DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.775 STATE MEDICAID FRAUD CONTROL UNITS
CFDA 93.777 STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS (Title XVIII) MEDICARE
CFDA 93.778 MEDICAL ASSISTANCE PROGRAM (Medicaid; Title XIX)

Note: In accordance with OMB Circular A-133, §___.525(c)(2)/2 CFR section 200.519, 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 Medical Assistance Program (Medicaid) 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. In addition, the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. No. 111-148, as amended) will result in significant expansion of the program in the future (see IV, "Other Information," in this program supplement).

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 and audit documentation should support the consideration.

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.

State Medicaid Fraud Control Units

States are required as part of their Medicaid State plans to maintain a State Medicaid Fraud Control Unit (MFCU), unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement. The mission of the MFCUs is to investigate and prosecute fraud by Medicaid providers. 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. States are required to refer all suspected violations of applicable Medicaid laws and regulations by providers to the MFCU. 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 a re-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 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 also are required as a condition of Medicaid participation, and the Medicaid program contributes to covering program costs accordingly. 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.

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 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) 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) sharing with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries' use of more cost effective medical care; (4) 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 (5) including 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. 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 2 to 5 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.

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 financial (e.g., income/resources) and non-financial (e.g., age, pregnancy, disability, citizenship/immigration status) criteria. The States must cover mandatory eligibility 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.

States must provide limited Medicaid coverage for "Qualified Medicare Beneficiaries" (QMB). These are aged and disabled persons who are entitled to Medicare Part A, whose income does not exceed 100 percent of the Federal poverty level, and whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index (Section 1860D-14(a)(3)(D) of the Social Security Act (42 USC 1395w-114)).

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 must allow individuals and families to apply online, by telephone, via mail, or in person and must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and

handwritten signatures transmitted via any other electronic transmission must be accepted. The State agency must have facts in the case record to support the agency's eligibility determination, including a record of having verified citizenship or 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 discontinuing assistance. (42 CFR sections 435.907, 435.913, and 435.914; 42 USC 1320b-7).

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.

Medicare Buy-In Program

The Medicare Buy-In Program, also known as QMB (Qualified Medicare Beneficiary) and SLMB (Specified Low-Income Medicare Beneficiary), is designed to protect low-income Medicare beneficiaries from the significant and growing costs required to receive Medicare coverage, including out-of-pocket cost sharing expenses (deductibles and co-payments). 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 deductible 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 2013, the asset limit for the QMB program is $6,680/individual and $10,020/couple. If individuals are eligible for the QMB program, the State Medicaid program pays their Medicare Part B premiums and cost-sharing amounts.

For individuals with slightly higher incomes, the SLMB Program pays only the Part B premium. To be eligible for the SLMB program, the individual/couple can have incomes between 100 and 120 percent of the poverty level. The SLMB program has the same asset limits as the QMB program.

Maintenance of Effort

The maintenance of effort (MOE) provisions in the Affordable Care Act generally ensure that States' coverage for adults under the Medicaid program remains in place until January 1, 2014 and that coverage for children remains in place through September 30, 2019. Sections 1902(a)(74) and 1902(gg) of the Social Security Act require that, as a condition of receiving Federal Medicaid funding, States maintain Medicaid "eligibility standards, methodologies, and procedures" that are not more restrictive than those in effect on March 23, 2010. Certain exceptions may apply for States experiencing or projecting a deficit, which would permit Medicaid eligibility restrictions for certain non-pregnant, nondisabled adults.

Indian Care

Although Medicaid allows States to impose enrollment fees, premiums, and cost-sharing charges on Medicaid and Children's Health Insurance Program (CHIP) participants, Section 5006 of ARRA precludes them from imposing these charges on Indian applicants, according to the guidance released by CMS. Medicaid regulations at 42 CFR section 447.56(a)(1)(x), which are effective January 1, 2014:

- exempt Indians from paying enrollment fees, premiums or similar charges if they are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services (CHS);

- exempt Indians from paying cost sharing (deductibles, coinsurance, copayments or similar charges) for Medicaid-covered services if they are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under CHS; and

- prohibit any reduction in payment due under Medicaid to the Indian health care provider serving an Indian (i.e., a State must pay these providers the full Medicaid payment rate for furnishing the service).

Statutory Changes Affecting the Future Direction of the Medicaid Program

The Affordable Care Act includes numerous health-related provisions affecting the Medicaid program. The provisions of the ACA have varying implementation dates. The ACA allows flexibility in (1) implementing certain provisions and (2) tailoring the individual State's program to comply. A summary of the relevant provisions of these statutes is included in IV, "Other Information." Auditors should be aware of the provisions of these laws in designing their audit procedures.

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.

