STATEMENT OF

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

IMPROPER PAYMENTS IN STATE ADMINISTERED PROGRAMS: MEDICAID

BEFORE THE

U.S. HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

SUBCOMMITTEE ON GOVERNMENT OPERATIONS AND

SUBCOMMITTEE ON INTERGOVERNMENTAL AFFAIRS

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Statement of Tim Hill
on
"Improper Payments in State Administered Programs: Medicaid"
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Subcommittee on Government Operations and
Subcommittee on Intergovernmental Affairs
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Chairmen Meadows and Palmer, Ranking Members Connolly and Demings, and members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS's) efforts to prevent and reduce improper payments in Medicaid. We appreciate how much work this Committee has done over the years to promote program integrity and prevent improper payments, both in the programs managed by CMS and across the government. At CMS, we share this Administration's vision to ensure that Medicaid works for those it was designed to serve. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our overall efforts to refocus Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.

This Administration takes the integrity of the Medicaid program very seriously, and is taking a fresh look at how CMS can more effectively fulfill our responsibility to protect taxpayer dollars, including making sure States use Federal Medicaid resources properly and appropriately apply eligibility criteria. We appreciate the ongoing work done by the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (GAO) to highlight potential program integrity vulnerabilities and provide recommendations on strengthening safeguards. CMS relies on GAO and OIG recommendations to inform our improvement activities across our programs. We have taken action to address a number of the recommendations made by OIG and GAO. For example, the President's Fiscal Year (FY) 2019 Budget includes an administrative proposal to establish unique identifiers for personal care service (PCS) attendants.[1] We also requested new legislative authorities to address OIG and GAO concerns. For instance, the FY 2019 Budget requests authority to implement prepayment

[1] https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf

controls to prevent inappropriate PCS payments and to allow Medicaid Fraud Control Units to investigate beneficiary abuse and neglect that occurs in home- and community-based settings.[2] CMS will continue to identify and take additional steps to safeguard taxpayer dollars and enhance the quality of services provided to Medicaid beneficiaries while maintaining the flexibility States need to design Medicaid programs that best meet the unique needs of their residents.

Restoring a Strong Federal-State Relationship through Flexibility and Accountability

Although the Federal government establishes general guidelines for the program, States design, implement, and administer their own Medicaid programs. The Federal government matches State expenditures on medical assistance based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent. Ultimately, States and the Federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars.

However, far too much of States' time is spent mired in a maze of one-size-fits-all Federal laws, regulations, and processes that often do not translate to better health outcomes. Our aim is to restore a strong State-Federal relationship while also modernizing the program to deliver better outcomes for all populations being served and protecting taxpayer dollars.

CMS has outlined a bold agenda to transform the Medicaid program that is centered on three key pillars: flexibility, accountability, and integrity. CMS believes that States understand best the unique needs of their residents and has committed to restoring balance to the Federal and State partnership. This commitment to flexibility is being fulfilled through efforts that include relieving burdensome regulatory requirements, speeding the processing of waivers and State Plan Amendments, and opening new avenues to State-led reforms through demonstrations. But this new flexibility must be balanced by a system that holds States accountable for producing improvements in program outcomes, as well as appropriate Federal oversight of program integrity to protect the American taxpayers. CMS is committed to achieving this balance and has

[2] https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf

developed a strategy that prioritizes accountability and integrity protections with a high return on investment.

A core component of this effort is confronting the program integrity challenges that were created when the Patient Protection and Affordable Care Act (PPACA) significantly expanded Medicaid eligibility, allowing States to enroll childless, non-disabled adults with incomes below 138 percent of the poverty level. It also provided States with an enhanced Federal contribution toward this newly eligible population, covering 100 percent of these costs from 2014 through 2016, 95 percent of costs in 2017, and 94 percent this year. This match rate will decline until 2020, at which point States will receive an ongoing 90 percent match for this newly eligible population. This enhanced Federal match increases the need for robust Federal oversight since States receive a higher percentage match for someone who is determined to be newly eligible for Medicaid. In 2016, an estimated 11.2 million Medicaid enrollees were classified as newly eligible, and, from 2016 through 2025, Medicaid expenditures for newly eligible adults are projected to amount to $806 billion ($741 billion paid by the Federal government)[3].

