Centers for Medicare & Medicaid Services

Blog

Jun 25, 2019

Medicaid Program Integrity: A Shared and Urgent Responsibility

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Fraud, waste, & abuse   Medicaid & CHIP   Safety

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Medicaid Program Integrity: A Shared and Urgent Responsibility

The Medicaid program has grown from $456 billion in 2013 to an estimated $576 billion in 2016, largely fueled by a mostly federally financed expansion of the program to more than 15 million new working age adults. For these adults, the estimated cost per enrollee grew about 7 percent from FY2017 to 2018, compared to about 0.9 percent for other enrollees. With this historic growth comes a commensurate and urgent responsibility by CMS on behalf of the American taxpayers to ensure sound stewardship and oversight of our program resources. While the primary responsibility for ensuring proper payments in Medicaid lies with states, CMS plays a significant role in supporting states' efforts and holding them accountable through appropriate oversight and increased transparency.

That's why the Trump Administration has proposed numerous changes to the Medicaid program such as improving overpayment collection when states pay for ineligible beneficiaries, streamlining provider terminations to remove bad actors, and consolidating provider enrollments in Medicaid and the Children's Health Insurance Program (CHIP) to improve efficiency.

One year ago we took a significant step to address these challenges when we released a Medicaid Program Integrity Strategy based on the three pillars of flexibility, accountability and integrity. Our strategy seeks to reduce Medicaid

and Medical Loss Ratios (MLRs) to ensure plans aren't being overpaid, including reviews of high-risk vulnerabilities identified by the Government Accountability Office (GAO) and OIG. As of December 31, 2018, prior CMS efforts led to CMS **recovering $9.63 billion from California** in relation to our efforts to ensure appropriate payments to managed care plans specific to the new adult group.

Data Sharing and Partnerships. Strong data collection and analysis will enable smarter efforts to tackle fraud, waste, and abuse. We are enhancing data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. We are now collecting and optimizing enhanced Medicaid data from all states and two territories through the Transformed Medicaid Statistical Information System (T-MSIS). New efforts to use this data to detect fraud, waste, and abuse represent the first use of T-MSIS data for program integrity purposes, moving CMS closer to its goal of comprehensive, timely, national analytic data for Medicaid.

Education, Technical Assistance and Collaboration. The best way to manage improper payments is to help states avoid them at the outset. As part of CMS' work to provide guidance and assistance for state implementation of the Medicaid Managed Care Final Rule from 2016, CMS released guidance in 2018 regarding Medicaid provider screening and enrollment for Medicaid managed care organization network providers. To further educate and collaborate with states, CMS engages in the following activities:

- CMS' Medicaid Integrity Institute (MII) provides training and education to more than 1,000 state Medicaid program integrity staff annually. Course topics include provider screening and enrollment, managed care, and personal care services.

- CMS has engaged with states to share over a dozen promising practices that were identified and submitted by states on various program integrity practices covering provider and beneficiary enrollment, managed care, fraud and abuse referrals, and high-risk providers.

- CMS conducts State Program Integrity Reviews to assess the effectiveness of the state's program integrity efforts, including its compliance with federal statutory and regulatory requirements. The reviews also assist in identifying effective state program integrity activities and sharing best practices with other states. As a result of the opioid desk reviews, several states have acknowledged the need to increase their opioid-related audit activity and have engaged with the Unified Program Integrity Contractors (UPICs) to develop projects to address this weakness.

- Conduct provider screening on behalf of states for Medicaid-only providers to improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of error as measured by PERM.

- Medicaid provider education through Targeted Probe and Educate—which identifies providers who have high error rates and educates them on billing requirements—to reduce aberrant billing, as well as education provided through Comparative Billing Reports—which show providers their billing patterns compared to their peers.

- Audit state claiming of federal matching dollars to address areas that have been

As we give states the flexibility they need to make Medicaid work best in their communities, integrity and oversight must be at the forefront of our role. Beneficiaries depend on Medicaid and the Trump Administration is committed to the program's long-term viability. We are using the tools we have to hold states accountable as we work with them to keep Medicaid sound and safeguarded for beneficiaries. These initiatives are the vital steps necessary to respond to Medicaid's evolving landscape and fulfill our responsibility to beneficiaries and taxpayers.

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