Last Updated: 11/9/2023

RESPONSE TO INTERIM COMMITTEE REQUEST FOR INFORMATION

FOR: Children, Families, Health, and Human Services Interim Committee (CFHHS)

REQUESTED INFORMATION: The Department received the following questions related to Medicaid audits:

1. What are the SOPs for a Medicaid audit?
2. Were these audits triggered by CMS or state?
3. What allowance is there for provider oversight?
4. What are the expectations for repayment by providers? Is there a certain timeline in which they must repay, are payment plans available, may they request extensions or other assistance?
5. What percentage of the repayment will go to the state vs to CMS?

RESPONSE: The Office of Inspector General is responsible for reviewing Medicaid claims through the Surveillance Utilization Review Section of the Program Compliance Bureau. Responses to each of the committee's questions are below.

1. What are the SOPs for a Medicaid audit?
   SURS standard operating procedures follow the records review process outlined in MCA 53-6-1402. The initial SURS review is based on random checks, referrals, complaints, national trends, etc., and may result in a finding of overpayment requiring reimbursement and education. If errors are found within the data and/or records a recovery request is initiated. Appeal rights are in place for all adverse actions, beginning with an informal Administrative Review, Fair Hearing with an Administrative Law Judge (ARM 37.5.310), Board of Public Assistance (ARM 37.5.331), and District Court (ARM 37.5.334). Program Compliance Bureau maintains constant contact with providers during a SURS review.

2. Were these audits triggered by CMS or state?
   CMS does not routinely initiate audits/reviews. SURS initiates reviews based on referrals from the Medicaid Fraud Control Unit (MFCU), national trends, and referrals/complaints. For example, if MFCU received a provider billing complaint regarding the National Correct Coding Initiative guidance on a topic without proof of criminal intent they would submit it to SURS. SURS would review the

complaint to determine errors in claims payment. If there was an overpayment, SURS would initiate a fair repayment process ensuring that there is benefit of the provider when possible.

3. What allowance is there for provider oversight?
   There is no provision to excuse overpayment caused by provider oversight. 42 CFR 456.3 and 456.23 set forth the requirements for states to have procedures to monitor inappropriate use of Medicaid services and payments. ARM 37.85.406 (10)(a)(b) directs the Department to recover regardless of who is at fault, if it is found that the provider was not entitled to the payment.

4. What are the expectations for repayment by providers? Is there a certain timeline in which they must repay, are payment plans available, may they request extensions or other assistance?
   SURS routinely works with providers on repayment plans. All factors are taken into consideration such as overpayment amount, affordability, etc. to determine the length of a payment plan. However, states are required to return the Federal Share within 1 year from establishing an overpayment, determined when the review results and overpayment letter are sent to the provider.

5. What percentage of the repayment will go to the state vs to CMS?
   FFY23 percentages were 35.88% State and 64.12% Federal.