incentives
- Allocation of expenses
- Reporting of non-claims costs

During FYs 2024-2028, CMS will increase the number of MLR audits to approximately two to three audits per year and continue to refine the high-risk areas that are targeted in each audit.

[11] An MLR is the proportion of premium revenue that an insurance plan spends on covered services and quality improvement. *See* CMS, CPI Reports and Guidance, Medical Loss Ratio (MLR) Audits.

1.4 Program Integrity Guidance and Technical Assistance for Medicaid Managed Care

CMS has released guidance to assist states with implementing the program integrity requirements codified in the 2016 Medicaid Managed Care Final Rule.[12] Most recently, in FY 2023, CMS released toolkits on overpayment recoveries, payment suspensions, fraud referrals, and compliance program requirements.[13] During FYs 2024-2028, CMS will provide additional toolkits regarding the oversight of MCPs, such as establishing cost-avoidance processes and promising practices regarding contract language and other effective oversight activities.

CMS will also continue to provide educational opportunities and technical assistance for state Medicaid agencies by offering courses via the Medicaid Integrity Institute (MII) that address Medicaid managed care. MII courses will educate state program integrity staff on the unique challenges of Medicaid managed care, while providing valuable networking opportunities for states to share and discuss promising practices to improve their Medicaid managed care program integrity efforts. Additional information about the MII may be found in Section 5.1 of this Plan.

1.5 Managed Care Contract, Rate Certification, and State Directed Payment Reviews

Federal requirements in 42 CFR Part 438 specify detailed requirements for states compliance when contracting with Medicaid MCPs and setting actuarially sound Medicaid capitation rates. Among other things, the 2020 rule strengthened actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates.[14] These provisions are highlighted through CMS's published annual guidance for states to use when setting capitation rates, including rate development standards and documentation expectations for rate certifications.[15] Additionally, CMS has published guidance on the standards it uses to review and approve states' MCP contracts, including contractual requirements pertaining to program integrity.[16] CMS reviews and approves state contracts with Medicaid MCPs, and the associated capitation rate certifications. During FYs 2024-2028, CMS will continue to review state directed payment proposals that require prior approval. By reviewing these payment strategies, CMS will identify any areas requiring additional scrutiny to promote value in the delivery of services under Medicaid managed care.[17]

[12] CMS-2390-F, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (May 6, 2016).
[13] CMS, Program Integrity-Managed Care Toolkits.
[14] CMS-2408-F, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (November 13, 2020)
[15] CMS, Rate Review and Rate Guides.
[16] CMS, State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval.
[17] See also GAO, Medicaid Managed Care: Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency, GAO-24-106202, (December 2023).

2. Access to Care and Program Sustainability

Responsible stewardship of Medicaid and CHIP includes ensuring that beneficiaries have appropriate access to covered services. Fundamental to that access is the appropriate determination of Medicaid or CHIP eligibility. CMS is engaged in several initiatives that aim to improve the Medicaid and CHIP eligibility determination process to ensure that the eligibility of individuals applying for Medicaid and CHIP benefits is correctly determined and that existing beneficiaries remain enrolled when appropriate. The following initiatives reflect CMS' beneficiary access to care program integrity strategy for this 5-year period.

2.1 Audits of Beneficiary Eligibility Determinations

CMS conducts beneficiary eligibility audits to identify whether states determined Medicaid and CHIP eligibility at the point of application or redetermination in accordance with Federal and state eligibility requirements and claimed the appropriate Federal Medical Assistance Percentage (FMAP) on behalf of these beneficiaries. This includes determinations that either enroll an individual into Medicaid or CHIP or terminate an individual's coverage. This approach is critical to ensuring that beneficiaries have appropriate access to care, while also protecting taxpayer dollars from being inappropriately expended.

As of FY 2023, CMS completed beneficiary eligibility audits in seven states, including those where the HHS-OIG previously identified vulnerabilities in the states' eligibility systems and processes, or states identified by other state audit findings.[18] During FYs 2024-2028, we will further refine our audit approach by conducting a risk-based analysis to identify high-risk states, programs, and eligibility categories/processes for future audits.

2.2 Medicaid Eligibility Quality Control Program

Under the Medicaid Eligibility Quality Control (MEQC) program, states conduct audits of their Medicaid and CHIP eligibility determinations during the two off-years between their triennial Payment Error Rate Measurement (PERM) review years. (See Section 2.4 for a detailed discussion of the PERM program.) States are required to review a minimum of 400 active (currently enrolled) and 400 negative (denied or terminated) cases. When reviewing active cases, states are permitted to choose specific areas of focus, which will help reduce future PERM improper payment rates by concentrating on known or suspected vulnerabilities. States are required to submit corrective action plans (CAPs) to address identified errors and deficiencies. States are also encouraged to rectify system and caseworker errors as quickly as possible to reduce repeat errors in the future.

