

STATEMENT OF

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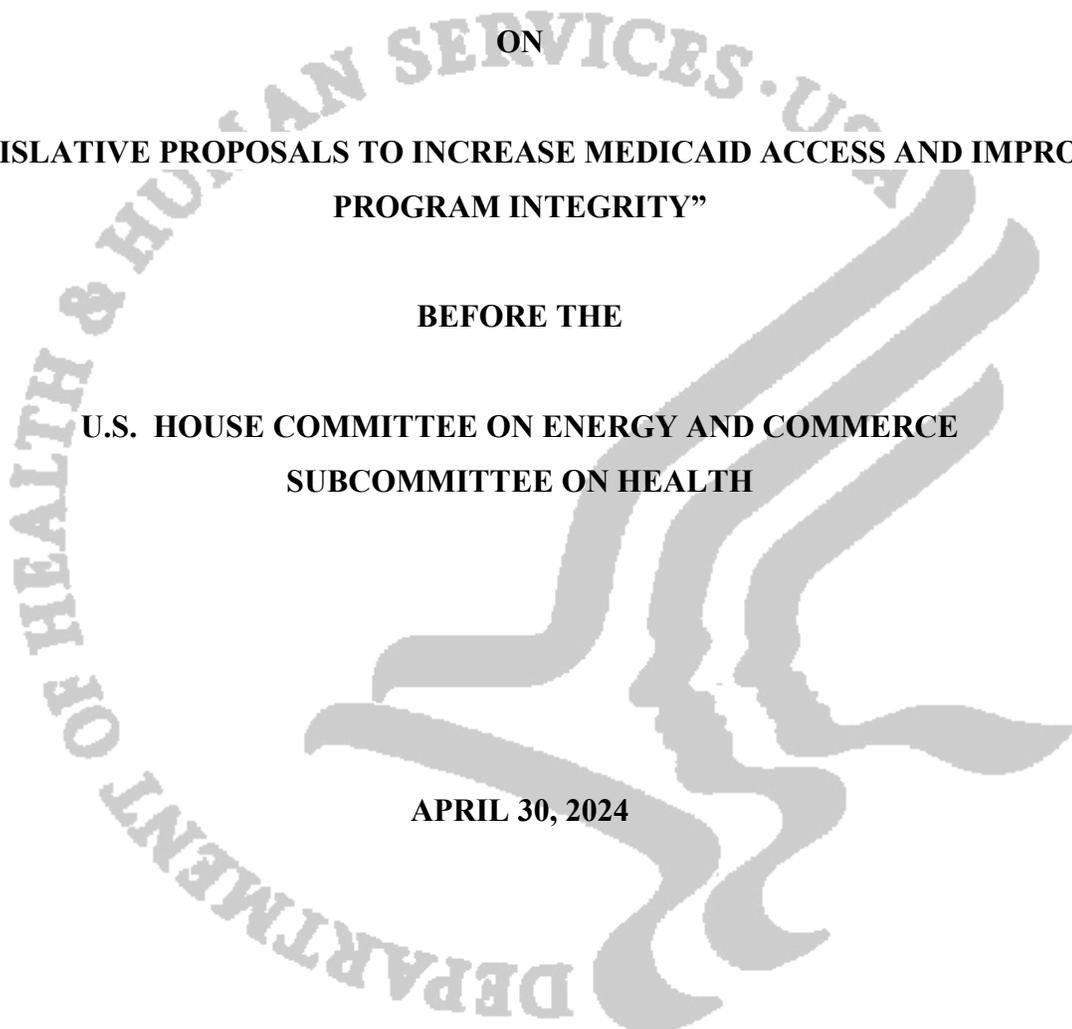
ON

**“LEGISLATIVE PROPOSALS TO INCREASE MEDICAID ACCESS AND IMPROVE
PROGRAM INTEGRITY”**

BEFORE THE

**U.S. HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH**

APRIL 30, 2024



**Statement of Daniel Tsai,
Deputy Administrator and Director of the Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
on
“Legislative Proposals to Increase Medicaid Access and Improve Program Integrity”
House Committee on Energy and Commerce
Subcommittee on Health
April 30, 2024**

Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and Members of the Subcommittee, thank you for the opportunity to discuss the Centers for Medicare & Medicaid Services’ (CMS’) work to administer, protect, and strengthen Medicaid. Medicaid is the largest source of health care coverage in the United States and provides access to critical health services to more than one in four Americans. As the largest payer of long-term services and supports (LTSS) in the nation, Medicaid plays a crucial role in helping millions of people with disabilities and older Americans access long term care, both home and community-based services (HCBS) as well as care in institutional settings, such as nursing homes.

This Administration is committed to focusing on key areas including Medicaid coverage and access, equity, and innovation and whole-person care, including for the millions of people who receive LTSS through Medicaid today. To that end, we have and will continue to protect and expand coverage for eligible people and strengthen access to care. Additionally, we are committed to the responsible stewardship of these programs in order to continue safeguarding the health and welfare of all enrollees today and in the future.¹ We are committed to executing this vision and continuing to build and support a stronger Medicaid program.

¹ Adapted from 2021 Health Affairs Blog: <https://www.healthaffairs.org/content/forefront/strategic-vision-medicaid-and-children-s-health-insurance-program-chip>

Medicaid is a Lifeline for Millions of Americans

Medicaid, with the Children's Health Insurance Program, provides access to comprehensive health services for about 85 million² children, pregnant women, adults, older Americans, and people with disabilities. To qualify for Medicaid coverage, individuals must meet certain categorical and financial eligibility standards. States have the flexibility to extend coverage to additional groups, including lower-income adults with incomes up to 138 percent of the federal poverty level through Medicaid expansion.

Medicaid is a state-federal partnership in which states administer their own Medicaid programs consistent with federal requirements. Medicaid is jointly funded by states and the federal government. The federal government pays states for a specified percentage of program medical expenditures, called the Federal Medical Assistance Percentage (FMAP), as well as a percentage of program administrative expenditures. States establish their own Medicaid provider payment rates within federal requirements, and generally pay for services through fee-for-service or managed care arrangements.³ Additionally, within federal guidelines, states determine the type, amount, duration, and scope of services they provide. Federal law requires states to provide certain mandatory benefits and allows states the choice of covering other optional benefits, such as home and community-based services (HCBS).⁴ States have significant flexibility to choose options that enable them to deliver high quality, cost-efficient care for their residents. Under this

² <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

³ <https://www.medicaid.gov/medicaid/financial-management/index.html>

⁴ <https://www.medicaid.gov/medicaid/benefits/index.html>

partnership, both the federal government and states play key roles as stewards of the program. CMS and states work closely together to carry out these responsibilities.⁵

Strengthening Access to Quality Long-Term Services and Supports through Medicaid

Millions of Americans, including children, adults, and seniors, need long-term care services because of disabling conditions and chronic illnesses, and Medicaid is the largest payer across the nation for LTSS. Medicaid allows for the coverage of these services through several vehicles and over a continuum of settings, ranging from institutional care to HCBS. CMS works in partnership with states, consumers and advocates, providers, and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services that assure optimal outcomes, such as independence, health, and quality of life.⁶ This includes working to support increased availability and provision of quality HCBS, which help older adults and individuals with disabilities live safely and independently in their homes and communities.

Improving Access to Quality Care

CMS is engaged in important efforts to improve access to quality LTSS for beneficiaries. In January 2014, CMS finalized the Home and Community-Based Services Settings Final Rule (“HCBS Settings Rule”), which set forth new requirements for several Medicaid authorities under which states may provide home and community-based LTSS. The regulations enhanced the quality of HCBS and provided additional protections to individuals that receive services under these Medicaid authorities. CMS has been working very closely with states and

⁵ 5.2.17 CMS Testimony on Medicaid PCS before the U.S. House Energy & Commerce Committee, Subcommittee on Oversight and Investigations

