DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP 20 2019

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Medicaid Program Integrity Strategy. We value your long-standing interest and steadfast leadership in addressing this important issue. These initiatives are designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. CMS continuously works to strengthen Medicaid program integrity efforts to ensure that taxpayer dollars are spent appropriately. As you noted, CMS recently celebrated the one-year anniversary of the Medicaid Program Integrity Strategy last month with a blog post highlighting our accomplishments thus far.[1]

The Medicaid program has grown from $456 billion in 2013 to an estimated $576 billion in 2016, largely fueled by the primarily federally financed expansion of the program to more than 15 million new working age adults. For these adults, the estimated cost per enrollee grew about 7 percent from FY 2017 to 2018, compared to about 0.9 percent for other enrollees. With this historic growth comes a commensurate and urgent responsibility by CMS on behalf of the American taxpayers to ensure sound stewardship and oversight of program resources. While the primary responsibility for ensuring proper payments in Medicaid lies with states, CMS has a significant role in supporting states' efforts and holding them accountable through appropriate oversight and increased transparency.

In addition to our ongoing Medicaid program integrity work, there are other ways that we could continue to strengthen our efforts, especially concerning state beneficiary eligibility determinations. CMS believes it is vital that states make correct beneficiary eligibility determinations to prevent misuse of taxpayer dollars; however, current law restricts CMS's ability to recover eligibility-related overpayments from states. To help address this, a legislative proposal in the FY 2020 President's Budget would expand extrapolation and disallowance authority for certain eligibility audits. Specifically, it would permit CMS to issue disallowances outside of the current improper payment rate measurement process and allow CMS and the Department of Health and Human Services Office of Inspector General (OIG) to extrapolate

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[1] "Medicaid Program Integrity: A Shared and Urgent Responsibility," Available at: https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility

findings on beneficiary eligibility to ensure federal recovery of incorrect eligibility determinations. Additionally, the proposal would strengthen CMS's ability to issue disallowances for eligibility errors by eliminating the current three percent threshold for states' eligibility-related improper payments. We would be happy to meet with you to discuss this proposal and would welcome your leadership on its consideration by Congress.

We appreciate the opportunity to provide you with an update on the initiatives we announced in June 2018.

State Beneficiary Eligibility Determinations

Even absent these legislative changes - as part of CMS's strategy to improve program integrity and increase oversight of states' beneficiary eligibility determinations, CMS is auditing states previously found to be high risk by the OIG and State Auditors to examine how the states determine eligibility for Medicaid benefits. These states are New York, Kentucky, California and Louisiana. These audits include assessing the effect of Medicaid expansion and its enhanced federal match rate on state eligibility policy. The objectives of the audits are to determine whether beneficiary eligibility was adjudicated appropriately for the new adult group and whether services for beneficiaries in the new adult group were assessed the correct Federal Medical Assistance Percentages. The audits are ongoing in all four states, and we expect the audits to be completed by fall 2019.

In addition to conducting audits, CMS issued a CMCS Informational Bulletin to state Medicaid and Children's Health Insurance Program agencies on June 20, 2019 that outlines the necessary assurances that states should make to ensure that program resources are reserved for those who meet eligibility requirements.[2] The guidance includes a Program Readiness Checklist to assist states in ensuring operational capacity to make accurate eligibility determinations and claim Federal Financial Participation (FFP) at the appropriate matching rate.

CMS is also developing a proposed rule, *Strengthening the Program Integrity of the Medicaid Eligibility Determination Process,* that would implement policies designed to enhance the Medicaid and CHIP eligibility and enrollment process and to ensure that beneficiaries continue to be eligible after enrollment. The proposals focus on the areas with the greatest potential for beneficiary changes to occur between regularly scheduled redeterminations – income and residency. The requirements being proposed are based on the lessons learned from state audits and other program integrity efforts.

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[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf

Medical Loss Ratio (MLR) Audit

To increase oversight over Medicaid managed care plans, CMS has begun auditing Medicaid managed care plans' financial reporting and Medical Loss Ratios (MLRs) to ensure plans are not being overpaid, including reviews of high-risk vulnerabilities identified by the Government Accountability Office (GAO) and OIG. As a follow-up to the MLR review previously conducted by the California Department of Health Care Services (DHCS), CMS commenced an examination of California's managed care plans to ensure that the financial information submitted by the managed care plans and used by DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems.

The primary objectives are to (1) determine if the MLR was reasonably represented by California's Medicaid managed care plans, specifically whether the numerator, which is comprised of medical-related expenses, was accurately reported to DHCS with appropriate documentation and consistent with generally accepted accounting principles; (2) assess if Medicaid managed care plans' provider incentive payments and payments to related parties were consistent with California's contractual requirements and documented appropriately; (3) focus on Medicaid managed care plans that required multiple re-submissions of MLR calculations to DHCS to determine the cause of those re-submissions and if the causes of the re-submissions have been corrected; and (4) determine and understand what factors are responsible for large variations across Medicaid managed care plans in components of the MLR calculations to ensure that the Medicaid managed care plans have sufficient documentation related to the factors to support the MLR calculations. The review is currently underway, and we expect it to be completed later this year. The results of our MLR examination in California will inform the need for future CMS oversight in this space.

Optimize State Provider Claims and Provider Data

CMS is validating the quality and completeness of the enhanced data currently being submitted to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). CMS's Unified Program Integrity Contractors (UPICs) are currently working with Medicaid Management Information System (MMIS) state data for investigative activities, and our work to validate T-MSIS data for program integrity purposes is a critical first step to support our ability to utilize advanced analytics and other innovative solutions. New efforts to use this data to detect fraud, waste, and abuse represent the first use of T-MSIS data for program integrity purposes, moving CMS closer to its goal of comprehensive, timely, national analytic data for Medicaid. CMS is validating T-MSIS data for all states and territories for program integrity use. CMS is on track to complete all states' T-MSIS data validation by the end of calendar year 2019.

CMS also continues to encourage states to use data and algorithms for program integrity purposes. CMS is sharing its extensive knowledge, gained from processing and analyzing large, complex Medicare data sets, to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation. In addition to the use of T-

MSIS data, CMS provides states access to Medicare data as needed for their dual eligible populations, including the One Program Integrity (One PI) system and the State Data Resource Center (SDRC). CMS also assists states with provider screening and enrollment compliance, and allows them to leverage Medicare data and activities. For example, CMS is making the Social Security Administration's Death Master File, Medicare enrollment and revalidation data available for States to support provider enrollment activities.

Finally, CMS is exploring future rulemaking to add transparency into Medicaid payments and promote fiscal accountability.

Thank you for your continued interest in the steps CMS is taking to combat Medicaid fraud, waste and abuse and for your partnership on this important issue. We would be glad to work with you on developing additional statutory flexibilities to help us hold states accountable for their use of taxpayer dollars and ensure that the Medicaid program remains a sustainable safety net for the future. Should you have additional questions, please contact the CMS Office of Legislation at 202-690-8220.

Sincerely,

Seema Verma