

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- CFDA 93.775 STATE MEDICAID FRAUD CONTROL UNITS**
CFDA 93.776 HURRICANE KATRINA RELIEF
CFDA 93.777 STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS
CFDA 93.778 MEDICAL ASSISTANCE PROGRAM (Medicaid; Title XIX)

Note: In accordance with OMB Circular A-133, §___.525(c)(2), when the auditor is using the risk-based approach for determining major programs, the auditor should consider that the Department of Health and Human Services (HHS) has identified the Medicaid Assistance Program as a program of higher risk.

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 payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, and any payment for an ineligible service, any duplicate payment, payments for services not received, and any payments that does not account for credit for applicable discounts.

While not precluding an auditor from determining that the Medicaid Cluster qualifies as a low-risk program (e.g., because prior audits have shown strong internal controls and compliance with Medicaid requirements), the above should be considered as part of the risk assessment process.

I. PROGRAM OBJECTIVES**Medical Assistance Program**

The objective of the Medical Assistance Program (Medicaid or Title XIX of the Social Security Act, as amended, (42 USC 1396 *et seq.*)) is to provide payments for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children.

State Medicaid Fraud Control Units

The mission of the State Medicaid Fraud Control Units (MFCUs) is to investigate and prosecute violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan. The State MFCUs also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan, and may review complaints of misappropriation of patients' private funds in such facilities. Federal requirements for the establishment and continued operations of the units are contained in 42 USC 1396b(a)(6), 1396b(b)(3), and 1396b(q); and 42 CFR part 1007. A key requirement of the governing regulations is that a unit must be a single identifiable entity of State government.

The HHS Office of the Inspector General (OIG) is the agency responsible for the Federal oversight of the State MFCUs. In order to receive the Federal grant funds necessary to sustain their operations, the units must submit an application for Federal assistance to the OIG on an annual basis.

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 Medicaid program are in compliance with regulatory health and safety standards and conditions of participation. This program is administered in a manner similar to Medicaid and includes an approved State plan that addresses Federal requirements.

Even though the State MFCUs and State Survey and Certification of Health Care Providers and Suppliers have substantially less Federal expenditures than the Medicaid Assistance Program, 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.

Hurricane Katrina Relief

The objectives of the Hurricane Katrina Relief program are to provide (1) additional Federal payments under Hurricane Katrina-related multi-State Section 1115 demonstrations to reimburse affected States for the non-federal share of specified medical care hurricane-related expenditures and associated administrative costs, and the total uncompensated care costs for affected States; and (2) with respect to counties or parishes in Alabama, Louisiana, and Mississippi affected by Hurricane Katrina, this program is intended to provide the non-federal share of medical care expenditures furnished to Title XIX and Title XXI individuals under existing State plans. In addition, if approved by the Secretary, funds may be used by the State to restore access to health care in Katrina-impacted communities.

II. PROGRAM PROCEDURES

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 U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) administers the Medicaid program in cooperation with State governments. 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 U.S. territories: Puerto Rico, the Virgin Islands, Guam, American Samoa,

and the Northern Mariana Islands. Medicaid operates as a vendor payment program, with States paying providers of medical services directly. Participating providers must accept the Medicaid reimbursement level as payment in full. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

State Plans

States administer the Medicaid program under a State plan approved by CMS. The Medicaid State plan is a comprehensive written statement submitted by the State Medicaid agency 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 is referenced to the applicable Federal regulation for each requirement and will also contain references to applicable State regulations.

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 level of Federal financial participation in the State program. The State plan must specify a single State agency (hereinafter referred to as the "State Medicaid agency") 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 State Medicaid agency to determine eligibility.

The State plan also specifies the criteria for determining the validity of payments disbursed under the Medicaid program. This encompasses the system the State will use to ensure that payments are disbursed only to eligible providers for appropriately priced services that are covered by the Medicaid program and provided to eligible beneficiaries. Payments must also be based on claims that are adequately supported by medical records, and payments must not be duplicated.

A State plan or plan amendment will be considered approved unless CMS sends the State written notice of disapproval or a request for additional information within 90 days after receipt of the State plan or plan amendment. Copies of the State plan are available from the State Medicaid agency.