⁶ Medicaid.gov LTSS page: <https://www.medicaid.gov/medicaid/long-term-services-supports/index.html>

stakeholders since the issuance of the HCBS Settings Rule to ensure its successful and effective implementation. This rule provides the framework for ensuring that HCBS are truly person-centered, and the settings within which they are provided facilitate autonomy and independence.⁷

The HCBS Settings Rule requires that all home and community-based settings meet certain qualifications. This includes ensuring that each setting is integrated in and supports full access to the greater community; is selected by the individual from among setting options; ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint; optimizes autonomy and independence in making life choices; and facilitates choice regarding services and who provides them.⁸

States were required to come into full compliance with the HCBS Settings Rule by March 2023. To help states meet this deadline, in 2022, CMS shared an updated strategy for implementation of the HCBS Settings Rule, developed in partnership with the Administration for Community Living (ACL), that aligns the focus of federal support and state compliance activities with the realities of the direct care workforce crisis, exacerbated by the COVID-19 public health emergency. As we continue beyond the COVID-19 pandemic, CMS is committed to the implementation of the HCBS Settings Rule in a way that enhances the ability of states' HCBS systems to facilitate beneficiary autonomy and community participation.⁹

Additionally, in 2022, CMS released its first HCBS Quality Measure Set to promote consistent quality measurement within and across state Medicaid HCBS programs by providing a set of

⁷ HCBS Final Regulation Medicaid.gov page: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>

⁸ 1.10.14 Summary of Key Provisions HCBS Setting Rule Fact Sheet: <https://www.medicaid.gov/sites/default/files/2019-12/hcbs-setting-fact-sheet.pdf>

⁹ HCBS Final Regulation Medicaid.gov page: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>

nationally standardized measures that states may use in their quality assessment of their Medicaid HCBS programs. This voluntary measure set is intended to provide insight into the quality of HCBS programs and enable states to measure and improve health outcomes for people relying on LTSS in Medicaid. The release of this voluntary measure set was a critical step to promoting health equity among the millions of older adults and people with disabilities who rely on these services, and access to this data will create opportunities for CMS and states to have better comparative quality data on HCBS programs.¹⁰ While use of this measure set is voluntary at this time for Medicaid HCBS programs authorized under section 1915 of the Social Security Act, CMS has incorporated use of the measure set into the reporting requirements for grants under the Money Follows the Person (MFP) program and section 1115 demonstrations approved since 2022¹¹ that include HCBS. CMS recently issued the Ensuring Access to Medicaid Services final rule (“Access Rule”), which requires states to adopt and report on the HCBS Quality Measure Set for certain Medicaid HCBS programs beginning 4 years after the effective date of the Access Rule.¹²

The HCBS Quality Measure Set is comprised of measures that assess quality across a broad range of domains identified as measurement priorities for HCBS. In addition to claims-based measures and measures that require assessment or other beneficiary records, the HCBS quality measure set extensively leverages existing beneficiary surveys used by states to assess beneficiary experience of care, which is critical for improving the quality and outcomes of HCBS and ensuring that services are person-centered and support beneficiaries’ goals and

¹⁰ 7.21.22 HCBS Quality Measure Set Press Release: <https://www.cms.gov/newsroom/press-releases/cms-releases-first-ever-home-and-community-based-services-quality-measure-set>

¹¹ 4.11.24 CMCS Informational Bulletin: <https://www.medicaid.gov/media/175216>

¹² 7.21.22 State Medicaid Directors Letter on HCBS Quality Measure Set: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf>

preferences for care. The measure set also includes other nationally standardized and tested measures related to key areas, such as access, LTSS rebalancing, community integration, health and safety, and person-centered practices.¹³ CMS updated the measure set in April 2024 and expects to continue to update the set in the future in accordance with the policies and regulations finalized in the Access rule, including adding newly developed measures that address measure gaps, as the field of HCBS measure development advances.¹⁴

Strengthening Access and Continuity of Coverage

Ensuring that beneficiaries can access covered services is a critical function of the Medicaid program and a top priority of CMS. To that end, CMS has taken crucial steps to support continuous access to coverage, reduce administrative barriers for Medicaid beneficiaries, and improve access to providers for people seeking care.