CMS believes that the risk associated with the incentives created by the enhanced match require us to make sure that States are making correct eligibility determinations. For example, OIG recently conducted reviews of newly eligible beneficiaries in three States and identified potential vulnerabilities in eligibility determinations. OIG found that in a sample of 130 beneficiaries, New York did not determine eligibility for 37 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that beneficiaries were newly eligible for 4 potentially ineligible beneficiaries.[4] OIG found that in a sample of 150 beneficiaries, California made payments on behalf of 27 ineligible and 14 potentially ineligible beneficiaries.[5] OIG found that in a sample of 120 beneficiaries, Kentucky did not determine eligibility for 9 beneficiaries in accordance with Federal and State requirements.[6] CMS appreciates the work that the OIG has already done to identify vulnerabilities in the eligibility

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[4] https://oig.hhs.gov/oas/reports/region2/21501015.asp
[5] https://oig.hhs.gov/oas/reports/region9/91602023.asp
[6] https://oig.hhs.gov/oas/reports/region4/41608047.asp

determination processes in some expansion States, which informs our approach to confronting and addressing the program integrity challenges created by the Medicaid expansion, ensuring that the law is followed and Federal taxpayers are protected.

In addition to eligibility concerns, the per newly eligible enrollee costs are much higher than previously expected. In its 2016 report, the CMS Office of the Actuary estimates that Medicaid expansion enrollees cost an average of $5,926 in FY 2016, which is 64% higher than the $3,606 pre-enrollee cost they projected in the 2014 report.[7] CMS estimated that Medicaid expansion enrollees would be 27 percent less expensive than those previously enrolled in FY 2016. However, per-enrollee spending on expansion enrollees was 28 percent higher than previously eligible non-disabled adult enrollees in FY 2015 and 14 percent higher in FY 2016.[8]

Most States covered newly eligible adults through managed care programs. Due to the limited historical data and experience for the newly-eligible adult Medicaid expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. In particular, there was uncertainty regarding assumptions for pent-up demand and the health status of new enrollees, leading to the possibility of greater utilization of services than that of other adult enrollees already covered by Medicaid.

To address the uncertainty regarding this population, some States employed risk mitigation strategies in setting their managed care rates. Under this approach, the State requires managed care plans to pay at least 85 percent of their capitation rates on health care expenditures for their enrollees. If the plan ultimately spends under 85 percent, they are required to remit the difference to the State. The State is then required to pay back the Federal portion of those costs to the Federal government. Because of the enhanced match prescribed by the ACA, 100 percent of the costs for this population was covered by the Federal government for the first three years. The Administration is aware of concerns that managed care rates resulted in significant profits for insurance companies, and is committed to reviewing these rates and is taking action when

[7] *CMS Medicaid Actuarial Report 2014. CMS Medicaid Actuarial Report 2016.*
[8] Id.

appropriate. For example, CMS initiated oversight action to ensure that the State of California resolves a collection issue and returns a significant amount of funding owed to the Federal government related to the State's Medicaid expansion.

Financial Management

Oversight of States' financial management of their Medicaid programs is a critical component of our work and is vital to ensuring that Federal Medicaid funds are spent lawfully and appropriately. We take our responsibility to ensure that States correctly report their Medicaid expenditures seriously. CMS oversight over State expenditures is a careful balance of ensuring that States receive the appropriate Federal share, while also ensuring that Federal funds are only spent on allowable activities in the Medicaid program.

Every quarter, States must submit to CMS their estimated quarterly expenditures costs and CMS distributes a monetary advance; States may submit a supplemental request for additional funding if their original request proves insufficient, but they must provide justification for doing so. To verify that actual expenditures reconcile with the received monetary advance, CMS (in accordance with statutory and regulatory requirements) requires States to report actual expenditures and include supporting documentation such as invoices, cost reports, and eligibility records to ensure that the Federal financial participation matches with States' actual expenditures. These reports must be submitted within 30 days after the end of the budget quarter, and this process applies whether or not some or all of a State's expenditures are authorized through a State plan or a section 1115 demonstration. CMS employs a team of accountants and financial management specialists in regional offices to review these submissions, look for anomalies, and request additional documentation or justifications as necessary.

