DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.775 STATE MEDICAID FRAUD CONTROL UNITS

ASSISTANCE LISTING 93.777 STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS (Title XVIII) MEDICARE

ASSISTANCE LISTING 93.778 MEDICAL ASSISTANCE PROGRAM (Medicaid; Title XIX)

I. PROGRAM OBJECTIVES

Note: This program is considered a "higher risk" program for 2021, pursuant to 2 CFR section 200.519(c)(2). Refer to the "Programs with Higher Risk Designation" section of Part 8, Appendix IV, Internal Reference Tables, for a discussion of the impact of the "higher risk" designation on the major program determination process.

Medical Assistance Program

The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act, 42 USC 1396 et seq. Under the program, the federal government provides matching funds to states to enable them to provide medical assistance to residents who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services. Medicaid serves as the nation's primary source of health coverage for low-income populations.

States are not required to participate. Those that do must comply with federal Medicaid laws under which each participating state administers its own Medicaid program, establishes eligibility standards, determines the scope and types of services it will cover, and sets the rate of payment. Eligibility requirements vary from state to state, and because someone qualifies for Medicaid in one state, it does not mean he or she will qualify in another. The federal Centers for Medicare & Medicaid Services (CMS) monitors the state-run Medicaid programs and establishes requirements for service delivery, quality, funding, and eligibility standards.

Medicaid Fraud Control Units (MFCUs)

Under section 1902(a)(61) of the Social Security Act, states are required as part of their Medicaid state plans to maintain a MFCU, unless the secretary of HHS waives the requirement after making the determination that a MFCU would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the state plan and that beneficiaries under the plan would be protected from abuse and neglect in connection with the provision of medical assistance under the plan without a MFCU. The primary mission of the MFCUs is to investigate and prosecute fraud by Medicaid providers, to review and investigate complaints alleging abuse or neglect of patients in Medicaid-funded health care facilities, and, as an optional authority, to review and investigate complaints of patient abuse or neglect in board and care facilities or involving Medicaid beneficiaries in

noninstitutional and other settings. States are required to refer to the MFCU all cases of suspected provider fraud.

State Survey and Certification of Health Care Providers and Suppliers

The objective of the State Survey and Certification of Health Care Providers and Suppliers program is to determine whether the providers and suppliers of health care services under the Medicare program are in compliance with regulatory health and safety standards and conditions of participation/coverage. For certain types of providers, compliance with these health and safety standards are also required as a condition of Medicaid participation, and the Medicaid program contributes to program costs accordingly.

II. PROGRAM PROCEDURES

A. Overview

The following paragraphs are intended to provide a high-level, overall description of how Medicaid generally operates. It is not practical to provide a complete description of program procedures because Medicaid operates under both federal and state laws and regulations and states are afforded flexibility in program administration. Accordingly, the following paragraphs are not intended to be used in lieu of or as a substitute for the federal and state laws and regulations applicable to this program.

Administration

The Medicaid program is jointly financed by the federal and state governments and administered by the states. For purposes of this program, the term "state" includes the 50 states, the District of Columbia, and five United States territories: the US Virgin Islands, Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. Medicaid operates through state Medicaid agencies, with states paying providers of medical services directly or through the use of managed care plans. Participating providers must accept the Medicaid payment amount as payment in full. Federal law and regulation set forth mandatory and optional eligibility groups and services. States are required to cover mandatory eligibility groups and services and may elect to cover optional groups and services. Within these broad federal rules, each state decides eligible beneficiary groups, types and range of services, payment levels for services, and administrative and operating procedures. CMS administers the Medicaid program in cooperation with state governments. CMS oversees state operations through its organization consisting of a headquarters and field offices. CMS uses technical assistance extensively to promote improvements in state operation of the program, and compliance with federal rules, as well as enforcement mechanisms as the agency deems appropriate. The HHS Office of Inspector General (OIG) is the agency responsible for the federal oversight of the state MFCUs. As stated in 42 CFR 1007.5, a key requirement of the governing regulations is that a unit must be a single identifiable entity of state government. In order to receive the federal grant funds necessary to sustain their operations, the units must submit a reapplication for federal assistance to the OIG on an annual basis.

The State Survey and Certification of Health Care Providers and Suppliers program is administered by CMS in a manner similar to Medicaid and includes an approved state plan that addresses federal requirements.

Medicaid State Plans

States administer the Medicaid program under a CMS-approved state plan for each state. The Medicaid state plan is a comprehensive written statement submitted by the State Medicaid Agency (SMA) describing the nature and scope of its Medicaid program. A state plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of each particular state's program. The state plan references the applicable federal regulation and statute for each requirement.

The state plan contains all information necessary for CMS to determine whether the state plan can be approved to serve as a basis for determining the availability of federal financial participation. The state plan must specify a single state agency (hereinafter referred to as the "State Medicaid Agency – SMA") established or designated to administer or supervise the administration of the state plan. The state plan must also include a certification by the state attorney general that cites the legal authority for the SMA to administer or supervise the administration of the state plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

The state plan also describes methodologies to pay providers for covered care and services under the Medicaid program. The payment methodologies must be clear and auditable to ensure that payments are disbursed only to qualified providers, in the appropriate amount, for medically necessary services covered by the Medicaid program and provided to eligible beneficiaries under a fee-for-service arrangement. Payments must also be based on claims that are adequately supported by medical records, and payments must not be duplicated.

At any time, a state may propose changes to the state plan through a state plan amendment (SPA). A state submits a SPA to CMS when a state proposes to modify its state plan to make changes to its Medicaid program design, policies, or operational approach. States must submit SPAs to CMS to reflect changes in federal and state law, regulation, policy, or court decisions. Federal and state governments use the SPA process to negotiate and agree on the terms of the amendment. The SPA submission is reviewed by CMS to determine whether the proposal meets federal requirements. If more information is required to determine whether the proposal can be approved, CMS sends the state a request for additional information (RAI) within 90 days after receipt of the SPA. States have 90 days from the issuance of the RAI to provide a response to CMS. If the state does not respond within this 90-day period, CMS may choose to disapprove the SPA. Once the state submits the requested information, a new 90-day review clock begins

and CMS must decide to approve or disapprove the SPA. While CMS maintains state submission records, copies of approved SPAs are available on CMS' Medicaid.gov website https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html or can be obtained from the SMA. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html.

In accordance with an approved state plan or approved waiver (see the Waivers and Demonstrations section below), CMS makes quarterly grant awards to the state to cover the federal share of Medicaid expenditures for services and program administration. The grant award authorizes the state to draw federal funds as needed to pay the federal portion, as determined through the application of the Federal Medical Assistance Percentage (FMAP) or other applicable federal matching rate set by statute, of approved Medicaid expenditures. The amount of the quarterly grant is initially determined on the basis of quarterly budget estimates submitted by the SMA on the Form CMS-37. Thirty days after the end of the quarter, states must submit the Form CMS-64, which includes expenditures and recoveries and other items that reduce expenditures for the quarter and prior period expenditures. Quarterly, CMS reviews the state's expenditures for accuracy and allowability, then CMS issues a finalization grant reconciling the initial grant award determined on the basis of budget estimates to the actual expenditures reported on the Form CMS-64. The amounts reported on the Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. States use the Medicaid Budget and Expenditure System (MBES) to electronically submit the Form CMS-37 and Form CMS-64 directly to CMS.

Waivers and Demonstrations

The SMA may apply for a waiver of federal requirements, subject to CMS approval. The most common modes to waive federal requirements are under the authority of section 1115 called demonstrations and waivers under section 1915 of the Social Security Act (the Act). Additionally, section 1115(a) demonstrations authority permits states to request federal financial participation for costs that would not otherwise be included as expenditures under section 1903 of the Act, and to request waiver authority of requirements under section 1902(a) of the Act.

Section 1115(a) demonstrations and section 1915 waivers are intended to provide the flexibility needed to enable states to test new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs or groups of beneficiaries. Demonstrations and waivers are not interchangeable, however, they both allow exceptions to state plan requirements and permit a state to implement innovative programs or activities on a time-limited basis, subject to specific safeguards for the protection of beneficiaries and the program, and provided that there is an evaluation of the program.

Actions that states may take if waivers of section 1915 of the Act are obtained include, but are not limited to: (1) implementing a primary care case-management system or a specialty physician system; (2) designating an entity to act as a central broker in assisting Medicaid beneficiaries to choose among competing health care plans; (3) limiting beneficiaries' choice of providers to providers that fully meet reimbursement, quality, and utilization standards, which are established under the state plan and are consistent with access, quality, and efficient and economical furnishing of care; and (4) including as medical assistance, under its state plan, home and community-based services (HCBS) furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital, nursing facility or other institutional settings, and is reimbursable under the state plan. A state may also obtain a waiver of statutory requirements to provide an array of HCBS, which may permit an individual to avoid institutionalization (42 CFR Part 441, Subpart G). Depending on the type of requirement being waived, a waiver may be effective for initial periods ranging from two to five years, with varying renewal periods. Copies of approved SPAs are available on CMS' Medicaid.gov website https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html. The section 1115 demonstrations main page is located at https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html. Lists of states' 1115 demonstrations can be found at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

Actions that states may take within the confines of a section 1115 demonstration include, but are not limited to: (1) sharing with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries' use of more cost effective medical care; (2) enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and (3) advancing innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

Beneficiary Eligibility

Beneficiary eligibility for Medicaid is generally based on financial (e.g., income and resources, as applicable) and nonfinancial (e.g., age, pregnancy, disability, and citizenship/immigration status, as applicable) criteria. Income eligibility is most often expressed in terms of a percent of the Federal Poverty Level (FPL), which is defined and updated by the HHS on an annual basis. Resources may include things like savings, non-home property, stocks, and other non-cash assets.