Most recently, CMS finalized the Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes Final Rule (“Eligibility and Enrollment Rule”), which strengthens access to affordable, quality health coverage by simplifying the enrollment process and maintaining continuity of health coverage populations, including underserved populations like children, older individuals, and individuals who have a disability. This final rule will help reduce coverage disruptions, further streamlines Medicaid eligibility and enrollment processes, reduces the administrative burden on states and people applying to and enrolled in Medicaid, and increases enrollment and retention of eligible individuals. In doing so, this final rule will help millions of

¹³ 7.21.22 State Medicaid Directors Letter on HCBS Quality Measure Set: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf>

¹⁴ 4.11.24 CMCS Informational Bulletin: <https://www.medicaid.gov/media/175216>

eligible people with disabilities and elderly individuals access and maintain coverage for LTSS going forward.

For example, for individuals whose eligibility is based on being 65 or older, having blindness, or having a disability, the final rule requires states to: conduct eligibility renewals no more than once every 12 months (with limited exceptions); use prepopulated renewal forms; provide a minimum 90-day reconsideration period after procedural termination for failure to return information needed to redetermine eligibility; limit requests for information about a change in circumstances to information on the change; and accept renewals through multiple modalities, including online, phone, mail, and in-person. In addition, the rule includes changes to help expand access to services and supports in the community and reduce institutional bias by permitting deduction of constant and predictable non-institutional expenses, along with institutional expenses, when determining medically needy eligibility. Previously, states were only permitted to allow medically needy individuals to deduct from income their prospective institutional expenses, but not non-institutional expenses, to establish medically needy eligibility.

CMS has also recently taken steps to improve connections between beneficiaries and care providers. In December, CMS issued guidance¹⁵ to help states adopt tools to better connect direct support workers to individuals receiving HCBS. Specifically, this guidance highlighted how states can build and maintain worker registries, which are worker management platforms that make qualified health workers easier to find. Helping states build and maintain these registries can help more people to find and receive high-quality, affordable, and person-centered care in the setting of their choice, while also facilitating recruitment and retention of individuals who

¹⁵ https://www.medicaid.gov/sites/default/files/2023-12/cib12122023_0.pdf

provide HCBS.¹⁶ These tools are also important to supporting state oversight activities related to program integrity, monitoring access to and quality of care for beneficiaries who receive services, and maintaining a system for communication with workers.

Improving Transparency and Accountability

In addition to the efforts described above, CMS recently finalized the Access Rule and the Managed Care Access, Finance, and Quality Rule (“Managed Care Rule”), which together finalize major improvements to advance access to care, quality of care, and transparency and oversight of services, including HCBS.

For example, the Access Rule establishes a new strategy for oversight, monitoring, quality assurance, and quality improvement for HCBS programs; strengthens person-centered service planning and incident management systems in HCBS; and improves data collection regarding compensation to the direct care workforce. The rule also provides key insight into access challenges for HCBS by requiring states to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker, home health aide, and habilitation services; and a standardized set of HCBS quality measures.

Additionally, the Access Rule requires states to ensure that providers spend a specified percentage of total Medicaid payments (excluding certain costs) they receive for certain HCBS on compensation for direct care workers who furnish those HCBS, rather than administrative overhead or profit. Subject to certain requirements and exceptions, the Access Rule generally requires states ensure providers spend at least 80 percent of Medicaid payments they receive for personal care, homemaker, and home health aide services be spent on compensation for the