These accountants and financial management specialists also perform focused financial management reviews of specific Medicaid service and administrative expenditures, which generally involves reviewing a sample of paid claims related to certain types of Medicaid services. CMS staff have frequent communication with States in order to provide clarification and guidance around allowable expenses. These individuals also perform audit resolution tasks and coordinate with State auditors and OIG to ensure that State expenditures and corresponding

claims for Federal matching funds are allowable. In FY 2017, CMS worked with States to resolve $2.1 billion and recover an additional $647 million from States, totaling $2.7 billion in questionable costs. Furthermore, an estimated $457 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with States to promote proper State Medicaid financing.

Enforcement

In addition to State flexibility, the Administration is also focused on accountability. When a State provides inadequate documentation or justification for Medicaid claims, CMS can issue deferrals and disallowances. A deferral withholds funds from the State until additional clarification or documentation is received from the State regarding Medicaid expenditures claimed. A disallowance is a formal determination by CMS that a claimed expenditure or portion of a claim by a State for Federal funds is unallowable or is not supported by the State's documentation. States have the right to appeal a disallowance, in whole or in part. CMS has taken disallowances or deferrals for a wide range of issues. For example, CMS has disallowed Federal Financial Participation because of providers not meeting conditions of participation to be enrolled as a Medicaid provider, not having administrative cost allocation plans in place and lacking documentation support for a claimed expenditure. We take this enforcement responsibility seriously and are committed to ensuring that CMS stays current in issuing these types of actions to ensure that improperly spent funds are recovered in a timely manner. We will not ignore States' improper spending, even when it occurred in previous years.

In addition to taking action to address improper activities, CMS is also committed to addressing State financing practices that are not an appropriate use of Federal taxpayer dollars. CMS recognizes that one of the biggest risks to the Federal budget was the continued abuse of Medicaid waiver financing. As such, late last year, CMS took action to wind down some section 1115 demonstration projects that raised oversight concerns. These designated State health program (DSHP) demonstrations provided Federal funding for State expenditures that were previously funded entirely by the State, without Federal funds. Since 2005, CMS has approved over $25 billion in Federal spending for these State-funded programs in 10 States.

One stated purpose of Federal DSHP funding was to ensure the continuation of these beneficial State programs while the State was incurring additional expenditures for health service delivery reform or expansion under the demonstration project. However, the result has been that many States are not contributing State funds toward these delivery system reform efforts. Instead, these States are primarily relying on dollars freed up by the Federal Medicaid contribution to DSHP to draw down additional Federal Medicaid matching expenditures to support delivery system reforms. On December 15, 2017, we issued new policy guidance closing this financing loophole.

Improper Payments in Medicaid

Through the Payment Error Rate Measurement (PERM) program, CMS annually estimates the improper payment rate and a projected dollar amount of improper payments for Medicaid[9] using an open and transparent process, as required by statute.[10] This measurement and reporting process is one of many tools CMS uses to identify and address areas at risk for – and factors contributing to – improper payments. It is important to remember that not all improper payments constitute fraud or result in monetary loss to the government. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. For example, if a physician provides a legitimate service to a legitimate beneficiary but accidentally fills out the paperwork incorrectly or is missing documentation, this would be considered an improper payment.

The PERM program measures and reports an estimate of the improper payment rate for Medicaid. Because it is not feasible to verify the accuracy of every Medicaid payment, CMS uses a statistically valid methodology that samples a subset of payments, then extrapolates to the "universe" of payments. Through the PERM program, CMS reviews States in cohorts, or cycles. There are three total cycles, each including 17 States; one cycle is reviewed every year, meaning each State is reviewed once every three years. From within each State, a stratified random sample of payments is selected and reviewed for errors. The PERM program measures three

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[9] https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf

[10] Established by the Improper Payments Information Act of 2002 (IPIA) and amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).

components: fee-for-service, managed care, and eligibility. The findings are used to estimate a national improper payment rate. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all 50 States and the District of Columbia are captured in one rate. For FY 2017, the Medicaid improper payment rate was 10.10 percent, a decrease from FY 2016 (10.48 percent).[11]

Through the improper payment rate measurement, CMS identifies and classifies types of errors and shares this information with each State. States then analyze the findings to determine the root causes for improper payments by error type, which is necessary for a State to develop and implement effective corrective actions. Similar to recent years, the driver of the Medicaid improper payment rate was State difficulties complying with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Although the 17 States reviewed this year had better compliance results for Medicaid compared to their previously measured cycle, non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the Medicaid improper payment rate. Additionally, Medicaid improper payments due to no or insufficient medical documentation increased in FY 2017.