As part of complying with the above requirement, a state may obtain a Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization (SSAE 16) Type II report from its service organization (if the state has a service organization). The Statement on Auditing Standards No. 70, Service Organizations (SAS 70) is superseded by SSAE 16. A SSAE 16 Type I 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 SSAE 16 report differ according to each individual service organization's operations; however, in every instance, the Type II report procedures assess the sufficiency of the design of an organization's controls and test their effectiveness. A number of commonly covered areas include:

- Control Environment
- Systems Development and Maintenance
- Logical Security
- Physical Access
- Computer Operations
- Input Controls
- Output Controls
- Processing Controls

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. The MMIS' 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. The MMIS incorporates many edits and controls to identify aberrant billing practices for follow-up by State staffs. However, the State may use systems other than MMIS to process medical assistance payments. In many cases the operation and maintenance of the MMIS is contracted out to a private contractor. The State plan will describe the administration of each State's claims-processing subsystems.

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

The regulations at 42 CFR part 431, subpart Q, specify requirements for estimating improper payments in Medicaid.

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 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 subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92/the HHS implementation of 2 CFR part 200, 45 CFR part 75. 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-87/2 CFR part 200, subpart E.

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.

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 12 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) 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. 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 (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 claim for payment is issued.
- 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 function. 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 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 allowability 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.

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 be used only 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 (42 USC 1396n(g); 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 (42 USC 1315)). 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.

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 (42 USC 1396r-4).

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 from the HHS OIG home page, Special Fraud Alerts section (http://oig.hhs.gov/fraud/fraudalerts.asp).

7. *Medicare Part B Buy-In* – 42 CFR section 431.625(d)(1) and CMS Medicaid Manual – State Buy-in (Pub24) Sections 110 and 180 specify that Federal Financial Participation (FFP) is not available for States buy-in for non-cash Medical Assistance Only groups, e.g., the special income level group or the medically needy. FFP is available only for those individuals who are considered as some class of cash recipients or deemed to be a cash recipient or one of the Medicare Savings Program (MSP) groups.

8. *Electronic Health Records (EHR)* – States participating in the EHR incentive program can receive 90 percent FFP for approved processes, systems, and activities necessary to ensure the EHR incentive payments are being properly made (Section 1903t of the Social Security Act, as amended by Section 4201 of the Health Information Technology for Economic and Clinical Health (HITECH) Act (42 USC 1396b)).

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 USC 1396K; 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 (42 CFR sections 433.300 through 433.320, and 433.40).

   Under Section 6506 of the Affordable Care Act (42 USC 1396b(d)(2)), States now have up to 1 year (rather than 60 days) from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud , the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

3. 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 1396b(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)).

   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).

4. Section 1927 of the Social Security Act (42 USC 1396r-8) 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, including drug utilization data of those Medicaid beneficiaries enrolled in managed care organizations. 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

The auditor should not test eligibility for determinations based on Modified Adjusted Gross Income (MAGI-based determination). Detailed testing is performed under the Medicaid and CHIP Eligibility Review Pilots, which serve as CMS' oversight of Medicaid and CHIP eligibility determinations during the initial years of Affordable Care Act implementation. Since the Medicaid and CHIP Eligibility Review Pilots do not focus on non-MAGI-based cases (i.e. Aged, Blind, and Disabled), the auditor should test non-MAGI determinations as described below.

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 non-financial requirements for Medicaid. These include that the State or its designee shall:

(1) Accept an application submitted online, by telephone, via mail, or in person 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) Request information from other agencies in the State and other State and Federal programs to the extent that such information is useful in verifying the financial eligibility of an individual. As described in the State's verification plan submitted to the Secretary of HHS, this may include information from the agencies administering State unemployment compensation laws, the State Wage Information Collection Agency, the Social Security

Administration (SSA), the Internal Revenue Service, the State-administered supplementary payment programs under Section 1616(a) of the Social Security Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act. States may also use information related to eligibility or enrollment from the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, CHIP, or the Exchange (Marketplace). If information provided by or on behalf of an individual is reasonably compatible with information obtained from the electronic data sources, 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).

(3) Require, as a condition of eligibility, that each individual seeking Medicaid furnish his or her Social Security number (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) because of well-established religious objections, refuses to obtain a SSN. In re-determining eligibility, if the case record does not contain the required SSN, the agency must require the recipient to furnish the SSN (42 USC 1320b-7(a)(1); 42 CFR sections 435. 910 and 435.920).

(4) Verify each SSN of each applicant and recipient with SSA to ensure that each SSN furnished was issued to that individual and to determine whether any others were issued (42 CFR sections 435.910(g) and 435.920).

(5) Verify and document the citizenship and immigration status of each applicant (42 USC 1320b-7(d)).

