CHAPTER 5

Update on Program Integrity in Medicaid

Key Points

Update on Program Integrity in Medicaid

- Program integrity activities are intended to ensure that public dollars are spent appropriately on delivering high-quality, medically necessary care. An effective program integrity approach should prevent improper payments, reduce waste and abuse particularly when it leads to patient harm, and help achieve value.
- An effective program integrity strategy in Medicaid requires coordination among state and federal agencies, a task complicated by the fact that current activities are governed by multiple federal statutes and regulations. Each state develops its own approach to program integrity, while federal activities are guided by a comprehensive plan that was last updated in 2009. A new plan, which will take into account lessons learned from prior initiatives, is expected to be released in the fall of 2013.
- Program integrity includes both a discrete set of activities related to the detection and prevention of fraud, waste, and abuse (such as post-payment review) but also other aspects of Medicaid program administration such as individual enrollment (eligibility), provider enrollment, service delivery, and payment. States and the federal government conduct mandatory and optional activities in all of these areas.
- In some programmatic areas such as eligibility determination, there are multiple program integrity initiatives, while other areas, such as managed care, receive comparatively little attention. Attention should be paid to identifying opportunities to better distribute and coordinate resources and shift focus to higher-value activities.
- The Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) eligibility reviews are an example of duplicative program integrity initiatives. While both programs review the accuracy of individual Medicaid and CHIP eligibility determinations, the rules for the two programs overlap and do not align well with each other.
- Future Commission work will focus on identifying specific opportunities to streamline regulatory requirements, and point the way to eliminating redundant functions, promoting greater integration of state and federal activities, or investing additional resources.

CHAPTER 5

Update on Program Integrity in Medicaid

This chapter continues MACPAC's work on program integrity in Medicaid and the State Children's Health Insurance Program (CHIP). As described in the Commission's March 2012 report to the Congress, program integrity consists of initiatives to detect and deter fraud, waste, and abuse (Box 5-1). These problems exist throughout the health care system, not just in Medicaid and CHIP. Even so, maintaining the ability to ensure that federal and state dollars are spent appropriately on delivering quality, necessary care to eligible individuals in Medicaid and CHIP is a priority for policymakers.[1]

Although estimates vary, the size and reach of the Medicaid program is expected to increase substantially due to changes made by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended): in 2014, the Centers for Medicare & Medicaid Services (CMS) estimates that the program will cover an additional 11.5 million people on average over the course of the calendar year, while the Congressional Budget Office (CBO) estimates that Medicaid and CHIP together will cover an additional 9 million people on average (CMS 2013a and CBO 2013). In addition to preparing for enrollment growth, states are implementing a variety of policy and operational changes to manage interactions with exchange coverage and shift to value-based payment methods (KFF 2013). An effective program integrity approach will be essential to preventing improper payments, protecting enrollees, and achieving value as Medicaid and CHIP evolve.

Successful program integrity efforts depend on coordination among various state and federal agencies. The size and diversity of the 56 state and territorial Medicaid programs makes these efforts complex (GAO 2012a). Furthermore, within and among individual states and within the federal government, program integrity activities require coordination among a variety of discrete monitoring and detection activities and administrative processes (e.g., eligibility determinations, provider enrollment, service delivery, and claims payment).

The success of these efforts will also depend on investment in activities known to work. Many program integrity strategies have been conceived as independent efforts and may require rethinking or revisions to stay current as the evidence base grows or newer strategies emerge. A broad view of Medicaid program integrity activities across a range of programmatic areas at the state and federal levels can help identify opportunities to better distribute and coordinate resources and shift focus to higher-value activities. For example, many program integrity efforts remain focused on fee-for-service (FFS) payments, while states are increasingly shifting to capitated and other payment approaches. The Commission plans to look more carefully at program integrity issues related to managed care in future reports.

Previous Commission Review and Recommendations

Over the past two decades, but particularly since the passage of the Deficit Reduction Act of 2005 (P.L. 109-107) and creation of the federal Medicaid Integrity Program, there has been growing interest in Medicaid program integrity at the federal level and greater investment by states in a range of activities. In our March 2012 report, we described the status of those activities, provided an overview of federal and state oversight responsibilities, summarized how various federal agencies and states coordinate program integrity activities, described the challenges associated with quantifying program integrity outcomes, and discussed how managed care plans address program integrity. We identified a number of challenges associated with implementation of an effective and efficient Medicaid program integrity strategy, including:

- overlap between federal and state responsibilities;
- insufficient collaboration and information sharing among federal agencies and states;
- diffusion of authority among multiple federal and state agencies;

BOX 5-1. Regulatory Definitions of Fraud and Abuse

Medicaid regulations define fraud and abuse as follows:

- **Fraud:** "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law."
- **Abuse:** "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."
- **Waste,** which is not defined in federal Medicaid regulations, is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program. Examples include avoidable hospitalizations, duplication of services, and the use of emergency departments for non-emergent care.

Both providers and enrollees can contribute to waste, fraud, and abuse.