CMS recognizes the importance of regular eligibility reviews and is also implementing a Medicaid Eligibility Quality Control (MEQC) program for States in the two off-cycle years of PERM reviews. In particular, MEQC requires States to review their eligibility processes in years when they are not subject to a PERM review and is intended to help States ensure that their corrective actions are addressing issues identified as part of PERM.

Working with States to Address Error Causes

CMS works closely with States following each measurement cycle to develop State-specific corrective action plans (CAPs) to reduce these errors. All States are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from CMS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns.

[11] https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf

In addition to the development, execution, and evaluation of the State-specific CAPs, CMS has implemented corrective actions to specifically address compliance with Medicaid provider screening, enrollment, and revalidation efforts to reduce errors related to this category. Specific corrective actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and continuing to implement process improvements to the provider enrollment process to make it easier for ordering and referring providers to enroll in the program. In addition, State Medicaid agencies may rely on Medicare's enrollment and screening of providers. For example, since May 2016, CMS has offered a data compare service that allows a State to rely on Medicare's screening, in lieu of conducting State screening, particularly during revalidation. This allows States to remove dually-enrolled providers from their revalidation workload. Using the data compare service, a State provides an extract of Medicaid provider enrollment data to CMS and then CMS returns information indicating the providers for which the State can rely on Medicare's screening.[12] In addition, CMS issued guidance to allow States to rely on any site visits conducted by CMS for a provider that has an approved Medicare enrollment status. CMS has also worked with the Federal Bureau of Investigation to publish guidance to help States implement fingerprint-based criminal background checks for high risk providers. CMS also provides ongoing guidance, education, and outreach to States on Federal requirements for Medicaid enrollment and screening. In addition, CMS continues to update the Medicaid Provider Enrollment Compendium[13] to provide additional sub-regulatory guidance to assist States in applying the regulatory requirements.

CMS procured a State Assessment Contractor to assist with ongoing State technical assistance and process improvements related to provider screening and enrollment.[14] The contractor assessed compliance with provider screening and enrollment requirements, conducted a gap analysis, and developed strategic blueprints to help States improve processes. In addition to the

[12] Alabama, Arizona, California, Idaho, Iowa, Louisiana, Maine, Michigan, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, the District of Columbia, Vermont, and Virginia have participated in the data compare service
[13] https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf
[14] In FY 2017, the State Assessment contractor visited Alabama, California, Connecticut, Indiana, Iowa, Nevada, Ohio, Oregon, and Texas.

State Assessment Contractor visits, CMS continues to conduct State site visits to assess provider screening and enrollment compliance, and provide technical assistance.[15]

CMS has also worked with the Social Security Administration (SSA) to provide access to the death information SSA maintains in its records (also called the Death Master File, or DMF). Previously, States had raised concerns with the costs of completing the SSA-DMF check as part of provider screening. In May 2017, CMS made DMF data available to some States via the same file server where States have access to Medicare provider file extracts, Medicare revocations, Medicaid terminations, and OIG sanctions (i.e., suspensions, debarments, and exclusions). CMS has begun expanding access to the DMF data to additional States, beyond the pilot States, and will continue to do so.

Insufficient documentation is another contributing factor to the national Medicaid improper payment rate. To help address these types of errors, State CAPs also include provider communication and education to reduce errors related to these categories. These methods include: holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written State policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

Outreach and education to States is also an important component of our efforts to lower the Medicaid improper payment rate, and we are committed to giving States the tools they need to be successful. In addition to providing States with informational bulletins and guidance, we offer and facilitate education and training options, such as those offered through the Medicaid Integrity Institute, and provide States with reports to help them identify areas of concern through efforts such as State program integrity reviews.

[15] CMS internally provided screening and enrollment assistance through visits to Delaware, Georgia, Minnesota, Missouri, North Carolina, South Carolina, Virginia, and the District of Columbia in FY 2017

Modernizing the PERM Program

This Administration is committed to making the PERM program as accurate and as effective as possible in measuring the Medicaid improper payment rate so that CMS and States can take appropriate corrective actions. On June 29, 2017, CMS published a final rule[16] implementing policy and operational improvements to the PERM program that will reduce State burden, improve program integrity, and promote State accountability.