Waivers

The State Medicaid agency may apply for a waiver of Federal requirements. Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and are subject to specific safeguards for the protection of beneficiaries and the program.

Actions that States may take if waivers are obtained include: (1) implement a primary care case-management system or a specialty physician system; (2) designate an entity to act as a central broker in assisting Medicaid beneficiaries to choose among competing health care plans;

(3) share with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries' use of more cost effective medical care; (4) limit 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; (5) include as medical assistance, under its State plan, home and community-based services furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital or nursing facility, and is reimbursable under the State plan; and (6) impose a deduction, cost-sharing or similar charge of up to twice the nominal charge established under the State plan for outpatient services for certain non-emergency services (except that, pursuant to the Deficit Reduction Act of 2005, a State may, at its option and without a waiver, charge higher co-payments for non-emergency services provided in an emergency room). A State may also obtain a waiver of statutory requirements to provide an array of home and community-based services, 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 waivers are available from the State Medicaid agency.

Payments to States

Once CMS has approved a State plan and waivers, it makes quarterly grant awards to the State to cover the Federal share of Medicaid expenditures for services, training, and administration. The amount of the quarterly grant is determined on the basis of information submitted by the State Medicaid agency (in quarterly estimate and quarterly expenditure reporting). The grant award authorizes the State to draw Federal funds as needed to pay the Federal financial participation portion of qualified Medicaid expenditures. The HHS Payment Management System, Division of Payment Management (PMS-DPM) in Rockville, Maryland, disburses Federal funds to States including funding under Medicaid. Currently, all States use a system developed by HHS, called SMARTLINK, to request funds on an as-needed basis. States may use one of two payment mechanisms which are linked to SMARTLINK: (1) wire transfers through the Automated Clearinghouse in conjunction with the Federal Reserve Bank, which are settled the day after the request date, or (2) FEDWIRE transfers through the Department of the Treasury, which is a same-day payment mechanism. The payment method is selected by the State and approved by the Department of the Treasury and HHS before payments are made through either mechanism. States report cash activity to PMS-DPM with a quarterly Cash Transactions Report (PSC-272).

State Expenditure Reporting

Thirty days after the end of the quarter, States electronically submit the CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance Program*. The CMS-64 presents expenditures and recoveries and other items that reduce expenditures for the quarter and prior period expenditures. The amounts reported on the 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 to electronically submit the CMS-64 directly to CMS.

Eligibility

Eligibility for Medicaid is based on categorical (e.g., families and children, aged, blind, and disabled) and financial (e.g., income/resources) status. The States must provide services to mandatory categorically needy and other required special groups. States may provide coverage to members of optional groups and medically needy individuals (individuals who are eligible for Medicaid after deducting medical expenditures from their income). Eligibility criteria will be specified in the individual State plan.

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the cash welfare program known as Aid for Dependent Children (AFDC) was repealed and replaced with block grants to States known as Temporary Assistance for Needy Families (TANF). Under Medicaid, children and parents who received AFDC were automatically enrolled in Medicaid. However, Medicaid for children and parents who would have met the State's old AFDC income and asset standards in place on July 16, 1996, has been preserved whether or not these individuals are eligible for the new TANF system (Pub. L. No. 104-193).

States must provide limited Medicaid coverage for "qualified Medicare beneficiaries." These are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI (42 CFR section 407.40).

The State plan will specify if determinations of eligibility are made by agencies other than the State Medicaid agency and will define the relationships and respective responsibilities of the State Medicaid agency and the other agencies. States are required to have (1) documentation of qualified alien status if the applicant/recipient is not a U.S. citizen, (2) facts in the case record to support the agency's eligibility determination, and (3) a written application on a form prescribed by the agency and signed under a penalty of perjury. The State must require a written application signed under penalty of perjury and include in each applicant's case record facts to support the agency's decision on his/her application. The State must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for discontinuing assistance. In cases of persons who are not U.S. citizens, the State must obtain documentation of qualified alien status (42 CFR sections 435.907, 435.912, and 435.913; 42 USC 1320b-7; Section 1137 of the Social Security Act).