Source: 42 CFR 433.304 and 42 CFR 455.2.

- lack of information on the effectiveness of program integrity initiatives and appropriate performance measures;
- lower federal matching rates for state activities not directly related to fraud control;
- incomplete and outdated data; and
- few program integrity resources for delivery system models other than FFS (e.g., managed care).

To address these issues, the Commission made two recommendations related to program integrity.

First, in order to ensure that current program integrity requirements make efficient use of federal resources and do not place undue burden on states or providers, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services (HHS) (the Secretary) should collaborate with states to "create feedback loops to simplify and streamline program integrity requirements, determine which current federal program integrity initiatives are most effective, and take steps to eliminate programs that are redundant, outdated, or not cost-effective" (MACPAC 2012).

Second, in order to enhance states' abilities to detect and deter fraud and abuse, the Commission recommended that the Secretary should "develop methods for better quantifying the effectiveness of program integrity activities, assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective, improve dissemination of best practices in program integrity, and enhance program integrity training programs" (MACPAC 2012).

Current Status of Federal Medicaid Program Integrity Activities

Federal Medicaid program integrity activities are guided by a Comprehensive Medicaid Integrity Plan, which is developed by the Medicaid Integrity Group (MIG) within CMS (CMS 2009a). The plan was last updated in 2009; CMS is in the process of updating its strategy, and a new comprehensive plan is expected to be released in the fall of 2013 (CMS 2013c).

In addition to the Commission, others have also questioned the effectiveness and efficiency of the current federal approach as outlined in the 2009 plan. In a series of reviews published in 2012, the Government Accountability Office (GAO) found that the hiring of separate contractors for the National Medicaid Audit Program was inefficient and led to duplication. Other MIG oversight and support activities, such as the Medicaid Integrity Institute and State Program Integrity Assessments, showed mixed results (GAO 2012a, GAO 2012b).

CMS concurred with many of the suggestions GAO provided to improve the efficiency of federal Medicaid program integrity activities, and as part of a broader effort to increase program efficiency, has begun revising its approach to program integrity and expanding efforts to support states (CMS 2013c). This new federal approach aligns with the recommendations made by the Commission in 2012 (Table 5-1).

The new comprehensive plan will include additional changes based on the lessons learned from various initiatives implemented over the last eight years, including:

- ensuring that new Medicaid initiatives, particularly those based on Medicare approaches, are appropriately tailored and take into account the diversity of state programs;

- aligning and coordinating federal resources around program integrity functions and goals instead of individual statutes and initiatives;
- promoting collaboration between federal staff (including contractors) and states and among states; and
- using risk assessment to identify areas of focus, rather than taking a "one size fits all" approach.

This updated approach to federal Medicaid program integrity efforts will also leverage improvements in Medicaid and CHIP data described by CMS in a February 2013 presentation

TABLE 5-1. Updates to CMS Medicaid Program Integrity Activities

MACPAC Recommendation	Recent CMS Actions Related to Recommendations
Determine which federal program integrity activities are most effective and eliminate programs that are redundant, outdated, or not cost-effective	Shifting the focus of the National Medicaid Audit Program from independent audits based on federal data to collaborative audits that leverage state expertise and state data Suspending collection of the annual State Program Integrity Assessment dataset while CMS streamlines questionnaires to eliminate duplication
Assess analytic tools and promote use of those that are most effective	Working with states to develop new provider screening tools Using state-supplied Medicaid Management Information System (MMIS) data to support federal Medicaid Integrity Contractor audits while CMS separately works to improve the quality and timeliness of federal Medicaid Statistical Information System (MSIS) data
Improve dissemination of best practices	Launched a Medicaid program integrity workgroup to identify best practices for financial management and provide input for a CMS framework to strengthen the federal-state Medicaid program oversight partnership Providing a secure online platform for states to exchange best practices and documents on program integrity Published prescriber guidelines to promote best practices for therapeutic drug classes identified as high risk
Enhance program integrity training programs	Created a new managed care program integrity curriculum for states and the first Certified Program Integrity Professional program of study through the Medicaid Integrity Institute Offering distance learning webinars to increase access to training opportunities for state Medicaid staff

Sources: GAO 2012b; Thompson 2012

to the Commission (Boughn 2013). The Transformed Medicaid Statistical Information System (T-MSIS), which will begin incorporating state data later in 2013, builds on existing person-level and claims-level MSIS data submitted by states and will provide more robust analytic capabilities for CMS. See Chapter 4: *Update on Medicaid and CHIP Data for Policy Analysis and Program Accountability* for more details on T-MSIS and other CMS data improvement initiatives.

Key Programmatic Areas in Program Integrity

In our March 2012 report, we highlighted federal-state coordination as a particular concern for program integrity efforts. In this section, we present an overview of program integrity activities from a state program administration point of view, while highlighting strategies that are embedded in larger program functions (e.g., individual and provider enrollment, service delivery, and payment) and dedicated program integrity activities that cross multiple functions (e.g., post-payment review, reporting, and follow-up).