Eligibility Reviews in the PERM Program

As a first step, beginning in the FY 2019 reporting period, the PERM program will once again measure the current improper payment rate for the eligibility component, under a revised methodology. In light of changes made by the Patient Protection and Affordable Care Act to the way States adjudicate eligibility for applicants for Medicaid, CMS did not conduct the eligibility measurement component of the PERM program for FYs 2014 through 2018 in order to update the eligibility component measurement methodology and related PERM program regulation. During this time, the FY 2014 national eligibility improper payment rate[17] was being used as a proxy rate, and all States conducted a pilot program with rapid feedback for improvement (known as Eligibility Review Pilots) to maintain oversight of State eligibility determinations.

To reduce State burden and improve review accuracy and consistency, under our new rule, beginning with the FY 2019 reporting period a Federal contractor will conduct PERM eligibility reviews with support from each State. Unlike under the previous rule, the eligibility reviews will be conducted on the beneficiary associated with the same fee-for-service and managed care payments that were sampled, helping to also reduce the burden on each State.

Increasing Reporting Accuracy and State Accountability

The new rule takes steps to increase the reliability and consistency of the data collected, so we can more effectively provide oversight. For example, improper payments will be cited if the Federal share amount is incorrect (even if the total computable amount is correct). Under

[16] https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicaid-program-and-childrens-health-insurance-program-chip-changes-to-the

[17] During this time, for the purpose of computing the overall national improper payment rate, the Medicaid eligibility component improper payment rate is held constant at the FY 2014 national rate of 3.11 percent.

previous regulations, improper payments were only cited on the total computable amount (i.e., Federal share plus State share).

Under both the previous rule and the current rule, the national sample size equals the total of the State-specific sample sizes. However, under the new rule, the national sample size is determined first and distributed among the States; under the previous rule, State-specific sample sizes were determined first and added together to total the national sample size. State-specific sample sizes are based on factors such as each State's expenditures and previous improper payment rate.

States will continue to implement CAPs for all errors and deficiencies; however, there will be more stringent requirements added for States that have consecutive PERM eligibility improper payment rates over the three percent national standard established in statute.[18] In addition, States will have to provide an evaluation of whether actions they take to reduce eligibility errors will also avoid increases in improper denials.

Potential payment reductions/disallowances in statute[19] will be applicable for eligibility reviews conducted during PERM years in cases where a State's eligibility improper payment rate exceeds the three percent national standard. CMS will only pursue disallowances if a State does not demonstrate a good faith effort to meet the national standard.

Medicaid Program Integrity

In addition to our work to measure and prevent improper payments, CMS utilizes many tools across our programs to fight fraud, waste, and abuse. We work with partners across the public and private health care sectors to share and apply valuable data and information about bad actors, emerging schemes, and best practices. CMS provides a variety of educational materials and guidance to make sure States, beneficiaries, providers, contractors, and plans have the information they need to improve their own efforts to fight fraud, waste, and abuse. For example, CMS published guidance to States on Medicaid fraud prevention, provider screening and enrollment initiatives, and State-specific program integrity review reports. We also facilitate

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[18] Social Security Act, Section 1903(u)
[19] Social Security Act, Section 1903(u)

States' efforts to address fraud, waste, and abuse within their Medicaid programs by offering technical assistance, education, collaborative audits, and access to relevant Medicare data. Throughout our efforts, we are cognizant of the need to balance an appropriate level of accountability with the need to avoid overburdening States and providers.

Improving Data to Support Program Integrity

As technology advances across the health care industry, data will continue to play an increasing role in our program integrity efforts. As a payor and steward of taxpayer dollars, one of our most important roles is to share valuable data and facilitate its use among our Federal and State law enforcement partners, States, providers, and plans. That's why improving Medicaid and CHIP data and systems is a high priority for CMS. Through strong data and systems, CMS and States can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. CMS has been working with States to implement changes to the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). More robust, timely, and accurate data via T-MSIS will strengthen program monitoring, policy implementation, and oversight of Medicaid and CHIP programs. It will also enhance CMS's and States' ability to identify potential fraud, waste, and abuse and improve program efficiency. T-MSIS will also reduce administrative burden on States by streamlining the reporting process and reducing the number of reports and data requests CMS requires.

As part of the transition to T-MSIS, CMS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements, and improving the timeliness of data submission by moving from quarterly to monthly State data submissions.