During FYs 2024-2028, CMS will continue oversight of the MEQC program. To assist states' MEQC efforts, CMS will modernize reporting and oversight through the implementation of the new Medicaid and CHIP Program Integrity Reporting Portal. This portal will reduce the burden

[18] CMS, Medicaid Program Integrity Reports, Beneficiary Eligibility Reviews. These audits were released between FY 2020 and 2023 and focused on a time period prior to the PHE unwinding.

on states and CMS, while allowing for more effective oversight, monitoring, and trend analysis to better reduce future Medicaid and CHIP improper payments. Additionally, effective FY 2024, Puerto Rico will begin undertaking triennial MEQC pilot reviews under federal oversight.[19]

2.3 Beneficiary Eligibility & Enrollment Systems and Policies

CMS monitors state eligibility determinations through a number of mechanisms, including regular review and analysis of states' data regarding application and renewal processing, and provides technical assistance to states if potential issues are identified. CMS also reviews Modified Adjusted Gross Income (MAGI)-based verification plans, which outline state processes and procedures for verifying eligibility, including use of data sources. In addition, CMS recently implemented a new outcome-based system certification process, which enables CMS to use test data, key performance indicators, and metrics to measure the performance of eligibility systems on an ongoing basis. This allows 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.[20]

2.4 Payment Error Rate Measurement Corrective Action Plans (CAPs)

The PERM program calculates improper payment rates for three components of Medicaid and CHIP—fee-for-service payments, managed care capitation payments, and beneficiary eligibility determinations. PERM reviews take place on a rotating cycle with one-third of states being reviewed each year. Following each measurement cycle, states must complete and submit CAPs based on the errors and deficiencies identified.

States develop CAPs by identifying the drivers of errors and establishing mitigations to reduce repeat findings in the future. After each state submits its CAP, CMS monitors and evaluates the effectiveness of the state's progress in implementing effective corrective actions. Throughout the process, CMS provides training and guidance to ensure compliance with federal policies. CMS requires states to meet more stringent reporting requirements if they have consecutive PERM eligibility improper payment rates exceeding the 3 percent national standard established in section 1903(u) of the Act.

During FYs 2024-2028, CMS will continue oversight of the PERM CAP process. To assist states' PERM CAP efforts, CMS will modernize reporting and oversight through the implementation of the new Medicaid and CHIP Program Integrity Reporting Portal. This portal will reduce the burden on states and CMS while allowing for more effective oversight, monitoring, and trend analysis to better reduce future Medicaid and CHIP improper payments. CMS will also continue facilitating the County Eligibility Workgroup, which allows states with state-supervised and county-administered beneficiary eligibility determination processes to better determine root causes and implement effective CAPs, considering the structure of their Medicaid eligibility processes and operations.

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[19] Consolidated Appropriations Act, 2020 (P.L. 116-94), Division N, Title 1, Subtitle B – Section 202(a)(2)

[20] CMS, Informational Bulletin Medicaid Enterprise Systems Compliance and Reapproval Process for State Systems with Operational Costs Claimed at the 75 Percent Federal Match Rate (May 2024).

3. High-Risk Vulnerabilities

CMS conducts various risk analyses, data and screening processes, audits, and investigations to identify and address vulnerabilities in Medicaid and CHIP. To help target oversight activities, CMS uses risk-based approaches to prioritize and evaluate appropriate mitigations to implement based on identified vulnerabilities. Risk-based approaches are key to responsible stewardship and accountability because they focus efforts on high-risk states, providers, MCPs, and program areas to maximize a return on investment, while reducing the burden on good actors. The following initiatives reflect CMS' program integrity strategy to address high-risk Medicaid and CHIP vulnerabilities for this 5-year period.

3.1 Medicaid Risk Assessments and Vulnerability Analyses

CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (VCC), is comprised of CMS leadership and subject matter experts that work collaboratively to conduct risk assessments that identify and mitigate vulnerabilities in payment and coverage policies. CMS aligned the VCC's risk-based approach with GAO's Fraud Risk Management Framework.[21] Risk assessments include a risk-scoring process in which vulnerabilities are ranked according to dollars at risk, patient harm, and likelihood, as well as other qualitative considerations. This process helps ensure that vulnerabilities with the highest level of risk are prioritized for developing mitigations. Once mitigations have been implemented, they are monitored to determine if the desired impact has been achieved.