Services

Medicaid expenditures include medical assistance payments for eligible recipients for such services as hospitalization, prescription drugs, nursing home stays, outpatient hospital care, and physicians' services, and expenditures for administration and training. In order for a medical assistance 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 an entity, such as an insurance company, to arrange for medical services to be available for beneficiaries. The State pays a fixed rate per person (capitation rate) without regard to the actual medical services utilized by each beneficiary.

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

Control Systems

Utilization Control and Program Integrity

The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including those provided by long-term care institutions. In addition, the State must have: (1) methods of 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.

These requirements may be met by the State Medicaid agency assuming direct responsibility for assuring the requirements or by contracting with a quality improvement organization (QIO) (formerly known as peer review organization (PRO)) to perform such reviews. The reviewer must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services.

The State Medicaid agency must have procedures for the ongoing post-payment review, on a sample basis, for the necessity, quality, and timeliness of Medicaid services. The State Medicaid agency may conduct this review directly or may contract with a QIO.

Suspected fraud identified by utilization control and program integrity should be referred to the State Medicaid Fraud Control Units.

Inpatient Hospital and Long-Term Care Facility Audits

States are required to establish as part of the State plan standards and methodology for reimbursing inpatient hospital and long-term care facilities based on payment rates that represent the cost to efficiently and economically operate such facilities and provide Medicaid services. The State Medicaid agency must provide for the filing of uniform cost reports by each participating provider. These cost reports are used by the State Medicaid agency to aid in the establishment of payment rates. The State Medicaid agency 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 State Medicaid agency in ensuring that established payment rates are proper.

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.

Medicaid Management Information System (MMIS)

The MMIS is the mechanized Medicaid benefit claims processing and information retrieval system that States are required to have, unless this requirement is waived by the Secretary of HHS. HHS provides general systems guidelines (42 CFR sections 433.110 through 433.131) but it does not provide detailed system requirements or specifications for States to use in the development of MMIS systems. As a result, MMIS systems will vary from State to State. The system may be maintained and operated by the State or a contractor.

The MMIS is normally used to process payments for most medical assistance services and normally includes edits and controls that identify unusual items for follow up by the utilization control and program integrity unit. However, the State may use systems other than MMIS to process medical assistance payments. In many cases the operation of the MMIS is contracted out to a private contractor. The State plan will describe the administration of each State's claims-processing system.

Generally, the MMIS does not process claims from State agencies (e.g., State-operated intermediate care facility for the mentally retarded (ICF/MR)) and certain selected types of claims. The claims payments that are not processed through MMIS may be material to the Medicaid program.

Federal Oversight and Compliance Mechanisms

CMS oversees State operations through its organization consisting of a headquarters and 10 regional offices.

CMS program oversight includes budget review, reviews of financial and program reports, and on-site reviews, which are normally targeted to cover a specific area of concern. CMS conveys areas of national and local concerns to the States through the regions. Technical assistance is used extensively to promote improvements in State operation of the program but enforcement mechanisms are available. CMS considers the single audit as an important internal control in its monitoring of States.

Federal program oversight, because of its targeted nature, should not be used as a substitute for audit evidence gained through transaction testing.

Medicaid Program Payment Error Rate Measurement

On October 5, 2005, an interim final rule, with an opportunity for comment, was published in the *Federal Register* setting forth the State requirements to provide information to CMS for the purpose of estimating improper payments in the Medicaid program, as required under the Improper Payments Information Act (IPIA) of 2002. The effective date of these regulations is November 4, 2005.

Source of Governing Requirements

The auditor is expected to use the applicable laws and regulations (including the applicable State-approved plan) when auditing this program. 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 Hurricane Katrina Relief program is authorized under the Deficit Reduction Act of 2005, Subtitle C-Katrina Relief, Section 6201, Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations, Pub. L. No. 109-171.

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 (CFDA 93.778) are no longer excluded from coverage under the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal fiscal year (FY) 2004. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

Availability of Other Program Information

The HHS OIG issues fraud alerts, some of which relate to the Medicaid program. These alerts are available on the Internet from the HHS OIG home page, Special Fraud Alerts section (<http://oig.hhs.gov/fraud/fraudalerts.html>).