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 5 years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this 5-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 5-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. 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 eligible, 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-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. 0938-0067)* – 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. (**Note**: The Paperwork Reduction Act clearance for this report expires in January 2015)

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:
(a) professional certification, license, or specialized training;

(b) the reputation and standing of licensed medical professionals in the view of peers; and (c) 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 Objective – 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 Type II reviews following Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization (SSAE 16) that may have been performed on outside processors (service organizations).

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, "Activities Allowed or Unallowed;" III.B, "Allowable Costs/Cost Principles;" and III.E.1, "Eligibility – Eligibility for Individuals."

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 (42 USC 1396a(a)(9)) and the providers must make certain disclosures to the State (42 CFR part 455, subpart B, sections 455.100 through 455.106).

Audit Objectives – 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. Medicaid Fraud Control Unit

Compliance Requirement – States are required as part of their Medicaid State plans to maintain a MFCU, unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement.

Audit Objective – To determine whether the State ensures suspected criminal violations are referred to an office with authority to prosecute cases of provider fraud.

Suggested Audit Procedures

a. Determine whether the State has a MFCU and, if not, if it has received a waiver from the Secretary, HHS, and has alternate policies and procedures in place to detect Medicaid fraud and abuse.

b. Obtain an understanding of the States policies and procedures that ensure violations of Medicaid laws and regulations by providers are identified and are referred to an office with authority to prosecute cases of provider fraud.

c. Select a sample of violations of Medicaid laws and regulations by providers 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.

IV. OTHER INFORMATION

Transfers into Medicaid (Title XIX)

As described in Part 4, CHIP (CFDA 93.767), III.A.1, "Activities Allowed or Unallowed," qualifying States may apply certain Medicaid program expenditures against their available CHIP allotments. In particular, qualifying States may use such Medicaid expenditures in amounts up to 20 percent of their available CHIP allotments through 2008 and, beginning April 1, 2009, as authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA), Public Law 111-3 of 2009, up to 100 percent of their available CHIP allotments for FY 2009 and following fiscal years. 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.

Improper Payments

Auditors should be alert to the following which have been identified in audit findings both as non-compliance and material weaknesses.

1. *Eligibility Determinations*

   Findings related to eligibility determinations found internal control deficiencies including:

   - eligibility determination and renewal were not performed timely or performed within the timeliness standards,

- lack of internal controls over obtaining adequate documentation used to support eligibility determinations,
- the data inputted into the eligibility system were not accurate,
- clients information were not verified according to the State's verification plan, and
- program staff did not have sufficient knowledge of program requirements and policies due to high turnover and lack of training.

2. *Medicaid Claims Processing*

Findings related to Medicaid claims processing found significant weaknesses including:

- 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;
- lack of internal control in drawing down ARRA funds;
- 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; and
- review of cost report and recoupment of rate adjustments were not timely.

3. *Other areas of weaknesses* identified included--

- 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 were in file or in the Medicaid Management Information System (MMIS);
- inadequate internal control related to implementation of MMIS replacement system;
- inadequate internal control regarding user access to the MMIS including terminated employees' user access rights; and
- MMIS was not programmed and updated timely and accurately with proper information.

Medicaid EHR Incentive Payment Program

Title IV, Division B of ARRA established voluntary Medicare and Medicaid EHR incentive payments to eligible professionals, eligible hospitals and critical access hospitals, and certain Medicare Advantage organizations for the adoption and demonstration of meaningful use of certified EHR technology, as one component of the HITECH Act.

Section 4201 of the HITECH Act amends section 1903 of the Act to provide 100 percent Federal financial participation (FFP) to States for incentive payments to certain eligible providers participating in the Medicaid program to purchase, implement, operate (including support services and training for staff) and meaningfully use certified EHR technology.

Auditors should be aware that funds made available to States for the Medicaid incentive program and the State's expenditure of those funds, including payments to eligible providers and costs of State administration of the program, are subject to the audit provisions of OMB Circular A-133/ 2 CFR part 200, subpart F. Providers and other eligible entities receiving incentive funds are not subject to the audit provisions of OMB Circular A-133/2 CFR part 200, subpart F by virtue of receipt of those funds.