As CMS continues to refine and implement a national Medicaid program integrity strategy, it must balance the need to comply with existing statutory and regulatory requirements with the goals of making efficient use of federal resources and avoiding undue burden on states and providers. This is a delicate balancing act for two reasons.

First, program integrity relates to all aspects of the program, including eligibility, provider enrollment, claims payment, managed care oversight, and federal claiming. However, states must continually strike a balance between tight front-end controls in each programmatic area and other program goals, particularly access to a sufficient network of providers and efficient program administration.

Second, a Medicaid program integrity strategy must be executed within a state-federal program structure, where the federal government and states have shared responsibility for financing and administering the program. Because federal and state dollars are used to pay for Medicaid services, both levels of government have a strong interest in program integrity. However, state and federal government roles and responsibilities sometimes diverge and sometimes overlap, complicating their ability to jointly implement a program integrity strategy.

Seven programmatic areas are integral to a comprehensive program integrity approach: program integrity operations, individual enrollment, provider enrollment, service delivery, payment, post-payment review, and reporting and follow-up. States and the federal government conduct mandatory and optional activities in each area (Table 5-2); this section briefly reviews activities in each area. There are duplicative initiatives as well as areas that receive relatively little attention. There are also areas where state and federal responsibilities align and others where they overlap.

This section is followed by a more detailed discussion of one specific area of overlap and duplication—eligibility review—as an example of challenges states face in trying to comply with federal program integrity requirements that may be outdated and redundant. Future Commission work will investigate potential concerns surfaced by this analysis and help policymakers identify specific opportunities to streamline regulatory requirements, eliminate redundant functions, promote greater integration of state and federal activities, or invest additional resources.

Program integrity operations

Program integrity is identified in Title XIX of the Social Security Act (the Act) as an essential

TABLE 5-2. Overview of State and CMS Program Integrity Activities

	State	CMS
Program integrity operations	Establish overall strategy Develop operational plans Obtain necessary authorities Hire and train staff Obtain necessary data Develop appropriate linkages among state and federal agencies	Establish overall strategy Develop and implement curricula for the Medicaid Integrity Institute, provide no-cost training to state staff Review and approve state information system plans Develop and publish performance standards and best practices Provide individual and provider education regarding program integrity issues Develop appropriate linkages among state and federal agencies
Individual enrollment	Determine eligibility Collect third-party liability (TPL) information and coordinate benefits Verify reported information	Provide access to federal databases to verify individuals' reported application or redetermination information Support cross-state information sharing of individual application verification information through the Public Assistance Reporting Information System
Provider enrollment	Enroll providers Check exclusion lists Conduct onsite inspections and verifications Report any adverse provider application actions to the Office of Inspector General Contract with managed care plans	Provide access to Medicare provider databases and risk screen findings Support cross-state information sharing of provider application verification information Review managed care contracts
Service delivery	Develop and document coverage, billing, and payment policies Restrict (lock in) to certain providers those individuals prone to abusing services Verify eligibility at point of service Review prior authorization requests Review prospective drug utilization review requests	Review proposed Medicaid state plan amendments that relate to services

TABLE 5-2, Continued

	State	CMS
Payment	Apply prepayment edits Process service and payment edits Apply TPL information Use predictive modeling to flag potential errors Suspend potential fraudulent claims Adjudicate final payments Issue Explanation of Benefits statements Submit claims for federal matching funds	Develop, publish, and update National Correct Coding Initiative edits based on typical billing issues Develop, publish, and update predictive modeling algorithms to be applied pre-payment Review state claims for federal matching funds
Post-payment review	Conduct Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) eligibility reviews Participate in federal PERM fee-for-service (FFS) and managed care measurement Pursue third-party payments when available Perform retrospective reviews of care Conduct surveillance and utilization review Audit payments Support federal Medicaid Integrity Contractor (MIC) audits Contract with Recovery Audit Contractors (RACs) Supply data for Medicare-Medicaid (Medi-Medi) matches Identify potential fraud	Review MEQC and PERM sampling plans Conduct federal PERM FFS and managed care measurement Conduct federal MIC audits Conduct federal Medi-Medi data matches Review claims data for potential fraud and abuse Provide staff and other resources to support state field investigations
Reporting and follow-up	Refer suspected fraud to law enforcement Provide support for fraud investigations Terminate fraudulent providers and contracts Recoup overpayments from providers Return federal share of overpayments Calculate return on investment Compile program integrity statistics Complete federal State Program Integrity Assessment surveys Participate in comprehensive State Program Integrity Reviews Identify and implement corrective actions Report the identification and collection of overpayments due to waste, fraud, and abuse Report administrative expenses associated with program integrity activities	Conduct comprehensive State Program Integrity Reviews Conduct annual State Program Integrity Assessments Develop and implement national PERM corrective action plan Develop Medicaid integrity review "lessons learned" reports Facilitate access to federal databases and web portals for reporting payment suspensions, provider terminations, and state Recovery Audit Contractor activity

program function, and all Medicaid programs must have "methods and procedures relating to the utilization of and payment for care and services….as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care" (§1902(a)(30)).

