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

RE: Federal and State Oversight of Medicaid Expenditures

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 for states 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. 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 contributions 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 potential inefficiencies, aberrancies, or challenges which merit attention or corrective action by the partners. 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. Over the past year, CMS has been developing a new data reporting framework called Transformed Medicaid Statistical Information System, or TMSIS, preparation for which will begin to roll out across statesthis year. TMSIS 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 TMSIS. 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 annual 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, in 2013, we will require that states submit UPL demonstrations for inpatient hospital services, outpatient hospital services, nursing facilities. In 2014, state 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 state prior to the start of the state fiscal year. For most states, this means that a state submit, 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.

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. More guidance concerning the format and method of UPL demonstration will be forthcoming.

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 next year.

Sincerely,

Cindy Mann
Director

cc:

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