States must cover mandatory eligibility groups. States may provide coverage to members of optional groups and medically needy individuals (i.e., individuals who are eligible for Medicaid after deducting medical expenditures from their income). The eligibility groups covered in a state and the eligibility criteria are specified in the state plan. The state plan will also describe the income methodology used for determining eligibility.

States must provide payment for Medicare premiums and cost-sharing for certain older adults and people with disabilities who are entitled to Medicare Part A, and whose income and resources do not exceed specified standards (Section1902(a)(10)(E)) of the Social Security Act (42 USC1396a(a)(10)(E)). There are four mandatory eligibility groups, collectively called the Medicare savings program eligibility groups, each of which has its own eligibility requirements and coverage limitations. Depending on the group, the medical assistance available ranges from payment of all Medicare premiums and cost sharing expenses to payment of only the Medicare Part A or Part B premiums.

The state plan will specify if determinations of eligibility are made by agencies other than the SMA and will define the relationships and respective responsibilities of the SMA and the other agencies. States must allow individuals and families to apply online, by telephone, via mail, or in person and must require that all initial applications be signed under penalty of perjury. Electronic signatures, including those that are telephonically recorded, and handwritten signatures transmitted via any other electronic method, must be accepted. The state agency must have facts in the case record to support the agency's eligibility determination, including a record of citizenship or immigration status verification for each individual. The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for denial or terminating assistance (42 CFR sections 431.17, 431.210, 431.211, 435.907, 435.914, 435.917, 435.918; 42 USC 1320b-7).

Services

Medicaid expenditures include payments for services rendered to eligible beneficiaries, such as hospitalizations, prescription drugs, nursing home stays, outpatient hospital care, and physicians' services. A listing of mandatory and optional Medicaid services can be found at https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html. For a Medicaid payment to be considered valid, it must comply with the requirements of Title XIX, as amended (42 USC 1396 et seq.), and implementing federal regulations. Determinations of payment validity are made by individual states in accordance with approved state plans under broad federal guidelines.

Some states have managed care arrangements under which the state enters into a contract with a managed care plan, such as an insurance company, to arrange for or provide medical services to be available for beneficiaries. The state pays a risk-based periodic fixed rate per person (capitation payment) to the managed care plan for each beneficiary enrolled in that plan; the capitation payment is paid without regard to the actual medical services utilized by each beneficiary for the time period covered by the payment. There are three types of managed care plans that can be paid capitation rates: managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (see 42 CFR section 438.2). Managed care plans are required to provide covered services in accordance with the managed care plan's contract with the state and pursuant to federal regulations at 42 CFR Part 438.

Medicaid expenditures also include administration and training, the State Survey and Certification Program, and the establishment and operation of state Medicaid Fraud Control Units.

Addendum for the Public Health Emergency (PHE)

Medicaid and the Children's Health Insurance Program (CHIP) play a critical role in helping states and territories respond to public health emergencies (PHEs) and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the PHE for COVID-19, state Medicaid and CHIP agencies adopted many flexibilities to respond effectively to local outbreaks, including changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers' access by adjusting enrollment and screening processes. In addition, states made program changes to comply with the requirements of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136). Section 6008 of the FFCRA provides states with a temporary 6.2 percentage increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Act for certain Medicaid expenditures if states meet certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

CMS provided for program flexibilities and federal matching funds for certain services that should be considered when planning single audits, as described below In some instances, certain compliance requirements may not be relevant during this review period in light of the flexibilities offered to states. The flexibilities are unique to individual states and follow the typical documentation process, including CMS approval of state plans and waivers, in accordance with regulations and guidance.

It is important for auditors to be aware of the requirements and flexibilities implemented by the state Medicaid or CHIP agency in response to the PHE for COVID-19 so that a state is not determined to be out of compliance with requirements that would have been in place absent the PHE. In addition, to be eligible to receive the increased federal matching percentage (FMAP) funding, states were required to maintain the enrollment of all Medicaid beneficiaries who were enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, with certain exceptions. This requirement, described at section 6008(b)(3) of the FFCRA, is often referred to as the continuous enrollment requirement. The continuous enrollment requirement does not impact a state's obligation to continue to conduct renewals of eligibility and to act on changes in beneficiary circumstances, but it does prohibit a state from disenrolling a beneficiary who is determined ineligible, except under certain circumstances.

Initial CMS guidance on section 6008(b)(3) of the FFCRA prohibited states both from disenrolling a beneficiary and from making any changes to the benefits available to a beneficiary or to a beneficiary's required cost sharing or, in the case of institutionalized beneficiaries, to their financial responsibility for the cost of care under the post-eligibility treatment of income (PETI) rules. If a beneficiary became ineligible for one group and

eligible for another group with greater financial responsibility or lesser benefits, the state was required to maintain the beneficiary's coverage in the original eligibility group. Likewise, if a beneficiary reached age 21, and would no longer be eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the state was required to continue to provide EPSDT services to the beneficiary when medically necessary.

CMS issued an interim final rule with comment period (CMS-9912-IFC), effective November 2, 2020, that provided states with greater flexibility in implementing the continuous enrollment requirement. This rule is effective prospectively and does not apply to periods prior to November 2, 2020. Under the new regulation at 42 CFR section 433.400, in order to claim the temporary FMAP increase, states must maintain the Medicaid enrollment of validly enrolled beneficiaries in one of three tiers of coverage (minimum essential coverage (MEC), non-MEC coverage that includes testing and treatment for COVID-19, and non-MEC with limited benefits); states are permitted to make changes to beneficiary coverage, cost sharing and PETI without violating the condition in section 6008(b)(3) of the FFCRA. While the IFC became effective on November 2, 2020, it will take time for states to implement the necessary system and operational changes to begin transitioning beneficiaries between eligibility groups and adjusting beneficiaries' financial responsibilities as appropriate. Depending on the flexibilities adopted and the extent of the impact on state systems and processes, some states will need more time than others to implement the necessary changes. The CMS-9912-IFC Factsheet on Updated Policy for Maintaining Medicaid Enrollment During the Public Health Emergency for COVID-19, which is available online at https://www.medicaid.gov/state-resource-center/downloads/covid-19-tech-factsheet-ifc-433400.pdf, provides additional information on these changes. Further details were also provided by CMS stakeholder calls following issuance of the IFC; transcripts of these calls are available at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html.

Background

On January 31, 2020, the secretary of HHS declared a PHE, effective as of January 27, 2020, for the entire United States to aid the nation's health care community in responding to COVID-19. On March 13, 2020, the president declared the ongoing COVID-19 pandemic of sufficient severity and magnitude to warrant an emergency declaration for all states, tribes, territories, and the District of Columbia pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121-5207 (the "Stafford Act"), with a retroactive effective date of March 1, 2020. Furthermore, the current PHE was renewed effective January 21, 2021, for an additional 90 days. During a PHE or disaster, CMS can rely on various legal authorities to grant states emergency flexibilities critical to ensuring that states can respond to the crisis expeditiously to protect and serve the general public.

On December 22, 2020, CMS issued State Health Official Letter #20-004, entitled Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the

COVID-19 Public Health Emergency (https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf). This State Health Official Letter provides guidance on returning to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent where legally permissible and otherwise appropriate, ending the expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. States should have documentation available to describe the temporary changes made to their programs.

Some of the major areas to note include the following:

1. *Telehealth*

   Federal Medicaid telehealth requirements provide states with significant flexibility, and states have broad variability in their approaches to incorporating telehealth into their Medicaid and CHIP programs. CMS also recognizes that in many circumstances, states have adopted Medicaid and CHIP telehealth policies that mirror Medicare telehealth policies, for which regulatory flexibilities have been provided during the COVID-19 PHE. To assist states with understanding the flexibilities regarding Medicaid and CHIP telehealth policy as it relates to COVID-19, CMS issued a COVID-19 Telehealth Toolkit, which was updated on October 14, 2020, that highlighted policy and operational questions that a state may consider when designing their approach (State Medicaid & CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version* at https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf) (State Medicaid & CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version*: Supplement #1 at https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf). To support health care delivery while minimizing face-to-face encounters during the COVID-19 PHE, many states have significantly accelerated adoption of telehealth, including through telephonic modalities, across a wide variety of disciplines.

2. *Beneficiary Eligibility and Enrollment*

   States are facing a number of challenges due to the ongoing COVID-19 PHE that will leave many states with large volumes of outstanding eligibility and enrollment actions when the PHE ends. Different states have utilized different approaches to implement the continuous enrollment requirement and the eligibility and enrollment flexibilities available during the PHE**.** For example, **s**ome states adopted the optional eligibility group for COVID-19 testing and other states adopted new income and/or resource disregards under the state plan for the period of the PHE. As each state determines which flexibilities to maintain and which flexibilities to end, states are expected to develop an operational plan that documents and tracks compliance, including the timelines for making changes to application and renewal processing and verifications. Additional information is provided in SHO Letter #20-004 on planning for the resumption of normal

operations at the conclusion of the PHE, which is available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf. The flexibilities afforded to states as they respond to the PHE related to beneficiary eligibility and enrollment could lead to unintended vulnerabilities and risks. CMS reiterates the importance of states considering the appropriate program integrity activities related to beneficiary eligibility and enrollment. When considering statutory changes and other beneficiary eligibility waivers and flexibilities, CMS particularly encourages states to consider FFCRA requirements for the 6.2 percentage increase FMAP and other related provisions, as described below, when designing program integrity actions.

