

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Supra</i>	DATE <i>7-10-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000009</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Mr. Keck, Kost, Chavis, Depo, CMS file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services



SMD# 13-003

**RE: Federal and State Oversight of Medicaid
Expenditures**

March 18, 2013

Dear State Medicaid Director:

This letter discusses mutual obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars.

States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. CMS provides states with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, federal match for their expenditures, and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual programs, including setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. States have considerable discretion in the manner in which they operate their programs, but should always employ that flexibility in ways that enhance care, promote overall program effectiveness and efficiency and safeguard dollars expended, whether originating from federal or state sources. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers.

This federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. To this end, CMS and the National Association of Medicaid Directors (NAMD) are launching an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. The agenda and activities for the workgroup will be developed through mutual contributions from both federal and state partners, and will include work on areas of improvement previously suggested by NAMD to CMS, including better access to Medicare provider enrollment information, use of Medicare data for program integrity purposes, and additional work building on collaborative audit approaches, as well as topics generated by federal reviews, audits and reports. CMS is already planning for expanded access to and training for states on the Fraud Investigation Database, and we will consult with the workgroup on how to best accomplish that.

We anticipate that we will involve other interested stakeholders in these consultations over time. We hope that these conversations will help us identify innovations and opportunities for improved safeguards in areas of common concern; tools, resources, and training or technical assistance available or needed; and agreement on roles and cooperation needed between state and federal partners.

In addition, CMS intends to establish a regular, periodic process by which we work with each state partner to review state expenditures, claims information, federal or state audit results, and other program information, to identify and discuss overall performance; potential inefficiencies, aberrancies, or challenges which merit attention or corrective action by the partners, and best practices that can be utilized by other states. We will use these discussions to update status and reporting on recoveries and collections. We intend to work with the NAMD executive group to formulate a common data set and approach to these conversations, which will likely include both state and federal reporting of utilization and payment/expenditure reviews. We see this disciplined, standardized, data-driven focus on financial management and program integrity as an opportunity to test assumptions and interpretations, prioritize issues for further investigation, review progress, and measure impact, outside of normal day to day business transactions.

CMS will work with states to develop richer and more frequent data analysis tools to better identify potential anomalies and issues of interest, building on CMS, state, and private sector experience in managing and using large healthcare data sets. Over the past year, CMS has been developing a new data reporting framework called Transformed Medicaid Statistical Information System, or T-MSIS, preparation for which will begin to roll out across states this year. T-MSIS will contain a more granular, timely and relevant data set of transaction and reference data from states than has ever been collected before at the federal level. A key use for these data is to equip states and the federal government with better information with which to manage the program and monitor integrity. Additionally, we are also developing a new system called MACPRO, which will allow for the electronic submission and review of state plan amendments and waivers. MACPRO will offer a way to view and compare features of each state's program, providing a critical contextual framework for the analysis of the beneficiary, provider, and payment information in T-MSIS. The structured data submission required for MACPRO will also allow for better exposure and review of SPA content relevant to program oversight, program integrity, and program management.

Starting in 2013, we will require states to submit upper payment limit (UPL) demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Specifically, beginning in 2013, we will require that states submit UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014 and annually thereafter, states will be required to submit annual UPL demonstrations for the services listed above and clinics, physician services (for states that reimburse targeted physician supplemental payments), intermediate care facilities for the developmentally disabled (ICF/DD), private residential treatment facilities and institutes for mental disease (IMDs). This information must be submitted by the state prior to the start of the state fiscal year. For most states, this means that a state submits, for CMS review, these UPL demonstrations by June 30th of each year.

For states with a fiscal year other than July 1st, their demonstrations would be submitted by the last day prior to the beginning of the state's fiscal year. These annual demonstrations will include provider specific reporting on all payments made to the providers, including supplemental payments. The annual demonstrations may also be used by states to support ongoing compliance with the UPL as Medicaid payment changes are made throughout the year through the SPA process. States will need to appropriately update the annual demonstrations to reflect changes in Medicaid payment levels affected by the SPA submissions.

Through this process, states will also be asked as part of the submission to identify the source of non-federal funding for the payments described in the UPL. This is consistent with overall requirements to identify sources of non-federal funding set forth in section 1903(d)(1) of the Social Security Act. Such information will allow CMS and the state to have a better understanding of the variables surrounding rate levels, supplemental payments and total providers participating in the programs and the funding supporting each of the payments described in the UPL demonstration. Guidance concerning the format and method of UPL demonstration is being posted on Medicaid.gov alongside the release of this letter.

We will continue to refine and formulate improvements to ensure the highest level of stewardship for the Medicaid program in both the federal and state governments, and know that our state partners are equally committed to this goal. We expect that our further consultations with states will lead to additional letters on this topic this year.

Sincerely,



Cindy Mann
Director

cc:

CMS Regional Administrators

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Division of Medicaid and Children's Health Operations

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