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

General Audit Approach for Medicaid Payments

To be allowable, Medicaid costs for medical services must be: (1) covered by the State plan and waivers; (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis); (3) properly coded; and (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of 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 (e.g., are allowable under the State plan) without relying upon the systems and internal controls. Examples of complexities include:

- Dependence upon large and complex ADP systems to process the large volume of Medicaid transactions.
- Medical services are provided directly to an eligible beneficiary, normally without prior approval by the State.
- Medical service providers normally determine the scope and medical necessity of the services.
- Notice to the State that service is rendered is after-the-fact when a bill is sent.
- Payments systems do not include a review of original detailed documentation supporting the claim prior to payment.
- Complex billing charge structures and payment rates for medical services, including significance of proper coding of services (e.g., billing by diagnosis related groups (DRG)).
- Different types of Medicaid payments (e.g., inpatient hospital, physicians, prescription drugs and drug rebates).

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 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 MMIS); and (4) the MMIS normally includes edits and controls that identify unusual items for follow up by the utilization control and program integrity agency. The first three generally are performed by specialists retained by the State Medicaid agency. The following table indicates the major types of Medicaid payments 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

Each of the above Medicaid payment types is tested for compliance with applicable laws and regulations under either III.A, "Activities Allowed or Unallowed;" III.B, "Allowable Costs/Cost Principles;" or III.E.1, "Eligibility - Eligibility for Individuals." Based upon the assessed level of control risk, the auditor should design appropriate tests of the allowability of Medicaid payments. Testing likely will include tests of medical records, in which case the auditor should consider the need for assistance of specialists. The auditor may consider using the same specialists used by the State.

The auditor should consider the following in planning and performing tests of controls and compliance:

1. III.N, "Special Tests and Provisions" includes required internal controls, which are compliance requirements (i.e., controls (1), (2), and (3) above), and audit objectives and procedures for each. The audit procedures will entail tests of work performed by the State Medicaid agency.
2. Tests of compliance with laws and regulations relating to III.A, B, and E below, and the compliance requirements enumerated in III.N should be coordinated.

A. Activities Allowed or Unallowed

1. Funds can only be used for Medicaid benefit payments (as specified in the State plan, Federal regulations, or an approved waiver), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for State Medicaid Fraud Control Units (42 CFR sections 435.10, 440.210, 440.220, and 440.180).
2. *Case Management Services* - The State plan may provide for case management services as an optional medical assistance service. 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.

Medicaid case management services are divided into two separate categories:

Administrative case management - Services must be identifiable with Title XIX benefit (e.g., outreach services provided by public school districts to Medicaid recipients).

Medical/targeted case management - Services must be provided to an eligible Medicaid recipient. Services do not have to be specifically medical in nature and

can include securing shelter, personal needs, etc. (e.g., services provided by community mental health boards, county offices of aging).

Case management services is 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 provided through capitation (a process in which payment is made on a per beneficiary basis) or prepaid health plans, 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 (Pub. L. No. 99-272, Section 9508; 42 CFR part 434).

3. *Managed Care* - A State may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. For example, a waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Section 1115 of the Social Security Act). Managed care 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 clients for the proper period, and the capitation payment should be properly calculated. Medicaid medical services payments (e.g., hospital and doctors charges) should not be made for services that are covered by managed care. States should ensure that capitated payments to providers are discontinued when a beneficiary is no longer enrolled for services. Requirements related to beneficiaries' access to managed care services are covered under III.N.6 Special Tests and Provisions - Managed Care.
4. *Medicaid Health Insurance Premiums* - A State may enroll certain Medicare-eligible recipients under Medicare Part B and pay the premium, deductibles, cost sharing, and other charges (42 CFR section 431.625).
5. *Disproportionate Share Hospital* - Federal financial participation is available for aggregate payments to 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. Specific limits for the total disproportionate share hospital payments for the State and the individual hospitals are contained in the legislation (Section 1923 of the Social Security Act and 42 USC 1396(r)).
6. *Home and Community-Based Services* - A State may obtain a waiver of statutory requirements to provide an array of home and community-based services which may permit an individual to avoid institutionalization (42 CFR part 441, subpart G). The HHS OIG has issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was

published in the *Federal Register* on August 10, 1995, (page 40847) and is available on the Internet from the HHS OIG home page, Special Fraud Alerts section (<http://oig.hhs.gov/fraud/fraudalerts.html>).