3. *Managed Care*

As previously described in CMS guidance, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf (Page 77), if a benefit or other identified flexibility is covered under the Medicaid state plan, Medicaid waiver, or a state demonstration, CMS encourages states to amend their managed care plan contracts, if not already included, to extend the same flexibilities to the managed care plans during the COVID-19 PHE. States may also amend their managed care contracts and assess if changes are needed to capitation rates to: (1) reflect temporary increases in Medicaid fee-for-service (FFS) provider payment rates where an approved state directed payment requires plans to pay FFS rates; (2) require MCPs to make certain retainer payments allowable under existing authorities to certain habilitation and personal care providers; and (3) utilize state directed payments, when in compliance with 42 CFR section 438.6(c), to require MCPs to temporarily enhance provider payment under the MCP contract.

States must obtain prior approval from CMS to contractually require managed care plans to make state directed payments to providers; in addition to other requirements specified in 42 CFR 438.6(c), such state-directed payments must be tied to the delivery of services under the contract. To help mitigate the impacts of the PHE for COVID-19, in May 2020, CMS provided a framework through a CMCS Informational Bulletin for states to use in developing state directed payments (https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf). In addition, on January 8, 2021, CMS released additional guidance that discusses enhanced program integrity in the use of state directed payments, such as requiring additional documentation and justification from states as to their rationale for incorporating state directed payments through means other than adjustments to the base capitation rates as part of the preprint review (https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf).

CMS also recently published the 2020 Medicaid managed care final rule, (https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care), which became effective on December 14, 2020, and adopts new requirements for state risk-sharing mechanisms. In accordance with our finalized amendment to the

rule at 42 CFR section 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the managed care contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

The increased use of state directed payments in response to the PHE for COVID-19 may raise concerns about whether states and managed care plans are appropriately accounting for state directed payments in medical loss ratio (MLR) calculations.

4. *Other Benefits and Changes*

In response to COVID-19 PHE, many states have implemented emergency measures to ensure that Medicaid and CHIP beneficiaries continue to have access to essential health services. States have submitted disaster relief state plan amendments (SPAs), 1915(c) waiver Appendix K amendments, and requests for flexibilities under section 1115(a) demonstrations to suspend, add, and revise policies that could prevent enrollees from accessing needed care during the PHE.

B. Control Systems

Utilization Control and Program Integrity

The state plan must provide methods and procedures to safeguard against unnecessary or improper utilization of care and services.

In addition, the state must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials. Suspected provider fraud must be referred to the state MFCU.

Inpatient Hospital and Long-Term Care Facility Audits

States are required to establish, as part of the state plan, standards and methodologies for reimbursing inpatient hospital and long-term care facilities based on payment rates that represent the cost to operate such facilities efficiently and economically and provide services to Medicaid beneficiaries. The SMA must provide for the filing of uniform cost reports by each participating provider. These cost reports are used by the SMA to aid in the establishment of payment rates. The SMA must provide for periodic audits of the financial and statistical records of the participating providers. Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the SMA in ensuring that established payment rates are proper.

Automated Data Processing (ADP) Risk Analyses and System Security Reviews

The Medicaid program is highly dependent on extensive and complex computer systems that include controls for ensuring the proper payment of Medicaid benefits. States are required to establish a security plan for ADP systems that include policies and procedures to address: (1) physical security of ADP resources; (2) equipment security to protect equipment from theft and unauthorized use; (3) software and data security; (4) telecommunications security; (5) personnel security; (6) contingency plans to meet critical processing needs in the event of short- or long-term interruption of service; (7) emergency preparedness; and (8) designation of an agency ADP security manager.

State agencies must establish and maintain a program for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur. On a biennial basis, state agencies shall review the ADP system security of installations involved in the administration of HHS programs. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices.

As part of complying with the above requirement, a state may obtain a statement on Standards for Attestation Engagements (AT) Section 801, Reporting on Controls at a Service Organization Service Organization Control (SOC) 1 type 2 report from its service organization (if the state has a service organization). A SOC 1 type 1 report does not address the effectiveness of a service organization's controls and would need to be supplemented by additional testing of controls at the service organization.

The specific areas covered by a SOC 1 type 2 report differ according to each individual service organization's operations; however, in every instance, the type 2 report procedures assess the sufficiency of the design of an organization's controls and test their effectiveness. A number of commonly covered areas include:

a. Control Environment

b. Systems Development and Maintenance

c. Logical Security

d. Physical Access

e. Computer Operations

f. Input Controls

g. Output Controls

h. Processing Controls

Medicaid–Enterprise Systems

The MES are the set of required mechanized claims processing and information retrieval systems, including the eligibility and enrollment systems and other supporting systems, unless this requirement is waived. CMS provides general systems guidelines (42 CFR sections 433.110 through 433.131) but does not provide detailed system requirements or specifications for states to use in the development of MES systems. As a result, these systems will vary from state to state. The system may be maintained and operated by the state or a contractor overseen by the state.

A module of the MES is normally used to process payments for most Medicaid services. The Operations Management business area supports the Claims Receipt, Claims Adjudication, and Point-of-Service subsystems to process provider claims for Medicaid care and services to eligible medical assistance recipients. Many edits and controls are generally implemented to identify aberrant billing practices for follow-up by the state. The state plan will describe the administration of each state's claims-processing subsystems.

The state may use other MES modules, or other systems, to process some or all Medicaid payments, such as claims from state agencies (e.g., state-operated intermediate care facility for individuals with intellectual disabilities (ICF/IID) and certain selected types of claims). The claims payments processed these ways may be material to the Medicaid program.

C. Related Programs

Medicare Savings Program

The Medicare Buy-In Program, which includes QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-Income Medicare Beneficiary), QI (Qualified Individual), and Qualified Disabled and Working Individuals (QDWI), commonly referred to as the Medicare savings program, is designed to protect low-income Medicare beneficiaries from the significant and growing costs required to cover Medicare premiums, deductibles, coinsurance, and copayments. The program connects the two largest public health programs in the country, Medicare and Medicaid, as Medicaid pays for all or part of the Medicare premium and/or cost-sharing amounts for individuals who are financially eligible.

The QMB program serves individuals with modest assets with combined incomes that do not exceed 100 percent of the federal poverty level. For example, in 2020 the asset limit for the QMB program is $7, 860/individual and $11, 800/couple and the monthly income limits in 2020 are $1,084/individual and $1,457/couple for all states excluding Alaska and Hawaii. If individuals are eligible for the QMB program, the state Medicaid program pays their Medicare Part B premiums as well as Medicare Part A premiums for those who are not eligible for premium-free Part A, and their Medicare deductibles, coinsurance, and copayments.

For individuals with slightly higher incomes, the SLMB program pays only the Part B premium. To be eligible for the SLMB program, an individual must have income that exceeds 100 percent but is less than 120 percent of the federal poverty level. The SLMB program has the same asset limits as the QMB program.

The QI program also pays only the Part B premium. The QI program serves individuals with income at or above 120 percent but less than 135 percent of the federal poverty level. The QI program has annual allotments for each state. The QI program has the same asset limits as the QMB program.

QDWI program pays the Part A premium for working disabled persons under 65 who lost their premium-free Part A when they went back to work. These individuals are eligible for the QDWI program if their income does not exceed 200 percent of the federal poverty level and their resources do not exceed two times the SSI resource limit.

Indian Health Care

Federal Medicaid statute includes several protections specific to American Indians and Alaska Natives (AI/AN). These include:

a. Special treatment for certain AI/AN financial interests—as described at 42 CFR 435.603(e)(3), certain types of AI/AN income are excluded when determining household income based on modified adjusted gross income (MAGI).

b. Protections related to the imposition of enrollment fees, premiums, and cost sharing charges—as described at 42 CFR section 447.56(a)(1)(x), AI/ANs cannot be charged any enrollment fees or premiums if they are eligible to receive items or services furnished by an Indian health care provider, and they are exempt from all cost sharing if they are both eligible to receive and have received items or services furnished by an Indian health care provider or through referral under contract health services (CHS), now, Purchased Referred Care (PRC). In addition, 42 CFR section 447.56(c)(2) prohibits any cost sharing-related reduction in payment due under Medicaid to the Indian health care provider serving an AI/AN (i.e., a state must pay these providers the full Medicaid payment rate for furnishing the service).

c. Managed care protections – Network and coverage requirements related to AI/AN protections within managed care are codified at 42 CFR 438.14(b). These protections address network adequacy, access, claims payment, and disenrollment for AI/AN beneficiaries.

d. Requirements for payment to Indian Health Service (IHS) and tribal facilities – States receive 100 percent FMAP for Medicaid services provided to AI/ANs through an IHS or tribal facility. Per State Health Official Letter #16-002, states receive 100 percent FMAP for services provided to AI/ANs by non-IHS/tribal providers when a care coordination agreement is in place between an IHS/tribal

facility and a non-IHS provider, and other requirements of the State Health Official Letter are met. Payment methodologies, including rates, for all services provided by IHS/tribal facilities and non-IHS/tribal providers are described in the Medicaid state plan.

Payment Error Rate Measurement (PERM) Program

The PERM program is utilized by HHS to calculate national improper payment rates for Medicaid and CHIP. The regulations at 42 CFR Part 431, Subpart Q, specify requirements for estimating improper payments in Medicaid and CHIP. The PERM program annually measures the national Medicaid and CHIP improper payment rates and uses a 17-state three-year rotation process. The national Medicaid and CHIP improper payment rates include findings from the most recent three cycle measurements so that all states are captured in one rate. The national improper payment rates are comprised of three components: fee-for-service, managed care, and eligibility. States are expected to issue corrective action plans to address the root cause of errors and deficiencies.