Summary of Statutory Changes Affecting This Cluster Over Time

AFFORDABLE CARE ACT – MEDICAID

(Enacted March 23, 2010) Comprised of the Patient Protection and Affordable Care Act (PPACA), as amended by Pub. L. No. 111-148 and the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152

Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148

Title II – Role of Public Programs

Subtitle A – Improved Access to Medicaid

Section 2001. Medicaid Coverage for the Lowest Income Populations (as amended by Sections 10201(b)-(c) and Sections 1004(b)(1) and 1201 of HCERA)

- **Eligibility Expansion in 2014:** This provision creates a new Medicaid eligibility group for adults under the State plan. The new adult group consists of individuals whose income is at or below 133 percent of the FPL, who are under 65, not pregnant, not entitled to or enrolled for Medicare benefits under part A or B of Title XVIII of the Act, and not otherwise eligible for mandatory coverage under Medicaid. In addition, income eligibility for children ages 6 to 18 years of age is expanded from 100 percent of the FPL to 133 percent of the FPL. States also have the option to cover individuals over 133 percent of the FPL and are permitted to phase-in the optional extension of eligibility over 133 percent, so long as the State does not extend eligibility to higher-income individuals before covering lower-income individuals. For both the mandatory expansion to 133 percent and for any optional expansion over 133 percent, this provision requires that parents (or caretaker relatives) may not be enrolled under the Medicaid State plan or waiver of the plan unless their child is enrolled under the State

plan or waiver of the plan or under other health insurance coverage. States have the option to provide a period of presumptive eligibility for parents and non-pregnant childless adults in the same manner they provide a period of presumptive eligibility for children and pregnant women.

- **Early Expansion Option:** Effective April 1, 2010, this provision grants States the option to expand coverage early to individuals who will be in the new adult group prior to the eligibility expansion in 2014.

- **Benefit Requirements:** This provision requires individuals eligible under the new adult group to receive benchmark or benchmark-equivalent coverage consistent with Section 1937 of the SSA, regardless of whether the State has elected the option to provide benchmark or benchmark-equivalent coverage. This benchmark benefit requirement applies to individuals covered under the early expansion option as well as individuals who will be covered in 2014. Individuals who are currently exempt from the application of benchmark and benchmark-equivalent coverage will continue to remain exempt from this requirement; this includes mandatory pregnant women, blind and disabled individuals, and dual eligible individuals and other individuals as enumerated in Section 1937(a)(2)(B) of the SSA. This provision also adds mental health services and prescription drug coverage to the list of required basic services in benchmark-equivalent coverage and requires benchmark or benchmark-equivalent plans to comply with mental health parity services requirements. Beginning in 2014, benchmark and benchmark-equivalent plans must provide at least essential health benefits as described in Section 1302(b).

- **Medicaid Maintenance of Effort Requirement:** As a condition of continuing to receive Federal payments under Medicaid, this provision imposes a Medicaid maintenance of effort (MOE) requirement; the MOE requirement prohibits States from imposing eligibility standards, methodologies, or procedures that are more restrictive than those that were in effect as of the date of enactment. For adults, the Medicaid MOE requirement expires when the Exchange in the State is fully operational, but remains in effect for children through September 30, 2019. A State is not considered to be in violation of the MOE if it applies the modified adjusted gross income standard (as described in Section 2002) under the early expansion option prior to 2014. States also will not be in violation if they expand eligibility or move waiver populations into coverage under the State plan. However, States must continue to comply with the MOE requirements as a condition of receiving increased Federal medical assistance percentage (FMAP) payments as set forth in ARRA. This provision includes an exception to the MOE requirements for non-pregnant, non-disabled adults whose income exceeds 133 percent of the FPL, if during the period between January 1, 2011 and December 31, 2013, a State certifies, with the Secretary, that the State is projected to have a budget deficit.

- **Requirement for Continuation of Political Subdivision Payments:** Effective upon enactment, this provision provides that a State is not eligible for the increased FMAP available for the Medicaid expansion nor the ARRA FMAP increase if a State requires political subdivisions to pay a greater percentage of the non-Federal share of Medicaid expenditures than they were paying on December 31, 2009. Voluntary contributions by a political subdivision are not considered a violation of this provision.

- **Financing the Medicaid Expansion:** This provision establishes that, for the purpose of applying an increased FMAP, the term "newly eligible" includes individuals up to 133 percent of FPL, who are not under 19 years of age and who, as of December 1, 2009, were not eligible under the Medicaid State plan or under a waiver of the plan for full benefits or benchmark or benchmark-equivalent coverage. Individuals who were eligible, but not enrolled, for such benefits under a waiver with an enrollment ceiling are also considered to be "newly eligible." This provision also establishes a uniform FMAP for all 50 States and the District of Columbia for expenditures related to newly eligible Medicaid beneficiaries. The Federal Government will match the costs of covering "newly eligible" individuals as follows: 2014-2016: 100 percent; 2017: 95 percent; 2018: 94 percent; 2019: 93 percent; and 2020 and years thereafter: 90 percent. These matching rates do not apply to the early expansion option described above. States that opt to expand coverage between April 1, 2010 and January 1, 2014 will receive the regular Medicaid matching rate for such coverage until January 1, 2014.