¹⁶ 12.12.23 Worker Registry Press Release: <https://www.cms.gov/newsroom/press-releases/cms-provides-critical-tools-help-improve-access-millions-who-receive-medicare-home-and-community>

direct care workers who furnish those services.¹⁷ Data shows that direct care workers typically earn low wages and receive limited benefits, contributing to a shortage of direct care workers and high rates of turnover in this workforce, which can limit access to and impact the quality of HCBS. By supporting and stabilizing the direct care workforce, this provision will result in better qualified employees, lower turnover, and a higher quality of care, improving access to quality care for Medicaid beneficiaries.¹⁸ These policies support CMS’s efforts to ensure appropriate oversight of states’ HCBS systems as required by federal law, as well bolster our role as good stewards of Medicaid dollars.¹⁹ We greatly appreciate the support and engagement received during the comment period from stakeholders across the health care sector. We relied on this feedback to inform our final decisions on policies that ensure we strike the right balance of ensuring payments go to workers, while not disincentivizing training opportunities, and ensuring states have time to collect data and implement the policies effectively.

The Managed Care Rule includes important provisions that promote transparency and accountability within managed care, including with respect to payment rates for services. For example, the rule requires states to submit an annual payment analysis that compares managed care plans’ payment rates for certain services as a proportion of Medicare’s payment rate and, for certain HCBS, the state’s Medicaid state plan payment rate.

¹⁷ 4.27.23 Access Proposed Rule Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking>

¹⁸ Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI <http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf>

¹⁹ MACPAC Issue Brief. State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages. March 2022. <https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf>

Fostering State Innovation in HCBS

Thanks to the American Rescue Plan Act of 2021, qualifying states were provided with a temporary 10 percentage point increase to the FMAP for certain Medicaid HCBS expenditures. This increased funding represented a rare opportunity for states to identify and implement changes aimed at addressing HCBS structural issues, expand the capacity of critical services, and begin to meet the needs of people on HCBS waitlists and family caregivers.²⁰ States are taking action to recruit and retain direct care workers, including offering sign-up or incentive payments and increased rates, creating worker registries, and providing portals to help providers better manage the workforce. States are also providing training for workers, family caregivers and provider agencies; establishing online training, and offering certification programs and tuition supports. This funding is also allowing states to eliminate or reduce HCBS 1915(c) waiver waiting lists by opening additional waiver slots, providing supports for those on the waiting list, or informing individuals of other available services while on the waiting list, and make technological enhancements for providers, individuals and families to use electronic health records and assistive technologies to promote independence and improve daily living.²¹ CMS expects states to spend nearly \$37 billion on activities to enhance, expand and strengthen HCBS through March 31, 2025. CMS is committed to working with states as they put those funds towards over 1,200 innovative and exciting proposals in their spending plans to strengthen HCBS.²²

²⁰ ARP Sec. 9817 Medicaid.gov pg: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance-additional-resources/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html#:~:text=Sectio>

²¹ Overview of State Spending: https://www.medicaid.gov/sites/default/files/2023-12/arp-sec9817-overview-infographic_0.pdf

²² ARP Sec. 9817 Medicaid.gov pg: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance-additional-resources/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html#:~:text=Sectio>

Other innovative proposals from states include implementing new behavioral health crisis response services and developing deed-restricted accessible and affordable housing units for people with disabilities. CMS strongly supports states using the funds to implement structural changes to expand HCBS eligibility, offer a broader range of community-based services, and address social determinants of health and improve equity for older adults and people with disabilities.²³

The President’s FY2025 budget furthers the investments made in the American Rescue Plan Act of 2021, proposing a transformative \$150 billion investment in Medicaid HCBS. This investment would enable seniors and people with disabilities to remain in their homes and stay active in their communities, while also promoting better quality jobs for home care workers and enhancing supports for family caregivers.²⁴

Care in Nursing Homes and Institutional Settings

Approximately 1.5 million people receive Medicaid-funded long-term services and supports in nursing homes and intermediate care facilities for individuals with intellectual disabilities each year. Chronic understaffing and high rates of worker turnover in nursing facilities and intermediate care facilities for individuals with intellectual disabilities remains a persistent concern, undermining access to high-quality care for older adults and people with disabilities.²⁵

The Medicaid Institutional Payment Transparency Reporting provisions finalized in the Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities

²³ ARP Sec. 9817 Medicaid.gov pg: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance-additional-resources/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/>