CMS is working to transition all States to T-MSIS and has made significant progress. As of March 8, 2018, 49 States, the District of Columbia, and Puerto Rico have begun submitting T-MSIS data. These entities represent 98 percent of the Medicaid and CHIP population. CMS

continues to work with the remaining States to help them submit data and expects all States to report T-MSIS data. [20]

With a majority of States submitting T-MSIS data, CMS has begun to develop tools for T-MSIS users, as well as work with States to improve the quality of data submitted. For example, CMS is developing a data quality assessment for users, which aggregates data quality findings in a user-friendly tool. These efforts will help States report complete and comparable T-MSIS data which CMS plans to use for program oversight efforts.

CMS has requested that States provide complete and accurate T-MSIS data. However, CMS is dependent on States and their associated staffing and resources necessary to improve the quality of their data. CMS will continue to share information across States on known T-MSIS data limitations and will implement ways in which States can collaborate on an ongoing basis regarding T-MSIS implementation.

Medicaid Integrity Institute (MII)

As a payor, we work jointly with law enforcement to support State efforts to address fraud, waste, and abuse across our programs. Because Medicaid is a Federal-State partnership, CMS works closely with our State partners to provide them with the tools and knowledge to effectively operate their programs. For example, in collaboration with the Department of Justice (DOJ), CMS established the Medicaid Integrity Institute (MII), a program that offers courses on a variety of Medicaid program integrity issues for Medicaid employees and certain stakeholders. The mission of the MII is to provide effective training tailored to meet the ongoing needs of State Medicaid Program Integrity employees, with the goal of raising national program integrity performance standards and professionalism. Since 2008, the MII has provided professional education to more than 7,000 Medicaid employees from every State, the District of Columbia, and Puerto Rico. As the first national Medicaid integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to the States in a structured learning environment. The MII focuses on developing a comprehensive

[20] https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html

program of study addressing aspects of Medicaid program integrity to include: fraud investigation, data mining and analysis, and case development.

In FY 2017, the MII presented 20 courses, and has an additional 21 scheduled through FY 2018. One of these courses, held last month, was entitled "Emerging Trends in Medicaid: Beneficiary Eligibility and Fraud." This course was designed to focus on State Medicaid agencies' efforts both to ensure the accuracy of beneficiary eligibility determinations and to deter beneficiary fraud, waste, and abuse. Course participants included Federal and State employees whose responsibility is in beneficiary eligibility and/or fraud, regardless of where those activities are administered within the State Medicaid agency. The course focused on: best practices in determining eligibility; data sources that assist in eligibility determination, program oversight, and fraud and abuse identification; policies that support identifying and deterring beneficiary fraud, waste, or abuse; and individual case studies in beneficiary eligibility and fraud. Because of State and Federal interest in this topic, additional courses focusing specifically on beneficiary eligibility and beneficiary waste, fraud, and abuse will be scheduled in FY 2019.

In addition, CMS and the MII hold an annual advisory group meeting with senior State program integrity officials comprising the Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG provides CMS and the MII with critical input and recommendations for training topics and courses for the following year. The TAG provides State agency updates and guidance on what issues the States are facing in order to provide Subject Matter Experts (SMEs) for each course. The TAG is divided into workgroups that are charged with identifying and developing suggestions that can be shared during the monthly TAG call with States, CMS, and the MII. The success of the MII lies largely with the commitment of our State partners. The tailored courses are identified in the yearly meeting with the MII advisory group and developed by working group experts from States, CMS, and the MII. As a result, "Emerging Trends in Medicaid" courses in FY 2017 and FY 2018 have included Personal Care Services, Opioids, and Third Party Liability.

State Program Integrity Reviews

State program integrity reviews[21] provide effective support and assistance to States in their efforts to combat fraud, waste, and abuse. Through these reviews, CMS assesses the effectiveness of the State's program integrity efforts, including its compliance with Federal statutory and regulatory requirements. After completing two separate comprehensive, regulation-based review cycles for every State, the District of Columbia, and Puerto Rico, CMS made a strategic shift in FY 2014 to conduct more focused reviews of high-risk program integrity areas tailored to specific challenges facing States. Recent onsite reviews focused on specific areas of program integrity concern, including oversight of managed care organizations, provider screening and enrollment, personal care services, and non-emergency medical transportation.

