DEPARTMENT OF HEALTH & HUMAN SERVICES
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CMCS Informational Bulletin

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FROM: Calder Lynch, Acting Deputy Administrator and Director
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SUBJECT: **Oversight of State Medicaid Claiming and Program Integrity Expectations**

Purpose

This letter discusses mutual obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program and the program safeguards necessary to ensure proper and appropriate use of both federal and state dollars. States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act (the Act) and ensuring its overall fiscal integrity. This federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. CMS is reminding states of the requirements and expectations regarding their responsibilities to ensure proper and efficient administration of their Medicaid program. To the extent necessary, CMS will use its enforcement mechanisms which could include deferrals, disallowances or compliance actions to recoup federal funds as appropriate. We expect that all states are adhering to statutory requirements and monitoring compliance.

While fiscal integrity is imperative for every aspect of the Medicaid program, we particularly want to highlight these responsibilities with respect to coverage of the Medicaid adult expansion group authorized under section 1902(a)(10)(A)(i)(VIII) of the Act and for other expenditures that are claimed at an enhanced federal matching rate. CMS needs to ensure the fiscal integrity of the overall program. As part of CMS' ongoing program integrity efforts, any aspect of a state's Medicaid program may be subject to future program oversight reviews or audits as provided by 42 CFR 430.32. This guidance is critical in light of recent audits conducted by the U.S. Department of Health and Human Services Office of Inspector General and others that found that some states did not always determine Medicaid eligibility in accordance with Federal and state requirements, potentially resulting in States inappropriately claiming significant Federal funds.[1] Beyond this guidance, CMS is developing other regulatory or subregulatory efforts to strengthen Medicaid fiscal integrity.

Listed below, are the main four areas that a state should prioritize to ensure proper claiming federal match for their Medicaid program.

1. Development of necessary program integrity protections,
2. Implementation of appropriate system and financial oversight controls,

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[1] See: https://oig.hhs.gov/oas/reports/region9/91602023.asp; https://oig.hhs.gov/oas/reports/region2/21501015.asp
https://oig.hhs.gov/oas/reports/region4/41608047.asp

3. Monitoring the program effectively, and;
4. Documentation and evidence to support these activities.

This information is important for those states that may be considering adopting the Medicaid expansion, it should also help those states that have already adopted the Medicaid expansion and operational oversight of their program. The state should provide assurances of compliance with applicable program requirements to ensure appropriate expenditure categorization and claiming.

Background

States can elect to expand Medicaid coverage to adults age 19 or older and under the age of 65 with household incomes at or below 133 percent of the federal poverty level, and who are not eligible for Medicaid on the basis of pregnancy, eligible for or enrolled in Medicare Part A or B, a recipient of SSI benefits due to disability or blindness, or are not otherwise enrolled in mandatory Medicaid coverage through a state's Medicaid state plan, as outlined at 42 CFR 435.119. When a state elects to expand Medicaid coverage, states must have systems in place to accurately categorize individuals in this group as newly eligible or not newly eligible so that claims for Federal Financial Participation (FFP) are paid at the statutorily authorized matching rate. For any eligibility state plan amendment (SPA) or waiver, documentation must be available to clearly demonstrate how individuals are appropriately identified and categorized, and how expenditures made for the relevant category(ies) of beneficiaries are claimed in state systems to ensure that expenditures are appropriately accounted for in the correct eligibility category and ultimately claimed at the proper federal medical assistance percentage (FMAP) rate. To this end, each state must develop comprehensive test plans specific to their beneficiary eligibility processes, as outlined at 42 CFR 433.112(b)(17). These plans should describe the end-to-end testing strategy being employed to demonstrate the state's operational capacity for accurate eligibility determinations, including renewals, and accurate beneficiary expenditure categorization.

State Assurances

CMS has identified certain necessary assurances that states should make when submitting any SPA and has developed a program readiness checklist to support states' compliance with existing federal requirements addressed in these assurances, which states should consider in developing a SPA or demonstration submission. When a state expands Medicaid coverage, through the adoption of the adult group, states must submit three SPAs: Adult Group (Eligibility), FMAP and Alternative Benefits. The state should consider these elements and provide the following assurances about oversight of its program as listed below with its submission of the FMAP SPA. Further, for those states that have already adopted the adult group or who seek to do so, CMS will be developing an assurance template where states by which a state can attest to having proper systems and procedures in place to ensure appropriate claiming.

