Statement of Tim Hill, Commissioner, Medicaid and CHIP Payment and Access Commission (MACPAC)

House Committee on Energy and Commerce Subcommittee on Oversight and Investigations

Hearing on Examining How Improper Payments Cost Taxpayers Billions and Weaken Medicare and Medicaid
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Summary

Ensuring program integrity (PI) in Medicaid is important given the program's role as a key safety net program, serving 94 million beneficiaries in fiscal year 2022 and totaling $824 billion in federal and state benefit spending. Medicaid PI activities are meant to ensure that taxpayer dollars are spent appropriately to deliver high-quality and necessary care and to prevent and detect fraud, waste, and abuse.

When designed and implemented well, PI initiatives help to ensure that eligibility decisions are made correctly; prospective and enrolled providers meet federal and state participation requirements; services provided to enrollees are medically necessary and appropriate; and provider payments are made in the correct amount and for appropriate services. PI activities are designed to address fraud and abuse, which result from intentional acts or deception, as well as waste and improper payments, that are unintentional and not necessarily caused by fraud.

MACPAC's analysis of federal and state PI activities have identified opportunities to improve the efforts of and tools available to the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and other federal and state agencies that engage in the continuum of PI activities. These activities range from front-end controls to recoupments and corrective actions.

The Commission found that coordination of PI efforts is important for mitigating duplication and administrative burden. To address these concerns, MACPAC recommended that the Secretary of the U.S. Department of Health and Human Services (HHS) simplify and streamline regulatory requirements, identify the most effective federal PI activities, and eliminate programs that are redundant, outdated, or not cost effective. To address state challenges in assessing the effectiveness of PI activities, MACPAC recommended that HHS help states improve their ability to measure the effects of PI initiatives. MACPAC also recommended that HHS identify policy design features associated with success, and establish pilots to test PI strategies. Finally, given state challenges using recovery audit contractors, MACPAC recommended that Congress make this mandatory activity optional.

Statement of Tim Hill, Commissioner,

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Griffith, Ranking Member Castor, and members of the Subcommittee. I am Tim Hill, vice president for the Health Division at the American Institutes for Research (AIR); AIR is a non-partisan, not for profit behavioral and social science research firm. I have also served in various roles at the Center for Medicare & Medicaid Services (CMS), including as the chief financial officer, program integrity director, deputy director of the Center for Consumer Information and Insurance Oversight, and deputy director of the Center for Medicare. Today, I am here in my capacity as a MACPAC commissioner. MACPAC is a congressional advisory body charged with analyzing and reviewing policies for Medicaid and the State Children's Health Insurance Program (CHIP) and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on issues affecting these programs. The Commission's 17 members, including Chair Melanie Bella and Vice Chair Bob Duncan, are appointed by the U.S. Government Accountability Office (GAO).

The insights and information I will share this morning are based on analyses conducted by MACPAC's staff, and they represent the views of the Commission. We appreciate the opportunity to share MACPAC's work as this body considers the importance of Medicaid PI.

Ensuring PI in Medicaid is especially important given the program's role as a key safety net program, serving 94 million beneficiaries in fiscal year 2022 and totaling $824 billion in federal and state benefit spending. Medicaid PI activities are meant to ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care and to prevent and detect fraud, waste, and abuse. Program integrity relates to all aspects of the program, including eligibility, provider enrollment, claims payment, managed care oversight, and federal claiming.

When designed and implemented well, program integrity initiatives help to ensure that:

- eligibility decisions are made correctly;
- prospective and enrolled providers meet federal and state participation requirements;
- services provided to enrollees are medically necessary and appropriate; and
- provider payments are made in the correct amount and for appropriate services.