B. Allowable Costs/Cost Principles

Recoveries, Refunds, and Rebates (Costs must be the net of all applicable credits)

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 a third-party liability is established after the claim is paid, reimbursement from the third party should be sought (42 CFR sections 433.135 through 433.154).
2. The State is required to credit the Medicaid program for (1) State warrants that are canceled and uncashed checks beyond 180 days of issuance (escheated warrants) and (2) overpayments made to providers of medical services within specified time frames. In most cases, the State must refund provider overpayments to the Federal Government within 60 days of identification of the overpayment, regardless of whether the overpayment was collected from the provider (42 CFR sections 433.300 through 433.320, and 433.40).
3. Section 1903(w)(1) of the Social Security Act (as amended by Pub. L. No. 102-234) provides that, effective January 1, 1992, before calculating the amount of Federal financial participation, 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 providers and entities related to providers (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 that exceed a specified limit (42 USC 1396(b)(w); 42 CFR section 433.57).

"Provider-related donations" are any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of local government by (1) a health care provider, (2) an entity related to a health care provider, or (3) an entity providing goods or services under the State plan and paid as administrative expenses. "Bona fide provider-related donations" are donations that have no direct or indirect relationship to payments made under Title XIX (42 USC 1396 *et seq.*) to (1) that provider, (2) providers furnishing the same class of items and services as that provider, or (3) any related entity (42 CFR sections 433.58(d) and 433.66(b)).

Permissible health care-related taxes are those taxes which are broad-based taxes, uniformly applied to a class of health care items, services, or providers, and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which CMS has granted a waiver. Health care-related taxes that do not meet

these requirements are impermissible health care-related taxes (42 CFR section 433.68(b)).

The provisions of Pub. L. No. 102-234 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; *Federal Register*, August 13, 1993, 58 FR 43156-43183).

4. Section 1927 of the Social Security Act allows States to receive rebates for drug purchases the same as other payers receive. Drug manufacturers are required to provide a listing to CMS of all covered outpatient drugs and, on a quarterly basis, are required to provide their average manufacturer's price and their best prices for each covered outpatient drug. 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 State Medicaid agency must provide to manufacturers drug utilization data. 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.

E. Eligibility

1. Eligibility for Individuals

- a. The State Medicaid agency or its designee is required to determine client eligibility in accordance with eligibility requirements defined in the approved State plan (42 CFR section 431.10).
- b. There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the State or its designee shall:
 - (1) Require a written application signed under penalty of perjury and include in each applicant's case records facts to support the agency's decision on the application (42 USC 1320b-7(d); 42 CFR sections 435.907 and 435.913).
 - (2) Use the income and eligibility verification system (IEVS) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration (SSA), and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States also: (a) may target the items of information for each data source that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verify the eligibility of all recipients;

- (b) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and (c) can exclude unemployment compensation information from the Internal Revenue Service or earnings information from SSA that duplicates information received from another source (42 USC 1320b-7(a); 42 CFR sections 435.948(e) and 435.953).
- (3) Require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish his or her social security account numbers (SSN) and the State shall utilize the SSN in the administration of the program. The State shall not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA. If the applicant cannot recall the SSN or has not been issued a SSN, the agency must assist the applicant in completing an application for an SSN and either send the application to SSA or, if there is evidence that the applicant has been previously issued a SSN, request SSA to furnish the number. A State may give a Medicaid identification number to an applicant who, because of well-established religious objections, refuses to obtain a SSN. In redetermining eligibility, if the case record does not contain the required SSN, the agency must require the recipient to furnish the SSN (42 CFR section 435.920(b)) (42 USC 1320b-7(a)(1); 42 CFR sections 435.910 and 920).
- (4) Verify each SSN of each applicant and recipient with SSA to insure that each SSN furnished was issued to that individual and to determine whether any others were issued (42 CFR sections 435.910(g) and 42 CFR 435.920).
- (5) Document qualified alien status if the applicant or recipient is not a U.S. citizen (42 USC 1320b-7d).
- (6) Redetermine the eligibility of Medicaid recipients with respect to circumstances that may change (e.g., income eligibility), at least every 12 months. The agency may consider blindness and disability as continuing until the review physician or review team determines that the recipient's blindness or disability no longer meets the definition contained in the plan. There must be procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. The State must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his or her eligibility (42 CFR section 435.916).

