



Fiscal Year 2009 Office of Inspector General Medicaid Integrity Report

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OIG

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A Message From the Office of Inspector General

Introduction

We are pleased to present the *Fiscal Year 2009 Office of Inspector General Medicaid Integrity Report*.

The Deficit Reduction Act of 2005 (DRA) included several provisions that built on existing efforts to strengthen Medicaid program integrity. Pursuant to the DRA, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) annually reports on the use of funds appropriated to it under DRA section 6034 and the effectiveness of the use of such funds. Accordingly, this report describes OIG's funding streams and highlights OIG's Medicaid related accomplishments for FY 2009.

Federal and State Medicaid Integrity Partnership

Medicaid, established under Title XIX of the Social Security Act, is a joint Federal-State program that supports States' coverage of medical care and other support services for designated categories of low-income individuals. For fiscal year (FY) 2009, Medicaid enrollment was estimated at 51.7 million beneficiaries, and total Federal and State Medicaid costs were approximately \$380.9 billion, of which the Federal share was \$250.9 billion.

The Federal Government pays a share, known as the Federal Medical Assistance Percentage (FMAP), of each State's Medicaid costs. Because Medicaid is a matching program, improper payments by States to providers virtually always result in corresponding improper Federal payments, whether payments for medical services or for administrative cost reimbursement. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State. The Federal and State governments jointly monitor the integrity of the Medicaid program.

Centers for Medicare & Medicaid Services (CMS). HHS's CMS has a key role in Medicaid program integrity as the Federal program manager. It is responsible for overseeing each State's comprehensive State Medicaid Plan to ensure State compliance with Federal laws, regulations, and departmental policies, including the detection, development, and referral of suspected fraud cases. CMS is required to review State Agency performance through onsite reviews and examination of case records.

Medicaid State Agencies. State Agencies are responsible for establishing policies, computer systems and edits to process Medicaid claims, and for conducting analyses of providers' patterns of practice (data-mining). Federal regulations require State Agencies to conduct

preliminary investigations when they identify questionable practices or receive complaints of suspected Medicaid fraud or abuse. Overpayments that are not the result of fraud generally remain in State Agencies' jurisdiction for collection.

Medicaid Fraud Control Units (MFCUs). State MFCUs investigate and prosecute provider fraud and patient abuse and neglect. They integrate the skills of criminal investigators, attorneys, and auditors to carry out their mission. Forty-eight States and the District of Columbia have established MFCUs. Most are in States' Attorney General offices. When the results of preliminary investigations by State Agencies present reason to believe that fraud has occurred, typically State Agencies must refer the matters to the States' MFCUs for further investigation.

Federal grants reimburse States for the operation of MFCUs at 90 percent of costs for the first 3 years after initial certification and 75 percent thereafter. The Social Security Act, § 1903(q)(6), requires that MFCUs be single identifiable entities of the State government and be certified annually by HHS as meeting Federal requirements, including location within State government, staffing, roles, and responsibilities. The Secretary of HHS delegated to OIG the responsibility for administering the Federal grants for MFCUs' operations. OIG's responsibilities for oversight of the funding and operation standards of MFCUs include certification and recertification, monitoring their overall performance and productivity, and ensuring that they devote their full-time efforts to Medicaid-covered health care fraud and patient abuse

Office of Inspector General. Protecting the integrity of all HHS programs, including Medicaid, is at the core of OIG's mission. Accordingly, OIG initiates audits, evaluations, and investigations of the expenditure of Medicaid dollars and the operation of the Medicaid program as appropriate. OIG frequently partners with CMS, State Agencies, MFCUs, the National Association of MFCUs (NAMFCU), State and local law enforcement, the HHS Administration on Aging, State Long Term Care Ombudsmen, the FBI, and the Department of Justice (DOJ) on Medicaid integrity matters. For example, OIG participates in joint investigations with MFCUs, particularly when Medicare is also involved.

Types of Medicaid Improper Payments

OIG's audit and evaluation reviews often reveal improper State and/or Federal Medicaid payments, which may arise for a number of reasons, including clerical errors, misinterpretations of rules, or poor record keeping. Improper payments include overpayments and underpayments and are generally adjusted or collected administratively. The following are common categories of improper payments.

- **Unsupported services.** Providers must maintain records that are sufficient to justify diagnoses, admissions, treatments performed, and continued care. When records are insufficient or missing, claims reviewers cannot determine whether services billed were actually provided to beneficiaries, the extent of the

services, or their medical necessity. An item or service that is not adequately documented should not be billed to Medicaid.

- **Medically Unnecessary Services.** The documentation in the medical records leads to an informed decision by a claims reviewer that the medical services or products received were not medically necessary.
- **Incorrect Coding.** Standard coding systems are used to bill State Medicaid programs for services provided. In a coding review, reviewers determine whether the documentation submitted by providers supports a lower or higher reimbursement code than was actually submitted.
- **Noncovered Costs or Services.** These are costs or services that Medicaid will not reimburse because they do not meet the State's reimbursement rules and regulations. A Federal share would not be paid for such costs or services.
- **Third-Party Liability.** Medicaid inappropriately pays claims, and is generally not reimbursed, for beneficiaries who have other sources of payment, such as private insurance.

Types of Fraudulent Activities

Some of the billings and related practices that are determined to be improper are also determined to be fraudulent. Fraudulent behavior may arise, for example, when enrollment procedures for providers are inadequate, internal controls are deficient, payment rates are excessive (inviting fraudulent or abusive behavior), or when especially vulnerable beneficiaries can be exploited easily. The types of fraudulent schemes in Medicaid in many ways mirror those of Medicare:

- **Billing for Services Not Provided.** This is one of the most common types of fraud. Examples include a provider who knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.
- **False Cost Reports.** A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on cost reports submitted to Medicaid.
- **Illegal Remunerations (Kickbacks).** A provider (such as a nursing home operator) may conspire with another health care provider (such as a physician or ambulance company) to share a part of the monetary reimbursement the health care provider receives in exchange for the referral of patients. Such kickbacks include not only cash, but vacation trips, automobiles, and other items of value. The practice results in encouraging unnecessary tests and services to be performed for the purpose of generating additional income to the referring source and to the provider of the service.

Scope of This Report

While the responsibility for detecting improper payments and investigating fraud and abuse in the Medicaid program is shared between the Federal and State governments, this report focuses on findings from OIG reviews and legal and investigative activities and outcomes that derive wholly or in part from OIG's appropriated resources.

Much of the information in this report and its appendixes was drawn from OIG's three core publications:

- FY 2009: *Office of Inspector General Semiannual Report(s) to Congress*
- *Office of Inspector General FY 2010 Work Plan*
- March 2010: *Compendium of Unimplemented Office of Inspector General Recommendations*

See also the *State Medicaid Fraud Control Units Annual Report*.

The publications are available on OIG's Web site at:

<http://www.oig.hhs.gov/publications.asp>

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Fiscal Year 2009

Medicaid Integrity Report

Funding for Program Integrity

In fiscal year (FY) 2009, the Office of Inspector General (OIG) of the Department of Health & Human Services (HHS) received funding to oversee the integrity of Medicaid activities from three sources:¹ the Health Care Fraud and Abuse (HCFAC) program, created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Medicaid Integrity Program (MIP), created by the Deficit Reduction Act of 2005 (DRA); and the Supplemental Appropriations Act of 2008.

Health Care Fraud and Abuse Control Program

The HCFAC program was established by HIPAA to be under the joint direction of the Attorney General and the Secretary of HHS, acting through the Inspector General. Funds are appropriated in amounts that the Secretary and Attorney General jointly certify as necessary to finance antifraud activities, up to ceilings fixed by the legislation. Certain of these funds are, by law, set aside for OIG “activities . . . with respect to Medicare and Medicaid.”² HIPAA also requires the Attorney General and the Secretary of HHS to submit a joint annual report to Congress identifying expenditures and accomplishments under the law (Social Security Act, § 1817(k)(5)). These reports are available on the Web sites of both agencies at: <http://oig.hhs.gov/reading/publications.html> and <http://www.usdoj.gov/dag/pubdoc.html>.

Since FY 1997, the HCFAC program has been the primary source of funding for Medicare and Medicaid fraud investigations and prosecutions by OIG and the Department of Justice (DOJ). Beginning in FY 2009, OIG began receiving discretionary funding in support of HCFAC activities through an allocation adjustment. Such adjustments are intended to provide additional administrative funding for current program integrity activities.

Medicaid Integrity Program

Section 6034 of the DRA established the MIP, through which OIG receives enhanced funding for fraud and abuse control activities “with respect to the Medicaid program” (section 6034(c)). This funding was to be provided annually from FY 2006 through FY 2010 in addition to OIG’s HCFAC resources and is available until expended. Specific DRA requirements that pertain to OIG are described in Appendix D.

¹ Funding for Medicaid oversight appropriated to OIG by the American Recovery and Reinvestment Act of 2009 (Recovery Act) is not included in this report.

² The Social Security Act, § 1817(k)(3)(A).

Medicaid Fraud and Abuse Supplemental Appropriation

The Supplemental Appropriations Act of 2008, P.L. No. 110-252, provided additional funding to OIG to reduce fraud and abuse in the Medicaid program under Title XIX of the Social Security Act. This funding, which was provided for FY 2009 in addition to other amounts appropriated for Medicaid oversight, is available until expended. It is referred to in this report as Medicaid fraud and abuse (MFA) funding.

Allocation of Statutory Funding Streams

The table that follows illustrates OIG's allocation of statutory funding streams for Medicaid integrity oversight for FY 2005 through FY 2009.

Allocation of Statutory Funding Streams for
Medicaid Integrity Oversight, FY 2005 – FY 2009
(Dollars in Millions)

Fiscal Year	Statutorily Mandated Funding Provided to OIG for Health Care Oversight		Estimated OIG Obligations for Medicaid Oversight		Estimated Total OIG Obligations for Medicaid Oversight	Estimated Percentage of OIG Health Care Oversight Obligations for Medicaid Integrity
	HIPAA/HCFAC	MIP & MFA ³	HIPAA/HCFAC	MIP & MFA ⁴		
2005	160	–	36.8	–	36.8	23 %
2006	160	25	44.8	–	44.8	28 %
2007	165.9	25	24.6	24.8	49.4	26 %
2008	169.7	25	32.5	28.3	60.8	31 %
2009	177.2	50	46.9	30.9 ⁵	77.8	34 %

Note: Numbers are approximate because of rounding.

The table illustrates that a sizable portion of OIG's HCFAC funds has been used for Medicaid oversight in recent years.

Overlap Among Oversight Activities

Because there is an overlap among the oversight activities funded by HCFAC, MIP, and other sources, OIG work relating to Medicaid may draw on funding from more than one source. For investigations and subsequent prosecutions, it is particularly difficult

³ In FY 2009, OIG was appropriated \$25 million for Medicaid oversight through the Supplemental Appropriations Act of 2008.

⁴ OIG began FY 2007 with \$25 million of unspent MIP funds that were appropriated during FY 2006. These funds are being used to fund OIG's continued Medicaid oversight from FY 2007 through FY 2010.

⁵ In FY 2009, OIG received a 26-percent increase in funding available for Medicare and Medicaid program integrity activities. Because of this significant increase, and consistent with the purpose of the funding, OIG intends to manage oversight activities over multiple years. In FY 2009, OIG obligated \$9.4 million in MIP funding and \$21.5 million in MFA funding.