HHS and CMS are required to issue every five years a comprehensive Medicaid Integrity Plan (Section 1936(d) of the Social Security Act (the Act)). CMS's 2018 – 2023 plan includes a variety of activities to be achieved in partnership with states: assessing the effectiveness of state PI activities; reviewing state PI activities; improving Medicaid fiscal accountability; sharing claims data, analytics, and audit capabilities; and providing CMS services to strengthen state PI activities (CMS 2024a).[1]

My testimony this morning will touch on background information and highlight key findings and recommendations from MACPAC's analytic work on Medicaid PI. MACPAC's work has centered on three key themes. First, given the range of state and federal entities with roles and responsibilities for Medicaid program integrity, greater coordination between them is needed. Second, there remains a need to identify high-value PI activities, but challenges in doing so persist. Third, states need information to determine which optional PI activities to invest in. In each of the three areas, CMS has an important leadership role. As such, it is the Commission's view that the federal government is in the best position to take the lead in identifying features that make PI approaches successful and in disseminating this information to states.

Background

Fraud, waste, and abuse

PI is grounded in the concepts of fraud, waste, and abuse, which can be related to each other, but also distinct in important ways. For example, fraudulent or abusive actions can lead to improper payments and could be considered wasteful, but wasteful spending is not necessarily due to fraud or abuse.

Fraud is 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 (42 CFR 433.304 and 455.2). Abuse refers to 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 is the overuse of services or other practices that directly or indirectly result in unnecessary costs to health care benefit programs (CMS 2022). Examples of waste could include duplication of tests that can occur when providers do not share information with each other (CMS 2022). Waste is not an intentional or criminal act (CMS 2022, MACPAC 2012).

Improper payments

Improper payments refer to payments that should not have been made or that were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, and include any payments for an ineligible recipient, any duplicate payments, any payments for services not received, any payments incorrectly denied, and any over- or under-payments (42 CFR 431.958). Improper payments are not necessarily caused by fraud.

Many oversight activities focus on identifying and recovering improper payments made to providers, such as payments that should not have been made or that were made in an incorrect amount. When an improper payment is identified, the state must return the federal share to CMS. States may use their share of the recovery in any manner otherwise lawful for the use of state funds.

Agencies responsible for program integrity

Ensuring Medicaid program integrity is a shared responsibility of state Medicaid programs and CMS with many other state and federal agencies having a role as well.

State agencies

State Medicaid programs have primary responsibility for PI, which includes a wide range of activities some of which are dedicated PI activities and others that are embedded in program functions such as individual and provider enrollment, service delivery, and payment. Over time, multiple requirements for what states must do to reduce fraud, waste, and abuse have been added to statute and regulation. States determine how to invest limited resources, for staff and contractors with legal, clinical, audit, or data expertise, and for tools such as data analytics. States must continually strike a balance between pursuing effective PI strategies and addressing other program goals, particularly ensuring access to a sufficient network of providers and efficiently administering multiple components of a complex program (MACPAC 2019, 2012).

At the state level, program integrity responsibilities may be shared by the state Medicaid agency and other state agencies. For example, states must have a Medicaid Fraud Control Unit (MFCU) to investigate fraud in the administration of the Medicaid program and providers suspected of defrauding Medicaid, prosecute or refer to prosecutors those defrauding Medicaid, and to collect overpayments (42 CFR Part 1007). Other state agencies that may be involved in Medicaid program integrity activities include the survey and certification agency, state inspector general, state attorney general, state auditor, and other law enforcement agencies (MACPAC 2012).

Federal agencies

The federal government has the responsibility to protect the integrity of the Medicaid program by “providing effective support and assistance to states to combat provider fraud and abuse” (§ 1936 of the Act). CMS defines in regulation the parameters for how states must address statutory requirements and conducts oversight to ensure compliance. CMS also supports state Medicaid integrity efforts by providing educational opportunities,

such as through the Medicaid Integrity Institute.[2] In addition, the agency provides one-on-one technical assistance to states (MACPAC 2019).