During FYs 2024-2028, CMS will continue conducting risk assessments for Medicaid and CHIP and developing mitigations to address the high-risk vulnerabilities that are identified. Specifically, CMS will conduct risk assessments on the following areas identified through the VCC: Medicaid managed care, Non-Emergency Medical Transportation (NEMT), dental benefits, nursing facilities, and Home- and Community-Based Services (HCBS) and, based on findings, will develop, implement, and monitor appropriate mitigation strategies.

3.2 Unified Program Integrity Contractors (UPICs)

CMS investigates instances of suspected fraud, waste, and abuse in Medicare and Medicaid with support of the UPICs. Multiple contractors serve as UPICs, each serving a defined multi-state area of the country. The UPICs perform data analysis and conduct investigations and audits using Medicare-only data, Medicaid-only data, as well as Medicare-Medicaid matched data. 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, inpatient hospitals, mental health services, prescribers/opioids, pharmacy, and laboratories.

[21] GAO, A Framework for Managing Fraud Risks in Federal Programs, GAO-15-593SP (July 2015).

During FYs 2024-2028, CMS expects that managed care, opioids, telehealth, mental health, durable medical equipment, NEMT, hospitals, laboratories, and hospice will continue to be areas of focus for the UPICs in their collaborative work with states, along with any other areas that may be identified through VCC risk assessments. CMS also expects to complete an in-depth risk assessment analysis of the UPIC Medicaid audit program to ensure that CMS is maximizing the use of the UPICs to address risks in the Medicaid program. CMS will implement a strategy to provide a more robust audit of MCP program integrity operations by leveraging the UPICs, as described in Section 1.2. Finally, CMS will harness the UPICs to provide investigative support to state Medicaid agencies for leads generated by the Healthcare Fraud Prevention Partnership (HFPP) and CMS' program integrity analytics contractor (see Section 4.3 for more information on the HFPP).

3.3 State Program Integrity Reviews

State Medicaid and CHIP programs are required to have a fraud detection and investigation program that meets certain federal standards. To help oversee this requirement, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, personal care services, and territory oversight operations.[22] These reviews include onsite or virtual visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

In addition to the focused reviews, CMS conducts desk reviews of states' program integrity activities, which allows CMS to conduct oversight of additional states each year. Desk reviews are less complex because they focus on other areas of concern, such as the progress of states' corrective actions, an evaluation of states' compliance with broader program integrity regulations, reviews of service areas such as NEMT and telehealth, as well as promising practices to share with other states.

During FYs 2024 - 2028, CMS will continue to conduct focused and desk reviews related to high-risk Medicaid program integrity areas and identify methods to expand the scope of these reviews, as appropriate.

3.4 Strengthen States' Claims Processing Systems

State governments, and the federal government, have invested heavily in the development and operations of Medicaid claims processing and information retrieval systems that engage in high volume transactions. In 2022, CMS released the new outcome-based Streamlined Modular Certification (SMC) process that allows CMS to comprehensively measure the performance of claims processing and information retrieval systems on an ongoing basis through test data, key performance indicators and metrics collected to measure system performance aligned to business

[22] CMS, State Program Integrity Reviews.

outcomes.[23] A more targeted monitoring of performance data tied to business outcomes allows CMS to validate that systems are meeting desired outcomes that best serve state Medicaid programs, i.e. timely and accurate claim payments, proper screening and enrollment of providers, member management, analytic and reporting capabilities that include accurate Transformed Medicaid Statistical Information System (T-MSIS) data reporting.

In addition, an important prepayment claim processing safeguard is the National Correct Coding Initiative (NCCI), a CMS program of medical claim coding prepayment edits that promote correct coding methodologies and reduce improper payments. Section 1903(r) of the Act requires CMS to notify states of which NCCI methodologies are compatible with Medicaid claims so that states can use these methodologies to prevent payment of improperly coded claims. To assist states in implementing NCCI methodologies, CMS provides states with NCCI edit files, policy and technical guidance manuals, and technical assistance. During FYs 2024 – 2028, CMS will continue to work with states to provide technical assistance on implementing NCCI edits, as well as encourage states to make consistent and robust estimates of their NCCI cost savings.[24] Although not required, these cost savings calculations may be used by states to monitor the effectiveness of Medicaid NCCI implementation.