(sometimes impossible) to accurately segregate enforcement activities by funding stream. For example, even if OIG conducts a given investigation exclusively with MIP funds, the prosecution of that case could draw upon DOJ's HCFAC money and the matter would be reportable pursuant to the requirements of both the HCFAC and MIP programs. An overlap could also occur when an investigation involves fraud in Medicaid and other Federal health care programs, such as Medicare, as is often the case. For these reasons, this document does not artificially divide accomplishments between the funding sources; OIG's Medicaid successes are typically the result of the combined funding from available resources.

In addition, OIG's audit, evaluation, and investigation work often requires more than 1 year to yield results. As a consequence, many of the accomplishments summarized in this document reflect the results of OIG work over several years that culminated in FY 2009.

Highlights of Findings From Audits and Evaluations

OIG's audits and evaluations monitor payments, processes, program administration, and information systems. In addition to identifying misspent funds, OIG's reviews are always intended to bring about program improvements and thus help reduce the cost of providing necessary services to Medicaid beneficiaries. In addition to its audits, OIG has an evaluation function that seeks to find ways to improve the program. These evaluations focus on whether the Medicaid program is managed properly and pays a fair price in the health care marketplace. The following are highlights of the findings of OIG's audits and evaluations issued in FY 2009 and summarized in OIG's *Semiannual Report(s) to Congress*, which, along with the full text of the reports, are posted on OIG's Web site at <http://www.oig.hhs.gov>.

Hospital Claims and Payments

Hospitals > Inpatient Family Planning Services

Federal Share of Inpatient Hospital Services Improperly Claimed at Enhanced Rate for Family Planning

New York improperly claimed enhanced 90-percent Federal reimbursement for inpatient family planning claims submitted by hospitals. Of the 173 claims in our sample, 3 qualified as family planning services and could be claimed at the enhanced 90-percent Federal reimbursement rate. However, the remaining 170 claims could not be claimed as family planning services or could be claimed only in part as family planning services. Based on our sample results, we estimated that the State received \$2.6 million in unallowable Federal Medicaid reimbursement. *Review of Inpatient Hospital Claims Billed as Family Planning Services Under the New York State Medicaid Program.* ([A-02-06-01007](#)) April 2009

Hospitals > Conditions of Participation Not Met

Medicaid Funds Paid to Ineligible Indiana Psychiatric Hospital

From July 1, 1996, through June 30, 2007, Indiana paid \$26.2 million (\$16.3 million Federal share) to a hospital that was not eligible to receive Medicaid payments for inpatient psychiatric services. The hospital did not meet Federal Medicaid eligibility requirements because it did not demonstrate compliance with two special Medicare Conditions of Participation (CoP) requirements. *Review of Medicaid Participation Eligibility for One Indiana State-owned Psychiatric Hospital for the Period July 1, 1996, Through June 30, 2007.*

([A-05-07-00076](#)) March 2009

Hospitals > Program Compliance Could Not Be Determined

No Accounting for How Two Pennsylvania Medical Schools Used Redirected Disproportionate Share Hospital Payments

For State FYs 2005–2006 and 2006–2007, we reviewed whether three hospitals associated with universities in Pennsylvania retained Medicaid disproportionate share hospital (DSH) payments that are authorized by the Centers for Medicare & Medicaid Services CMS to ensure that services are provided to the medical assistance population and help offset medical education costs incurred. We determined that two of the three hospitals did not retain their DSH payments but instead redirected payments totaling \$35.1 million (Federal share) to their university medical schools. Because the two hospitals did not require the medical schools to account for how they used the funds, we could not determine whether the schools used the DSH funds in compliance with the State Plan Amendments. *Review of State Plan Amendments Authorizing Disproportionate Share Hospital Payments by Pennsylvania to Hospitals of State-Related Universities.* ([A-03-07-00222](#)) February 2009

Home, Community, and Long-Term Care

Personal Care Services > Billing Practices Create Vulnerabilities

More Than 24 Hours in a Day Billed for Personal Care Services in Four States

In our review of Medicaid payments for personal care services (PCS) made by State Medicaid programs from October 1 through December 31, 2005, we found that 4 of 5 States paid 871 claims to providers that had billed for more than 24 hours of PCS in a day. PCS—such as dressing, bathing, cooking, and light housekeeping—help beneficiaries stay in their homes rather than receive constant care in more expensive institutional settings. A related OIG report issued in August 2008 focused on Medicaid payments for beneficiaries with overlapping institutional and PCS claims. Additional findings of this review included the following: (1) Medicaid programs in all 5 States paid 2,324 PCS claims, totaling \$3 million, which were associated with billings of between 16 and 24 hours of services per day, and (2) 3 State Medicaid programs allowed providers to bill for PCS in date ranges that included days on which no services were provided, a practice that makes it difficult to identify the number of PCS hours billed on any given day in a date range. *Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day.* ([OEI-07-06-00621](#)) October 2008

Some New York City Personal Care Services Claims Did Not Meet Requirements for Payment

New York State improperly claimed Federal Medicaid reimbursement for some personal care claims submitted by providers in New York City during calendar years (CY) 2004 through 2006. Of the 100 claims in our random sample, 80 complied with Federal and State requirements but 18 did not. We could not determine whether the two remaining claims, which involved services under the State's Consumer Directed Personal Assistance Program (CDPAP), complied with Federal and State requirements. Based on our sample results, we estimated that the State improperly claimed \$275.3 million in Federal Medicaid reimbursement during the audit period. *Review of Medicaid Personal Care Services Claims Made by Providers in New York City.* ([A-02-07-01054](#)) June 2009

Ohio Paid Multiple Providers for Single Occurrences of the Provision of Long-Term-Care Services

In our review of Ohio's Medicaid claims for payments to long-term-care (LTC) providers, we determined that the State overpaid more than \$18 million (\$10.5 million Federal share) from FYs 1999–2005 for LTC services claimed by more than one provider for the same services to the same beneficiary on the same date. As of the start of our audit in July 2007, the State had reported and refunded \$8.4 million (\$4.9 million Federal share) of the unallowable payments through adjustments, decreasing its Medicaid claims for prior quarters on its report to CMS for the quarter ended June 30, 2005. However, the State had not reported and refunded \$9.6 million (\$5.6 million Federal share). *Review of Ohio Medicaid Long-Term-Care Payments to Two Providers for the Same Beneficiaries for the Same Dates of Services From October 1, 1998, Through September 30, 2005.* ([A-05-07-00074](#)) October 2008

Long-Term-Care Cost Reimbursements to Utah Set Aside for Adjudication

Utah did not ensure that payments made under nonrisk contracts for LTC services were equal to or less than the upper payment limits (UPL). Under a nonrisk contract, the contractor (1) is not at financial risk for changes in utilization or for service costs incurred that are equal to or less than the upper payment limits specified in Federal regulations and (2) may be reimbursed by the State for the incurred costs, subject to specified limits. Because the State could not ensure that the costs claimed for LTC services were equal to or less than UPLs, we were unable to express an opinion on the \$27.4 million of Federal reimbursement that the State received for the costs of LTC services from July 1, 2000, through December 31, 2005. Therefore, we set aside these costs for adjudication by CMS. *Review of the Long-Term Care, Managed Care Program Costs Claimed by the Utah Department of Health.* ([A-07-08-02719](#)) May 2009

Other Medicaid Services Claims

Laboratory Services > Potential Improper Payments

Laboratory Services Fully Covered by Medicare but Also Paid by Medicaid

We determined that Medicaid programs in 8 of 11 selected States spent a total of \$1.3 million in potential improper payments for clinical diagnostic laboratory services that were provided on an assignment-related basis (i.e., Medicare payment was accepted as payment in full) to dual eligibles in FYs 2005 and 2006. Dual eligibles are beneficiaries who are enrolled in Medicare Part A and/or Part B and are also entitled to some Medicaid benefits. State Medicaid programs should not pay for any portion of outpatient clinical diagnostic laboratory services that were provided on an assignment-related basis to dual eligibles who are enrolled in Medicare Part B. *Potential Improper Medicaid Payments for Outpatient Clinical Diagnostic Laboratory Services for Dual-Eligible Beneficiaries.* ([OEI-04-07-00340](#)) April 2009

Inmates of Public Institutions > Services Excluded From Federal Share

Georgia Improperly Claimed Federal Share for Excluded Services for Juvenile Inmates of Public Institutions

For Federal FYs 2003 and 2004, the Georgia Medicaid agency inappropriately claimed \$3.8 million (\$2.3 million Federal share) in costs relating to noninpatient medical services provided to juvenile inmates of public institutions because neither the Georgia Department of Juvenile Justice nor the Medicaid agency had adequate controls to ensure that those services were excluded from Federal financial participation. *Review of Medicaid Services to Incarcerated Juveniles in the State of Georgia for Federal Fiscal Years 2003 and 2004.* ([A-04-06-00026](#)) May 2009

Family Planning Services > System Error Caused Duplicate Payments

Michigan Claimed Some Family Planning Services Twice

For FYs 2006 and 2007, Michigan claimed and received \$1.1 million (\$1 million Federal share) in unallowable reimbursement for family planning services that it claimed more than once. Our review showed that some services were claimed twice on behalf of the same beneficiaries on the same dates of service. The State reported the claims twice because the computer system that it used to report family planning services inappropriately compiled the same claim data from a report that identified family planning services for all places of service and another report that identified services only at family planning clinics. *Family Planning Services Claimed Twice in Michigan for October 1, 2005, Through September 30, 2007.* ([A-05-08-00064](#)) June 2009

Federal Share of Clinics' and Practitioners' Services Improperly Claimed at Enhanced Rate for Family Planning Services

In our review of New York's claims for Federal Medicaid reimbursement for family planning services from April 2003 through March 2007, we estimated that the State improperly received \$17.2 million for improperly claiming enhanced 90-percent Federal reimbursement. The rates for the Federal share of the Medicaid program were 52.95 percent and 50 percent for New York during our audit period. Under Federal law, a State may provide family planning services and supplies to individuals of childbearing age who are eligible under the State Medicaid plan and receive enhanced 90-percent Federal reimbursement for items and procedures that are clearly furnished or provided for family planning purposes.