Other federal agencies, including HHS, the HHS Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and GAO, are also involved in this work. These agencies have different roles, and this differentiation may help the agencies carry out their responsibilities impartially, avoiding conflicts of interest (MACPAC 2012). The HHS OIG conducts audits, investigations, and evaluations to combat fraud, waste, and abuse. The DOJ, through its divisions participates in investigations and enforcement actions. GAO conducts audits to determine whether federal funds are being spent efficiently and effectively, investigations into allegations of illegal and improper activities, and research assessing whether government programs and policies are meeting their objectives. Over the years, a number of federal interagency initiatives to coordinate activities to combat waste, fraud, and abuse in Medicaid, as well as federal efforts to coordinate with states have been implemented (MACPAC March 2012).

PI in Medicaid managed care

All state Medicaid programs, regardless of delivery system design, must comply with federal Medicaid program integrity requirements. However, managed care payment and contracting arrangements create new or different kinds of program integrity risks. For example, under a managed care contract, the state delegates provider contracting, utilization management, and claims processing to a managed care organization (MCO). The MCO, not the state, is primarily responsible for making sure that payments are accurate and that sufficient data are collected for oversight.

As a result, states with managed care programs have two additional program integrity responsibilities: conducting program integrity activities for the managed care program and making sure MCOs maintain effective program integrity programs of their own. For example states must at least every three years, independently audit the accuracy, truthfulness, and completeness of MCO encounter and financial data; directly enroll and screen, and check pertinent databases for MCO enrolled providers; investigate information received from whistleblowers

related to the integrity of MCOs, subcontractors, or network providers; ensure that MCO disclose personal and financial conflicts of interest for each person with at least a five percent ownership interest; and ensure that MCOs agree to provide information on business transactions upon request. States are also required by federal rules to put specific program integrity requirements in their contracts with Medicaid health plans (MACPAC 2017).

Medicaid managed care plans must comply with many specific requirements relating to program integrity, which are enforced through contracts with the states. As part of its contractually required policies and procedures to detect and prevent fraud, waste, and abuse, every participating Medicaid MCO must have the following:

- a formal compliance program with written policies, procedures, and standards of conduct;
- a designated compliance officer and regulatory compliance committee;
- a program integrity training program to educate MCO staff;
- disciplinary guidelines that enforce compliance program policies;
- a system for routine internal monitoring and auditing of compliance risks and for responding to compliance issues as they are raised or for investigating and correcting potential compliance problems when identified in the course of self-evaluation and audits; and
- a method to periodically verify whether billed services were received by enrollees (42 CFR 438.608).

PI activities

States engage in mandatory and optional activities to identify and address Medicaid fraud, waste, and abuse. PI activities span a continuum from front-end controls to recoupments, and corrective actions related to these activities may be embedded in other programmatic functions (e.g., eligibility determination, provider screening and enrollment, claims payment, and managed care oversight) (Appendix A-1). Other efforts are dedicated PI activities undertaken primarily to ensure that public dollars are appropriately spent (e.g., prepayment and postpayment reviews and audits).

Federal and state agencies may use a number of tools to identify and address fraud and abuse in the Medicaid program. Examples of specific methods are highlighted below.

Mandatory activities:

- Provider screening and enrollment is used to identify questionable providers before allowing them to provide Medicaid services. States must conduct criminal background checks, including fingerprinting, particularly if a provider is considered high risk, such as when they face a credible allegation of fraud, waste, and abuse.
- Electronic visit verification (EVV) is meant to ensure that services billed were rendered and to streamline paperwork and reduce duplication of records. EVV requires use of data systems that allow providers to check in from the site of service. PI staff, Medicaid or other state agency staff, MCO staff, or designated contractors may play a role in EVV.
- Audits are conducted to determine compliance with federal and state rules and regulations or to identify fraud and abuse. For example, since 2010 State Medicaid programs have been required to implement recovery audit contractor (RAC) programs (Section 1902(a)(42)(B)(i) of the Social Security Act). RACs identify and correct improper Medicaid payments, collect overpayments, and reimburse underpayments (CMS 2016).
- The Payment Error Rate Measurement (PERM) program conducts audits of a random sample of state payment and eligibility record to assess whether state Medicaid and CHIP payments and eligibility determinations are made in accordance with federal and state requirements. PERM uses the data collected to calculate a national improper payment rate, not a fraud rate (MACPAC 2024, 2012).