Medicaid Eligibility Quality Control (MEQC) Program

The regulations at 42 CFR Part 431, Subpart Q, specify the requirements for the MEQC program, which is designed to reduce erroneous expenditures by monitoring the accuracy of eligibility determinations and work in conjunction with the PERM program. The MEQC program requires each state to conduct an MEQC pilot in the two years between the state's PERM review periods and report case findings to CMS and implement corrective action to address all errors and technical deficiencies found to ensure continuous oversight of both Medicaid and CHIP state eligibility determinations. States have flexibility to review error prone areas identified through their PERM findings and must review areas not reviewed under the PERM program, such as denials and terminations.

Source of Governing Requirements

The federal law that authorizes these programs is Title XIX of the Social Security Act (Title XIX), enacted in 1965 and subsequently amended (42 USC 1396 et seq.). The federal regulations applicable to the Medicaid program are found in 42 CFR parts 430 through 456, 1002, and 1007.

Awards under the Medical Assistance Program (Assistance Listing 93.778) are subject to the requirements of 45 CFR Part 95 and the cost principles under Office of Management and Budget Circular A-87/2 CFR Part 200, Subpart E.

Federal requirements for the establishment and continued operations of the MFCUs are contained in 42 USC 1396b(a)(6), 1396b(b)(3), and 1396b(q); and 42 CFR Part 1007.

This program is subject to the requirements of 45 CFR Part 75 (the HHS implementation of 2 CFR Part 200) and 45 CFR Part 95.

In December 2020, the Consolidated Appropriations Act, 2021 was enacted. This legislation requires additional state reporting on provider specific Medicaid supplemental payments effective October 1, 2021. (Pub. L. No. 116-260).

Availability of Other Program Information

The HHS OIG issues fraud alerts, some of which relate to the Medicaid program. These alerts are available from the HHS OIG home page, Special Fraud Alerts section (https://oig.hhs.gov/compliance/alerts/index.asp).

Up-to-date program information, including State Medicaid Director and State Health Official letters, is available through Medicaid.gov at http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html.

Up-to-date information on Medical Loss Ratio is available at https://www.medicaid.gov/medicaid/managed-care/guidance/medical-loss-ratio/index.html.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/ Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	N	N	N	Y	N	Y

General Audit Approach for Medicaid Payments

To be allowable, Medicaid costs for medical services must be (1) covered by the state plan or CMS approved waivers/demonstrations; (2) reviewed by the state consistent with the state's documented procedures and system for determining medical necessity of claims; (3) properly coded; and (4) paid at the rate allowed by the state plan. Furthermore, beneficiaries must be eligible (or presumptively eligible) at the time of service, whether covered under fee-for-service or managed care. Additionally, Medicaid costs must be net of beneficiary cost-sharing obligations and applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

Due to the complexity of Medicaid program operations, it is unlikely the auditor will be able to support an opinion that Medicaid expenditures are in compliance with applicable laws and regulations (i.e., are allowable under the state plan) without relying upon the systems and internal controls. Examples of complexities include:

1. Dependence upon large and complex ADP systems to process the large volume of Medicaid transactions for fee for services arrangements.

2. Medical services are normally provided directly to an eligible beneficiary without prior approval by the state.

3. Medical service providers normally determine the scope and medical necessity of the services.

4. Notice to the state that a service was rendered is after-the-fact when a claim for payment is issued.

5. Payments systems do not include a review of original detailed documentation supporting the claim prior to payment.

6. Complex payment structures for various medical services may exist, including significance of proper coding of services for fee for service (e.g., billing by diagnosis-related groupings (DRG)). Managed care and waiver based programs are dependent on the respective SPA and resulting agreements with the providers. Managed care programs are dependent on the authority for the program and the contracts with the managed care plans.

7. Payment rates and policies differ among service types and delivery methods, such as fee for service arrangements, managed care, and waivers (e.g., inpatient hospital, physicians, prescription drugs and drug rebates, and risk-based capitation payments for a specific set of covered services).

8. State contracts with third parties, such as managed care plans, to provide or arrange for services for all or part of beneficiary care. Managed care plans have contracts with providers to create a network. Managed care plan may also subcontract with other

managed care plans and/or administrative services organizations to delegate some of their contractual obligations.

Medicaid has required control systems that should aid the auditor in obtaining sufficient audit evidence for Medicaid expenditures. These control systems are discussed in the preceding Program Procedures section under Control Systems and are: (1) utilization control and program integrity; (2) inpatient hospital and long-term care facility audits; (3) ADP risk analyses and system security reviews (e.g., of the MES); and (4) MES claims processing and other modules normally include edits and controls that identify unusual items for follow up by the utilization control and program integrity function. The first three generally are performed by specialists retained by the SMA. The following table indicates the major types of Medicaid services (i.e., excludes administrative expenses) to which these controls will likely relate:

Type of Medicaid Payment	1	2	3	4
Inpatient Hospital	X	X	X	X
Physicians (including dental)	X		X	X
Prescription Drugs (net of rebates)	X		X	X
Institutional Long-Term Care	X	X	X	X
Managed Care Waiver	X	X	X	X
Home and Community Based Waiver Program	X		X	

Each of the above Medicaid payment types is tested for compliance with applicable laws and regulations under one of the following: III.A, "Activities Allowed or Unallowed;" III.B, "Allowable Costs/Cost Principles;" or III.E.1, "Eligibility – Eligibility for Individuals." Based on the assessed level of control risk, the auditor should design appropriate tests of the allow-ability of Medicaid payments, which may include a sample of medical claims. Given the complexity of medical records, if medical claims are sampled, the auditor should consider engaging the assistance of specialists in the medical community to assist in the review. The auditor may consider using the same specialists used by the state. Appropriative privacy measures must be taken to protect health information (i.e., medical claims).

A. Activities Allowed or Unallowed

1. *Summary* – FFP funds can be used only for Medicaid benefit payments (as specified in the state plan, federal regulations, or an approved waiver/demonstration), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for the establishment and operation of state MFCUs (42 CFR sections 435.10, 440.210, 440.220, and 440.180). Payments may only be made to providers determined by the SMA to be eligible to participate in the Medicaid program. See III.N.4 "Provider Eligibility (Screening and Enrollment)" for related testing.

2. *Case Management Services* – Medicaid case management services may fall under the category of an administrative expense or as an optional medical state plan benefit. The term "case management services" means services that will assist individuals eligible under the plan in gaining access to needed medical, social,

educational, and other services. Services, programs, and providers to which the individual is gaining access do not have to be specifically medical in nature and may include services for securing shelter, personal needs, and so forth (e.g., services provided by community mental health boards, county offices of aging). Case management services are an area of risk because of the high growth of expenditures and prior experience that indicates problems with the documentation of case management expenditures.

With the exception of case management services (covered under a periodic payment (usually monthly) for each beneficiary) or risk-based managed care, federal regulations typically require the following documentation for case management services: date of service; name of recipient; name of provider agency and person providing the service; nature, extent, or units of service; and place of service (section 1915(g) of the Act (42 USC 1396n(g)); 42 CFR Part 434).

Administrative case management – Services must be assessed as a Title XIX benefit (e.g., outreach services provided by public school districts to Medicaid recipients).

Administrative case management – Services must be assessed as a Title XIX benefit (e.g., outreach services provided by public school districts to Medicaid recipients).

Case Management/targeted case management provided as an optional state plan service – Services must be provided to an eligible Medicaid recipient, and must include: a comprehensive assessment and periodic reassessment of individual needs, development (and periodic revision) of a care plan that is based on the information collected through the assessment, making referrals to help the eligible individual obtain needed services and monitoring to ensure that the care plan is implemented and services are meeting the individual's needs.

3. *Managed Care* – A state may obtain a waiver of statutory requirements under 1915(a) or (b)waivers, or amend its state plan under 1932(a) authority, or use1115(a) demonstration authority, in order to develop a managed care delivery system that is intended to more effectively addresses the health care needs of its population. For example, a waiver/SPA/Demonstration may involve the use of managed care plans for the delivery of some or all Medicaid benefits for selected beneficiaries. Managed care plans use networks of providers must be eligible to participate in the program at the time services are rendered, payments to managed care plans should only be for eligible beneficiaries for the proper period and use the proper rate cell, and the capitation rates must be actuarially sound. Generally, FFS Medicaid should not pay claims for services that are covered by managed care plan contract. States should ensure that capitated payments to managed care plans are discontinued when a beneficiary is no longer enrolled in a plan. All Medicaid managed care guidance can be found at https://www.medicaid.gov/medicaid/managed-care/guidance/index.html.

Examples of payment risks in Medicaid managed care can exist at the state level plan level, and the network provider level. At the state level, inaccurate state payments can be made to plans/managed care organizations because of inaccurate data or because the rate setting includes costs that should be excluded when calculating and setting payment rates.

4. *Medicaid Health Insurance Premiums* – A state may pay premiums for employer sponsored insurance or private group health insurance, on behalf of a Medicaid beneficiary, if it is cost effective to do so. When providing premium assistance, states must ensure that participating beneficiaries have access to all benefits available to other Medicaid beneficiaries, and that they are not required to incur greater out-of-pocket costs for premiums, deductibles, co-payments, or similar cost sharing charges than other Medicaid beneficiaries. A state's policy related to premium assistance are described in the Medicaid state plan.