Over time, many additional statutory and regulatory requirements for how states must monitor, detect, and measure fraud, waste, and abuse have been added to statute and regulation. States have developed a variety of strategies to implement these rules, ranging from largely decentralized to highly coordinated program integrity functions. States' resource constraints are a fundamental issue: with limited budgets, states must often shift limited resources to mandated activities in lieu of other preferred activities.

With the creation of the MIG in 2005 and the allocation of substantially greater resources to support Medicaid program integrity, the federal government has increased its support for state program integrity activities. In September 2007, CMS established the Medicaid Integrity Institute, a national Medicaid program integrity training center for states that has provided no-cost training to over 3,000 state employees and is highly regarded by states (GAO 2012a). The federal government has also created new initiatives that require state resources, such as the comprehensive State Program Integrity Reviews (MACPAC 2012).

Other federal efforts to support states in building internal program integrity infrastructure and capacity have had more limited impact. The federally contracted Education Medicaid Integrity Contractor (Education MIC) provides support for the MIG in developing materials and conducting training on Medicaid fraud, waste, and abuse. As of April 2013, the Education MIC had developed and broadly disseminated guidance on a small number of topics (CMS 2013d). CMS has also used information collected during periodic reviews of state Medicaid program integrity activities to identify three sets of best practices and provide technical guidance for other states (CMS 2013e). States, through the National Association of Medicaid Directors, have asked that CMS devote a greater share of contractor resources to support training, education, and implementation of state-level tools (NAMD 2012).

Individual and provider enrollment

One of the strongest tools that state Medicaid agencies have to prevent fraud, waste, and abuse is the ability to conduct initial and periodic assessments of individuals and providers and exclude ineligible, unqualified, or inappropriate individuals from participation. Long-standing federal policies require states to verify and validate individual eligibility at the time of application and periodically thereafter and to promptly disenroll persons who are not eligible. In recent years, greater focus has been placed on screening providers who seek to participate in the program, routinely verifying their continuing eligibility to bill Medicaid, and promptly suspending or removing providers who are suspected or convicted of defrauding the program.

States must balance their interest in excluding ineligible persons with the responsibility to ensure that eligible persons are not inappropriately denied participation or dissuaded from completing the application process due to rules designed to protect program integrity. This applies to providers as well: states must verify that only providers who meet program criteria are allowed to bill the program, but must also take care that the process does not deter qualified providers from participation and negatively affect enrollee access to care.

Medicaid enrollee eligibility. In order to support state efforts to ensure that only persons who meet eligibility criteria are enrolled in the program, the federal government provides access to national data sources to facilitate state validation of individual application enrollment information. For example, the HHS maintains a database of income and program participation information from multiple states and federal programs. States can access the data to determine duplicate program enrollment or the accuracy of application information. CMS is in the process of developing a comprehensive federal eligibility data hub to support real-time, electronic verification of enrollee eligibility information beginning in late 2013 (CMS 2013f). The availability of systems to automate the validation of data that are available electronically, once fully implemented, could reduce burden on state staff and eventually support the reallocation of resources that would have been spent collecting and reviewing paper-based information to other activities.

State Medicaid programs are federally required to conduct two different types of retrospective reviews of eligibility determinations.

- **Medicaid Eligibility Quality Control (MEQC).** All states are required to conduct monthly MEQC reviews of active Medicaid cases to determine whether eligibility decisions were made correctly: whether enrollees were eligible for services, and whether denied or terminated Medicaid applications were correctly processed. States calculate and report state-specific error rates.
- **Payment Error Rate Measurement (PERM).** States must also participate in the federal PERM eligibility measurement every three years. One requirement of the program is to sample and review a small number of eligibility cases each month. PERM error findings are reported to CMS for inclusion (along with the FFS and managed care findings) in the state and national error rates and are used at the state level to inform corrective action.

PERM and MEQC are discussed in greater detail later in this chapter.

Provider enrollment. States must ensure that providers comply with state rules regarding qualification to participate in the Medicaid program. States must also ensure that they do not enroll or make payments to providers excluded by the Medicare program or other state Medicaid programs and terminate providers whose billing privileges have been revoked by other programs for cause (42 CFR 455(e)). In 2011, CMS expanded the provider screening rules for Medicare and required states to implement them in the Medicaid program; specifically, states must obtain certain disclosures from providers upon enrollment (and periodically thereafter), search exclusion and debarment lists and databases, and take action to exclude providers who appear on such lists. Medicaid managed care organizations (MCOs) must also conduct routine screens to ensure that excluded providers are not permitted to participate. States are now required not only to check federal databases but also to share information on provider enrollment decisions proactively with federal program administrators (42 CFR 1002.3(b)(3)).

States report that current processes to conduct the required checks are difficult to implement and time consuming to operate (NAMD 2013). Systems that streamline application data collection, automate exclusion checks, and target enhanced checks at riskier providers could help to reduce state and provider burden and improve efficiency. Because all states must comply with the same provider screening rules and conduct the same database checks, and because most of these databases are federally maintained, a comprehensive system to

support states in the Medicaid provider enrollment process could greatly improve efficiency.