  The Medicaid improper payment rate (comprised of reviews in 2021, 2022, and 2023) was 8.58%, or $50.3 billion, a significant decrease from the 2022 reported rate of 15.62%. Of the 2023 Medicaid improper payments, 82% were the result of insufficient documentation (CMS 2023). These payments typically involve situations where a state or provider missed an administrative step and do not necessarily indicate fraud or abuse.

- Under the Medicaid Eligibility Quality Control (MEQC) program, states evaluate Medicaid and CHIP eligibility determination processes in order to reduce erroneous spending. States conduct a series of pilot studies during which they review a set of eligibility decisions, and for decisions determined to be erroneous, states review paid claims to understand the financial effects of the error (CMS 2021). MEQC is intended to complement PERM by ensuring state operations make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals.
- State MFCUs investigate provider fraud of the Medicaid program and providers suspected of defrauding Medicaid, prosecute or refer to prosecutors those defrauding Medicaid, and to collect overpayments. In FY 2023, nationwide, MFCUs recovered $1.2 billion, including $272 million in criminal recoveries and $963 million in civil recoveries (OIG 2024).

Optional activities:

- Data mining can be conducted to identify possible fraud and abuse for further examination. Suspicious patterns and aberrations found in payment data can be used to audit specific providers. Although data mining as a strategy is not federally mandated, it is one approach states may apply in meeting the mandate that all state Medicaid programs conduct postpayment reviews.
- Unified program integrity contractors perform fraud, waste, and abuse detection, deterrence, and prevention activities under contract to CMS. CMS contracts with unified program integrity contractors in five regions. The contractors are required to coordinate with each state in their region to identify and investigate providers.
- Providers can audit themselves upon state request or because they have identified an issue that merits investigation, such as an inappropriately paid claims that do not involve fraud or abuse.
- The Public Assistance Reporting Information System (PARIS) matches data from certain public programs to find beneficiaries who receive benefits in more than one state, receive duplicate federal and state benefits, or may be eligible but not enrolled in other programs. PARIS helps to ensure appropriate enrollment and retention in public programs, which can reduce the opportunity for improper payments. All states must report data to PARIS but are not required to the use the results

- Lock-in programs assign certain beneficiaries to specific providers or pharmacies to prevent pharmacy or doctor shopping. These programs allow states to act when they identify patterns of service misuse by a beneficiary as well as when providers are billing inappropriately.
- States can use prior authorization to help control utilization and avoid unnecessary procedures. State procedures vary.
- States can take enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud.
- CMS provides technical assistance and education for state staff so they are able to prevent and identify fraud and abuse.
- Federal and state governments conduct outreach to and education of the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements) (MACPAC 2019).

MACPAC findings on program integrity and recommendations

Successful program integrity efforts depend on coordination among various state and federal agencies. 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).

MACPAC has examined program integrity since 2012, including making recommendations in 2012 and 2019. To conduct our work, we reviewed federal rules and requirements for Medicaid program integrity, reviewed publicly available reports, interviewed state and federal officials as well as other stakeholders, and engaged panels of experts during Commission meetings. Our analyses have focused on Medicaid PI approaches for preventing and detecting provider fraud and abuse and the roles of the federal and state entities with authority and responsibility for Medicaid PI. We followed up on our initial work with an in-depth examination of state, federal, and MCO PI activities to assess the scope of current efforts, and their perceived effectiveness. Over the years, key themes and findings have emerged that remain relevant today as do our recommendations.

Based on the evidence from MACPAC's analytic work, the Commission has recommended a range of policy changes to improve the effectiveness of PI activities. Today, I wanted to highlight three primary themes emerging from the work.