5. *Disproportionate Share Hospital* – FFP is available for payments to qualifying hospitals that serve a disproportionate number of low-income patients with special needs. The state plan must specifically define a disproportionate share hospital and the method of calculating the rate for these hospitals. Section 1923 of the Social Security Act limits DSH payments on a state-wide basis to annual DSH allotments and on a hospital-specific basis to each qualifying hospital's uncompensated care costs. Section 1923(j) of the Social Security Act 42 USC 1396r 4 *(OMB PRA 0938-0746*) also requires each state to obtain, and submit to CMS, an annual independent certified audit of their Medicaid DSH program.

6. *Home and Community-Based Services (HCBS)* – A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Social Security Act. States must operate their HCBS programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

7. *Medicare Part B Buy-In* – 42 CFR section 431.625(d)(1) specify

   FFP funds are available for state payment of

   - Medicare Part B premiums for cash assistance recipients (SSI/SSP) and "deemed" cash recipients;

   - Part A or B premiums, deductibles, coinsurance, and copays for QMBs; and

   - Part B premiums for SLMBs and QIs.

FFP is not available for state payment of Part B premiums for other categories of Medicaid for individuals 65 years old and older or who have blindness and disability.

B. Allowable Costs/Cost Principles

1. States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party resources should be exhausted prior to paying claims with program funds. Where third party liability is established after the claim is paid, reimbursement from the third party should be sought (section 1915 of the Act 42 USC 1396k; 42 CFR sections 433.135 through 433.154).

2. Before calculating the amount of FFP, certain revenues received by a state will be deducted from the state's medical assistance expenditures. The revenues to be deducted are (1) donations made by health care providers or related entities (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes. The requirements for provider-related donations and health care-related taxes are specified in section 1903(w) of the Social Security Act and implementing regulations at 42 CFR 433 Subpart B.

   These provisions apply to all 50 states and the District of Columbia, except those states whose entire Medicaid program is operated under a waiver granted under Section 1115 of the Social Security Act (42 CFR Part 433).

3. Section 1927 of the Social Security Act (42 USC 1396r-8) requires manufacturers that wish to have their covered outpatient drugs covered by Medicaid to enter into an agreement with CMS under which the manufacturers agree to pay rebates for drugs dispensed and paid for by state Medicaid agencies under the state plan ("rebate agreement"). Those rebates are shared between the state and federal governments. Claims are submitted on a medical claim transaction using either Healthcare Common Procedure Coding System (HCPCS) or revenue codes as the primary billing method. In addition to identifying the claims that are for covered outpatient drugs, the units need to be appropriate to the definition of the rebate program. Within 30 days of receipt of the utilization data from the state, the manufacturers are required to pay the rebate or provide the state with written notice of disputed items not paid because of discrepancies found.

   In addition, to receive payments for a single source physician-administered drugs States must also provide for collection and submission of such utilization data using the National Drug Code (NDC) (42 USC 1396r-8(a)(7)). Physician-administered drugs include both injectable and non-injectable drugs. They are typically administered by medical professionals in physicians' offices, clinics, or hospitals.

Generally, in order for payment to be available for covered outpatient drugs, drug manufacturers are required to have entered into a rebate agreement and meet various product and price reporting requirements, in addition to paying rebates. As part of the product and price reporting requirements, manufacturers must certify to CMS all covered outpatient drugs and, on a quarterly basis, are required to provide their average manufacturer's price and their best price for each covered outpatient drug, as applicable. Based on these data, CMS calculates a unit rebate amount for each drug, which it then provides to states. No later than 60 days after the end of the quarter, the SMA must provide drug utilization data to manufacturers, including drug utilization data of those Medicaid beneficiaries enrolled in managed care plans.

4. In the "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability" final rule, published in the *Federal Register* on May 6, 2016 (81 FR 27498), CMS adopted medical loss ratio (MLR) requirements for Medicaid and CHIP managed care programs. The state must require each Medicaid managed care plan to calculate and report a MLR for rating periods starting on or after July 1, 2017; and require each CHIP managed care plan to calculate and report a MLR for rating periods in CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. If a state elects to mandate a minimum MLR, that minimum MLR must be at least 85 percent. The regulation, at 42 CFR section 438.8(e)(4), incorporates the standards adopted for the private insurance market MLR (45 CFR section 158.150) for the treatment of fraud prevention expenses in the numerator of the MLR calculation. The MLR is reported for a rating period, using data from that rating period.

   With regard to capitation rate setting for Medicaid managed care plans, under 42 CFR sections 438.4 and 438.5, several requirements exist: (1) states must provide all the validated encounter data, FFS data (as appropriate), and audited financial reports to be served by the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to the actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period, (2) the rates must be approved by CMS, which uses the services and expertise of the Office of the Actuary, and (3) the rate adjustments must be approved and valid. In addition, for Medicaid and CHIP managed care plans, the rates must be developed so that the managed care plan is projected to meet an 85 percent MLR (42 CFR sections 438.4(b)(9) and 457.1203(c)(1)).

5. *Non-Disproportionate Share Hospital Supplemental Payments* – States make supplemental payments to hospitals and other providers such as nursing homes and physician groups that serve high-cost Medicaid beneficiaries. The upper payment limit (UPL) against which non-disproportionate share hospital supplemental payments are measured is codified at 42 CFR 447.272 for Institutional Services and 42 CFR 447.321 for Outpatient Hospital and Clinic Services.

6. *Non-Risk Contracts* – Non-risk contracts are defined in 42 CFR section 438.2 as contracts between a state and a PIHP or PAHP under which the contractor (1) is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR section 447.362 of this chapter; and (2) may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. States do not document non-risk arrangements with its managed care plans consistently (i.e., some use contracts separate from the risk based contracts while others incorporate the non-risk provisions into the risk based contracts). Regardless of the method chosen by a state, the regulatory requirements apply.

E. Eligibility

As discussed in the General Audit Approach for Medicaid Payments, the auditor may coordinate III.A, "Activities Allowed or Unallowed," III.B, "Allowable Costs/Cost Principles," and III.E, "Eligibility." Therefore, compliance requirements related to amounts provided to, or on behalf of, eligible individuals and presumptively eligible individuals are combined with III.A, "Activities Allowed or Unallowed" and III.B, "Allowable Costs/Cost Principles" such as, was the service incurred during the period the beneficiary was eligible to receive benefits and was the provider paid the correct amount for the service billed."

The state verifies the financial and nonfinancial factors of eligibility, with the exceptions described below, by checking electronic data sources in accordance with federal requirements at 42 CFR 435.948 through 435.956 and state requirements as documented in the state plan, verification plan and manual used by state eligibility workers. The state is required (as described at 42 CFR 435.914) to maintain facts in the case file to support the eligibility determination. When data sources used by the state are not available to the auditor, or information is not required to be available for the period under audit, auditors would not be expected to test verification other than the requirement to maintain information in the case file. For states that accept applicant self-attestation for certain factors of eligibility such as household composition, and do not require further verification or documentation, the auditors are not expected to test beyond the requirements of the state.

The exceptions to the verification process described above are eligibility determinations made by an Exchange, either the Federally Facilitated Exchange (FFE) or a state-based Exchange, findings from an express lane agency, and presumptive eligibility determinations made by qualified entities. In states that have delegated eligibility determinations to the FFE or a state-based exchange, the state relies on the verifications conducted by the Exchange and auditors are not expected to test verification. When express lane eligibility is used, the SMA relies upon elements of the determination made by an express lane agency. For presumptive eligibility determinations, the qualified entity accepts attestation of all needed information and states may not require verification or documentation of any eligibility criteria. When testing a presumptive eligibility determination, auditors are not expected to test verification.

1. Eligibility for Individuals

To participate in Medicaid, federal law requires states to cover certain groups of individuals. Examples of these mandatory eligibility groups are Infants and Children under Age 19, Pregnant Women, and Individuals Receiving Supplemental Security Income (SSI). States may also elect to extend coverage to optional groups of individuals. Examples of optional eligibility groups are Individuals Needing Treatment for Breast or Cervical Cancer, Optional State Supplement Recipients, and Family Opportunity Act Children with a Disability. In addition, states have the option to provide coverage to medically needy individuals who have income and/or resources that exceed the eligibility standards otherwise applicable to such individuals. Mandatory, optional, and medically needy coverage options are described at 42 CFR Part 435, subparts B, C, and D and the options elected by a state are detailed in its Medicaid state plan.

Eligibility for Medicaid includes both financial and nonfinancial requirements and each eligibility group has its own specific standards. Financial eligibility for most individuals is based on modified adjusted gross income or MAGI, which is described at 42 CFR 435.603. MAGI-based income is calculated using the financial methodologies defined in section 36B of the Internal Revenue Code with certain exceptions, such as the exclusion of certain types of AI/AN income (described above) and special rules for individuals who do not expect to file taxes or to be claimed as a tax dependent (non-filer rules). MAGI-based financial eligibility determinations include only an income test; states cannot apply a resource test when determining eligibility based on MAGI.

Certain groups of individuals are excepted from the use of MAGI. MAGI-excepted individuals are described at 42 CFR 435.603(j) and include individuals whose eligibility does not require a determination of income by the agency, such as individuals who are eligible based on their receipt of SSI; individuals whose eligibility for Medicaid is determined based on being age 65 or older or having blindness or a disability (often referred to as aged, blind or disabled, or ABD); and individuals being evaluated for coverage as medically needy.

When making non-MAGI financial eligibility determinations, states generally apply the income and resource methodologies of the most closely associated cash assistance program. For most individuals, the SSI financial eligibility methodology would be applied, including SSI rules related to both income and resources, in accordance with 42 CFR 435.601 and 435.602. MAGI-excepted eligibility determinations may include a resource or asset test.