- **"Expansion State" Policy:** This provision defines "expansion States" as States that currently offer health coverage statewide to parents and non-pregnant childless adults with income that is at least 100 percent of the FPL. To qualify as an expansion State, the coverage offered to parents and non-pregnant childless adults must include inpatient hospital services, coverage that is not dependent on access to employer coverage, an employer contribution for coverage, and coverage that is not limited to premium assistance, hospital-only benefits, a high deductible plan, or alternative benefits under a Health Opportunity Account. For these expansion States, this provision provides an increased FMAP to reduce the State share of costs attributable to previously eligible, non-pregnant, childless adults under 133 percent of the FPL.

  For previously eligible childless adults with incomes up to 133 percent of the FPL, each expansion State will receive an increase in its FMAP equal to a specified percentage of the gap between its regular Medicaid matching rate and the enhanced match rate provided to other States. The "transition percentage" changes by year as follows: 2014: 50 percent; 2015: 60 percent; 2016: 70 percent; 2017: 80 percent; 2018: 90 percent; 2019 and years thereafter: 100 percent. In 2019 and thereafter, expansion States will be responsible for the same State share of the costs of covering non-pregnant, childless adults as non-expansion States will be (e.g., 7 percent in 2019, 10 percent thereafter). Also, between January 1, 2014 and December 31, 2015, a State that does not have any "newly eligible" individuals and has not been approved to divert its Medicaid disproportionate share hospital payments to fund coverage expansions will receive a 2.2 percentage point increase in the FMAP for the costs of covering non-newly eligible individuals.

- **Reporting Requirements:** Beginning in January 2015 and annually thereafter, this provision requires each State to submit a report to the Secretary that includes: 1) the total number of enrolled and newly enrolled individuals in the State plan or waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population; 2) a description of outreach and enrollment processes used by the State; and 3) any other data reporting determined necessary by the Secretary to monitor enrollment and retention. Beginning in April 2015 and annually thereafter, the Secretary is required to submit a Report to Congress on the total enrollment and new enrollment in Medicaid on a

national and State-by-State basis and shall include recommendations for administrative or legislative changes to improve enrollment in Medicaid.

Section 2002. Income Eligibility for Nonelderly Determined using Modified Gross Income (as amended by Section 1004 of HCERA)

This provision establishes new rules, effective January 1, 2014, for determining eligibility for Medicaid, CHIP, and the Exchanges. These rules will generally replace the use of disregards in Medicaid and CHIP with the application of a modified adjusted gross income (MAGI) based methodology. States are required, when determining MAGI eligibility, to subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies.

This provision also generally prohibits the use of income disregards and asset tests in Medicaid, with certain exceptions for specific individuals, including the disabled and elderly, and individuals whose income is determined as a result of eligibility for other Federal or State assistance programs (e.g., SSI, foster care). These individuals are also exempt from the MAGI requirements.

This provision requires States to establish income eligibility thresholds for Medicaid populations using MAGI and household income that are not less than the effective income eligibility levels that are applied under the State plan or waiver on the date of enactment. Such eligibility thresholds are to be submitted to the Secretary for approval and the Secretary must ensure that the thresholds proposed by the State will not result in children losing coverage. This provision also requires States to develop an equivalent income test that ensures that individuals eligible for Medicaid on the date of enactment do not lose coverage during the transition to the MAGI standard, and requires that MAGI and household income be determined based on an individual's income as of the point in time at which the application for Medicaid is processed.

Section 2003. Premium Assistance for Employer-Sponsored Insurance (as amended by Section 10203(b))

Effective as if included in Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), this provision aligns the definition of "cost effective" in Sections 1906(e)(2) and 1906A(a) of the SSA to the definition in Section 2105(c)(3)(A) of this Act and applies the definition to adults as well as to children. CHIPRA requires that premium assistance be cost effective relative to either the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage to the child or family involved; or the aggregate amount of expenditures a State would have made under the child health plan, including administrative expenditures, for providing coverage under the plan for the child or their family.

Section 2004. Medicaid Coverage for Former Foster Care Children (as amended by Section 10201(a))

Effective January 1, 2014, this provision creates a new mandatory eligibility category for individuals who have aged-out of the foster care system and had previously received Medicaid while in foster care, so that they can remain eligible for Medicaid until they turn 26. Presumptive eligibility rules are amended to apply to this new mandatory eligibility category. This provision also specifies that former foster care children remain eligible for the full scope of Medicaid benefits, rather than benchmark or benchmark-equivalent benefits as mandated for individuals receiving coverage under Section 2001.