3.5 Screening Medicaid Providers

An effective Medicaid provider enrollment screening process is an important tool for preventing bad actors from entering the program and exacerbating program vulnerabilities. Some states have faced challenges implementing the required activities to fully comply with enhanced provider screening requirements, and CMS provides assistance in the form of ongoing guidance, education, and outreach. To reduce the burden of conducting screening for enrollments and revalidations, CMS allows states to use provider screening results from Medicare, CHIP, or other state Medicaid agencies. During FYs 2024 – 2028, CMS will continue to make a data compare service available that allows a state to rely on Medicare's provider screening in lieu of the state conducting it themselves.[25] This service reduces state burden, particularly for provider revalidation, because it allows states to remove dually enrolled providers from their revalidation workload. As of December 2023, 39 states and territories participated in the data compare service. During FY 2024-2028 CMS will continue to provide accurate and up-to-date guidance to states regarding provider enrollment, screening, and disclosure requirements through the quarterly publication of the Medicaid Provider Enrollment Compendium (MPEC). CMS conducts monthly provider enrollment technical assistance group calls to discuss any changes to provider enrollment policies and regulations and to address any questions/concerns from the states regarding implementation of these requirements. CMS is also working to establish state specific touchpoints to meet with states one-on-one to provide direct support and guidance to ensure complete and accurate compliance, including revalidation, with provider enrollment requirements.

[23] CMS, Streamlined Modular Certification.
[24] CMS, NCCI MUE and PTP Edit Savings Guidance for State Medicaid Agencies, November 2019.
[25] For example, see GAO, Medicaid Providers: CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements, GAO-20-8 (October 2019). and GAO, CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities, GAO-23-105494 (December 2022).

3.6 Single Audits for Medicaid and CHIP

The Single Audit Act of 1984 established requirements for audits of states that administer federal financial assistance programs, and the Compliance Supplement is based on the requirements of the 1996 Amendments and 2 CFR Part 200, Subpart F, which provide for the issuance of a compliance supplement to assist State Auditors in performing the required audits.[26] A state's single audit includes an organization-wide audit of Medicaid and CHIP in which the State 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 Medicaid and CHIP.[27]

CMS has collaborated closely with State Auditors to revise the Compliance Supplement for Medicaid and CHIP. CMS also reviews State Auditor reports to help inform vulnerability assessments and prioritize future state audits and technical assistance. During FYs 2024 – 2028, CMS will continue collaborating with State Auditors; informing State Auditors on program requirements, as needed; and reviewing State Auditor reports, findings, and recommendations. CMS will also continue issuing Management Decision Letters to states and monitoring corrective actions to ensure State Auditor findings are resolved and recommendations are implemented.

4. Data Sharing and Collaboration

Data sharing and other collaborative efforts further CMS' goals to enhance the federal-state partnership, ensure equity in Medicaid and CHIP, and pursue innovative solutions to program vulnerabilities. CMS has implemented several data sharing and collaboration opportunities to provide a holistic view of nationwide Medicaid and CHIP data and ensure all state partners have access to critical information when overseeing their programs. States may use this information to strengthen their program integrity efforts by implementing new prepayment protections, conducting audits and investigations, and making referrals to law enforcement as appropriate and consistent with confidentiality and privacy protections in federal law and regulations. The following initiatives reflect CMS' Medicaid and CHIP data sharing and collaboration program integrity strategy for this 5-year period.

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

In 2019, CMS began releasing a robust set of research-ready T-MSIS data files and user support materials, including data quality briefs and technical guidance documents.[28] Opening T-MSIS data to third-parties enables greater collaboration between CMS and states, MCPs, and other stakeholders to address both the quality and usability 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. During FYs 2024 – 2028, CMS will continue to work with states to assess and improve T-MSIS data

[26] Current Compliance Supplement.
[27] State single audits are performed under the requirements of Office of Management and Budget Circular A-133.
[28] Medicaid and CHIP T-MSIS Analytic Files Data Release Fact Sheet (November 7, 2019).

quality and expand how stakeholders use T-MSIS data.