Certain nonfinancial requirements, such as age limitations, pregnancy, or parent/caretaker requirements, apply only to specific eligibility groups. Other nonfinancial requirements apply to all eligible individuals. Medicaid beneficiaries must generally be residents of the state in which they are receiving Medicaid, and they must be either US citizens or qualified noncitizens (aliens). Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22,

1996, are not eligible for Medicaid for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five-year bar under the terms of 8 USC 1613. States must provide Medicaid to certain qualified aliens in accordance with the terms of 8 USC 1612(b)(2), provided that they meet all other eligibility requirements. States may provide Medicaid to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (the five-year bar). States also have the option to provide Medicaid coverage to lawfully residing pregnant women and children under age 21 in accordance with 42 USC 1396b(v)(4). All aliens who otherwise meet the Medicaid eligibility requirements are eligible for treatment of an emergency medical condition under Medicaid, as defined in 8 USC 1611(b)(1)(A), regardless of immigration status or date of entry.

To facilitate immediate access to services for individuals who are likely Medicaid eligible, without having to wait for a final eligibility determination to be made, states may establish a program of presumptive eligibility (PE). Under this option, the state authorizes certain health care providers, schools, and/or other outside entities (referred to as "qualified entities") to screen for Medicaid eligibility and immediately enroll individuals who appear to be eligible. PE is time limited and ends within two months unless the individual submits a full Medicaid application.

The processes used by states to determine and renew eligibility for Medicaid must comply with certain federal requirements, which are described at 42 CFR Part 435, Subpart J. State processes for presumptive eligibility are described at 42 CFR Part 435, Subpart L. However, states have flexibility within this framework to establish processes that meet the unique needs of their state. Specific requirements to be considered when auditing eligibility determinations for individuals include:

a. Eligibility Determination

(1) States must accept applications submitted online, by telephone, via mail, or in person. This includes electronic, telephonically recorded, and handwritten signatures. The SMA must have documentation in the case record to support the agency's eligibility determination, including a record of verification of income and citizenship or satisfactory immigration status for each individual. The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for denial or termination of assistance (section 1137(d) of the Act 42 USC 1320b-7(d); 42 CFR sections 435.907, 435.914, 435.917, 431.17, 431.211, 431.213, 431.214).

(2) Federal law requires that certain types of information be collected during the application process. As a condition of eligibility, each individual seeking Medicaid must furnish his or her Social Security number (SSN) as described at 42 CFR 435.910. If the individual does not recall his/her SSN or has not been issued an

SSN, the state must assist the individual in obtaining or applying for an SSN. This requirement does not apply if the individual (a) is not eligible to receive an SSN, (b) does not have an SSN and may be issued an SSN only for a valid non-work reason, or (c) refuses to obtain a SSN because of well-established religious objections.

(3) States are directed, at 42 CFR 435.912, to determine eligibility promptly and without undue delay. For individuals applying for Medicaid on the basis of disability, the determination of eligibility may not exceed 90 days. For all other applicants, the determination of eligibility may not exceed 45 days.

(4) The 42 CFR 435.1200 requires coordination between SMAs and other insurance affordability programs, including the federal and state exchanges. Typically, electronic accounts must be transferred from the Medicaid/CHIP agency to the exchange and vice versa. states utilizing the FFE must enter into an agreement in which the FFE makes either a determination or an assessment of MAGI Medicaid/CHIP eligibility and sends the individual's electronic account to the SMA for enrollment (FFE determination) or a final determination and enrollment (FFE assessment). Additional information may be found in the July 25, 2016, CMCS Informational Bulletin on Coordination of Eligibility and Enrollment between Medicaid, CHIP, and the Federally Facilitated Marketplace available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf.

(5) When determining eligibility for a child, SMAs may rely on elements of a determination made by an express lane agency (as defined in section 2.1(e) of the Medicaid state plan) as to whether a child satisfies one or more requirements of Medicaid eligibility. The SMA may use an income determination from an express lane agency without regard to differences in budget unit, income disregards, deeming, or other differences in methodology between the express lane agency and Medicaid. Auditors are not expected to test verification of express lane determinations relied upon by the SMA. Additional information may be found in section 1902(e)(13) of the Social Security Act (42 USC 1396a(e)(13)) and State Health Official Letter #10-003 issued on February 4, 2010.

b. Eligibility Verification

(1) States must request information from reliable electronic data sources, including other agencies in the state and other state and federal programs to the extent that such information is determined useful in verifying the financial eligibility of an individual. As

described in the state's verification plan for MAGI determinations, and in state policies and procedures for both MAGI and non-MAGI determinations, this may include information from agencies such as the State Wage Information Collection Agency, the Social Security Administration, and the Internal Revenue Service. States may also use information related to eligibility or enrollment from other state programs such as the Supplemental Nutrition Assistance Program. For MAGI determinations, if information provided by or on behalf of an individual is reasonably compatible with information obtained from the electronic data sources, as described in the state's verification plan, then the agency must determine or renew eligibility based on such information and may not require the individual to provide any further documentation. If the information is not reasonably compatible, then the agency must provide the individual with a reasonable period of time to explain the discrepancy or furnish additional information (42 CFR sections 435.948 and 435.952).

(2) States may choose to accept self-attestation of information needed to determine or renew eligibility except with respect to income, SSN, and citizenship or immigration status. When self-attestation is accepted, further information, including documentation, cannot be required from the individual. In such cases, auditors would not be expected to test documentation other than required by the state. States must follow the requirements described at 42 CFR 435.948 through 435.956, for verification and documentation of income and citizenship and immigration status.

(3) Asset Verification Program – Section 1940 of the Social Security Act (42 USC 1396w) requires states to have a mechanism in place to verify assets, through access to information held by financial institutions, for purposes of determining or renewing Medicaid eligibility when an asset test is applicable for aged, blind, and disabled Medicaid applicants or recipients.

c. Periodic Renewal

As required at 42 CFR 435.916, states must renew MAGI-based determinations of eligibility once every 12 months and no more frequently than once every 12 months. For non-MAGI beneficiaries, states must renew eligibility at least once every 12 months as described in the Medicaid state plan. When renewing eligibility, states must first attempt to renew based on reliable information available to the agency without requiring information from the individual. If sufficient information is not available to complete a renewal, or if the state has information that suggests that the beneficiary is ineligible, the state must provide the beneficiary with a renewal form and inform the individual of any

additional information or documentation needed to determine eligibility. For MAGI-based determinations, the renewal form must be prepopulated with the most recent and reliable information known to the agency. Consistent with regulations at 42 CFR 435.930(b), the agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation unless and until they are determined to be ineligible for eligibility under all groups covered by the state. Additional information may be found in the CMCS Informational Bulletin on Medicaid and CHIP renewal requirements issued on December 4, 2020, and available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

d. Presumptive Eligibility

States have the option to establish PE for specific eligibility groups, as described at 42 CFR Part 435 Subpart L. In general, states must provide PE for pregnant women and children before extending PE to most other MAGI-based eligibility groups. The options elected by each state are described in the Medicaid state plan.

When electing the PE option, states designate qualified entities, such as health care providers, community-based organizations, and schools to make PE determinations. These qualified entities are trained on the state's PE screening process and state-specific requirements for PE. In many states, qualified entities also help individuals to complete the full application process. A qualified entity is responsible for collecting and recording all information necessary to make a PE determination.

To be determined presumptively eligible, an individual must meet the basic requirements of an eligibility group for which PE is available. For example, to be presumptively eligible for the Infants and Children Under Age 19 group, the individual must be a child aged 18 or younger and must have household income at or below the standard established by the state for this group. When determining income, states may use a simplified method such as gross income. In addition to the basic requirements of the eligibility group, states may, but are not required to, consider state residency and US citizenship or eligible immigration status when making a PE determination. Other information that would be collected on a full application, cannot be required for a PE determination. In addition, individuals attest to all information needed for a PE determination. States may not require verification or documentation of any eligibility criteria as a condition of presumptive eligibility.

The PE period begins the day on which the qualified entity makes the PE determination. The end date varies depending on whether or not the individual submits a Medicaid application. If the individual submits a

Medicaid application by the last day of the month following the month in which PE was determined, the PE period will continue until full Medicaid eligibility is either approved or denied. If the individual does not submit a Medicaid application, the PE period ends on the last day of the month following the month in which PE was determined. States must adopt reasonable standards regarding the number of PE periods that will be authorized for an individual.

2. Eligibility for Group of Individuals or Area of Service Delivery

Not Applicable

3. Eligibility for Sub-recipients

Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching

The state is required to pay part of the costs of providing Medicaid services and part of the costs of administering the program. The percentage of federal funding is determined based on the amount of the expenditure and the application of the FMAP that is determined for each state using a formula set forth in section 1905(b) of the Social Security Act (42 USC 1396d), or other applicable federal matching rates specified by the statute.

2. Level of Effort

Not Applicable

3. Earmarking

A state waiver may contain an earmarking requirement.

L. Reporting

1. Financial Reporting

a. *SF-270, Request for Advance or Reimbursement* – Not Applicable

b. *SF-271, Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable

c. *SF-425, Federal Financial Report* – Applicable for expenditure reporting for the administrative costs of the state MFCUs; not applicable for expenditure reporting all other components of the cluster

d. *CMS-64, Quarterly Statement of Expenditures for the Medical Assistance Program (OMB No. 0938-1265)* – Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the state MFCUs), prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter.