CMS has implemented a system that provides some information to states, but it is incomplete. The web-based application allows states to share information regarding Medicaid providers who have been terminated for cause and to view information on Medicare providers and suppliers who have had their billing privileges revoked for cause. However, the system does not provide information on other types of exclusions (Budetti 2013). The available systems are also not updated in real time (some only monthly). Thus, states must conduct additional checks to exclude ineligible providers.

Service delivery

Program integrity activities at the time of service delivery (often referred to as the point of service) focus on confirming enrollee eligibility to receive a particular service and ensuring that services provided are medically necessary, appropriate, and provided in accordance with program rules. In FFS Medicaid, states determine which services are covered and what restrictions or limitations apply to each service. Medicaid covers a broader range of rehabilitative, habilitative, and support services than most private insurers and has many unique coverage and payment rules, so states provide written guidance (in the form of manuals and bulletins) to providers and conduct periodic training to help promote understanding of and compliance with program rules.

States can also require providers to receive prior approval for some services, but the approval process can be costly to the state, create burdens for providers, and delay the initiation of treatment. States must weigh all of these factors when determining which front-end controls to implement.

CMS reviews state policy change requests to ensure that covered services and payment mechanisms comply with federal laws and regulations and that proposed payment strategies align with Medicaid financing rules (HHS and DOJ 2012). However, CMS does not typically review—or even collect—the detailed guidance that states develop to instruct providers on what can be covered, nor does it assess the extent to which states impose pre-payment controls apart from those explicitly required by federal statute. CMS has provided detailed policy guidance for states to support accurate coverage and payment determinations and to decrease fraud, waste, and abuse associated with prescription drugs, but has not broadly disseminated guidance for most Medicaid-covered services, including those known to be vulnerable to fraud and abuse such as certain home and community-based services (CMS 2013d). CMS, like states, generally relies on post-payment audits (discussed in greater detail below) to assess the degree to which paid claims comply with state and federal coverage and billing requirements.

Payment

In most cases, Medicaid provider payments are triggered by the submission of a claim by a provider indicating that a service has been provided, and the systems that adjudicate most payment requests have numerous controls built in to support program integrity. States use the information presented on a claim and other data contained in their systems to adjudicate the claim and determine the appropriate payment.

Federal statute and rules mandate many of the checks that states must conduct, including requirements to verify provider authorization, check for logical consistency (e.g., whether the patient on an obstetrical claim is a woman), prevent duplicate payments, and verify payment amounts (42 CFR 447.45(f)). States must also develop and

apply edits to ensure that appropriate limitations are put on claims submitted on behalf of enrollees who are eligible for a restricted or alternate benefit package, who have third-party coverage (including Medicare), or who are enrolled in a Medicaid managed care plan (42 CFR 433.137). Most of these checks and reviews are automatically conducted by the claims processing system and the majority of claims are processed without any manual intervention. Because Medicaid claims are subject to complex adjudication rules, consistent and accurate application of these rules is a critical aspect of program integrity.

Every state claims payment system must meet certain requirements in order to be approved by CMS and receive enhanced federal funding. These requirements generally pertain to specific functionality that the system must support, including having a surveillance and utilization review component to support program integrity (42 CFR 456). Beginning in 2010, the Congress created two new requirements that extend Medicare program integrity strategies to state Medicaid payment systems. These are:

- **National Correct Coding Initiative (NCCI).** NCCI promotes national correct coding methodologies and reduces improper coding, which may result in inappropriate payments. The ACA required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.
- **Predictive modeling.** As part of the Small Business Jobs Act of 2010 (P.L. 111-240), the Congress mandated that CMS implement predictive modeling technologies (i.e., analyze large datasets for suspicious patterns, anomalies, or other factors that may be linked to fraud, waste, and abuse) to help identify potential fraud prior to making Medicare payments. By April 1, 2015, CMS must begin expanding the program to Medicaid and CHIP and apply lessons learned from the use of predictive modeling in Medicare (Budetti 2012).

Post-payment review

A variety of post-payment reviews are conducted to correct over- and underpayments and identify potential fraud and abuse.

Federal rules require states to conduct post-payment reviews of provider payments to assure appropriate utilization and to identify potential fraud and abuse.

Routine reviews of accuracy and quality. States conduct a variety of limited-scope analyses of provider records, claims, and supporting documentation after they have issued payments. States use both automated computer analysis and manual review to assure proper utilization and payment. These analyses may not be as extensive as an audit, but seek to determine quality of care, compliance with accepted standards of care, program compliance, and validity of services.

States can also provide state claims data and payment policies to the federal Medicare-Medicaid Data Matching Project (Medi-Medi), which combines Medicaid and Medicare claims and identifies data patterns indicating improper payments that previously went undetected in either program.