Our findings included the following: (1) of our 119 sampled claims, 17 qualified as family planning services that were eligible for enhanced 90-percent Federal reimbursement; (2) of the 102 claims that did not qualify for the 90-percent Federal reimbursement rate, 33 were not eligible for any Federal Medicaid reimbursement, including 27 claims for abortion procedures, and 63 were eligible for reimbursement at the applicable matching rate of 50 or 52.95 percent; and (3) the remaining six claims were unallowable for reasons including lack of adequate or required documentation. *Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program.* ([A-02-07-01037](#)) November 2008

Colorado's Supplemental Mental Health Services Payments Found Unallowable

In our review of Colorado's supplemental Medicaid payments made from 2001–2004 for mental health services provided to foster care children in child placement agencies, we determined that these payments were not fully consistent with Federal and State requirements. Because of unanticipated stresses on Medicaid funding for these services, the State began making supplemental payments (i.e., payments in addition to the monthly capitation payments) to its contracted mental health assessment and service agencies (MHASA) in 2001. Of the \$23 million (\$11.7 million Federal share) in supplemental payments, \$3.3 million Federal share was unallowable because the State had not obtained, as required, CMS's approval of contracts covering the supplemental payments for a portion of the audit period. In addition, the State did not provide documentation that the remaining \$8.4 million Federal share in supplemental payments had been removed from the capitation payments that the State made to MHASAs. *Review of Colorado Medicaid Mental Health Capitation and Managed Care Program.* ([A-07-06-04067](#)) October 2008

School-Based Services > Timely Filing Requirements Not Met

West Virginia Retroactive Claims for School-Based Services Not Exempt From 2-Year Filing Period Rule

West Virginia did not fully comply with Federal requirements for an exemption to the 2-year limit for filing retroactive claims for Medicaid school-based services. A portion of the State's retroactive claim, \$4.1 million Federal share, fell outside the required 2-year filing period because it related to expenditures made by the State in the quarters ending December 31, 2000, through June 30, 2001. Of this amount, \$2.3 million Federal share related to new cost components that were not in the original rates used to calculate the claims for school-based services and did not reflect the settlement of previously identified costs. As a result, the \$2.3 million Federal share was not exempt from the 2-year time limit and was unallowable. The remaining \$1.8 million Federal share met the requirements for an exemption because it reflected the settlement of previously identified salary and fringe benefit costs. *Review of Timeliness of West Virginia's Retroactive Claims for Medicaid School-Based Services.* ([A-03-06-00201](#)) April 2009

Rehabilitation Option Services > Overpayments, Interest Not Reported to CMS

Indiana Did Not Report \$23.4 Million in Medicaid Overpayments

In our review of Indiana's Medicaid Rehabilitation Option Program for FYs 2000–2005, we found that the State did not report overpayments of \$23.4 million (\$14.5 million Federal share) and interest earned on the overpayments totaling \$130,000 (\$82,000 Federal share) in accordance with Federal requirements. States are required to refund the Federal share of Medicaid overpayments and to report to CMS any interest earned on overpayments each quarter. *Review of Indiana's Reporting Fund Recoveries for the Medicaid Rehabilitation Option Program on the Form CMS-64 for Fiscal Years 2000 to 2005.* ([A-05-07-00072](#)) October 2008

Targeted Case Management Services > Claims Unsupported, Insufficiently Documented

Requirements for Targeted Case Management Services Claims Not Met

Pennsylvania's claims for targeted case management (TCM) services did not always comply with Federal and State requirements. Federal law authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. These services are referred to as TCM when they are furnished to specific populations in a State. Based on our review of 375 claims in 100 sampled beneficiary-months, 36 claims included in 15 beneficiary-months were unallowable because the services were unsupported by case records or insufficiently documented. We estimated that as a result, during CYs 2003 through 2005, the State claimed \$11.9 million (\$6.5 million Federal share) in unallowable TCM costs. *Review of Pennsylvania's Medicaid Payments for Targeted Case Management Services for Calendar Years 2003 Through 2005.* ([A-03-06-00202](#)) September 2009

Medicaid Prescription Drug Programs

Prescription Drugs > Drugs Not FDA Approved, Not Correct in AMP file

Most Drug Categorizations Accurate, but Potential Problems Found

We found that manufacturers typically categorize their drugs in the average manufacturer price (AMP) file in the same manner as national compendia. However, our manual review of drug categorizations identified (1) a potential problem with Medicaid payment for drugs that do not have the Food and Drug Administration's (FDA) approval and (2) instances in which certain drugs appear to have been categorized incorrectly in the AMP file, potentially resulting in a loss of rebates for States. *Accuracy of Drug Categorizations for Medicaid Rebates*. ([OEI-03-08-00300](#)) July 2009

Prescription Drugs > Program Requirements Not Met

Reviews Revealed Noncompliant Expenditures for Outpatient Prescription Drug Products

In separate reviews of Medicaid outpatient prescription drug expenditures, we found that States had claimed Federal reimbursement for expenditures that did not fully comply with Federal requirements. Medicaid generally covers outpatient drug products if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. Under the Medicaid drug rebate program, CMS provides the States with a quarterly Medicaid drug tape, which lists all covered outpatient drug products; indicates each drug product's termination date, if applicable; and specifies whether FDA has determined the drug product to be less than effective. CMS guidance instructs the States to use the tape to verify coverage of drug products for which they claim reimbursement. Our findings were as follows:

- **California** – For FYs 2004 and 2005, California claimed \$24 million Federal share for unallowable Medicaid expenditures, which included \$21 million in unsupported drug expenditures and \$3 million in drug expenditures that were not eligible for Medicaid coverage because the drugs were dispensed after their termination dates. The State also claimed \$10.9 million Federal share for drug products not listed on the quarterly drug tapes for which the State did not provide conclusive evidence that the drugs were eligible for Medicaid coverage. *Review of Medicaid Outpatient Drug Expenditures in California for Fiscal Years 2004 and 2005*. ([A-09-07-00039](#)) April 2009
- **Michigan** – Michigan claimed Medicaid reimbursement for \$106,000 Federal share in FY 2005 for outpatient expenditures for drug products that were not eligible for Medicaid coverage because they were dispensed after their termination dates or were less than effective. In addition, the State claimed \$2.9 million Federal share for drug products that were not listed on the CMS quarterly drug tapes. Because the State did not verify whether the drugs missing from the tapes were eligible for Medicaid coverage, these drug expenditures may not be allowable for Medicaid

reimbursement. *Review of Medicaid Outpatient Expenditures in Michigan for the Period October 1, 2004, Through September 30, 2005.* ([A-05-08-00048](#)) June 2009

- **New York** – New York State claimed Medicaid reimbursement for \$1.2 million Federal share in FYs 2004 and 2005 for outpatient expenditures for drug products that were not eligible for Medicaid coverage because they were dispensed after their termination dates, were less than effective, or were inadequately documented. The State also claimed \$16.2 million Federal share for drug products that were not listed on the CMS quarterly drug tapes. Because the State did not verify whether the drugs missing from the tapes were eligible for Medicaid coverage, these drug expenditures may not be allowable for Medicaid reimbursement. *Review of Medicaid Outpatient Drug Expenditures in the State of New York for the Period October 1, 2003, Through September 30, 2005.* ([A-02-07-01028](#)) May 2009
- **Tennessee** – In our review of Tennessee’s claims for reimbursement of Medicaid outpatient drug expenditures for FYs 2004–2005, we determined that of the \$4.5 billion (\$3 billion Federal share) claimed, \$8 million Federal share represented expenditures for drug products that were not eligible for Medicaid coverage because their termination dates had passed or because the drugs were determined to be less than effective. An additional \$13.2 million Federal share represented expenditures for drug products that were not listed on CMS’s quarterly drug tapes. Because the State did not verify that the drugs missing from the tapes were eligible for Medicaid coverage, some of the expenditures may not have been allowable for Medicaid reimbursement. *Review of Medicaid Outpatient Drug Expenditures in Tennessee for the Period October 1, 2003, Through September 30, 2005.* ([A-04-07-00027](#)) November 2008
- **Pennsylvania** – Our review of Pennsylvania’s claims for reimbursement of Medicaid outpatient drug expenditures for FYs 2004 and 2005 found that the State had not fully complied with Federal requirements. Of the State’s \$1.96 billion (\$1.1 billion Federal share) in Medicaid outpatient claims, \$4.4 million Federal share represented expenditures for drug products that were not eligible for Medicaid coverage because, for example, the drugs were terminated or the drug expenditures were not supported by adequate documentation. An additional \$5.9 million Federal share represented expenditures for drug products that were not listed on the quarterly drug tapes. Because the State had not verified whether these drugs were eligible for Medicaid coverage, the drug expenditures may not have been allowable for Medicaid reimbursement. *Review of Medicaid Outpatient Drug Expenditures in Pennsylvania for the Period October 1, 2003, Through September 30, 2005.* ([A-03-07-00203](#)) October 2008

Medicare Part D and Medicaid Pharmacy Reimbursement Amounts Compared for Selected Drugs

In our comparison of Part D and Medicaid pharmacy reimbursement for 40 single-source and 39 multiple-source drugs in the third and fourth quarters of 2006, we found that Part D and Medicaid pharmacy reimbursement amounts for most of the single-source drugs that we reviewed were similar. However, Medicaid reimbursement amounts for the multiple-source drugs that we reviewed were typically higher than the Part D amounts. Our study compared only the amounts reimbursed to pharmacies by Part D and Medicaid; it did not compare total program expenditures, nor did it examine the impact of rebates or post-point-of-sale price concessions.

For the five States selected for our review, we found that the Medicaid and Part D ingredient cost reimbursement amounts were similar for single-source drugs. In all five States, the average Medicaid ingredient costs exceeded the average Part D ingredient costs for most multiple-source drugs under review. In addition, Medicaid dispensing fees were substantially higher than average Part D dispensing fees for both the single-source and multiple-source drugs under review.

Congress took action to reduce multiple-source drug prices in the Medicaid program through provisions in the DRA. These provisions would have expanded the number of drugs subject to Federal upper limits (FUL) and reduced the FUL amounts for these multiple-source drugs. These provisions would have also granted States access to AMP data, which, in turn, would have allowed States to base Medicaid drug reimbursement on AMPs. However, a Federal judge issued a preliminary injunction to prevent the implementation of AMP-based FULs and AMP-based Medicaid reimbursement amounts. Therefore, Federal upper limits and Medicaid reimbursement amounts are still based on published prices, which previous OIG work found to result in inflated payments for multiple-source drugs. CMS agreed with the methodology and concurred with the findings in the report. ([OEI-03-07-00350](#)) February 2009

State Claims for Administrative Costs

New Mexico Claimed Enhanced Rate for Administrative Costs Improperly Allocated, Not Meeting Other Federal Requirements

In our review of New Mexico's claimed Medicaid administrative costs for the quarter ending September 30, 2004, we found that the State claimed \$1.5 million (\$1.1 million Federal share) of unallowable costs consisting of \$1.1 million (\$883,000 Federal share) for costs claimed because of errors in compiling the Form CMS-64 and \$374,000 (\$187,000 Federal share) resulting from errors in the random moment timestudy base that was used to allocate eligibility fieldworker costs. The State also claimed \$509,000 at unallowable enhanced Federal funding rates. Although these costs were eligible for Federal

reimbursement at the standard 50-percent Federal share rate, they did not meet the guidelines for a 90-percent enhanced Federal share rate. Therefore, the State improperly received \$128,000 in enhanced funding. Also, we could not determine what portion of \$772,000 (\$386,000 Federal share) in salary costs for medical assistance workers and temporary assistance for needy families (TANF) and what portion of \$8.5 million (\$6.4 million Federal share) in TANF transition costs were allowable because these costs benefited other programs. *Review of New Mexico's Medicaid Administrative Costs for the Quarter Ended September 30, 2004.* ([A-06-07-00072](#)) December 2008

Administrative Costs > Calculations Undocumented, Not Reviewed

Some Indirect Administrative Costs Claimed by New York Lacked Supporting Documentation

The New York Office of Mental Retardation and Developmental Disabilities (OMRDD) did not maintain documentation to support its indirect administrative cost rate calculations. The New York State Department of Health (DOH) did not review OMRDD's administrative costs before claiming them on the Form CMS-64. As a result, \$8.1 million (\$4 million Federal share) of the \$9.7 million (\$4.8 million Federal share) in indirect administrative costs that DOH claimed from January 1, 2003, through June 30, 2006, was unallowable. *Review of Medicaid Indirect Costs Submitted by the New York State Department of Health on Behalf of the Office of Mental Retardation and Developmental Disabilities.* ([A-02-06-01028](#)) March 2009

Administrative Costs > Deviations From Acceptable Practices, Documentation Issues

Allowability of Connecticut's Community-Based Administrative Cost Claims Uncertain

In this CMS-requested review of Connecticut's claims for community-based Medicaid administrative costs for State FY 2004, we found that the State's \$9.3 million claim may not have fully complied with Federal requirements. The State claimed reimbursement from CMS for administrative case management activities provided by contracted organizations that provide mental health and related services. Because the State made omissions and deviated from acceptable practices when calculating its claim and was unable to provide adequate documentation, we were unable to express an opinion on the claim's allowability. *Review of Connecticut's Community Based Medicaid Administrative Claim for State Fiscal Year 2004.* ([A-01-06-00008](#)) February 2009

Medicaid Administration

Recovery Act Funds > Calculations in Accordance With Law

HHS's Calculations of Recovery Act Medicaid Funds Found Compliant

In two reviews during this semiannual period, we evaluated HHS's compliance with certain provisions of the Recovery Act, which provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession

adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides \$87 billion in additional Medicaid funding based on temporary increases in States' Federal Medical Assistance Percentages (FMAP), which vary depending on States' relative per capita incomes.