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions

1. Utilization Control and Program Integrity

Compliance Requirements The state plan must provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, the state must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Suspected fraud must be referred to the state MFCUs (42 CFR Part 455.21). See Special Test #6, MFCU.

The SMA must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. The SMA may conduct this review directly or may contract with an independent entity (42 CFR sections 456.5, 456.22 and 456.23).

Audit Objectives Determine whether the state has established and implemented procedures to: (1) safeguard against unnecessary utilization of care and services, including long term care institutions; (2) identify suspected fraud cases; (3) investigate these cases; and (4) refer those cases with sufficient evidence of suspected fraud cases to law enforcement officials. Consider testing in conjunction with Special Test #6, MFCU.

Suggested Audit Procedures

a. Obtain the procedures used by the SMA to conduct utilization reviews and identify suspected fraud.

(1) Evaluate the qualifications of the personnel conducting the reviews and identifying suspected fraud. Ascertain that the individuals possess the necessary skill or knowledge by considering the following: (a) professional certification, license, or specialized training; (b) the reputation and standing of licensed medical professionals in the view of peers if relevant; and (c) experience in the type of tasks to be performed.

(2) Ascertain if the personnel performing the utilization review and identifying suspected fraud are organized sufficiently independent of other Medicaid operations to objectively perform their function.

(3) Ascertain if the SMA or independent entity's sampling plan was properly designed and executed.

b. Test a sample of the cases examined by SMA or the independent entity and ascertain if such examinations were in accordance with the SMA's procedures.

c. Test a sample of the identified suspected cases of fraud and ascertain if the agency took appropriate steps to investigate and, if appropriate, make a referral.

2. Inpatient Hospital and Long-Term Care Facility Audits

Compliance Requirements The SMA pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the state plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the state plan (42 CFR section 447.253).

Audit Objectives Determine whether the SMA performed inpatient hospital and long-term care facility audits as required and established in the state plan.

Suggested Audit Procedures

a. Review the state plan and SMA operating procedures and document the types of audits performed (e.g., desk audits, field audits), the methodology for determining when audits are conducted, and the objectives and procedures of the audits.

b. Through examination of documentation, determine if the sampling plan was carried out as planned.

c. Select a sample of audits and ascertain if the audits were in compliance with the SMA's audit procedures.

3. ADP Risk Analysis and System Security Review

Compliance Requirements SMAs must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate and cost effective safeguards are incorporated into new and existing systems. SMAs must perform risk analyses whenever significant system changes occur. SMAs shall review the ADP system security installations involved in the administration of HHS programs on a biennial basis. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices. The SMA shall maintain reports on its biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site reviews (45 CFR section 95.621).

Audit Objectives Determine whether the SMA has performed the required ADP risk analyses and system security reviews.

Suggested Audit Procedures

a. Review the SMA's policies and procedures, and document the frequency, timing, and scope of ADP security reviews. This should include any Service Organization Control (SOC) 1 type 2 reviews following statement on Standards for Attestation Engagements (AT) Section 801, Reporting on Controls at a Service Organization that may have been performed on outside processors (service organizations).

b. Evaluate the appropriateness and extent of reliance on such reviews based on the qualifications of the personnel performing the risk analyses and security reviews and their organizational independence from the ADP systems.

c. Review the work performed during the most recent risk analysis and security review to determine if findings were identified and what actions the SMA took to address the findings.

4. Provider Eligibility (Screening and Enrollment)

Compliance Requirements In order to receive Medicaid payments, providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and Section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)); (2) screened and enrolled in accordance with 42 CFR Part 455, Subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (42 CFR Part 455, Subpart B, sections 455.100 through 455.106). Medicaid managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR Part 438, Subpart H. States must also follow guidance issued in the Medicaid Provider Enrollment Compendium (MPEC) at https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf to enroll providers into their Medicaid programs.

Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the Medicaid program. (See 42 CFR 455.436). Lists may be

found at https://oig.hhs.gov/exclusions/?utm_source=oigNewsletter&utm_medium=oig-nl-nav&utm_campaign=leie-nl.

Audit Objectives Determine whether Medicaid providers of medical services have the required medical licenses and are eligible to participate in the Medicaid program in accordance with federal, state, and local laws and regulations, and whether the providers have made the required disclosures to the state.

Suggested Audit Procedures

a. Obtain an understanding of the state plan's provisions for licensing and entering into agreements with providers.

b. Select samples from both Medicaid fee-for-service providers and managed care network providers to determine if:

   (1) The provider is screened, licensed, and enrolled in accordance with the state plan and the requirement of 42 CFR 455 Subpart E.

   (2) The agreement with the provider complies with the requirements of the state plan, including the disclosure requirement of 42 CFR 455 Subpart B.

   (3) The provider complied with the requirements of the state plan, including the disclosure requirements of 42 CFR 455 Subpart B and Section 1.4 of the MPEC at https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf.

   (4) The provider was not on the OIG's exclusion list at the time the services were provided.

5. Provider Health and Safety Standards

Compliance Requirements Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR Part 442). The standards may be modified in the state plan.

Audit Objectives Determine whether the state ensures that hospitals, nursing facilities, and ICF/IID that serve Medicaid patients meet the prescribed health and safety standards.

Suggested Audit Procedures

a. Obtain an understanding of the state plan provisions that ensure that payments are made only to institutions that meet prescribed health and safety standards.

b. Select a sample of providers who received payments for each provider type (i.e., hospitals, nursing facilities, and ICF/IID) and ascertain if the SMA has documentation that the provider has met the prescribed health and safety standards.

6. Medicaid Fraud Control Unit (MFCU)

Compliance Requirements States are required as part of their Medicaid state plans to maintain a MFCU unless the HHS secretary determines that a MFCU would not be cost-effective. States must have an agreement between the MFCU and the State Medicaid agency, which includes methods of coordination and procedures for referring potential fraud, including potential fraud arising in managed care networks.

Audit Objectives Determine whether the state ensures suspected fraud or other criminal violations are referred to the MFCU, or in jurisdictions without a MFCU, to another office with authority to prosecute cases of provider fraud, and to ensure that the state accurately reports overpayment recoveries resulting from MFCU activities on the CMS-64 in accordance with sections 1903(d)(2)(C) and (D) of the Act. Consider testing in conjunction with Special Test #1, Utilization Control and Program Integrity.

Suggested Audit Procedures

a. Ascertain if the state has a MFCU and, if not, it has received a waiver from the HHS secretary and has alternate policies and procedures in place to detect Medicaid fraud and abuse.

b. Examine the current memorandum of understanding (MOU) between the MFCU and state and ascertain whether the MOU for the MFCU and state comply with the requirements of sections 455.21(c) and 1007.9(d)

c. Obtain an understanding of the state's policies and procedures that ensure suspected provider fraud is identified and referred to an office with authority to prosecute such cases.

d. Select a sample of cases with identified suspected provider fraud and ascertain if the cases were referred to the state MFCU or, if the state does not have a MFCU, to an office with authority to prosecute cases of provider fraud.

e. Obtain records of overpayments and other monetary recoveries identified as a result of MFCU activities and ascertain whether the recoveries were appropriately reported in each applicable quarter for the corresponding quarter on the CMS-64.

7. Refunding of Federal Share of Medicaid Overpayments to Providers

Compliance Requirements The 42 CFR 433 Subpart F outlines the requirements SMAs are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Social Security Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS via Form CMS-64 Summary, Line 9C1- Fraud, Waste & Abuse Amounts, regardless of whether recovery is made from the provider. The state must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the one-year period ends following

discovery, whichever is earlier, with limited exceptions. Under 42 CFR 433.316(d), for overpayments resulting from fraud, if not collected within one year of discovery, the SMA has until 30 days after the final judgment of a judicial or administrative appeals process to return the federal share.

Additionally, in accordance with 42 CFR 433.320(a)(4), the state will be charged interest for any non-recovered, non-refunded overpayment amounts. Any appeal rights offered to the provider does not extend the date of discovery per 42 CFR 433.316(h).

The repayment of the federal share is not required in cases where the state is unable to obtain recovery because the provider has filed for bankruptcy or the provider is otherwise out of business as outlined in 42 CFR 433.318.

The 42 CFR 433.320(c)(1) allows for downward adjustments previously credited to CMS if it is properly based on the approved state plan, federal law and regulations governing Medicaid, and the appeals resolution process specified in state administrative policies and procedures. States are not able to enter into settlement agreements with providers that reduces the federal share of the overpayment in order to avoid the expense of litigation. The Departmental Appeals Board (DAB) decision No. 1391 from February 19, 1993 (https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1993/dab1391.html), addressed overpayment settlements between the states and providers. This decision affirmed that states may not reduce the federal share by settling overpayment receivables for less than the actual amount of the overpayment based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses.

Audit Objectives Determine whether the SMA reported and returned Medicaid provider overpayments in accordance the federal requirements.

Suggested Audit Procedures

a. Review applicable federal laws and regulation, including 1903(d)(2)(C) of the Act (42 USC 1396b), 42 CFR 433 Subpart F, and the Departmental Appeals Board Decision No. 1391.

b. Obtain an understanding of the process to identify overpayments.

c. Perform tests to ascertain if the federal share has been returned accurately in accordance with federal laws and regulations, including ensuring the full amount was refunded and any downward adjustments were made.

8. Medicaid National Correct Coding Initiative (NCCI)

Compliance Requirements Effective October 1, 2010, SMAs were required to incorporate NCCI methodologies into the state Medicaid programs pursuant to the requirements of Section 6507 of the Affordable Care Act (section 1903(r) of the Social Security Act).