- c. 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). 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.
- d. *Medicaid Eligibility Quality Control System (MEQC)*
- (1) States are required to operate a MEQC system in accordance with requirements established by CMS. The MEQC system redetermines eligibility for individual sampled cases of beneficiary eligibility made by State Medicaid agencies, or their designees. Statistical sampling methods are used to select claims for review and project the number and dollar impact of incorrect payments to ineligible beneficiaries (42 USC 1396b; 42 CFR sections 431.800 through 431.865).
- (2) However, most States are operating MEQC pilots or have been given a waiver from the traditional MEQC program described in regulation. The pilots and waivers differ from the traditional MEQC program by performing special studies, targeted reviews, or other activities that are designed to ensure program integrity or improve program administration (42 USC 1396b; 42 CFR sections 431.800 through 431.865).
- The auditor will need to evaluate the reliability of the internal control provided by a particular State's MEQC program to ascertain if they can be tested and relied upon in meeting the applicable eligibility audit objectives and the extent to which other auditing procedures may be required.
- e. As discussed in the General Audit Approach for Medicaid Payments, the auditor will likely combine 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 eligibles were combined with III.A, "Activities Allowed or Unallowed."

2. Eligibility for Group of Individuals or Area of Service Delivery - Not Applicable

3. **Eligibility for Subrecipients - Not Applicable**

G. Matching, Level of Effort, Earmarking

1. **Matching**

The State is required to pay part of the costs of providing health care to the poor and part of the costs of administering the program. Different State participation rates apply to medical assistance payments. There are also different Federal financial participation rates for the different types of costs incurred in administering the Medicaid program, such as administration (including administration of family planning services), training, computer, and other costs (42 CFR sections 433.10 and 433.15). The auditor should refer to the State plan for the matching rates.

2. **Level of Effort**

A State waiver may contain a level-of-effort requirement.

3. **Earmarking**

A State waiver may contain an earmarking requirement.

L. Reporting

1. **Financial Reporting**

- a. SF-269, *Financial Status Report* - Applicable for the administrative costs of the State MFCUs. Not Applicable for all other components of the cluster.
- b. SF-270, *Request for Advance or Reimbursement* - Not Applicable
- c. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* - Not Applicable
- d. SF-272, *Federal Cash Transactions Report* - The PMS-272, *Quarterly Cash Transactions Report (OMB No. 0937-0200)* is required in lieu of the SF-272.
- e. CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance Program (OMB No. 0938-0067)* - Required to be used in lieu of the SF-269, *Financial Status Report*, and is required to be 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**

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, including long-term care institutions. In addition, the State must have: (1) methods or 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 should be referred to the State Medicaid Fraud Control Units (42 CFR part 1007).

The State Medicaid agency 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 State Medicaid agency may conduct this review directly or may contract with a QIO.

Audit Objectives - To 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.

Suggested Audit Procedures

- a. Obtain and evaluate the adequacy of the procedures used by the State Medicaid agency to conduct utilization reviews and identifying suspected fraud.
 - (1) Consider 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: (1) professional certification, license, or specialized training; (2) the reputation and standing of licensed medical professionals in the view of peers; and (3) experience in the type of tasks to be performed.
 - (2) Consider if the personnel performing the utilization review and identifying suspected fraud are sufficiently organized outside the control of other Medicaid operations to objectively perform their function.
 - (3) Ascertain if the sampling plan implemented by the State Medicaid agency or the QIO was properly designed and executed.
- b. Test a sample of the cases examined by State Medicaid agency or the QIO and ascertain if such examinations were in accordance with the agency'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.
- d. Based on the above procedures, consider the degree of reliance that can be placed on the utilization review and identification of suspected fraud in performing tests under III.A, "Activities Allowed or Unallowed," III.B, Allowable Costs/Cost Principles," and III.E.1, "Eligibility - Eligibility for Individuals."