Section 2005. Payments to Territories (as amended by Section 10201(d) and Section 1204 of HCERA)

This provision specifies the terms and conditions for Territories that choose to establish an Exchange and provides $1 billion to the Territories for this purpose effective for CYs 2014-2019. In addition, it raises the Territories' spending caps by $6.3 billion, beginning on July 1, 2011, through FY 2019. As of July 1, 2011, this provision permanently raises the Territories' FMAP rate from 50 percent to 55 percent.

Section 2006. Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster (as amended by Section 10201(c)(5))

Starting January 1, 2011, this provision reduces projected decreases in the FMAP for States that have experienced major, statewide disasters. The criteria listed for a State to qualify for an FMAP adjustment are: (1) the President has declared for the State a major disaster under the Stafford Disaster Relief and Emergency Assistance Act during the preceding 7 fiscal years, and determined as a result of such disaster that every county or parish in the State warranted public assistance under that Act; and (2) the State would have a decrease in its FMAP of at least three percentage points from the previous fiscal year, including a decrease in the base FMAP in any covered fiscal year as established by ARRA. Under this provision, a qualifying State would see an initial 50 percent reduction in the FMAP decrease it would otherwise experience under current law, and a 25 percent reduction in the subsequent years the State qualifies for this adjustment.

Subtitle C – Medicaid and CHIP Enrollment Simplification

Section 2201. Enrollment Simplification and Coordination with State Health Insurance Exchanges

The provision requires States, as a condition of participation in Medicaid and receipt of Federal financial participation for calendar quarters beginning after January 1, 2014, to establish procedures for the following:

- Enabling individuals to apply and renew their Medicaid eligibility through an Internet website;

- Enrolling without any further determination individuals who are identified by an Exchange established by the State as eligible for Medicaid or CHIP;

- Ensuring that individuals who are determined ineligible for Medicaid or CHIP are screened for eligibility for enrollment in qualified health plans offered by an Exchange, including eligibility for any premium tax credits and cost-sharing reductions;

- Ensuring that the Medicaid agency, CHIP agency, and Exchange utilize a secure electronic interface to allow for Medicaid, CHIP, and premium assistance eligibility determinations;

- Coordinating Medicaid, CHIP, and Exchange coverage including Early and Periodic Screening, Diagnosis, and Treatment services; and

- Conducting outreach to and enrolling vulnerable and underserved populations including children, homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individual with mental health or substance-related disorders, and individuals with HIV/AIDS.

In addition, the provision permits a State Medicaid and State CHIP agency to make eligibility determinations for premium tax credits and cost-sharing reductions on behalf of the Exchange. By not later than January 1, 2014, the provision requires States to have an Internet website that allows for comparisons of benefits, premiums, and cost-sharing applicable to an individual under Medicaid with those available under a qualified health plan offered through an Exchange. These requirements are included in a new Section 1943 of the SSA.

See CFDA 93.525 in the Supplement.

Section 2202. Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations

Effective January 1, 2014, this provision allows hospitals that are participating Medicaid providers to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for Medicaid for purposes of providing medical assistance during a presumptive eligibility period. This provision broadens the populations for which presumptive eligibility decisions may be made. The Secretary of HHS shall establish guidance related to this provision.

Subtitle D – Improvements to Medicaid Services

Section 2301. Coverage for Freestanding Birth Center Services

Effective upon enactment, this provision requires States to cover services provided by freestanding birth centers as a mandatory service. A freestanding birth center service is defined as a service provided in a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, is licensed or otherwise approved by the State, and complies with State requirements. A grace period is granted to provide States an opportunity to pass legislation to amend their Medicaid State plans, if necessary under State law.

Section 2302. Concurrent Care for Children

Effective upon enactment, this provision allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

Section 2303. State Eligibility Option for Family Planning Services

Effective upon enactment, this provision establishes a new optional eligibility group for individuals who are not pregnant and whose income does not exceed the highest income eligibility level for pregnant women. The medical assistance available to an individual eligible under this group is limited to family planning and family planning related services. This provision also allows for such coverage during a presumptive eligibility period and adds family planning services and supplies as a required element of benchmark or benchmark-equivalent plans.

Section 2304. Clarification of Definition of Medicaid Medical Assistance

Effective upon enactment, this provision amends Section 1905 of the Act to clarify the original intent of Congress that "medical assistance" encompasses both payment for services provided and the services themselves.

Subtitle E – New Options for States to Provide Long-Term Services and Supports

Section 2401. Community First Choice Option (as amended by Section 1205 of HCERA)

The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover home and community-based attendant services and supports for individuals with incomes not exceeding 150 percent of the FPL or, if greater, who have been determined to require an institutional level of care. It also requires States to make such services and supports available to individuals under a person-centered plan of care for purposes of assisting them in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. States are provided an additional six percentage point increase in Federal Medicaid matching funds for services and supports provided to such individuals. The provision requires State compliance with certain requirements, an evaluation, and two Reports to Congress, with an interim report due not later than December 31, 2013 and a final report due by December 31, 2015.