Audits. States conduct a variety of post-payment reviews to verify the accuracy of payments made for certain services or to certain types of providers. Many of these audits are federally required, each authorized through separate legislation and many being implemented in different centers within CMS.[2] Key requirements include the following:

- States must audit any provider that is paid on a cost-related basis and audit payments made to disproportionate share hospitals.
- States are required to participate in the periodic PERM error rate measurement, where federal contractors conduct audits of a random sample of claims to assess whether payments were made in accordance with federal and state requirements.
- States are required to cooperate with federal Medicaid Integrity Contractors (MICs), which are under contract to CMS to review provider claims, audit providers, identify overpayments, and educate providers, payers, and enrollees about program integrity.
- States are required to contract with a Recovery Audit Contractor (RAC) to identify underpayments and overpayments and to recoup overpayments on a contingency basis.

Fraud detection. State Medicaid agencies use many of the post-payment data analysis activities described above to identify potential fraud. States must also verify with enrollees whether services billed by providers were received (42 CFR 455.20). States that use managed care delivery systems must require MCOs to have a fraud and abuse or compliance plan, or both, and to report promptly any instances of provider fraud and abuse to the state.

When any of these activities uncover potential fraud, states must make referrals to appropriate external entities for investigation and prosecution. States also provide support to fraud investigators (e.g., provide access to claims data) and recoup improper payments.

As the number of federal Medicaid-related post-payment review activities has grown over time, states and others (including the Commission) have raised concerns about duplication of effort. For example, PERM, MICs, and RACs all audit FFS providers, but CMS has not created a mechanism for the various contractors to coordinate with each other or with state program integrity reviews to ensure that the same providers are not reviewed multiple times (NAMD 2012).

Reporting and follow-up

Federal rules require states to take certain actions when they identify improper payments, whether due to fraud, abuse, or inadvertent errors. States are also required to return the federal share of any identified overpayments within one year of identification—whether or not the state is able to recoup the erroneously paid amount from the provider. To prevent future improper payments, states use findings from program integrity activities to strengthen program controls, such as implementing new claims payment edits or conducting additional provider screenings. They may also analyze the outcomes of program integrity efforts to assess the return on staff and technology investments.

Every state must have a Medicaid Fraud Control Unit (MFCU), an entity of state government that investigates program administration and health care providers, prosecutes (or refers to prosecutors) those defrauding the programs, and collects overpayments. Federal regulation requires states to refer all cases of suspected provider fraud to the MFCU, comply with document requests from the MFCU, and initiate administrative or judicial action for cases referred to the state by the MFCU. When providers are convicted of fraud, the state must terminate the providers' participation in Medicaid, place them on exclusion lists, and notify the federal HHS Office of Inspector General (OIG). States also cooperate with a variety of other federal fraud task forces such as the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a partnership between the federal HHS and the U.S. Department

of Justice designed to gather resources across the federal government to prevent fraud, waste, and abuse in Medicare and Medicaid.

At the federal level, CMS collects a variety of Medicaid program integrity information. The MIG conducts a comprehensive review of each state integrity program every third year to assess the effectiveness of state program integrity activities and compliance with federal program integrity laws. Findings from these reviews are published on the MIG website. Until recently, the MIG conducted an annual State Program Integrity Assessment for all states, which collected statistics about program integrity staffing, expenditures, audits, and recoveries. This process has been temporarily suspended while CMS streamlines the questionnaire to eliminate duplication (GAO 2012a). Information from these reviews and from other MIG activities is used to develop descriptive reports for each state, identify areas for technical assistance, and assess state performance over time. CMS also reviews state claims for program integrity expenditures and periodic reports on recoveries, which states report separately for certain defined program integrity activities (e.g., National Medicaid Audit Program, state-initiated activities, and OIG-initiated audits).

PERM and MEQC: An Opportunity to Streamline

As noted earlier, states must strike a balance between front-end controls to support program integrity and other program goals, such as access. These competing priorities can be seen in the area of individual eligibility determinations: while states are required to verify eligibility, they also have the responsibility to ensure that enrollment of eligible persons is not inappropriately denied or delayed due to rules designed to protect program integrity. Retrospective eligibility reviews, conducted after an eligibility determination is made, can help states maintain program integrity without complicating or delaying the eligibility determination process. However, current federal rules regarding retrospective eligibility reviews are perceived by states to be costly and difficult to implement (CMS 2009b).

States must conduct two different types of retrospective reviews of eligibility determinations, MEQC and PERM. The rules for these two programs are overlapping and do not align well with each other (Table 5-3). They also have not been aligned with changes that have been made in eligibility policies and processes, particularly the significant changes required by the ACA. The result is illustrative of the challenges states face in trying to comply with federal program integrity requirements that may be outdated and redundant.

Medicaid Eligibility Quality Control

The MEQC program was created in 1978 to monitor the accuracy and timeliness of Medicaid eligibility determinations in order to avoid inappropriate payments and eligibility decision delays (§1903(u) of the Act). MEQC was also intended to identify methods to reduce and prevent errors related to incorrect eligibility determinations. The program is implemented by the states and overseen by CMS, per federal regulations at 42 CFR 431.800ff.