Assurances:

1. The state is in compliance with section 1902(a)(4) of the Act regarding proper and efficient operation of the plan.

2. The state is in compliance with the requirements of section 1903 of the Act, including non-federal share financing and the availability and limitations on FFP.

3. The state is in compliance with program integrity provisions in 42 CFR Part 455.

4. The single state agency and/or any agency delegated to make eligibility determinations is able to determine eligibility for all individuals applying for or receiving benefits in accordance with regulations in 42 CFR Part 435 (also see §1902(a)(4) and (5) of the Act) and specifically, if applicable, 42 CFR 435.119 (also see §1902(a)(10)(A)(i)(VIII.)

5. In accordance with 42 CFR 433.112(b)(14) a state's eligibility/enrollment and claims systems must support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.

Program Readiness Checklist:

This bulletin contains a Program Readiness Checklist to assist states in ensuring operational capacity to make accurate eligibility determinations and claim FFP at the appropriate matching rate that can be demonstrated on an ongoing basis. The checklist can also assist in preparing for potential audits and/or program reviews.

Ensuring Accurate Eligibility Determinations:
- ✓ Systems readiness testing and results: State eligibility and enrollment (E&E) systems must support accurate and timely processing of eligibility determinations and acceptable MAGI-based system functionality must be demonstrated through performance testing (42 CFR 433.112(b)(14) and (17)). Each state must have a comprehensive test plan specific to their environment and the plan should describe the end to end testing strategy. CMS has developed recommendations for state E&E systems testing that can be found in Appendix A. As states implement new systems functionality needed to support changes in eligibility, for example adoption of a new eligibility group, the end-to-end testing should be conducted far enough in advance to ensure all errors or defects can be corrected and retested prior to going live.

- ✓ Updates to eligibility policies, procedures, and staff training to reflect any changes in eligibility, including adoption of the adult group identified in 42 CFR 435.119, if applicable. This would include revisions to state rules and eligibility manuals (as referenced at 42 CFR 431.18). States must also provide a training program for Medicaid agency personnel, including continuing training opportunities to improve the operation of the program (42 CFR 432.30). This training should include all updates and the eligibility requirements for any Medicaid eligibility group that is newly added or for whom the eligibility requirements are changed, so that staff can make accurate eligibility determinations and otherwise ensure the proper and efficient administration of the plan. To the extent that audits, Payment Error Rate Measurement (PERM), Medicaid Eligibility Quality Control (MEQC), or other quality assurance efforts identify areas for improvement, these topics should be addressed as part of the training program and all relevant policies should be clarified in the eligibility manual.

- ✓ Verification Plan: Regulations at 42 CFR 435.945(j) require states to develop and update a plan describing the eligibility verification policies and procedures adopted by the agency. We encourage states to review their existing verification plans and update the

plan as needed to ensure the state has a robust verification process that includes electronic data sources and effective processes to resolve inconsistencies including documentation requirements. If a state has updated its verification plan, then the plan should be submitted to CMS for review.

Ensuring State Claiming of FFP at the Appropriate FMAP or Administrative Matching Rate:
- ✓ Systems readiness testing and results: States must be able to demonstrate the operational capacity to claim FFP at the appropriate match rate. As stated above, each state should have a comprehensive test plan specific to its environment and the plan should describe the end-to-end testing strategy. Tests should include and check for interfaces with systems (e.g., MMIS) that perform payment operations and support claiming at the appropriate FMAP or administrative federal matching rate. As states develop system functionality, testing should be conducted far enough in advance to ensure all errors or defects can be corrected and retested prior to go-live. CMS has developed recommendations for state eligibility/enrollment and claims systems testing that can be found in Appendix A.

- ✓ Systems documentation related to claiming FFP for the adult group, if applicable: States should document how their systems are applying the threshold methodology to correctly claim increased FMAP only as allowable under the statute and regulations, consistent with requirements outlined at 42 CFR 433.112. This includes the way the state's MMIS interacts with the eligibility system and how the requirements in place result in accurate claiming for FFP, both initially and over time. This should also include the ability to distinguish individuals in the adult group as newly eligible or not newly eligible and how individuals are identified/flagged in the state's system.

Program Oversight Monitoring:
- ✓ Detailed program oversight monitoring plan: CMS expects a strong plan to assess on an ongoing-basis the continued accuracy of eligibility determinations and claiming of FFP, and include sampling methodologies, ongoing audit and monitoring activities, and a process for ensuring that any issues identified are addressed and resolved promptly.

- ✓ Ability to share audit and testing results: CMS expects states to share audit, review, and systems testing results as well as any corrective action plans, as they are approved and implemented, with CMS for at least a one-year period after an approved SPA has been implemented, and at least annually thereafter.