- The first review found that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) calculated the temporary FMAP increases for the first 2 quarters of FY 2009 for the 50 States and the District of Columbia in accordance with the Recovery Act. ASPE provided these FMAP increases to CMS for use in determining the amount of Federal funds to award to States through the Medicaid grant process. *Review of the Calculations of Temporary Increases in Federal Medical Assistance Percentages Under the American Recovery and Reinvestment Act.* ([A-09-09-00075](#))
May 2009
- The second review found that for the first two quarters of FY 2009, CMS calculated the additional Medicaid funding awarded under the Recovery Act in accordance with the Social Security Act and the Recovery Act. Based on its calculations, CMS made available to States about \$15.2 billion for the first two quarters of FY 2009. *Review of the Calculation of Additional Medicaid Funding Awarded Under the American Recovery and Reinvestment Act.* ([A-09-09-00080](#))
July 2009

Program Integrity > Nonemergency Medical Transportation Services

Survey of State Agencies Describes Safeguards, Investigative Activities for Nonemergency Medical Transportation Services

In a survey of State Medicaid Agencies, we found that States concentrate their Medicaid nonemergency medical transportation (NEMT) safeguard activities on screening providers, requiring prior approval for services, and implementing methods to prevent and detect improper payments. If a State detects evidence of potential fraud and abuse, it must refer those cases to the State Medicaid Fraud Control Unit (MFCU) or other law enforcement agency, such as a local district attorney, for investigation. OIG also found that State MFCUs investigated 509 NEMT fraud and abuse cases from 2004 to 2006, with the most common types involving billing for services not rendered, unspecified overbilling, and upcoding. Of the 509 cases reported by State MFCUs, 73 percent were closed and the remaining 27 percent were open at the time the State MFCUs submitted data to OIG during the second half of 2007. Among the closed cases, 40 percent were dismissed because the allegations were unsubstantiated after investigation and another 18 percent were investigated and closed without prosecution. Twelve percent of closed cases resulted in criminal convictions, and parties agreed to settlements in another 10 percent of closed cases. *Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services.* ([OEI-06-07-00320](#)) May 2009

Medicaid Data Systems > Data Requirements Not Enforced

Medicaid Statistical Information System Usefulness Limited by Missing Encounter Data

We found that all 40 States with capitated Medicaid managed care collect encounter data from managed care organizations (MCO). CMS guidance states that the Medicaid Statistical Information System (MSIS) must include encounter data to be representative of Medicaid beneficiaries because over 65 percent of Medicaid beneficiaries receive all or part of their health care services through Medicaid managed care. However, although all States with Medicaid managed care are collecting encounter data from MCOs, CMS accepted MSIS submissions without encounter data from 15 States. The usefulness of the MSIS is limited by the absence of encounter data, and CMS staff members indicated that encounter data are needed to measure what Medicaid is paying for. *Medicaid Managed Care Encounter Data: Collection and Use.* ([OEI-07-06-00540](#)) May 2009

Medicaid Data Systems > Data Not Timely, Accurate, or Comprehensive

Medicaid Statistical Information System Data Found Inadequate for Detecting Medicaid Fraud, Waste, and Abuse

We determined that the MSIS data were not timely, accurate, or comprehensive for detection of fraud, waste, and abuse. The MSIS is the only source of nationwide Medicaid claims and beneficiary eligibility information. CMS collects the MSIS data directly from States to, among other things, assist in detecting fraud, waste, and abuse in the Medicaid program. We determined that during FYs 2004 through 2006, the MSIS data were an average of 1.5 years old when they were released to all users. In addition, CMS did not fully disclose or document information about the accuracy of MSIS data. As of June 2009, the MSIS had not captured many of the data elements that can assist in fraud, waste, and abuse detection. Our results indicate opportunities for States and CMS to reduce the timeframes for file submission and validation, respectively. Opportunities exist for CMS to improve the documentation and disclosure of error tolerance adjustments and expand State Medicaid data collection and reporting to assist in fraud, waste, and abuse detection. *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse.* ([OEI-04-07-00240](#)) August 2009

Gulf Coast Hurricane-Related Reviews

Hurricane-Related Funding > State Agency Administration

Medicaid State Agencies' Uncompensated Care Claims Generally Compliant in One State, Mostly Unallowable in Another

Pursuant to the Social Security Act, § 1115, CMS authorized certain States to operate an uncompensated care pool (UCCP) to reimburse providers for medically necessary services provided to Hurricane Katrina evacuees and affected individuals and to Hurricane Rita evacuees without other coverage. We evaluated UCCP reimbursement in two States.

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- **Alabama** – For services supplied through January 31, 2006, by five providers that received high UCCP reimbursement, the State generally claimed reimbursement in accordance with the approved section 1115 demonstration and UCCP plan. However, we found that nine claims totaling \$27,000 were unallowable because the individuals who received the services were not from an area affected by Hurricane Katrina or Rita, had health care coverage under other programs, or did not provide addresses that could be used to establish eligibility. One other claim totaling \$16,000 was allowable as a UCCP claim, but the State inappropriately used this claim in its Medicaid DSH calculation. *Allowability of Alabama's Hurricane Katrina-Related Uncompensated Care Claims.* ([A-04-08-03040](#)) March 2009
 - **Louisiana** – Louisiana did not always claim reimbursement for services provided by a hospital in accordance with Federal and State laws and regulations or with the approved provisions of the UCCP plan. Of the \$8.3 million in costs claimed as of December 31, 2006, for services provided by the hospital, \$7.7 million was unallowable. The State claimed the unallowable costs because it (1) did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan, (2) did not instruct the hospital to analyze its uncompensated care claims to determine whether payments had been received from other sources, (3) relied on the hospital to verify that the costs claimed were based on actual inpatient days, and (4) did not have procedures to ensure that it identified all duplicate claims. *Review of Southeast Louisiana Hospital's Hurricane-Related Uncompensated Care Claims.* ([A-06-08-00023](#)) July 2009

Highlights of Legal and Investigative Activities

In addition to conducting audits and evaluations of Medicaid, OIG investigates allegations of criminal and civil wrongdoing in Medicaid and, in conjunction with DOJ and others, conducts administrative enforcement and litigation and provides technical support for such efforts. OIG's enforcement work and industry guidance are often designed to have broad impact on Federal health care programs. In large part, OIG's industry outreach and enforcement efforts affect other health care programs as well as Medicaid. The following table presents a summary of OIG's investigative, enforcement, and industry outreach activities during FY 2009 related to Medicaid.

OIG's Medicaid-Related Investigations and Legal Services in FY 2009

OIG Activity Area ⁶	Number
Enforcement	
Medicaid Cases Worked	1,390
Joint Investigations Conducted With State MFCUs	987
Total Medicaid Cases Opened	511
Criminal Convictions	222
Civil Actions ⁷	103
Program Exclusions – Imposed	2,556
Program Exclusions – Appeals Filed	74
Civil Monetary Penalty Actions	25
Emergency Medical Treatment and Labor Act Actions (aka "Patient Dumping")	6
Corporate Integrity Agreements – New	42
Corporate Integrity Agreements – Monitored	408
Outreach	
Advisory Opinions	24

Advisory Opinions

In accordance with section 205 of the HIPAA, OIG, in consultation with DOJ, issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. OIG provides case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. OIG advisory opinions for Medicare and Medicaid are available at: <http://oig.hhs.gov/fraud/advisoryopinions.asp>.

⁶ Matters listed here are not necessarily Medicaid specific. Many also involve fraud against other health care programs.

⁷ The category "Civil Actions" does not include civil monetary penalty (CMP) actions.

Provider Self-Disclosure Protocol

OIG makes available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. OIG's "Provider Self-Disclosure Protocol" gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation may entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a reasonable monetary settlement and potentially avoid being excluded from participation in Federal health care programs. The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG Web site at: <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>.

The following are Medicaid-related examples:

Michigan – Courtyard Manor of Farmington Hills, Inc. (Courtyard Manor), an adult foster care facility, agreed to pay \$1.7 million to resolve its Civil Monetary Penalties Law (CMPL) liability for receiving Federal health care program funds while being subject to a 10-year exclusion from participation in all Federal health care programs. The company also agreed to an additional 2-year exclusion. The original exclusion, imposed in August 2002, was the result of a May 2001 no contest plea to a charge of involuntary manslaughter after the death of a Courtyard Manor resident. As disclosed under OIG's Provider Self-Disclosure Protocol, Courtyard Manor discovered in May 2007 that it had contracted with several agencies that were funded, in part, by the Michigan Medicaid Program.

Louisiana – Walgreen Louisiana Co. (Walgreen) agreed to pay \$1,053,774 to settle its liability under OIG's CMPL authority for allegedly employing an individual that Walgreen knew or should have known was excluded from participation in Federal health care programs. As reported under OIG's Provider Self-Disclosure Protocol, Walgreen submitted to Medicare, Medicaid, and TRICARE claims for prescriptions filled by an excluded pharmacist who had applied for his job using his middle name, thereby allegedly obscuring his excluded status. However, if Walgreen had checked his pharmacy license, as it is required to do, it would have uncovered his first name, under which he was excluded. The State of Louisiana was a party to the settlement agreement and released its administrative claims.

Program Exclusions

During FY 2009, OIG excluded 2,556 individuals and entities from participating in Medicare, Medicaid, and other Federal health care programs. Most of the exclusions

resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. A Medicaid example follows:

Rhode Island – John Montecalvo, a nursing home executive, was excluded for a minimum of 17 years based on two convictions—one for equity skimming and the other for embezzlement, conspiracy, and patient neglect. From January 1998 to May 2004, Montecalvo used funds that had been issued by the Department of Housing and Urban Development (HUD) for the operation of nursing homes for purposes other than what was reasonable and necessary. He was sentenced to 24 months of incarceration and was ordered to pay \$780,539 in restitution. In a related State case, Montecalvo was sentenced to 10 years in prison with 9 years suspended, to be served concurrently with the Federal sentence, for his involvement in a Medicaid fraud scheme and for failing to provide treatment and care to patients at a nursing home.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the civil False Claims Act Amendments of 1986 (FCA).