Coordination of PI efforts are important for mitigating duplication and administrative burden

Many federal and state agencies are involved in program integrity activities. Our work found that the agencies may conduct audits at the same time on the same or similar topics. Providers may be subject to multiple Medicaid audits over the course of a year. Many audits find unintentional provider errors when they submit claims. Providers have said that the complexity of the billing process and the length or the provider manual can lead to errors. Coordination of these activities can prevent duplication of government activities and lessen administrative burden on providers. Because program integrity initiatives have developed over time, there may be overlap and duplication of activities at times because newer initiatives sometimes repeat efforts already underway in existing programs. PI initiatives have not always been examined as a whole to evaluate which are duplicative, which could be improved, and which may place an unnecessary burden on states or providers (March 2012).

Successful coordination of PI activities between the agencies can be challenging because the agencies may have differing mandates and goals, which could lead to misaligned outcome measures. For example, a state Medicaid agency's priority may be to ensure service delivery for beneficiaries, a MFCU's priority may be to prosecute Medicaid fraud, and an auditor's priority may be to verify proper documentation that a service was provided. MACPAC also found that feedback loops that help to correct identified problems and prevent them from happening again may be absent or insufficient (March 2012).

To address the concerns described above, MACPAC recommends that the HHS Secretary ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the HHS Secretary should:

- Create feedback loops to simplify and streamline regulatory requirements;
- Determine which current federal program integrity activities are most effective; and

- Take steps to eliminate programs that are redundant, outdated, or not cost-effective (March 2012).

States face challenges in measuring program integrity activities

MACPAC analysis has found that states face challenges in assessing the effectiveness, such as the return on investment, of program integrity approaches and that states lack the information needed to identify efficient state PI activities (MACPAC 2019, 2012). States have little information on the relative value of their current PI activities to determine which are most effective in detecting and deterring fraud and abuse, and can result in misapplication of their limited resources. For example, many states face difficulty tracking and reporting the costs and returns from various PI activities. Even when states are able to measure cost avoidance achieved from PI activities, they sometimes use different measures making it difficult to make state comparisons.[3]

In addition, states use multiple PI activities, making it difficult to attribute costs or recoveries to particular interventions. In some cases, states may not invest resources to measure costs, avoidances, or recoveries of PI activities such as provider screening, electronic visit verification, and recovery audit contracts because the activities are federally required regardless of the investment required or return on investment. However, states have expressed interest in additional information on the policy design and implementation features that lead to success across the broad spectrum of PI approaches available (June 2019).[4]

In March 2012, the Commission recommended that to enhance the states' abilities to detect and deter fraud and abuse, 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 to provide additional distance learning opportunities and additional courses that address program integrity in managed care (March 2012).

It is important to note that CMS has taken a number of steps related to these recommendations (June 2013). These include for example ongoing technical assistance to states and developing a variety of training opportunities and materials. Nonetheless, these recommendations remain relevant because of persistent concerns related to program integrity, and there may be ongoing opportunities for further improvement and streamlining of PI activities.

In June 2019, MACPAC further recommended that the HHS Secretary should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states (June 2019).

In MACPAC's view, the federal government should take a lead role in developing and disseminating information on the effectiveness of Medicaid PI approaches. Specifically, as part of its statutory authority to protect the integrity of the Medicaid program, CMS should examine current state activities and establish pilot projects for new approaches to identify the policy design and implementation features that best help states reduce fraud, waste, and abuse, and provide specific information to states on PI activities that have high rates of return on investment.

MACPAC's second recommendation in June 2019 was that to provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a RAC program optional.

Under the RAC program, states must contract with auditors to conduct postpayment reviews of Medicaid claims to identify overpayments. These vendors are charged with finding and recovering overpayments and they are paid on a contingency basis, receiving as compensation a portion of their collections. The program requires minimal investment from the state, but the state does need to comply with the requirement of engaging a RAC. The RAC program was made mandatory for all state Medicaid programs in 2010. After some years of successful implementation, however, RAC recoveries declined by about 85 percent from 2013 to 2017, and states are now

having difficulty finding RACs willing to partner with them, forcing states to seek waivers. For many states, the RAC program has become an administrative burden due to the time and resources it takes to solicit a RAC vendor, manage procurements (many of which have failed), and prepare waiver applications and renewals.