The purpose of the NCCI Program is to promote correct coding, prevent coding errors, prevent code manipulation, reduce improper payments and reduce the paid claims improper payment rate. The Annual Report to Congress – Medicare and Medicaid Integrity Programs – Fiscal Year 2017 **(**2017 RTC (cms.gov)**)** reported that the NCCI program saved at least $698.1 million in Medicare in FY 2017.

In paying applicable Medicaid claims, states' MES are required to completely and correctly implement the following six Medicaid NCCI methodologies to ensure that only proper payments of procedures are reimbursed.

a. NCCI Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) claims.

b. NCCI PTP edits for outpatient hospital services, including emergency department, observation care, and outpatient hospital laboratory services.

c. Medically Unlikely Edit (MUE) units of service (UOS) edits for practitioner and ASC services.

d. MUE UOS edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.

e. MUE UOS edits for durable medical equipment (DME) billed by providers.

f. NCCI PTP edits for durable medical equipment (added in October 2012).

States are also required to use:

- all four components of each Medicaid NCCI methodology;
- the most recent quarterly Medicaid NCCI edit files for states;
- the Medicaid NCCI edits in effect for the date of service on the claim line or claim;
- the claim-adjudication rules in the Medicaid NCCI methodologies; and
- all modifiers for Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes needed for the correct adjudication of applicable Medicaid claims.

The NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual **contain** additional requirements for implementation of the NCCI methodologies.

The Medicaid NCCI methodologies must be applied to Medicaid fee-for-service claims submitted with, and reimbursed on the basis of, HCPCS codes and CPT codes. This includes claims reimbursed on a fee-for-service basis in state Medicaid Primary Care Case Management managed care programs. Application of NCCI methodologies to fee-

for-service claims processed by other entities, including limited benefit plans or Managed Care Organizations, is not required; however, if SMAs require the application of NCCI methodologies to fee-for-service claims processed by such entities, then such entities must meet NCCI program requirements, including compliance with the NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual.

Audit Objectives To determine whether SMAs have implemented the required six NCCI methodologies and met the NCCI program requirements, as described in the NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual.

Suggested Audit Procedures

a. Ascertain if each of the six NCCI methodologies have been implemented.

b. Ascertain if the SMA downloaded the correct quarterly files from the Medicaid Integrity Institute and implemented in their system timely.

c. Process test claims to ascertain if:

   (1) SMAs implemented NCCI edits as automated edits;

   (2) SMAs apply edits in the required order;

   (3) SMAs correctly denied payment for all units of service on test claims that trigger medically unlikely edits;

   (4) SMAs correctly used medically unlikely edits on test claims with date spans;

   (5) SMAs followed NCCI program requirements for using modifiers for test claims for procedure-to-procedure edits;

   (6) SMAs are paying for services that should have been denied by NCCI edits by using test claims; and

   (7) SMAs are incorrectly denying payment for services; by using test claims.

d. Ascertain if the SMA has Confidentiality Agreement(s) in place as required by the Technical Guidance Manual, sections 7.1.1 and 7.1.2.

9. Medical Loss Ratio (MLR)

Compliance Requirements For all contracts, the state must ensure that each MCO, PIHP, and PAHP submits a report with the data elements specified in 42 CFR sections 438.8(k) and 438.8(n). The report should contain the required 13 data elements in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the calculation of the MLR. The state should have a policy and procedure to

indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation payments are revised retroactively.

Audit Objectives Determine whether the state's oversight of the content and submission of MLR reports meets the requirements.

Suggested Audit Procedures

a. Perform procedures to ascertain if the state obtained the required MLR reports;

b. Verify the 13 required elements are included;

c. Verify the reporting period covered is 12 months;

d. Verify the report contains an attestation statement to address accuracy;

e. Ascertain if the state did not permit plans to submit multiple MLR reports for a specific reporting year except when a state had retroactive changes to capitation payments.

10. Managed Care Financial Audit

Compliance Requirements Two types of audits are required for managed care:

1. Audited Financial Reports – The contract with each MCO, PIHP, and PAHP must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. These audits must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR section 438.3(m)).

2. Periodic Audits – Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR section 438.602(e) and (g); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920).

Audit Objectives Determine whether the required audits were conducted and the audit reports for the Periodic Audits were posted on the state's website.

Suggested Audit Procedures

a. Review the state's policies and operating procedures for obtaining audited financial reports, conducting these required audits and for posting the Periodic Audits on the state's website.

b. Perform tests to ascertain if: (1) the state obtained annually the required Audited Financial Reports from the MCO, PIHP, and PAHP; and (2) the independent auditor's report on the financial report stated the audit was conducted in accordance with generally accepted auditing standards.

c. Perform tests to ascertain if: (1) the state conducted or contracted for the required Periodic Audits for the-MCO, PIHP, and PAHP at least once in the most recent three year period; and (2) the audits were posted on the state's website.

11. External Quality Review Organization (EQRO)

Compliance Requirements The SMA must ensure that each managed care organization is evaluated annually on quality, timeliness, and access to the health care services by an EQRO. The state must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438 Subpart E, 42 CFR section 438.354).

Audit Objectives Determine whether the SMA has ensured the EQRO's conducting the annual reviews meet the requirements for competence and independence.

Suggested Audit Procedures

a. For states with managed care perform procedures to ascertain if:

(1) The SMA's policies and procedures meet the requirement to ensure the EQROs are competent and independent.

(2) The SMA monitoring of EQROs followed the SMA's policies and procedures.

IV. OTHER INFORMATION

Medicaid is the largest dollar federal grant program and, under OMB budgetary guidance and Pub. L. No. 107-300, HHS is required to provide an estimate of improper payments for Medicaid. Improper payments mean any payments that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes payments for services provided to ineligible providers, payments for an ineligible service, duplicate payments, payments for services not received, and payments that do not account for credit for applicable discounts.

While not precluding an auditor from determining that the Medicaid cluster qualifies as a low-risk program (if prior audits have shown strong internal controls and compliance with Medicaid requirements), the above should be considered as part of the risk assessment process and audit documentation should support the consideration. In addition, even though the state Medicaid Fraud Control Units (MFCUs) and State Survey and Certification of Health Care Providers and Suppliers have substantially fewer federal expenditures than Medicaid, they are clustered with Medicaid because these programs provide significant controls over the expenditures of Medicaid

funds. It is unlikely that the expenditures for these two programs would be material to the Medicaid cluster; however, noncompliance with the requirements to administer these controls may be material.

Portion of Medicaid (Title XIX) Expenditures Claimed at CHIP Enhanced FMAP

As described in Part 4, CHIP (Assistance Listing 93.767), III.A.1, "Activities Allowed or Unallowed," certain qualifying states meeting the criteria provided in section 2105(g) of the Social Security Act, 42 USC 1397ee(g), may opt to receive the CHIP enhanced FMAP for certain Medicaid program expenditures. For certain qualifying states that choose this option, the enhanced portion of such expenditures (that is, the portion that is equal to the difference between the CHIP enhanced FMAP and the standard Medicaid FMAP) is funded by their available CHIP allotments. Qualifying states were permitted to use up to 20 percent of their CHIP allotment to fund the enhanced portion of such Medicaid expenditures for allotments through the fiscal year 2008 CHIP allotment and up to 100 percent of their available CHIP allotments beginning with the fiscal year 2009 CHIP allotment. The qualifying states, determined by CMS under section 2105(g) of the Social Security Act, 42 USC 1397ee(g) are Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

Amounts transferred into the state's Medicaid program are subject to the requirements of the Medicaid program when expended and should be included in the audit universe and total expenditures of this program when determining Type A programs. On the Schedule of Expenditures of Federal Awards, the amounts transferred in should be shown as expenditures of this program when such amounts are expended.

Improper Payments

Auditors should be alert to the following that have been identified in audit findings both as noncompliance and material weaknesses: If these items are identified, the auditors should determine if further review is appropriate.

1. Beneficiary Eligibility Determinations

   Findings related to internal control deficiencies for eligibility determinations include:

   - eligibility determination and renewal were not performed timely and/or performed within the timeliness standards;
   - eligibility determinations are not made accurately;
   - lack of internal controls over obtaining adequate documentation to support eligibility determinations, when applicable;
   - eligibility system data was not accurate;
   - beneficiary information was not verified according to the state's verification plan;

- program staff did not have sufficient knowledge of program requirements and policies due to high turnover and/or a lack of training; and
- MEQC review staff were not functionally and physically separate from both the eligibility determination staff and the Medicaid policy staff.

2. Medicaid Claims Processing

Findings related to significant weaknesses in Medicaid claims processing include:

- inadequate documentation to support the payments claimed in the CMS-64;
- payments reported on the CMS-64 were not readily traceable to the individual claims or information in the sub-system or the financial statements;
- inadequate internal control over utilization, fraud, and accuracy of the Medicaid claims;
- lack of understanding of when to report payments in the CMS-64;
- inadequate internal control to assure that payments to providers were made in compliance with federal regulations (e.g., payments for services that were not medically necessary and providers were not eligible Medicaid providers);
- review of cost report and recoupment of rate adjustments were not timely.

3. Other areas of weaknesses identified include:

- inadequate monitoring and oversight of subcontractors;
- inadequate monitoring and oversight to assure provider licensing, agreements or required certification were in effect and up-to-date, and that the related documentation was in file or in the state MES;
- inadequate internal control related to implementation of MES module;
- inadequate internal control regarding user access to the MES modules, including terminated employees' user access rights; and
- MES module was not programmed and updated timely and accurately with proper information.