The successful resolution of false claims often involves the combined investigative efforts and resources of OIG, FBI, MFCUs, and other law enforcement agencies. OIG is responsible for assisting DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases before litigation. As part of their settlements, providers often agree to enter into integrity agreements with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the fraudulent conduct.

During FY 2009, the Government's enforcement efforts resulted in 515 criminal actions and 387 civil actions against individuals or entities that engaged in health-care-related offenses. These efforts resulted in \$3 billion in HHS and \$985.7 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs. Some of the notable enforcement actions are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Pharmaceutical Manufacturers and Distributors

Pennsylvania – Eli Lilly and Company (Lilly) entered into an approximately \$1.4 billion global criminal, civil, and administrative settlement to resolve allegations that it illegally marketed its antipsychotic drug Zyprexa. Under the civil settlement agreement, Lilly agreed to pay the Federal Government \$438,171,544 and participating States up to

\$361,828,456 to resolve FCA allegations that by marketing Zyprexa for certain uses unapproved by FDA, it caused false claims for payment to be submitted to Federal health care programs, such as Medicaid, from September 1999 to the end of 2005. The civil allegations were originally brought in four separate *qui tam* lawsuits. Lilly also agreed to pay a criminal fine of \$515 million and forfeit assets of \$100 million. In its plea agreement, Lilly admitted that from September 1999 to March 31, 2001, it promoted Zyprexa for unapproved uses in elderly populations as treatment for dementia, including Alzheimer's dementia. Lilly entered a 5-year Corporate Integrity Agreement (CIA) with several unique provisions, including (1) a requirement that Lilly notify doctors about the settlement and provide a means by which the physicians may report questionable conduct by sales representatives; (2) a requirement that Lilly post on its Web site information about payments made to physicians; and (3) flexible audit provisions, which allow for additional audits to be conducted throughout the term of the CIA at OIG's discretion and with limited advance notice. The CIA also provides for increased accountability by Lilly's board of directors and management in the form of an annual resolution by a board committee and annual certifications from managers about compliance.

Texas – Abbott Laboratories Inc. (Abbott), an Illinois-based pharmaceutical company, agreed to pay the State of Texas and the Federal Government a total of \$28 million in a Medicaid fraud settlement to resolve its civil liabilities related to the false pricing of certain intravenous drugs and blood products. Under Texas law, drug manufacturers participating in Medicaid are required to report their wholesale and other prices to the Medicaid program. These prices are the basis on which the Texas Medicaid program calculates reimbursement to Medicaid providers. The Government alleged that Abbott falsified price reports and inflated its prices for products that it submitted to the Texas Medicaid program. As a result of the alleged illegal pricing, Texas Medicaid allegedly overreimbursed providers for Abbott's drugs.

Minnesota – Walgreen Co. (Walgreen) agreed to pay the United States \$9.9 million to resolve allegations that it overcharged the Medicaid program in Minnesota, Michigan, Florida, and Massachusetts for prescription drugs by charging Medicaid for the difference between the Medicaid-negotiated amounts and the third-party primary insurer-negotiated amounts for the drugs. The Government alleged that Walgreen charged Medicaid a larger amount when it should have charged Medicaid only for the co-pay after the primary payer's payment. In addition to agreeing to the monetary settlement, Walgreen agreed to enter into an amendment to its June 2008 CIA. Under the amendment, Walgreen must train its pharmacists about the importance of billing Medicaid appropriate amounts and hire an independent review organization to annually audit its Medicaid claims in each of the four States.

Kentucky – Verlon Lane Pierce, a pharmacist, was sentenced to 6 months of home detention on charges of health care fraud and the sale of prescription drug samples. In addition, Pierce paid the United States \$850,000 as a forfeiture of proceeds from the criminal activity. He also paid the United States \$495,606 in an FCA settlement, making the combined criminal and civil recovery \$1,345,606. In his guilty plea, Pierce admitted that

from January 1, 2001, through December 1, 2004, he defrauded health care benefit programs, including Medicaid, by unlawfully billing those programs for pharmaceutical drug samples provided to patients. Pierce also admitted that he unlawfully purchased, sold, and traded prescription drug samples. Pierce's activities occurred in connection with his business, Medicine Arts Pharmacy.

South Carolina – The Medicine Dropper, Inc., and its pharmacist owners, John Frank Weeks and Derrelyn B. Weeks (collectively, Medicine Dropper), agreed to pay the United States \$500,000 plus interest to resolve allegations of violating the Controlled Substances Act (CSA) (enacted as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970) and applicable regulations and to settle allegations of violating the FCA for submitting false claims to Medicaid for prescriptions for three Medicaid recipients. The Government alleged that Medicine Dropper filled invalid Ketamine prescriptions and filled prescriptions that were not for a legitimate medical purpose. As part of the resolution of this matter, Medicine Dropper agreed to adopt reasonable and customary policies to prevent the use of its pharmacy for “doctor shopping,” fill prescriptions using the correct Drug Enforcement Administration (DEA) number for the physician, ensure that all required elements of a prescription are present before dispensing, and no longer dispense Ketamine products.

Laboratories

New York – Quest Diagnostics Incorporated (Quest) and its wholly owned subsidiary, Nichols Institute Diagnostics (NID), entered a \$302 million global criminal and civil settlement to resolve allegations raised in a qui tam complaint concerning various types of diagnostic test kits that NID manufactured, marketed, and sold to laboratories throughout the country between May 1, 2000, and April 30, 2006. As part of the criminal resolution, NID pleaded guilty to a felony misbranding violation of the Federal Food, Drug, and Cosmetic Act of 1938 (FDCA) relating to NID's Nichols Advantage Intact Parathyroid Hormone Immunoassay, a test used by laboratories throughout the country to measure parathyroid hormone (PTH) levels in patients. As part of the plea, NID agreed pay a criminal fine of \$40 million. Quest also entered into a nonprosecution agreement with the United States. As part of the civil settlement, Quest, as the parent company of NID, agreed to pay \$262 million plus interest to resolve FCA allegations relating to the Advantage Intact PTH assay and four other assays manufactured by NID that allegedly provided inaccurate and unreliable results. Quest also agreed to pay various State Medicaid programs about \$6.2 million to resolve similar civil claims. Quest entered a 5-year CIA that requires it to hire two independent reviewers. Quest's board of directors (board) is required to hire a compliance expert to determine how compliance concerns are communicated to senior management and the board. The company is required to retain an independent review organization to review Quest's compliance with FDA Quality System Regulation and labeling requirements.

Nursing Homes

Texas – Regency Nursing and Rehabilitation Centers, Inc. (Regency), agreed to pay \$4 million plus interest to resolve its potential FCA liability for violations allegedly committed at 10 of its nursing facilities in south, central, and east Texas. The allegations included submitting claims to Medicare and Medicaid for skilled services that were not medically necessary and/or were for patients who did not qualify for the claimed services. The Government also alleged that Regency falsely certified on its cost reports that all services had been provided in accordance with all applicable laws and regulations.

District of Columbia – Grant Park Care Center (GPCC), a 296-bed skilled nursing facility, agreed to pay the United States and the District of Columbia \$2 million to settle FCA allegations. GPCC is owned and managed by Centennial HealthCare Corporation; Grant Park Nursing Home Limited Partnership; Grant Park Management LLC; and eight other corporate entities (collectively, Centennial). Centennial is one of the largest nursing home owners in the United States.

The United States alleged that from January 1998 through December 2007, Centennial submitted claims to the Medicare and Medicaid programs for services that failed to meet the needs of the residents at GPCC in one or more of the following areas: resident nutrition and hydration; needs assessments and evaluations; care planning and nursing interventions; medication management; fall prevention and management; and pressure ulcer care, including the prevention and treatment of wounds. The United States also alleged that Centennial understaffed GPCC during the covered period with knowledge that resident care would be compromised.

As part of the settlement, Grant Park Nursing Home Limited Partnership and Grant Park Management, LLC, agreed to enter into a 5-year CIA with OIG that required them to establish a detailed compliance program and retain an independent monitor to assess their quality assurance and quality improvement systems.

Durable Medical Equipment Suppliers

Texas – Aniekan Jonathan Ekwere, owner of Coastal Medical Supply, was sentenced to 18 months of incarceration and ordered to pay \$702,963 in restitution for health care fraud and conspiracy to commit health care fraud. Through his durable medical equipment (DME) company, Ekwere submitted claims to Medicare and Medicaid for reimbursement of motorized wheelchairs. In most cases, Ekwere provided Medicare and Medicaid recipients in Texas and Louisiana with less expensive scooters or nothing at all. As part of his scheme, Ekwere paid Jude Akpan, an employee of one of Texas's largest not-for-profit hospital systems, for fraudulent prescriptions, certificates of medical necessity, and Medicare patient information. Akpan was sentenced to 5 years' probation and ordered to pay restitution of \$19,221, joint and several with Ekwere, for receiving illegal kickbacks.

Practitioners

Maryland – Virginia Vought Acree, a State-licensed clinical specialist in child and adolescent psychiatric and mental health nursing, was sentenced to 36 months of imprisonment and ordered to pay restitution in the amount of \$390,000 after her guilty plea to health care fraud. Acree falsely billed Medicare, Medicaid, and private health care plans for services that she did not provide on hundreds of occasions from January 2003 to November 2007. Acree often billed for face-to-face psychotherapy services on dates when she was on vacation in other States or countries or attending out-of-town conferences.

Medicaid Fraud Control Units

MFCUs are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2009, HHS awarded \$189.8 million in Federal grant funds to 50 State MFCUs, which employed a total of 1,835 individuals.⁸ Collectively, in FY 2009, the MFCUs reported 26,744 total investigations, of which 17,090 were related to Medicaid fraud and 9,654 were related to patient abuse and neglect, including patient funds cases. These cases resulted in 1,539 individuals' being indicted or criminally charged, including 960 for fraud and 579 for patient abuse and neglect, including patient funds cases. In total, 1,331 convictions were reported in FY 2009, of which 819 were related to Medicaid fraud and 512 were related to patient abuse and neglect, including patient funds cases. For civil and criminal cases handled by the 50 MFCUs, \$1.3 billion was recovered to the program. This translates to a return on investment of \$5.23 per \$1.00 contributed by both the Federal and State governments for the operation of the MFCUs. The total number of civil judgments and settlements for the FY was 642.

The MFCUs refer to OIG a significant number of cases for possible exclusion from participation in Medicare, Medicaid, and other Federal health care programs. In FY 2009, of the 2,556 OIG exclusions, 793 were based on referrals made to OIG by MFCUs.