- ✓ Data: CMS expects state eligibility systems to be capable of, and ready to, submit required performance indicator data to CMS, including information regarding the timeliness and accuracy of eligibility determinations, and that state personnel would monitor this data to ensure ongoing accurate system operation.

- ✓ Contract program integrity provisions: CMS expects states to indicate whether services to an eligibility group affected by a SPA will be provided via managed care, fee-for-service, or other delivery system, and share the program integrity provisions found in the state's managed care or other contracts related to the delivery system as well as the state's oversight plan for those contractual provisions.

Additional Program Integrity Tools:
- ✓ Previously completed beneficiary eligibility audit reports and quality reviews related to all covered Medicaid eligibility categories: This should include identifying beneficiary eligibility, program integrity, audit, and any other functions that have an impact on the functionality of a state's systems.

- ✓ Trend analysis: States should have and review a summary of trend analysis for eligibility-related fraud, waste, and abuse activities and use this information in their ongoing program monitoring activities.

- ✓ Corrective Action Plans: States should review and incorporate any other corrective action plans related to beneficiary eligibility as a result of PERM, MEQC, or any other audit or review findings as part of their program integrity efforts.

Financing:
- ✓ State share: Information on how the non-federal share for expenditures related to the SPA will be funded, including both medical assistance and administrative expenditures, as applicable.

Other information

Listed below are documents/reviews to which CMS has access and that may be used as part of its oversight efforts.

- ✓ State program integrity reviews.

- ✓ PERM findings and corrective action plans (when available).

- ✓ MEQC findings and corrective action plans (when available).

- ✓ OIG and GAO audit findings.

In part, this guidance is focused on ensuring that states can make accurate eligibility determinations and have the ability to appropriately claim FMAP. We also want to remind states of their obligation to ensure that beneficiaries continue to be eligible between regularly scheduled redeterminations. One strategy that states have successfully implemented to enhance program integrity is the use of periodic data matching to identify beneficiaries who may have had a change in circumstance that affects their eligibility. In accordance with 42 CFR 435.916(d), when implementing this strategy, the agency must promptly redetermine eligibility when it receives information about a change in the beneficiary's circumstances that may affect eligibility. If the information indicates that a beneficiary may no longer be eligible, the agency must also provide the individual an opportunity to respond and provide updated information. Currently, 43 states conduct periodic data matching against one or more income sources to identify changes in beneficiary income between renewal periods.

Conclusion

CMS is committed to working with states to comply with federal laws and regulations by assuring the accuracy of Medicaid eligibility determinations and states' ability to appropriately

claim FFP. The federal-state partnership is central to the success of the Medicaid program, and CMS will continue its work with states to strengthen Medicaid program integrity efforts. To the extent that states inappropriately or unlawfully claim Federal funds, CMS is committed to taking necessary actions to recoup those funds to ensure the program is properly managed. If you have questions or would like technical assistance on any of the issues addressed in this Informational Bulletin please contact Kristin Fan at 410-786-4581.

Appendix A:
State Eligibility & Enrollment and Claims Systems Testing

Regulations at 42 CFR 433.112(b)(17) requires that a state must have delivered acceptable MAGI-based system functionality, demonstrated by performance testing and results. To demonstrate this operational capacity for accurate eligibility determinations, renewal functionality, and claiming of FFP at the appropriate match rate, CMS anticipates each state will have a comprehensive test plan specific to its environment. These plans would, as per industry best practice, describe the end-to-end testing strategy being employed to ensure sufficient coverage, and must include:

- Systems Testing process: which encompasses the interactions between any subsystems, components, and interfaces necessary to support the functional validation of the outcome.
- Regression Testing process: which includes the both the initial implementation to production and how future changes in functionality are managed in the enterprise.
- Acceptance Testing process: which focuses on the final stage before the Medicaid Agency formally accepts the system functionality to move into operations.
- Error Resolution process: which details how errors are identified and resolved, both for true defects and instances where a system may be working as designed but is not producing the intended result.
- Specific Scenarios: which may include multiple test cases that are defined to establish the system is consistently producing accurate eligibility determinations. The focus is not on the number of test cases, but rather the comprehensive coverage of the functionality being introduced.
- Validation process: which can include the use of external/third party entities that potentially may be engaged to execute, validate and produce the results of the testing scenarios.

Overall, the testing strategy must support demonstrating operational capacity prior to initial implementation into production, but also consistently demonstrated over time.