Since 2019, CMS has required states to address data quality issues in high priority areas defined by CMS to improve the overall dataset. Initial priority areas centered around fundamental data items such as file integrity, basic eligibility data, and completeness and consistency of data provided on claims. In 2022, CMS transitioned to the Outcomes-Based Assessment (OBA) for states to address data quality issues. This latest methodology continues to include quality checks around file integrity, eligibility, and completeness and consistency of data provided on claims, but expands to include data around strategic priorities such as race/ethnicity reporting and managed care encounter data, enabling and accelerating states' and CMS's ability to monitor Medicaid and CHIP programs. CMS will continue to address new data quality areas to strengthen the overall data set. A data quality assessment map is displayed on Medicaid.gov.[29] During FYs 2024 – 2028, CMS will use advanced analytics and other innovative solutions to improve T-MSIS data reporting and maximize the potential for program integrity purposes, including for CMS' UPICs and other program integrity analytics contractors.

4.2 State Access to Medicare Data

Over 12.3 million Americans are dually enrolled in Medicare and Medicaid. Additionally, many providers and MCPs that serve Medicaid patients also participate in Medicare.[30] This overlap means that Medicare program integrity data offers the potential to 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), states 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. The SDRC provides technical advisors who help states determine how to use available data based on state priorities for Medicare-Medicaid coordination and program integrity.

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. Although CMS has historically partnered with individual states for Medi-Medi program participation in the Medi-Medi program. CMS has directed the UPICs to analyze all work through matched claims data, regardless of the state. If aberrancies are identified in each program, the UPICs use the appropriate Medicare and Medicaid line items to track workload and collaborate with state Medicaid agencies to conduct investigations and audits, as described in Section 3.2. Additionally, should workload consist of aberrancies in both programs, the UPIC links the workload in the Unified Case Management System so CMS can still identify traditional Medi-Medi workload should the need arise.

[29] CMS, Transformed Medicaid Statistical Information System (T-MSIS).
[30] CMS, People Dually Eligible for Medicare and Medicaid Fact Sheet (March 2023).

CMS also provides states access, upon request, to Medicare data sources in a data warehouse environment. These Medicare data sources include Medicare Parts A and B claims and Part D pharmacy claims. By using these data sources, CMS and states can identify duplicate Medicare and Medicaid payments and other types of improper payments for services billed to both programs.

CMS continues to expand its efforts to assist states with meeting Medicaid provider screening and enrollment requirements by sharing screening and enrollment data with states via the data exchange (DEX) system, which is used to share data among CMS and each state's Medicaid program. This system stores all state-submitted "for cause" terminations, Medicare revocations, OIG exclusion data, and Death Master File data, as well as extracts from the Provider Enrollment, Chain, and Ownership System (PECOS) and the Medicare Exclusion Database (MED).

During FYs 2024 – 2028, CMS will continue these data sharing efforts with states through the SDRC and expansion of efforts through sharing data via DEX.

4.3 Healthcare Fraud Prevention Partnership

In September 2012, CMS launched the Healthcare Fraud Prevention Program (HFPP), a public-private partnership that seeks to identify and reduce fraud, waste, and abuse across the health care sector. As of January 2024, the HFPP consists of 305 total partners, including 82 federal and state law enforcement agencies, 6 federal agencies, 139 private plans (including MCPs), 15 associations, and 63 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.[31] For example, analyses of HFPP data have successfully identified fraud schemes and improper billing issues across payers, such as "improbable day" billing, billing for unnecessary COVID-19 add-on testing, billing patterns and trends for substance use disorder treatment, potential billing irregularities of certain medications, and the suspicious frequency of genetic testing.

The TTP utilizes healthcare fraud, waste, and abuse industry experts to assist data sharing partners with reviewing study results identifying potential investigational leads, conducting supplementary trend analysis, and providing tips on how to best utilize HFPP study results. In addition, the TTP has acquired state Medicaid data through T-MSIS to conduct the cross-payer studies. As of January 2024, the TTP has data from 49 Medicaid programs, allowing the TTP to utilize Medicaid data to conduct cross-payer fraud, waste, and abuse studies and provide individual and summary results to each member program. During FYs 2024 – 2028, efforts will focus on enabling data-sharing partners to discover actionable data insights using dashboards more quickly within the HFPP Portal, performing analytics on areas of concern as identified by the partners, and continuing to explore the use of machine learning to further enhance ongoing data analysis of the cross-payer dataset

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

5. Education and Technical Assistance

CMS provides education and technical assistance to support and strengthen states' program integrity activities by offering training to state program integrity staff at the MII, provider and beneficiary education, and technical assistance to help states identify vulnerabilities and implement mitigation strategies. This helps to ensure compliance and enhance the federal-state partnerships for Medicaid and CHIP. The following initiatives reflect CMS' Medicaid and CHIP education and technical assistance program integrity strategy for this 5-year period.