Joint Federal and State Investigations

Indiana – Gabriele Reginald Harden was sentenced to 41 months of imprisonment and ordered to pay restitution of \$1,683,412, after a guilty plea to health care fraud and money laundering. Harden owned and operated a mobile dental unit, Dental Express, which operated out of a recreational vehicle and focused primarily on low-income Medicaid-eligible children. The mobile unit arranged for visits, typically to inner city schools, day care facilities, and subsidized housing projects. He routinely billed Medicaid for fillings when sealants were actually applied to primary teeth, a procedure not covered by Medicaid. He also improperly billed for x-rays that were not taken at the direction of a

⁸ With the exception of the total grant award and exclusion information, which are maintained by OIG, these totals are based on information supplied by the MFCUs and have not been independently verified by OIG. The MFCUs maintain separate case information for patient abuse and neglect as well as for patient funds cases, which were included by OIG as a single total.

dentist, were not diagnostic, or were developed long after the patients were seen on the mobile unit. Harden had ceased billing for sealants as fillings because of mounting pressures from staff and an investigation in Ohio, but he restarted the scheme after the staff had either quit or been fired. The investigation involved OIG, FBI, the Internal Revenue Service (IRS), and the Indiana MFCU.

Indiana – Dennis Lennartz was sentenced to 43 months of incarceration and ordered to pay \$964,852 in restitution for his guilty plea to health care fraud. The investigation revealed that Lennartz received payments from Medicaid by having his business partner bill for transportation services purportedly provided to Medicaid beneficiaries from August 2006 through December 2008. Lennartz had obtained about 160 Medicaid numbers of nursing home patients with developmental disabilities and used the numbers to submit the false claims to Medicaid. Lennartz, who was previously convicted of health care fraud, hid his involvement in the scheme by having the Medicaid provider number registered to one of his former employees. The investigation involved OIG, the FBI, and the Indiana MFCU.

Texas – Brothers Mazen and Wesam Abdallah were each sentenced to 30 months' imprisonment and were ordered to pay \$637,425 in joint and several restitution for their involvement in a scheme to defraud Medicare and Medicaid. After a 5-week trial in which more than 50 witnesses testified, a jury convicted the brothers of conspiracy to commit health care fraud and convicted Wesam Abdallah of additional charges of health care fraud and an anti-kickback violation. The Abdallahs owned and operated Americare Medical Service (Americare), an ambulance company that specialized in transporting dialysis patients to and from their treatments. Many of the patients did not qualify for transportation and either had no prescriptions or used prescriptions on which the doctors' signatures were photocopied or procured by tricking doctors into signing the prescriptions. In addition, the Abdallahs recruited patients using public transportation manifests that they had purchased and by paying kickbacks to patients. Defendants Ayad Fallah and Murad Almasri, who owned and operated Americare before selling it to Mazen Abdallah, were previously sentenced pursuant to their guilty pleas to conspiracy. Fallah and Almasri were each sentenced to time served and ordered to pay \$1,660,113 in joint and several restitution. A third previous owner of Americare was also charged but remains a fugitive. The investigation involved OIG, FBI, IRS, and the Texas MFCU.

Rhode Island – Carmine DeTomasis, a pharmacist and co-owner of Prime Drug, Inc. (Prime Drug), was sentenced to 1 year and 1 day of incarceration and ordered to pay \$404,125 in joint and several restitution for illegally buying and selling pharmaceuticals and defrauding health care insurers. DeTomasis's codefendant, Louis Romanelli, was sentenced to 30 months of imprisonment for his role in the scheme. DeTomasis supplied Romanelli with the drug Vicodin, which Romanelli then sold on the street. Prime Drug also purchased HIV/AIDS drugs and controlled prescription drugs from beneficiaries through Romanelli at one-third the cost of the purchase price from a legitimate drug wholesaler. Upon receiving the prescription drugs from Romanelli, Prime Drug repackaged them for redistribution to Medicare Part D and Medicaid beneficiaries at the full reimbursement rate. DeTomasis also submitted false reimbursement claims to health

insurance carriers for prescription drugs that the store had not dispensed. Also implicated in the scheme was former North Providence Police Officer Paul Vittorio, who had warned Romanelli that he might be under investigation and suggested that Romanelli move his operation. Vittorio also admitted trying to influence the testimony of a grand jury witness. Vittorio was sentenced to 5 months of imprisonment and ordered to pay a fine of \$17,627 for misprision of a felony, tampering with a witness, and making false statements. The investigation involved OIG, FDA, the Rhode Island MFCU, the U.S. Postal Inspection Service, IRS, and DEA.

Maryland – Chesapeake Youth Center (CYC), a former residential treatment center for adolescents, agreed to pay \$259,120 to resolve its potential FCA liability. The United States alleged that from January through July 2005, CYC submitted or caused to be submitted claims to Medicaid for inpatient adolescent psychiatric services that were not provided or were substandard or worthless. The investigation involved OIG, the Maryland MFCU, and the Civil Division of DOJ.

Conclusion

OIG's Medicaid oversight generally takes the form of a continuous stream of projects that may require more than 1 year to yield results. The use of funding in 1 year often bears fruit in future years. Accordingly, the accomplishments highlighted in this document reflect the results of OIG work over time that culminated in FY 2009. Also, in the first three appendixes to this report, we list (1) titles of Medicaid audit and evaluation reports issued in FY 2009; (2) FY 2010 Medicaid work in progress and planned starts; and (3) open Medicaid recommendations that, if implemented, could save Federal tax dollars and improve HHS programs. The final two appendixes describe the DRA requirements that pertain to OIG and provide a list of acronyms and abbreviations used in the report.

Appendix A: Audit and Evaluation Reviews Completed in Fiscal Year 2009

Medicaid Hospitals

Review of Inpatient Hospital Claims Billed as Family Planning Services Under the New York State Medicaid Program (A-02-06-01007)

Review of State Plan Amendments Authorizing Disproportionate Share Hospital Payments by Pennsylvania to Hospitals of State-Related Universities (A-03-07-00222)

Review of Pennsylvania's Determination of Medicaid Disproportionate Share Hospital Eligibility for State-Operated Institutions for Mental Diseases (A-03-08-00202)

Review of Medicaid Participation Eligibility for One Indiana State-Owned Psychiatric Hospital for the Period July 1, 1996, Through June 30, 2007 (A-05-07-00076)

Review of Medicaid Inpatient Hospital Transfer Payments in Indiana for October 1, 2003, Through September 30, 2006 (A-05-07-00081)

Review of Medicaid Credit Balances at Lakeview Hospital, as of February 1, 2008 (A-05-08-00026)

Review of Medicaid Inpatient Hospital Transfer Payments in Michigan for October 1, 2003, Through September 30, 2006 (A-05-08-00045)

Review of Medicaid Credit Balances at Weiss Hospital as of February 29, 2008 (A-05-08-00049)

Review of Medicaid Credit Balances at Mercy Hospital as of April 1, 2008 (A-05-08-00063)

Review of Medicaid Credit Balances at Hennepin County Medical Center as of March 31, 2008 (A-05-08-00065)

Review of Medicaid Credit Balances at St. Joseph Hospital as of June 30, 2007 (A-05-08-00089)

Review of East Louisiana State Hospital's Hurricane-Related Uncompensated Care Claims (A-06-07-00024)

Review of Southeast Louisiana Hospital's Hurricane-Related Uncompensated Care Claims (A-06-08-00023)

Review of Medicaid Credit Balances at Scripps Memorial Hospital Encinitas as of December 31, 2008 (A09-09-00056)

Review of Medicaid Credit Balances for Kuakini Medical Center as of December 31, 2008 (A-09-09-00072)

Review of Hawaii Medicaid Credit Balances for Kapi'olani Medical Center at Pali Momi as of December 31, 2008 (A-09-09-00073)

Review of Medicaid Credit Balances at Oroville Hospital as of February 28, 2009 (A-09-09-00077)

Review of Medicaid Credit Balances at French Hospital Medical Center as of February 28, 2009 (A-09-09-00079)

Medicaid Home, Community, and Nursing Home Care

Review of Connecticut's Community Based Medicaid Administrative Claim for State Fiscal Year 2004 (A-01-06-00008)

Review of Connecticut's Community Based Medicaid Administrative Claims for State Fiscal Years 2005 and 2006 (A-01-08-00003)

Partnership Review of Medicaid Claims Processed by Cerebral Palsy and Stavros for Personal Care Attendant Services Provided to Beneficiaries During Inpatient Stays (A-01-08-00001)

Review of Medicaid Overpayments at Greenwood Center in Maine for Calendar Years 2004 Through 2006 (A-01-08-00006)

Review of Medicaid Overpayments at Varney Crossing Nursing Care Center for Calendar Years 2004 Through 2006 (A-01-08-00008)

Review of Medicaid Overpayments at Ledgeview Living Center for Calendar Years 2004 Through 2006 (A-01-08-00010)

Review of Medicaid Overpayments at North Country Associates, Inc., for Calendar Years 2004 Through 2006 (A-01-08-00011)

Review of Medicaid Overpayments at Victorian Villa Rehabilitation and Living Center for Calendar Years 2004 Through 2006 (A-01-08-00012)

Review of Medicaid Personal Care Services Claims Made by Providers in New York City (A-02-07-01054)

Review of Ohio Medicaid Long-Term-Care Payments to Two Providers for the Same Beneficiaries for the Same Dates of Services From October 1, 1998, Through September 30, 2005 (A-05-07-00074)

Review of Section 1915(c) Mental Retardation or Related Conditions Waiver Services at ACR Homes, Inc., From July 1, 2004, Through June 30, 2005 (A-05-08-00025)

Review of Social Security Act Section 1915(c) Waiver Payments for Home and Community-Based Services at Search Developmental Center, July 1, 2004, Through June 30, 2005 (A-05-08-00060)

Review of New Mexico Developmental Disabilities Home and Community-Based Services Waiver (A-06-07-00097)

Review of Texas Medicaid Payments for Medicare Coinsurance of Dual-Eligible Beneficiaries in Skilled Nursing Facilities (A-06-08-00006)

Collaborative Effort To Identify Overlapping Claims for Dual-Eligible Beneficiaries Receiving Medicare Part A and Medicaid Long Term Care Services in Texas (A-06-08-00053)

Review of The Long Term Care, Managed Care Program Costs Claimed by the Utah Department Of Health (A-07-08-02719)

Review of Medicaid Credit Balances at Colorado State Veterans Home at Fitzsimons (A-07-09-02751)

Review of Medicaid Credit Balances at Boulder Manor Nursing Home (A-07-09-02755)

Review of Medicaid Credit Balances at Sunny Vista Living Center (A-07-09-02756)

Review of Medicaid Credit Balances at Pioneers Memorial Healthcare District as of December 31, 2008 (A-09-09-00054)

Nursing Home Corporations Under Quality of Care Corporate Integrity Agreements (OEI-06-06-00570)

Medicaid-funded Personal Care Services Billed in Excess of 24 Hours a Day (OEI-07-06-00621)

Medicaid and Medicare Home Health Payments for Skilled Nursing and Home Health Aide Services (OEI-07-06-00641)

Other Medicaid Services

New Hampshire Medicaid Payments for Skilled Professional Medical Personnel at the Enhanced Rate from October 1, 2004 Through September 30, 2006 (A-01-07-00011)

Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program (A-02-07-01037)

Review of Family Planning Claims Submitted by Selected Providers Under the New York State Medicaid Program (A-02-09-01015)

Review of Timeliness of West Virginia's Retroactive Claims for Medicaid School-Based Services (A-03-06-00201)

Review of Pennsylvania's Medicaid Payments for Targeted Case Management Services for Calendar Years 2003 Through 2005 (A-03-06-00202)

Review of Medicaid Services to Incarcerated Juveniles in the State of Georgia During Federal Fiscal Years 2003 and 2004 (A-04-06-00026)