In the traditional MEQC program, states select a sample of eligibility cases over each six-month period. The sample includes both active cases (cases in which the individual or family was found to be eligible) and negative cases (cases in which Medicaid eligibility was denied). Only Medicaid cases are selected for review. Stand-alone CHIP programs are not subject to MEQC. Reviewers independently verify eligibility information as of the review month (the month in which the case

is sampled), including interviewing enrollees and applicants and conducting home visits.

States are required to report their findings to CMS at the end of each six-month period, and then CMS calculates an error rate. Per the statute, states with error rates over 3 percent are subject to disallowances of federal matching funds, but states are permitted to request good faith waivers of disallowances. By the end of 1994 most states reduced and maintained their error rates to less than 2 percent, and only one state has been liable for disallowances since 1996 (CMS 2000).

Due to the consistently low error rates, in 1994 CMS developed criteria that allowed states to freeze their error rates as of the most recent completed MEQC period and develop pilot programs to find alternate ways to identify and reduce erroneous payments (CMS 2000). Over time, most states elected to conduct pilots under MEQC or an 1115 waiver; as of 2013, only eight states still conducted traditional MEQC reviews. (This number can fluctuate from year to year.) In the pilots, which must be approved by CMS, states can use a different sample size, focus on specific eligibility subgroups, and implement alternate review methodologies.

Payment Error Rate Measurement

PERM eligibility measurement was implemented in 2006 to comply with the Improper Payments Information Act of 2002 (P.L. 107-300) and related guidance, which identified Medicaid and CHIP as susceptible to significant erroneous payments. Among other requirements, CMS must produce an annual estimate of the amount of improper payments in Medicaid and CHIP and report on actions to reduce them.[3] The eligibility portion of the measurement is conducted by the states and overseen by CMS, per federal regulations at 42 CFR 431.950ff.

One third of states are included in the PERM measurement each year. Every three years, the state must measure error rates for a full 12-month period. States select a sample of eligibility cases, drawing separate samples for Medicaid and CHIP. Children enrolled in Medicaid-expansion CHIP programs are included in the CHIP sample. Like MEQC, the sample includes both active and negative cases.

Unlike MEQC, reviewers rely on information in the case record to determine whether the last action on a case was determined accurately. Reviewers only independently verify eligibility criteria where evidence is missing or outdated and likely to change, or if the last action was more than 12 months prior.

States are required to report their findings to CMS on a monthly basis and CMS calculates an error rate at the end of each measurement cycle. Overpayments identified based on PERM eligibility review are subject to disallowances (§1903(u) of the Act).

Initial PERM eligibility review guidance did not allow states to accept an applicant's self-declaration or self-certification of various eligibility criteria, although many states relied extensively on self-declaration to expedite the enrollment process, particularly for CHIP programs (HHS 2009). Many PERM eligibility reviews were consequently "undetermined" and counted as errors, leading to high error rates in many states. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) required that the payment error rate not take into account payment errors resulting from failure to validate self-declared eligibility information, if the self-declaration was provided in accordance with federal rules. CHIP programs were excluded from the PERM measurement until after CMS promulgated regulations implementing the CHIPRA provisions in 2010.

TABLE 5-3. Comparison of Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC)

	Traditional MEQC	PERM
Time period	Six months, continuous	Twelve months, every third year
Sampling	Fixed sample size for each state, varies by state size (for most states, 550 active and 210 negative cases each year) Medicaid samples only	State-specific sample sizes recalculated each cycle based on statistical precision in prior cycle (base sample size is 504 active and 204 negative cases each year) Separate Medicaid and CHIP samples
Populations excluded	Children in foster care Supplemental Security Income (SSI) beneficiaries in states with an agreement with the Social Security Administration under §1634 of the Social Security Act Enrollees in separate CHIP programs Programs that are 100 percent federally funded	Children in foster care or adoption assistance SSI beneficiaries in §1634 agreement states Cases under active fraud investigation Cases approved using Express Lane eligibility Cases for which the state received no federal match
Verifications	Independently verify actual circumstances Applicant interviews and home visits required	Review case record and independently verify eligibility criteria only where evidence is missing, outdated and likely to change, or otherwise needed
Review period	Review eligibility in month sampled	Review eligibility as of date of last action on a case, up to 12 months prior to the sample month
Incomplete reviews	Cases can be dropped from review if beneficiary does not cooperate, cannot be located, or has moved out of state	Cases cannot be dropped Cases that cannot be completed are considered "undetermined" and counted as errors
Payment reviews	Collect payments for services received by sampled enrollees in the sample month (if paid in that month or the following four months)	Collect payments for services received by sampled enrollees in the sample month (if paid in that month or the following four months)
Error tolerance	Errors less than $5 are not counted	No tolerance for errors
Error rate calculation	Lower limit of statistical confidence interval used to calculate rate	Midpoint of statistical confidence interval used to calculate rate
Corrective action	Must take action to correct issues Correction plan must be submitted to CMS within 60 days of identification of error	Must take action to correct issues Correction plan must be submitted to CMS within 90 days of official notification of error rate

Note: As of 2013, only eight states still conducted traditional MEQC reviews. This number can fluctuate from year to year. Other states conduct pilots that may use a different sample size, focus on specific eligibility subgroups, or implement alternate review methodologies.