To supplement the onsite-focused reviews, CMS initiated desk reviews of program integrity efforts. These reviews allow CMS to increase the number of States that receive such customized program integrity oversight by conducting offsite reviews of documentation submitted by States on specified topics. Recent desk review topics included provider terminations, Medicaid Recovery Audit Contractors, implementation status of PERM CAPs, and State program integrity review CAPs. As another means of providing assistance to States, CMS has developed toolkits to address frequent findings. The toolkits identify common issues observed to help States better understand the requirements and provide practical solutions that States can implement to help them improve compliance with Federal regulations.

Unified Program Integrity Contractors (UPICs) and Collaborative Audits

The Unified Program Integrity Contractors (UPICs) consolidate Medicare and Medicaid program integrity functions, phasing out the Zone Program Integrity Contractors and the Audit Medicaid Integrity Contractors. The UPICs merge these separate contracting functions into a single contractor, in a geographic area, with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations. The UPIC contracting structure provides CMS with a flexible vehicle to address the complex landscape of program integrity across both Medicare and Medicaid. This means that the same contractor can conduct audits and

[21] For individual reports please visit: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html

investigations of providers enrolled in both Medicare and Medicaid, and can more easily make connections across the two programs.

As part of the UPICs' work, collaborative audits are conducted to augment a State's audit capacity by leveraging the resources of CMS and its UPICs, resulting in more timely and accurate audits. These audits combine the resources of CMS and the UPICs to assist States in addressing suspicious payments, including algorithm development, data mining, auditors, and medical review staff. This approach more effectively uses resources in support of States in their program integrity efforts. The collaborative process includes a discussion between the State and CMS regarding potential audit issues and the States' provision of Medicaid Management Information System data for data mining. The State, together with CMS, determines the audit processes the UPICs follow during the collaborative audit. In some instances, the UPICs conduct the entire audit. In other cases, the UPICs supplement State efforts by providing medical review staff and other resources.

Healthcare Fraud Prevention Partnership (HFPP)

CMS is engaging with the private sector in new ways to better share information and data to combat fraud. The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal government, State agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. HFPP partners regularly collaborate, share information and data, and conduct cross-payer studies to achieve these objectives. The HFPP applies multiple methods to detect anomalies; scan for suspect activities; and create informational content, such as white papers, to communicate its work to the larger public. Given the HFPP's broad membership encompassing a variety of players interested and involved in detection of fraud, waste, and abuse in the healthcare system, it is uniquely positioned to examine emerging trends and develop key recommendations and strategies to address them. The HFPP currently has almost 100 partners, including over 20 State and local

agencies[22] and is continuing to grow strategically by adding new partners and finding ways to proactively identify areas of mutual concern.

Health Care Fraud and Abuse Control (HCFAC) Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control (HCFAC) program, under the joint direction of the Attorney General and the HHS Secretary, acting through OIG. The HCFAC program is designed to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse.

Through the fraud, waste, and abuse prevention and enforcement efforts of the HCFAC program, in FY 2016 the Federal government won or negotiated over $2.5 billion in health care fraud judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. As a result of these efforts, as well as those of preceding years, in FY 2016 over $3.3 billion was returned to the Federal government or paid to private persons. Of this $3.3 billion, the Medicare Trust Funds received transfers of approximately $1.7 billion during this period, and over $235.2 million in Federal Medicaid money was similarly transferred separately to the Treasury as a result of these efforts.[23]

Conclusion

We share the Subcommittees' commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our overall efforts to refocus Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.

Because Medicaid is jointly funded by States and the Federal government and is administered by States within Federal guidelines, both the Federal government and States have key roles as

[22] https://hfpp.cms.gov/about/current-partners.html
[23] https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf

stewards of the program, and CMS and States work together closely to carry out these responsibilities.

Biography

Timothy Hill
Acting Director
Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

Mr. Hill is the Acting Director for the Center for Medicaid and CHIP Services (CMCS) within the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services. As Acting Director of CMCS, Tim Hill leads activities related to national Medicaid and CHIP policy and program operations, and works closely with states in the implementation of their Medicaid and CHIP programs.

Tim has held a number of senior leadership positions in CMS including Director of the CMCS Financial Management Group, CMS Chief Financial Officer, Deputy Director of the Center for Consumer Information and Insurance Oversight (CCIIO) and Deputy Director of the Center for Medicare (CM). He has an extensive background in financial management, program integrity, and state collaboration. Tim is a graduate of Northeastern University and has a Master's Degree from the University of Connecticut.