Family Planning Services Claimed Twice in Michigan for October 1, 2005, Through September 30, 2007 (A-05-08-00064)

Family Planning Services Claimed by Michigan During October 1, 2005, Through September 30, 2007 (A-05-09-00050)

Medicaid Payments Made for Nonemergency Services Provided to Undocumented Aliens and Legal Aliens Restricted to Emergency Services in Texas (A-06-07-00108)

Review of Colorado Medicaid Mental Health Capitation and Managed Care Program (A-07-06-04067)

Iowa Medicaid Payments Claimed for Children's Remedial Services (A-07-08-03112)

Improper Medicaid Payments for Outpatient Laboratory Services to Dual Eligible Beneficiaries (OEI-04-07-00340)

Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services (OEI-06-07-00320)

Medicaid Prescription Drugs

Review of Medicaid Outpatient Drug Expenditures in Connecticut for the Period October 1, 2003, Through September 30, 2005 (A-01-07-00003)

Audit of Controls Over Collecting Rebates on Single Source Drugs Administered by Physicians in Massachusetts (A-01-08-00005)

Follow-Up Audit of the Medicaid Drug Rebate Program in Rhode Island (A-01-08-00009)

Follow-Up Audit of the Medicaid Drug Rebate Program in New Hampshire (A-01-08-00013)

Review of Medicaid Outpatient Drug Expenditures in the State of New York for the Period October 1, 2003, Through September 30, 2005 (A-02-07-01028)

Review of New Jersey's Compliance With the "Reimbursement of State Costs for Provision of Part D Drugs" Medicare Demonstration Project Requirements (A-02-08-01007)

Review of Medicaid Outpatient Drug Expenditures in Pennsylvania for the Period October 1, 2003, Through September 30, 2005 (A-03-07-00203)

Review of Medicaid Outpatient Drug Expenditures in Tennessee for the Period October 1, 2003, Through September 30, 2005 (A-04-07-00027)

Follow-Up Audit of the Medicaid Drug Rebate Program in West Virginia (A-03-08-00200)

Follow-Up Review of the Medicaid Drug Rebate Program in Mississippi (A-04-07-07023)

Follow-Up Review of the Medicaid Drug Rebate Program in Georgia (A-04-07-07027)

Follow-Up Review of the Medicaid Drug Rebate Program in South Carolina (A04-08-07004)

Follow-Up Review of the Medicaid Drug Rebate Program in Ohio (A-04-08-07005)

Review of Medicaid Outpatient Drug Expenditures in Michigan for the Period October 1, 2004, Through September 30, 2005 (A-05-08-00048)

Review of Medicaid Outpatient Drug Expenditures in Texas for the Period October 1, 2003, Through September 30, 2005 (A-06-07-00092)

Review of Medicaid Outpatient Drug Expenditures in California for Fiscal Years 2004 and 2005 (A-09-07-00039)

Follow-Up Audit of the Medicaid Drug Rebate Program in Nevada (A-09-08-00026)

Follow-Up Audit of the Medicaid Drug Rebate Program in Alaska (A-09-08-00051)

Review of California's Compliance With Demonstration Project Requirements for Reimbursement of State Costs for Provision of Medicare Part D Drugs (A-09-08-00056)

Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid (OEI-03-07-00350)

Accuracy of Drug Categorizations for Medicaid Rebates (OEI-03-08-00300)

A Comparison of Medicaid Federal Upper Limit Amounts to Acquisition Costs, Medicare Payment Amounts, and Retail Prices (OEI-03-08-00490)

Outlier Average Manufacturer Prices in the Federal Upper Limit Program
(OEI-03-07-00740)

Medicaid Administration

Review of Medicaid Graduate Medical Education Revenue in New York State
(A-02-04-01015)

Review of Medicaid Indirect Costs Submitted by the New York State Department of Health
on Behalf of the Office of Mental Retardation and Developmental Disabilities
(A-02-06-01028)

Review of North Carolina's Accounts Receivable System for Medicaid Provider
Overpayments (A-04-06-07009)

Allowability of Alabama's Hurricane Katrina-Related Uncompensated Care Claims
(A-04-08-03040)

Review of Indiana's Reporting Fund Recoveries for the Medicaid Rehabilitation Option
Program on the CMS-64 for Fiscal Years 2000 to 2005 (A-05-07-00072)

Review of New Mexico's Medicaid Administrative Costs for the Quarter Ended September
24, 2004 (A-06-07-00072)

Centers for Medicare & Medicaid Services Resolution of Audit Recommendations
(A-07-07-04112)

Audit of the Indian Health Service Headquarters Cost Statement for Fiscal Year 2005
(A-09-07-00054)

Review of the Calculations of Temporary Increases in Federal Medical Assistance
Percentages Under the American Recovery and Reinvestment Act (A-09-09-00075)

Review of the Calculation of Additional Medicaid Funding Awarded Under the American
Recovery and Reinvestment Act (A-09-09-00080)

Review of Missouri's Medicaid Management Information System Expenditures for the
Period October 1, 2004, Through September 30, 2007 (A-07-08-04122)

Medicaid Managed Care Encounter Data: Collection and Use (OEI-07-06-00540)

Medicaid Information Systems, Data Management, and Security

Information Technology General Controls Audit of the State of Michigan Medicaid Claims
Processing System (A-05-07-00013)

Audit of General Controls for South Dakota Medicaid Claims Processing and Eligibility Determinations (A-07-08-00241)

Follow-Up Audit of General Controls for Medicaid Claims Processing for Missouri Department of Social Services (A-07-09-00276)

Usefulness of Medicaid Statistical Information System Data for Detecting Fraud, Waste, and Abuse (OEI-04-07-00240)

Appendix B:

FY 2010 Work in Progress and New Starts

This appendix lists the working titles of Medicaid-related audit and evaluation projects included in the Office of Inspector General's (OIG) fiscal year (FY) 2010 Work Plan designated as work in progress (as of October 1, 2009) or as new starts to begin during FY 2010. The work will be conducted by OIG's Office of Audit Services (OAS) and Office of Evaluation and Inspections (OEI). Summaries of the objectives and context of each project are provided in the *FY 2010 Work Plan*, which is available in the "Publications" section of the OIG Web site at: <http://www.oig.hhs.gov/publications.asp>.

Medicaid Hospitals

State Medicaid Agency Policies to Deny Payment for Hospital-Acquired Conditions
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Hospital Outlier Payments
(OAS; W-00-09-31069; W-00-10-31069; various reviews; expected issue date: FY 2010; work in progress)

Provider Eligibility for Medicaid Reimbursement
(OAS; W-00-10-31301; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Disproportionate Share Hospital Payment Distribution
(OAS; W-00-09-31302; W-00-10-31302; various reviews; expected issue date: FY 2010; work in progress)

Supplemental Payments to Private Hospitals
(OAS; W-00-10-31126; various reviews; expected issue date: FY 2010; work in progress)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services
(OAS; W-00-09-31127; W-00-10-31127; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Home, Community, and Nursing Home Care

Community Residence Rehabilitation Services
(OAS; W-00-08-31087; W-00-09-31087; W-00-10-31087; various reviews; expected issue date: FY 2010; work in progress)

Targeted Case Management
(OAS; W-00-05-31082; W-00-08-31082; W-00-09-31082; W-00-10-31082; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Payments to Continuing Day Treatment Providers

(OAS; W-00-09-31128; W-00-10-31128; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Home Health Agency Claims

(OAS; W-00-09-31304; W-00-10-31304; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Payments for Personal Care Services

(OAS; W-00-08-31035; W-00-09-31035; W-00-10-31035; various reviews; expected issue date: FY 2010; work in progress)

Compliance With States' Requirements for Medicaid-Funded Personal Care Service Attendants

(OEI; 07-08-00430; expected issue date: FY 2010; work in progress)

Medicaid Payments for Medicare-Covered Home Health Services

(OAS; W-00-09-31305; W-00-10-31305; various reviews; expected issue date: FY 2010; work in progress)

State and Federal Oversight of Home- and Community-Based Services in Assisted Living Facilities

(OEI; 09-08-00360; expected issue date: FY 2010; work in progress)

State and Federal Oversight of Home- and Community-Based Services

(OEI; 02-08-00170; expected issue date: FY 2010; work in progress)

Medicaid Adult Day Health Service Payments for Ineligible and Absent Beneficiaries

(OEI; 09-07-00500; expected issue date: FY 2010; work in progress)

Oversight of Nursing Home Minimum Data Set Data

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Transparency Within Nursing Facility Ownership

(OAS; W-00-10-31130; various reviews; expected issue date: FY 2010; work in progress)

States' Administration and Use of Civil Monetary Penalty Funds in Medicaid Nursing Homes

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid Nursing Home Patients: Quality of Care

(OAS; W-00-10-31330; various reviews; expected issue date: FY 2010; new start)

Medicaid Incentive Payments for Nursing Facility Quality-of-Care Performance Measures

(OAS; W-00-10-31331; various reviews; expected issue date: FY 2010; new start)

Medicaid Waiver Administrative Costs

(OAS; W-00-10-31332; various reviews; expected issue date: FY 2010; new start)

Medicaid Prescription Drugs

Timely Submission of Average Manufacturer Price Data

(OEI; 03-09-00060; expected issue date: FY 2010; work in progress)

Calculation of Average Manufacturer Prices

(OAS; W-00-10-31202; various reviews; expected issue date: FY 2011; new start)

Recalculation of Base Date Average Manufacturer Prices

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Medicaid Drug Claims

(OAS; W-00-10-31203; various reviews; expected issue date: FY 2010; work in progress)

Federal Upper Payment Limit Drugs

(OAS; W-00-10-31333; various reviews; expected issue date: FY 2011; new start)

Pharmacy Prescription Drug Claims

(OAS; W-00-09-31318; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments for Drugs Not Approved for Use by Children

(OAS; W-00-10-31131; various reviews; expected issue date: FY 2011; new start)

Medicaid Third-Party Liability for Prescription Drug Payments

(OAS; W-00-10-31134; various reviews; expected issue date: FY 2010; work in progress)

Compound Drugs

(OAS; W-00-08-31317; W-00-09-31317; W-00-10-31317; various reviews; expected issue date: FY 2010; work in progress)

Additional Rebates of Brand-Name Drugs

(OAS; W-00-09-31306; W-00-10-31306; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Reimbursement for Unapproved Drugs

(OEI; 03-08-00500; expected issue date: FY 2010; work in progress)

The Deficit Reduction Act of 2005: Impact on Medicaid Rebates for Authorized Generic Drugs

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Accountability Over Medicaid Drug Rebate Programs

(OAS; W-00-08-31205; W-00-09-31205; W-00-10-31205; various reviews; expected issue date: FY 2010; work in progress)

Update of States' Collection of Medicaid Rebates for Physician-Administered Drugs

(OEI; 03-09-00410; expected issue date: FY 2010; work in progress)

Medicaid Claims for Drugs Purchased Under Retail Discount Generic Programs

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Review of Medicaid Reimbursement to 340B Entities

(OEI; 05-09-00320; expected issue date: FY 2010; work in progress)

High-Cost HIV/AIDS Drugs

(OAS; W-00-10-31334; various reviews; expected issue date: FY 2011; new start)

Pharmacy Benefit "Carve Out"

(OAS; W-00-10-31335; various reviews; expected issue date: FY 2011; new start)