Source: CMS 2012a.

Due to substantial overlap in the MEQC and PERM eligibility review requirements and resulting burden on states, CHIPRA also directed CMS to take steps to harmonize the two programs and allow states the option of using PERM eligibility review findings to meet MEQC requirements and vice versa. While CMS has been able to implement the substitution requirement of CHIPRA, it has been unable to substantially harmonize the two programs due in part to other statutes and rules that were not changed by CHIPRA. States remain burdened by duplicative requirements.[4]

The process that CMS developed to allow states to use MEQC results to meet PERM requirements and vice versa requires states to draw a sample that meets the requirements of both traditional MEQC and PERM (CMS 2012a). For example, PERM measures Medicaid and CHIP separately, so enrollees in a Medicaid-expansion CHIP program must be excluded from an MEQC sample before it can be used to meet the PERM requirement. However, because all but a small number of states conduct MEQC pilots that cannot be substituted for PERM findings, most states must still conduct both MEQC and PERM reviews in the PERM measurement years.

Recent changes in eligibility policy may further complicate efforts to harmonize the programs or facilitate substitution. For example, MEQC excludes from the review persons whose Medicaid costs are borne completely by the federal government. Historically, this has included only a small proportion of enrollees eligible through special federal programs (e.g., American Indians receiving treatment in an Indian Health Service facility). However, under the ACA, the federal government will initially pay 100 percent of the cost of coverage for most persons in the adult expansion group. Although estimates of the number of individuals gaining Medicaid coverage under the ACA vary, CMS expects that the majority will be newly eligible adults for whom increased federal match is available (CMS 2013a). If these enrollees are excluded from MEQC but not PERM, it could be difficult for states to develop a sampling plan that would satisfy both programs.

It is also unclear how PERM and MEQC will be impacted by ACA-driven changes to the eligibility determination process. Beginning in 2014, Medicaid decisions can be made by state or federal exchanges in addition to state Medicaid agencies. CMS is evaluating the impact of the ACA on the PERM and MEQC eligibility measurements. However, at this time CMS has not issued rules or published guidance to indicate whether persons determined eligible by an exchange will be excluded from MEQC and PERM reviews, whether exchanges must share case information with states for purposes of eligibility review, or whether states will be accountable for verification or calculation errors made by exchanges. States must submit sampling plans for reviews that will take place in 2014 no later than August 1, 2013, but may have to amend these plans or obtain additional review resources depending on how CMS decides exchange-determined cases should be treated for purposes of MEQC and PERM reviews.

The Commission's Program Integrity Focus for the Coming Year

During the coming year, the Commission will continue to review Medicaid program integrity activities and highlight potential areas for program improvement. Specific areas of focus will include:

- **State and federal division of responsibilities.** Starting with the administrative perspective outlined in this chapter, we will look for opportunities to

improve efficiency by clarifying federal and state roles relating to Medicaid program integrity. We will isolate specific areas of overlap and redundancy that can be eliminated and identify areas in statute or regulation where a more rational allocation of state and federal responsibilities may result in greater efficiency and effectiveness.

- **Effectiveness of current efforts.** We will evaluate information on the effectiveness of various program integrity initiatives and identify successful initiatives that should be expanded and programs that are not cost-effective and should be eliminated. We also will identify where better performance measures or improved data are necessary to evaluate the effectiveness of certain activities.
- **Openings for additional guidance and support.** We will examine Medicaid program integrity activities associated with various program areas to determine if there are areas where additional guidance or greater cross-state consistency would support overall program integrity, or where improved technology could better support both integrity and efficiency. We will specifically consider Medicaid program integrity approaches for managed care delivery systems, which now enroll a majority of Medicaid enrollees (CMS 2012b). We will also consider emerging payment and delivery models and the extent to which new program integrity approaches may be required.

Endnotes

[1] State Children's Health Insurance Programs (CHIP) that are part of a Medicaid expansion are included in that state's Medicaid program integrity efforts. A separate CHIP program likely enrolls its enrollees in managed care, so some program integrity activities are carried out by the health plan.

[2] See Chapter 4, Annex 1 to MACPAC's March 2012 report to the Congress for a list of the corresponding statutes.

[3] PERM also measures the accuracy of FFS claims payments and managed care capitation payments through reviews conducted by federal contractors. Findings from the federal contractor review of FFS and managed care payments are combined with findings from state review of eligibility determinations to produce national Medicaid and CHIP program error rates.

[4] CMS estimated that the burden for a single state to conduct 504 active case reviews and 204 negative case reviews for both Medicaid and CHIP under the PERM methodology would be 9,980 labor hours (CMS 2010).

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