²⁴ FY2025 Budget in Brief: [fy-2025-budget-in-brief.pdf \(hhs.gov\)](https://www.hhs.gov/budget/fy-2025-budget-in-brief.pdf)

²⁵ 4.22.24 Minimum Staffing Final Rule Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid>

and Medicaid Institutional Payment Transparency Reporting Final Rule (“Nursing Home Staffing Rule”) are designed to promote public transparency related to the percentage of Medicaid payments for services in nursing facilities and intermediate care facilities for individuals with intellectual disabilities that are spent on compensation to direct care workers and support staff in institutional settings. These provisions are consistent with the Access Rule, which requires that states report to CMS and publicly on the percentage of Medicaid payments for certain HCBS that are spent on compensation for direct care workers. Taken together these requirements will provide a comprehensive look at Medicaid spending on the workforce across institutional and community-based settings. CMS is taking steps to improve access to quality care in these settings and to promote transparency. The Minimum Staffing Standards for LTC Facilities final rule establish comprehensive nurse staffing requirements to hold nursing homes accountable for providing safe and high-quality care for residents receiving care in Medicare and Medicaid-certified LTC facilities each day.²⁶ Furthermore, the budget will build on these standards by proposing an \$85 million increase in survey and certification funding, investing in nursing home quality and safety oversight.²⁷

In 2022, CMS issued an Informational Bulletin describing nursing home facility payment approaches that states can implement using existing Medicaid authority to advance health equity and improve health outcomes. CMS encouraged states to assess their approach to payments to long-term care providers and utilize flexibilities in establishing Medicaid base and supplemental payments, as appropriate, to provide adequate, performance-driven nursing facility rates to ultimately achieve better health care outcomes and address longstanding inequities for Medicaid

²⁶ Minimum Staffing Proposed Rule Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid>

²⁷ FY2025 Budget in Brief: [fy-2025-budget-in-brief.pdf](https://www.hhs.gov/budget/fy-2025-budget-in-brief.pdf) (hhs.gov)

beneficiaries residing in nursing facilities. The guidance describes a number of initiatives states can implement through the Medicaid state plan, waiver, or demonstration process. Through initiatives like these, CMS expects that Medicaid beneficiaries residing in nursing facilities will receive better care through the collaboration of CMS and states to realize the goals outlined in the Biden-Harris Administration’s Nursing Home Reform Action Plan. In addition, on behalf of those Medicaid beneficiaries who receive and will continue to require care through nursing facilities and other institutional long-term care settings, CMS encourages states to use the tools available through Medicaid to improve safety, accountability, quality, and overall resident experience in alignment with the measures established by CMS, such as the Nursing Home Five-Star Quality Rating System.²⁸

Enhancing Medicaid Program Integrity

As part of our ongoing work to support states and strengthen the Medicaid program, CMS is committed to being a responsible steward of public funds and to promoting the sustainability of these programs for future generations. We continuously strive to reduce improper payments in all programs, including Medicaid.

Accountability and Transparency in Managed Care

The Managed Care Rule includes important provisions to strengthen transparency and oversight in Medicaid managed care. Managed care is the predominant delivery system in Medicaid, with 85 percent of all beneficiaries receiving some or all of their care through a managed care plan in 2021. To help build stronger programs, the final rule strengthens standards for timely access to

²⁸ Adapted from CMCS Informational Bulletin: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib08222022.pdf>

care and states' monitoring and enforcement efforts; enhances quality as well as fiscal and program integrity standards for state directed payments (SDPs); specifies medical loss ratio requirements; and establishes a quality rating system for Medicaid managed care plans.²⁹

Improper Payments

Estimating an annual improper payment rate is also an important part of CMS's efforts to help states track, detect, and prevent improper payments within their Medicaid program. Improper payments are payments that do not meet CMS program requirements such as documentation, and are not necessarily payments for services that should not have been provided. While CMS' improper payments reporting programs are designed to protect the integrity of CMS programs, not all improper payments are the result of fraud or abuse. Improper payments can include overpayments or underpayments, or payments where insufficient information was provided. Most improper payments result from a situation where a state or provider missed an administrative step, including insufficient or missing documentation; as such, improper payment estimates are not fraud rate estimates.³⁰