5.1 Medicaid Integrity Institute (MII)

Since 2008, CMS has offered training through the MII to state program integrity staff at no cost to states. The MII provides both classroom training and distance learning webinars to enhance the professional qualifications of state Medicaid and CHIP integrity staff and foster a collaborative environment that allows CMS and states to quickly adapt to an ever-changing program integrity landscape. As of December 2023, the MII has trained approximately 13,000 state program integrity staff, representing all 50 states, the District of Columbia and 5 territories. The MII offers a variety of courses covering critical Medicaid and CHIP vulnerabilities, such as telehealth, COVID-19 flexibilities and waivers, provider auditing techniques, and Medicaid managed care, among others. Courses via the MII provide opportunities to discuss emerging trends, support new initiatives, and strengthen collaboration among state and federal partners. During FYs 2024 – 2028, CMS will enhance the MII's distance learning webinar opportunities to target known fraud schemes, focus on service-specific training (e.g., hospice, telehealth, personal care services), and collaborate with state, CMS, and law enforcement partners. CMS will also develop robust in-person training opportunities to maximize partner engagement.

5.2 Data Analytics Support

CMS remains committed to utilizing advanced analytics and other innovative solutions to 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 shares 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. During FYs 2024 – 2028, through forums such as the MII, the Fraud, Waste, and Abuse Technical Advisory Group (TAG), and the Data Analytics Subgroup, CMS will share FPS algorithms and provide data analytic support as necessary to assist states with their program integrity efforts.

5.3 Provider Enrollment Guidance and Technical Assistance

CMS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment, including:

- Publishing additional guidance in the Medicaid Provider Enrollment Compendium (MPEC).
- Sharing Medicare enrollment and screening data with states, as discussed in section four.
- Enhancing the data compare service to help states identify providers for which the state is able to rely on Medicare's screening as described in section three.
- Providing technical assistance to states through email and individual state calls.
- Holding monthly TAG calls.

During FYs 2024 - 2028, CMS will continue providing such guidance, as well as conducting monthly calls with states to understand challenges or barriers states currently face, facilitate the exchange of noteworthy practices among states, and respond to questions regarding guidance or other provider enrollment issues.

5.4 Fiscal and Beneficiary Safeguards in Home- and Community-Based Services

Home and Community-Based Services (HCBS) continue to be an area of focus, and CMS has launched several initiatives on fiscal oversight and on health and safety protections for beneficiaries. 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). Each state was required to incorporate functional EVV systems for Personal Care Services (PCS) no later than January 1, 2020 and for Home Health Care services (HHCS) no later than January 1, 2023, unless it received approval from CMS for a 12-month delay. At the end of FY 2023, 44 states and territories were fully compliant with the PCS component of the EVV requirement, and 19 states and territories were fully compliant with the HHCS component of the EVV requirement. To assist states with EVV implementation, CMS conducted EVV Learning Collaborative sessions for states, CMS, and other stakeholders to collaborate and openly discuss policy guidance and noteworthy practices. As of August 2023, CMS has held 16 EVV Learning Collaborative sessions. During FYs 2024 - 2028, CMS will continue to assess states' compliance with the EVV requirement and provide individualized technical assistance as needed to states to ensure compliance operationalization of this fiscal integrity control.

Maintaining critical beneficiary protections is an important pillar of Medicaid and CHIP 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, in FY 2019, CMS disseminated a national survey to monitor the status of incident management systems across the nation. In FY 2024, CMS plans to launch its second national survey to assess states' progress in implementing key incident management components. During FYs 2024 – 2028, CMS will continue to work with states to ensure a robust incident management system, including through the implementation of incident management provisions. For example, CMS's

recently issued Ensuring Access to Medicaid Services final rule[32] (CMS-2442-F) requires that states meet nationwide incident management system standards for monitoring HCBS programs.

Conclusion

CMS set forth its CMIP for FYs 2024–2028 to employ both new and evolving initiatives to enhance Medicaid and CHIP program integrity given the shared accountability with states to ensure proper and appropriate use of federal and state dollars. CMS will implement the strategies outlined in this Plan and work closely with our state partners. Mindful of the uniqueness of each state Medicaid program, this Plan empowers individual states to create innovative programs that best address program integrity challenges while providing CMS with the tools to effectively promote Medicaid program integrity and safeguard taxpayer dollars over the next 5 years.

[32] CMS-2442-F, Medicaid Program; Ensuring Access to Medicaid Services (May 10, 2024).