State managed care PI requirements, oversight of MCO PI activities, and coordination between states and MCOs vary

In June 2017, the Commission published findings from our in-depth examination of state, federal, and MCO program integrity activities. We found that state emphasis on managed care program integrity varies widely. For example, some states use only federally required contractual provision and others created additional requirements. The number and type of state staff focused on managed care program integrity also varies considerably, with some states hiring no dedicated managed care program integrity staff and others hiring large teams focused solely on reviewing health plan reports and conducting on-site health plan audits. Finally, the level of review and validation of MCO reporting, particularly on the medical loss ratio (MLR) and performance reports, also varies widely. This variation stems in part from a lack of consistent federal guidance as well as limited opportunities for states to share best practices.

States identified the need for greater collaboration among the state program integrity unit and managed care program unit, MFCU, and MCOs. Program integrity experts reported that the most common sources of fraud, waste, and abuse were the same in managed care and fee for service (FFS): providers found to have engaged in suspect practices in one MCO were likely also doing so in other MCOs, other states, and in other federal programs such as Medicare.

Differences between the approaches taken by MCOs and states to ensure program integrity create challenges for oversight agencies. State Medicaid agencies and managed care plans both use similar claims-editing processes to screen for potentially improper claims and conduct retrospective reviews to examine claims for patterns of fraud. The differences between the approaches available to states and MCOs create two challenges for oversight agencies. First, recoveries are a significant focus of program integrity activities: by law, state and federal overpayments must be identified and returned to the government, and, for managed care, factored into the rate-

setting process. Second, while MCOs are concerned primarily with the integrity of their own providers, state and federal officials are concerned with providers that participate in any Medicaid MCO or FFS program. Without clear guidance regarding required referrals to state investigators, MCOs may terminate providers without notifying the state about suspected fraud, waste, or abuse.

States use different incentives to encourage MCOs to rigorously pursue program integrity, but there is no clear information favoring one approach over others.

Conclusion

CMS, state Medicaid programs, and other agencies are already engaged in numerous activities to address Medicaid PI, but more work can be done to support and improve them. MACPAC's recommendations call for greater coordination across agencies with PI responsibilities to foster programmatic efficiency and reduce burden, to support state efforts to quantify the effectiveness of activities, and to provide learning opportunities regarding ways to address PI. The Commission also recommends the HHS Secretary examine PI activities to identify design features that facilitate success in PI efforts. Finally, MACPAC recommends making the RAC program optional so that states can focus on implementing high-value activities.

In addition to the program integrity recommendations described in this testimony, MACPAC has been examining the need for additional data to gain a better line of sight into the Medicaid program. For example, the Commission recently recommended that Congress require comprehensive reporting of the sources of non-federal share to improve the transparency of Medicaid and CHIP financing.

Appendix A-1

TABLE A-1. Medicaid Program Integrity Areas of Focus and Continuum of Activities

Area of focus	Program integrity activities
Beneficiary enrollment	• Determine eligibility • Collect third-party liability (TPL) information and coordinate benefits • Verify reported information • Check the Public Assistance Reporting Information System to verify that beneficiaries are not receiving duplicate federal and state benefits • Conduct monitoring and auditing activities • Conduct Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) eligibility reviews
Provider enrollment	• Screen and enroll eligible providers, reenroll providers, and revalidate providers • Check exclusion lists and other verification databases in accordance with state and federal screening requirements • Ensure appropriate disclosures are reported by providers and fiscal agents • Implement moratoria on providers when federally approved or mandated • Report any adverse provider application actions to the U.S. Department of Health and Human Services Office of Inspector General
Service delivery	• Develop and document coverage, billing, and payment policies • Lock in certain beneficiaries to certain providers or pharmacies to prevent so-called pharmacy or doctor shopping • Develop program integrity provisions for managed care contracts • Verify receipt of service using electronic visit verification • Review prior authorization requests consistent with state policy • Review prospective drug utilization review requests