2. Inpatient Hospital and Long-Term Care Facility Audits

Compliance Requirement - The State Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers. The State Medicaid agency must provide for the filing of uniform cost reports for each participating provider. These cost reports are used to establish payment rates. The State Medicaid agency 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 - To determine whether the State Medicaid agency performed inpatient hospital and long-term care facility audits as required.

Suggested Audit Procedures

- a. Review the State Plan and State Medicaid agency 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, ascertain that the sampling plan was carried out as planned.
- c. Select a sample of audits and ascertain if the audits were in compliance with the State Medicaid agency's audit procedures.
- d. Based on the above, consider the degree of reliance that can be placed on the inpatient hospital and long term-care facility audits in performing tests under III.A, "Activities Allowed or Unallowed," III.B, Allowable Costs/Cost Principles," and III.E.1, "Eligibility - Eligibility for Individuals."

3. ADP Risk Analysis and System Security Review

Compliance Requirement - State agencies must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur. State agencies 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 State agency 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 Objective - To determine whether the State Medicaid agency has performed the required ADP risk analyses and system security reviews.

Suggested Audit Procedures

- a. Review the State Medicaid agency's policies and procedures, and document the frequency, timing, and scope of ADP security reviews. This should include any reviews following Statement on Auditing Standards No. 70 (SAS 70) that may have been performed on outside processors.
- b. Consider 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.
- d. Based on the above, consider the degree of reliance that can be placed on the ADP Risk Analysis and System Security Reviews in performing tests under III.A, III.B, and III.E.1.

4. Provider Eligibility

Compliance Requirement - In order to receive Medicaid payments, providers of medical services furnishing services must 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) and the providers must make certain disclosures to the State (42 CFR part 455, subpart B (sections 455.100 through 455.106)).

Audit Objective - To determine whether providers of medical services are licensed 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 a sample of providers receiving payments and ascertain if:
 - (1) The provider is licensed in accordance with the State Plan.

- (2) The agreement with the provider complies with the requirements of the State Plan, including the disclosure requirements of 42 CFR 455 subpart B.

5. Provider Health and Safety Standards

Compliance Requirement - Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/MR (42 CFR part 442). The standards may be modified in the State plan.

Audit Objective - To determine whether the State ensures that hospitals, nursing facilities, and ICF/MR 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 payments for each provider type (i.e., hospitals, nursing facilities, and ICF/MR) and ascertain if the State Medicaid agency has documentation that the provider has met the prescribed health and safety standards.

6. Managed Care

Compliance Requirement - A State may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. A waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Sections 1115 of the Social Security Act).

Audit Objective - To determine whether the State is operating managed care in compliance with the approved State plan waiver.

Suggested Audit Procedures

- a. Obtain an understanding of the State plan's managed care waiver.
- b. Perform tests to ascertain if the State has a system to handle beneficiary complaints of not receiving necessary care and provider complaints of not receiving payments for services provided to Medicaid recipients.
- c. Perform tests to ascertain if the State has a system to ensure beneficiaries have adequate access to health care from managed care organizations which are being paid premiums on the beneficiaries' behalf.

IV. OTHER INFORMATION

Transfers into Medicaid (Title XIX)

As described in Part 4, Children's Health Insurance Program (CHIP) (CFDA 93.767), III.A.1, "Activities Allowed or Unallowed," qualifying States may use up to 20 percent of their available FY 1998, 1999, 2000, or 2001 CHIP allotments under the State's Medicaid program (CFDA 93.778). The qualifying States, determined by CMS using the criteria in Pub. L. No. 108-74 section 1(g)(2) and Pub. L. No. 108-127, section 1, 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.

Hurricane Katrina Relief Program

Funds awarded under the Hurricane Katrina Relief program (CFDA 93.776) should be audited as part of the Medicaid cluster.