Section 2402. Removal of Barriers to Providing Home and Community-Based Services (HCBS)

Amends Section 1915(i) of the Act effective October 1, 2010 to permit States to cover individuals who are eligible for home and community-based services under a Section 1915(c), (d), or (e) waiver or Section 1115 demonstration and also establishes a 5-year period to phase-in the enrollment of eligible individuals for States that choose to target services to specific populations with 5-year renewal periods, lifts the prohibition on covering other services, and eliminates a State's option to cap enrollment and disregard statewideness.

Section 2403. Money Follows the Person Rebalancing Demonstration

The provision extends the demonstration, which currently runs through FY 2011, through FY 2017 and, effective April 22, 2010, shortens the length of time from 6 months to 90 days that an individual is required to reside in a facility prior to transitioning to the community. For purposes of calculating the 90-day period, the provision precludes the counting of any days during which an individual resides in an institution on the basis of receiving short-term rehabilitative services covered by Medicare. Accordingly, $450 million for each of FYs 2012-2016 is provided for grants, of which not more than $1.1 million may be used each year for research on and a national evaluation of the program.

Section 2404. Protection for Recipients of HCBS Against Spousal Impoverishment

For a 5-year period beginning on January 1, 2014, the provision requires States to extend impoverishment protections to spouses of individuals receiving Medicaid HCBS, as they are currently required to do for spouses of individuals residing in an institutional setting.

Subtitle F – Medicaid Prescription Drug Coverage

Section 2501. Prescription Drug Rebates (as amended by Section 1206 of HCERA)

Effective January 1, 2010, this provision increases the minimum rebate for single source and innovator multiple source outpatient prescription drugs from 15.1 percent to 23.1 percent. Under the provision, the minimum rebate for brand name drugs with clotting factors and drugs with pediatric indications is increased from 15.1 percent of average manufacturer's price (AMP) to 17.1 percent of AMP and the rebate percentage for generic drugs is increased from 11 percent to 13 percent of AMP. This provision allows the Federal Government to capture savings from these increases in the minimum rebate percentages.

Effective upon enactment, this provision requires drugs dispensed to Medicaid managed care enrollees to be subject to the same rebate amount required under Section 1927 of the SSA. Capitation rates paid to a managed care organization (MCO) must be based on the actual costs related to the rebates and are subject to regulations requiring actuarially sound rates. MCOs are required to report on a timely basis information on the total number of units of each dosage form and strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to Medicaid managed care enrollees.

Effective January 1, 2010, this provision specifies the amount of the rebate for reformulated drugs. With respect to a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation will be the amount computed under Section 1927 of the SSA or, if greater, the product of the AMP for the line extension drug, the highest additional rebate under Section 1927 for any strength of the original single source drug or innovator multiple source drug, and the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period. These requirements also apply to orphan drugs. In addition, this provision establishes a limit on the rebate amount for brand name drugs at 100 percent of AMP.

Section 2502. Elimination of Exclusion of Coverage of Certain Drugs

Beginning on January 1, 2014, this provision prohibits States from excluding smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid coverage.

Section 2503. Providing Adequate Pharmacy Reimbursement (as amended by Section 1101(c) of HCERA)

Effective October 1, 2010, this provision revises the Federal Upper Limit (FUL) to be no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent multiple source drugs. This section also clarifies the definition of AMP to include sales by: 1) wholesalers for drugs distributed to retail community pharmacies; and 2) retail community pharmacies that purchase drugs directly from manufacturers. This section also excludes from the definition of AMP prompt payments, discounts provided by manufactures, and other discounts, and eliminates the requirement that AMP data be disclosed to the public. This provision also adds a requirement that the weighted average of monthly AMPs and the average retail survey prices be disclosed to the public.

Subtitle G – Medicaid Disproportionate Share Hospital (DSH) Payments

Section 2551. Disproportionate Share Hospital (DSH) Payments (as amended by Sections 10201(e)-(f) and Section 1203 of HCERA)

As amended, this provision reduces States' DSH allotments by an aggregate annual reduction totaling $18.1 billion for FYs 2014-2020 by applying a methodology that imposes the largest reductions on States with the lowest percentage of uninsured or States that do not target their DSH payments to hospitals with a high volume of Medicaid inpatients and high uncompensated care. A smaller reduction is applied to low DSH States. In addition, this provision extends Hawaii's DSH allotment through FY 2012, establishes Hawaii as a low DSH State beginning in FY 2013, and extends Tennessee's DSH allotment through FY 2013.