CMS estimates Medicaid improper payments using the Payment Error Rate Measurement (PERM) program. The PERM program uses a three-year, 17-state rotation, meaning each state is reviewed once every three years, and each cycle measurement includes one-third of all states. The most recent three cycles are combined to form each year's overall national rate. The PERM

²⁹ Adapted from Managed Care Rule Fact Sheet:

³⁰ 11.15.23 Improper Payments Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2023-improper-payments-fact-sheet>

program combines individual state component estimates to calculate the national component estimates, which are weighted by state size.³¹

The PERM rate, along with the data collected for its calculation, allows states to analyze the findings to determine the root causes of improper payments, and work with CMS to develop and implement effective corrective actions to safeguard taxpayer dollars.³²

Improved Data Collection

Updating outdated recordkeeping regulations for state Medicaid agencies is critical to enabling appropriate oversight and identifying errors in state policies and operations, since insufficient documentation is a leading cause of eligibility-related improper payments identified through the PERM program and other audits. The Eligibility and Enrollment Final Rule will enhance the integrity of Medicaid by clearly defining the types of eligibility determination information and documentation that should be maintained; requiring retention of Medicaid records and case documentation for at least three years in most cases; removing references to outdated technology and requiring storage of records in electronic format; and establishing minimum standards for states to complete a timely determination of beneficiary eligibility at renewal and following a change in circumstances. The recordkeeping regulations addressed in this final rule were last updated in 1986, resulting in inconsistent practices across states and contributing to improper payments. This modernization effort will improve efficiency and program integrity within Medicaid.

³¹ 11.15.23 Improper Payments Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2023-improper-payments-fact-sheet>

³² CMS Oversight Letter to Rep. Comer and Rep. Johnson

CMS also administers the Transformed Medicaid Statistical Information System (T-MSIS), a state data application and reporting tool that encompasses a collection of beneficiary eligibility and enrollment data, managed care and fee-for-service claims encounter data, and provider data produced in the daily operation of the Medicaid program. This national dataset is integral for program monitoring and oversight and is necessary for auditing and investigations.

T-MSIS provides tools to monitor the quality of state data submissions against priority reporting areas, in addition to expanded data quality checks, allowing CMS to review data for policy making and for program integrity purposes. Funding supports operations, efforts to continue data quality improvement, cloud computing resources to handle ongoing operations of files and the needs of a growing data user base, and a pilot to improve data submission and interoperability with states.³³

CMS collaborates with states in a number of ways to share information and help ensure they maintain the proper documentation to demonstrate that payments are being made correctly. Examples include the Medicaid Eligibility Quality Control (MEQC) Program and the Medicaid Integrity Institute (MII). Under MEQC, states evaluate the Medicaid eligibility determination process and review eligibility denials and terminations. Additionally, through MII, CMS offers training, technical assistance and support to state Medicaid program integrity officials.³⁴ CMS also provides states with analytic and investigative support and assistance to identify and investigate potential fraud waste and abuse in the Medicaid program including HCBS.

³³ FY 24 CJ p. 137

³⁴ 11.15.23 Improper Payments Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2023-improper-payments-fact-sheet>

Conclusion

About 85 million³⁵ people receive health coverage through Medicaid and CHIP. While these programs have done immeasurable good for hardworking families across our country, there is still more to do to continue to support and strengthen these programs. We are committed to continuing to build and support a stronger Medicaid program by serving the public as a trusted partner and steward, advancing health equity, expanding coverage, and improving health outcomes.³⁶ We look forward to continuing to work with Congress on advancing our mission, including by strengthening the Medicaid program and the critical long-term care services it provides. Thank you again for the opportunity to testify.

³⁵ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

³⁶ Adapted from 2021 Health Affairs Blog: <https://www.healthaffairs.org/content/forefront/strategic-vision-medicaid-and-children-s-health-insurance-program-chip>