Area of focus	Program integrity activities
Payment	• Develop, implement, and evaluate prepayment edits and audits • Apply third-party liability information • Use predictive modeling and other advanced data analytics to flag potential errors • Suspend payments to providers based on credible allegations of fraud • Adjudicate final payments • Issue explanation of benefits statements • Submit claims for federal matching funds
Postpayment review	• Create and implement methods and criteria for identifying suspected fraud cases • Conduct preliminary or full investigation on referrals of fraud or abuse • Establish and maintain a timely beneficiary verification procedure • Refer suspected fraud to law enforcement and collaborate with fraud investigations • Coordinate with Medicaid Fraud Control Unit and assist with prosecutions • Participate in federal PERM fee-for-service and managed care reviews • Pursue third-party payments when available • Perform retrospective reviews of care • Conduct surveillance and utilization reviews • Audit payments or ask providers to conduct self-audits • Support federal Unified Program Integrity Contractor audits • Procure and support recovery audit contractors • Supply data for Medicare-Medicaid matches and process results

Area of focus	Program integrity activities
Reporting and follow-up	• Terminate fraudulent providers and contracts and report such actions to appropriate parties • Recoup overpayments from providers • Return federal share of overpayments • Calculate return on investment • Compile program integrity statistics • Calculate and report payment suspensions due to credible allegations of fraud • Participate in state program integrity reviews (focused and desk reviews) • Identify and implement corrective actions and sanctions • Oversee managed care organization program integrity contract compliance • Report the identification and collection of overpayments due to waste, fraud, and abuse • Report annually the use of payment suspensions based on credible allegations of fraud • Report administrative expenses associated with program integrity activities

Appendix A-2. MACPAC recommendations

March 2012

Given that Federal and state government agencies and providers are required by law to participate in various program integrity activities. There may be overlap and duplication of activities at times because newer initiatives sometimes repeat efforts already underway in existing programs. This recommendation would help address this problem by promoting administrative simplification— successful initiatives that should be expanded would be identified, while programs that are redundant, outdated, or not cost-effective would be eliminated.

1. In March 2012, MACPAC recommended that the Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:

- Create feedback loops to simplify and streamline regulatory requirements;
- Determine which current federal program integrity activities are most effective; and
- Take steps to eliminate programs that are redundant, outdated, or not cost-effective.

2. To enhance the states' abilities to detect and deter fraud and abuse, 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 to provide additional distance learning opportunities and additional courses that address program integrity in managed care.

June 2019

1. The Secretary of the U.S. Department of Health and Human Services should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success. The Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states.

2. To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1902(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.

Endnotes

[1] According to the CMS fiscal year (FY) 2022 Medicare and Medicaid Integrity Programs Report to Congress, the FY 2024-2028 Comprehensive Medicaid Integrity Plan is under development (CMS 2023).

[2] The Medicaid Integrity Institute (MII) provides training to state and territorial Medicaid employees with program integrity responsibilities. The MII provides virtual and in person training on a range of PI topics including for example, fraud investigations, data mining and analysis, provider enrollment, and managed care oversight (CMS 2024a)

[3] Cost avoidance is an important component of many PI approaches, such as TPL and EVV. It is also the primary result of provider screening and enrollment, PARIS, beneficiary lock-in programs, and prior authorization (MACPAC 2019).

[4] In 2018, the Commission collected information from states on how they measure performance and ROI from a number of PI approaches. We reviewed state and federal agency websites, annual reports, and oversight reports as well as relevant laws, regulations, and policies. We conducted interviews with CMS, subject matter experts, and officials in eight states: Florida, Illinois, Kentucky, New Mexico, Ohio, Utah, Virginia, and Wyoming. We also held a listening session with a number of states in the spring of 2018 to get additional insights on the challenges and successes associated with Medicaid PI (June 2019).

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