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries

Section 2602. Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

No later than March 1, 2010, this provision requires the Secretary to establish a Federal Coordinated Health Care Office within CMS, intended to bring together officials and employees of the Medicare and Medicaid programs to more effectively integrate benefits under those programs, and improve the coordination between the Federal and State governments for individuals eligible for both Medicare and Medicaid benefits ("dual eligibles") to ensure that they have full access to the items and services to which they are entitled. It requires the Secretary, as part of the President's budget, to submit an annual Report to Congress containing recommendations for legislation that would improve care coordination and benefits for dual eligibles.

Subtitle I – Improving the Quality of Medicaid for Patients and Providers

Section 2702. Medicaid Health Care-Acquired Conditions

This provision directs the Secretary to identify State practices that prohibit payment for health care-acquired conditions and incorporate such practices, as appropriate for application to Medicaid, into regulations in effect as of July 1, 2011. The regulations will prohibit Medicaid payment for services related to health care-acquired conditions specified in the regulation. The Secretary shall apply forthcoming Medicare regulations prohibiting payment for health care-acquired conditions as appropriate to the Medicaid program. Further, the Secretary may exclude certain payment exclusions identified for Medicare if those conditions are inapplicable to Medicaid beneficiaries.

Section 2703. State Option to Provide Health Homes for Enrollees with Chronic Conditions

Beginning January 1, 2011, this provision creates a new Medicaid State plan option under which States may provide payment for designated providers or teams of health care professionals for furnishing health home services, including care management, transitional care, patient and family support, referrals to community and social support services, and use of HIT, for individuals with at least two chronic conditions, one chronic condition and at-risk of a second chronic condition, or one serious and persistent mental health condition. It allows States to claim a Federal Medicaid matching rate of 90 percent during the first 8 fiscal quarters for such health home services and provides $25 million in planning grants that the Secretary may award States for purposes of developing its State plan amendment. As a condition of receiving payment for health home services, designated providers must report to the State on quality measures and when appropriate and feasible, use HIT to provide such information.

This provision requires the Secretary to contract for an independent evaluation of States that have exercised this option on the effects of this option on reducing admission rates to hospitals, emergency rooms, and skilled nursing facilities (SNFs). Further, the Secretary shall provide an interim Report to Congress by January 1,2014 based on State survey data collected by the Secretary, and a final Report to Congress on the results of the independent evaluation by no later than January 1, 2017.

Subtitle K – Protections for American Indians and Alaska Natives

Section 2901. Special Rules Relating to Indians

This provision specifies that Indians with incomes at or below 300 percent of the FPL and enrolled in coverage through a State Exchange are exempt from cost-sharing (as specified in Section 1402(d)). This provision also establishes health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, or Urban Indian Organizations as the payer of last resort for services provided by those entities to eligible individuals. Finally, this section amends the Express Lane Option added by CHIPRA to specify that the IHS, an Indian tribe, tribal organization, or urban Indian organization can make Express Lane determinations.

Section 2902. Elimination of the Sunset for Medicare Part B Services

Effective January 1, 2010, this provision eliminates the 5-year sunset of reimbursement (scheduled to take effect for services performed after December 31, 2009) for Part B services furnished by a hospital or skilled nursing facility of the IHS, whether operated by the IHS or by an Indian tribe or tribal organization.

Subtitle L – Maternal and Child Health Services

Section 2951. Maternal, Infant, and Early Childhood Home Visiting Programs

This provision establishes a grant program for States, Territories, and Indian tribes to create maternal, infant, and early childhood home visitation programs. The provision also requires States to conduct an initial needs assessment within 6 months of the date of enactment to identify populations who could benefit from these programs. The Secretary, with an independent advisory body, shall develop a plan within one year of enactment to establish the grant program, giving priority to programs that target specific high-risk populations. The Secretary is responsible for setting benchmarks, evaluating applications, and developing procedures and requirements for States, tribal organizations, and non-profit organizations to propose and implement a program that demonstrates quantifiable and measurable improvement on several maternal, child, and infant health benchmarks. This provision also requires a Report to Congress by March 31, 2015 on the Secretary's evaluation of the initial State needs assessments, and a Report to Congress by December 31, 2015 on the status of grants authorized under this program.

Section 2954. Restoration of Funding for Abstinence Education

This provision restores funding for Abstinence Education programs (Section 510 of the SSA) through FY 2014.

Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152

Subtitle C – Medicaid

Section 1202. Improving Payments for Primary Care Services

For 2013 and 2014, this provision increases Medicaid fee-for-service and managed care payments for primary care services to equal that of payments under Medicare Part B. The provision defines primary care services as evaluation and management services and services related to immunizations delivered by a physician with a primary care designation of family medicine, general internal medicine, or pediatric medicine. The increase in payment for such services will equal a 100 percent Federal match.