Reporting Lowest Accepted Reimbursement Rates

(OAS; W-00-10-31336; various reviews; expected issue date: FY 2011; new start)

States' Use of the Average Manufacturer Price To Establish Medicaid Pharmacy Reimbursements

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Zero-Dollar Unit Rebate Amounts for Drugs in Medicaid's Drug Rebate Program

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Other Medicaid Services

Medicaid Dental Services

(OAS; W-00-09-31135; W-00-10-31335; various reviews; expected issue date: FY 2010; work in progress)

Family Planning Services

(OAS; W-00-09-31078; W-00-10-31078; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Payments for Transportation Services

(OAS; W-00-08-31121; W-00-09-31121; W-00-10-31121; various reviews; expected issue date: FY 2010; work in progress)

Early and Periodic Screening, Diagnostic, and Treatment Services

(OEI; 05-08-00520; expected issue date: FY 2010; work in progress)

Payments to Terminated and/or Excluded Medicaid Providers and Suppliers
(OAS; W-00-10-31337; various reviews; expected issue date: FY 2010; new start)

Medicaid Claims With Inactive or Invalid Physician Identifier Numbers
(OAS; W-00-10-31338; various reviews; expected issue date: FY 2010; new start)

Rehabilitative Services
(OAS; W-00-08-31028; W-00-10-31028; various reviews; expected issue date: FY 2010;
work in progress)

Medical Services for Undocumented Aliens
(OAS; W-00-07-31108; W-00-08-31108; W-00-09-31108; W-00-10-31108; various reviews,
expected issued date: FY 2010; work in progress)

Medicaid Payments for Personal Emergency Response Services
(OAS; W-00-10-31339; various reviews; expected issue date: FY 2010; new start)

Medicaid Physical and Occupational Therapy Services: Appropriateness of Payments
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Medicaid Administration

Contingency Fee Payment Arrangements
(OAS; W-00-07-31045; W-00-08-31045; W-00-09-31045; W-00-10-31045; various reviews;
expected issue date: FY 2010; work in progress)

Medicaid Payments for Services Under Section 1915(b) Managed Care Freedom
of Choice Waivers
(OAS; W-00-08-31125; W-00-09-31125; various reviews; expected issue date: FY 2010;
work in progress)

Medicaid Managed Care Fraud and Abuse Safeguards
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid Managed Care Marketing Practices
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Sections 1915(b) and (c) Concurrent Waivers
(OAS; W-00-08-31309; W-00-10-31309; various reviews; expected issue date: FY 2010;
work in progress)

Medicaid Payments for Services Provided Under Section 1915(c) Home- and Community-
Based Service Waivers
(OAS; W-00-09-31124; W-00-10-31124; various reviews; expected issue date: FY 2010;
work in progress)

Enrollment of Excluded Medicaid Providers

(OEI; 09-08-00330; expected issue date: FY 2010; work in progress)

State Agencies' Redeterminations of Medicaid Eligibility

(OAS; W-00-09-31140; W-00-10-31140; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Administrative Costs

(OAS; W-00-08-31123; W-00-10-31123; various reviews; expected issue date: FY 2010; work in progress)

Medicare/Medicaid Credit Balances

(OAS; W-00-09-31311; W-00-10-31311; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Management Information System Costs

(OAS; W-00-08-31312; W-00-09-31312; W-00-10-31312; various reviews; expected issue date: FY 2010; work in progress)

State Buy-In of Medicare Coverage

(OAS; W-00-09-31220; W-00-10-31220; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Services to Incarcerated Juveniles

(OAS; W-00-07-31222; W-00-10-31222; various reviews; expected issue date: FY 2010; work in progress)

Medicaid's All-Inclusive Rate for Reimbursement to the Indian Health Service

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

States' Effort To Improve Third-Party Liability Payment Collections in Medicaid

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Use of the Public Assistance Reporting Information System to Reduce Medicaid Benefits Received From More Than One State

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Compliance With Estate Recovery Provisions of the Social Security Act

(OAS; W-00-09-31113; W-00-10-31113; various reviews; expected issue date: FY 2010; work in progress)

Medicaid Claims That Exceed Timely Filing Requirements

(OAS; W-00-10-31340; various reviews; expected issue date: FY 2010; new start)

State Medicaid Agencies' Reclassification of Non-Federal Claims

(OAS; W-00-10-31341; various reviews; expected issue date: FY 2010; new start)

Feasibility of Applying Medicare National Correct Coding Initiative Edits to Medicaid Claims

(OAS; W-00-10-31342; various reviews; expected issue date: FY 2010; new start)

States' Efforts in Medicaid Enrollment, Outreach, and Retention

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid Information Systems and Data Security

Medicare and Medicaid Security of Portable Devices Containing Personal Health Information at Contractors and Hospitals

(OAS; W-00-10-41014; various reviews; expected issue date: FY 2010; new start)

Medicare and Medicaid Health Information Data Privacy

(OEI; 00-00-00000; various reviews; expected issue date: FY 2011; new start)

Medicaid Management Information Systems Business Associate Agreements

(OAS; W-00-10-41015; various reviews; expected issue date: FY 2010; new start)

Medicaid Security Controls Over State Web-Based Applications

(OAS; W-00-10-41016; various reviews; expected issue date: FY 2010; new start)

Medicaid Security Controls at the Mainframe Data Center That Processes States' Claims Data

(OAS; W-00-07-40019; expected issue date: FY 2009; work in progress)

Children's Health Insurance Program

Medicaid and Children's Health Insurance Program Citizenship Requirements

(OAS; W-00-09-31224; W-00-10-31224; various reviews; expected issue date: FY 2010; work in progress)

Children's Health Insurance Program Administrative Costs

(OAS; W-00-09-31226; W-00-10-31226; various reviews; expected issue date: FY 2010; work in progress)

Dually Enrolled Beneficiaries in a State

(OAS; W-00-10-31314; various reviews; expected issue date: FY 2010; work in progress)

Medicaid and Children's Health Insurance Program Payment Error Rate Measurement

(OAS; W-00-10-40036; various reviews; expected issue date: FY 2010; new start)

Compliance With Payment Error Rate Measurement Program: Medicaid and Children's Health Insurance Program Eligibility Determinations

(OAS; W-00-10-40038; expected issue date: FY 2010; new start)

Appendix C:

Opportunities for Medicaid Cost Savings and Program Improvements

This appendix lists Medicaid-related recommendations included in the March 2010 *Compendium of Unimplemented Office of Inspector General Recommendations* (Compendium). These recommendations, if implemented, could result in cost savings and program improvements. The recommendations are based on work conducted by the Office of Inspector General's (OIG) Office of Audit Services (OAS) and Office of Evaluation and Inspections (OEI). The Compendium contains explanations of the recommendations listed below and is available on OIG's Web site at: <http://www.oig.hhs.gov/publications.asp>

OIG relies on the Department of Health & Human Services' (HHS) management and governmentwide policymakers to decide which program recommendations are implemented. Although many OIG recommendations are directly implemented by organizations within HHS, some are acted on by States that collaborate with HHS to administer, operate, and/or oversee designated programs such as Medicaid. HHS and the States sometimes do not immediately implement OIG's recommendations for various reasons, including administrative complexities, the current policy environment, or a lack of statutory authority. In such cases Congress may step in to incorporate OIG's recommendations into legislative actions, many of which result in substantial funds being made available for better use or in program improvements.

Federal and State Partnership

Limit Enhanced Payments to Cost and Require That Medicaid Payments Returned by Public Providers Be Used To Offset the Federal Share

Improper Payments

Ensure Compliance With Requirements for Medicaid School-Based Health Services

Identify Duplicate Medicaid and Medicare Home Health Payments

Enforce Federal Medicaid Payment Policies for Personal Care Services

Prescription Drugs

Ensure That Medicaid Reimbursement for Brand-Name Drugs Accurately Reflects Pharmacy Acquisition Costs

Encourage States To Align Medicaid Generic Drug Pharmacy Reimbursements With Pharmacies' Acquisition Costs

Review Impact of New Federal Upper Limit Calculations

Establish a Connection Between the Calculations of Medicaid Drug Rebates and Drug Reimbursements

Provide More Guidance to Drug Manufacturers To Better Implement the Medicaid Drug Rebate Program

Implement an Indexed Best-Price Calculation in the Medicaid Drug Rebate Program

Extend Additional Rebate Payment Provisions to Generic Drugs

Identify Drugs That Are Ineligible for Federal Payments Under Medicaid

Medicaid Administration

Enforce Federal Requirements for Submission of Medicaid Managed Care Encounter Data

Establish a National Medicaid Credit Balance Reporting Mechanism

Advise States of Their Authority To Collect From Noncustodial Parents With the Ability To Contribute Toward Their Children's Medicaid or Children's Health Insurance Program Costs

Appendix D:

Deficit Reduction Act Requirements

Sections 6001, 6031, and 6034 of the Deficit Reduction Act of 2005 (DRA) include provisions that require the Department of Health and Human Services (HHS), Office of Inspector General (OIG), to conduct specified activities, as well as to report annually on overall Medicaid activities. These sections are summarized below.

Section 6001: Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions

Effective January 1, 2007, section 6001 required the Centers for Medicare & Medicaid Services (CMS) to change its Federal upper limit (FUL) calculations (i.e., the method of setting limits on what the Federal Government would reimburse Medicaid State agencies for prescription drug payments) to base the limits on average manufacturer price (AMP) and to provide AMP data to States on a monthly basis beginning July 1, 2006. This section also required OIG to, by no later than June 1, 2006, (1) review the requirements for, and manner in which, AMPs are determined under section 1927 of the Social Security Act and (2) submit to the Secretary of HHS and Congress recommendations for changes in such requirements or manner as the Inspector General determines to be appropriate.

OIG's Related Actions. On May 30, 2006, OIG issued a report entitled *Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005* (A-06-06-00063), which fulfilled this statutory requirement. In this report, OIG found that existing requirements for determining aspects of AMP were unclear and that manufacturers' methods of calculating AMPs were inconsistent. OIG recommended that the Secretary direct CMS to clarify requirements in regard to the definition of "retail class of trade" and the treatment of pharmacy benefit manager rebates and Medicaid sales and to consider addressing issues raised by industry groups. OIG also recommended that the Secretary direct CMS to issue guidance that specifically addresses the implementation of the AMP-related reimbursement provisions of the DRA and to encourage States to analyze the relationship between AMP and pharmacy acquisition cost before using AMP for their reimbursement methodology.

OIG continued to address topics related to the FUL for multiple source drugs and other drug payment provisions by issuing an evaluation report in June 2007 entitled *Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program*, (OEI-03-06-00400). Although not required by the DRA, OIG completed an additional evaluation report that compared FUL payment amounts to other prices in August 2009 entitled *A Comparison of Medicaid Federal Upper Limit Amounts to Acquisition Costs, Medicare Payment Amounts, and Retail Prices*, (OEI-03-08-00490). Similar to its previous work, OIG found that the FUL payment amounts calculated under the current method continue to be substantially higher than other payment amounts which cause Medicaid to overpay for certain drugs.

Other Related Actions. In July, 2007, CMS issued a final regulation at 72 Fed. Reg. 39142, which implemented the requirements of the DRA by establishing a new method of calculating FULs, based on AMPs and aimed at reining in inflated drug product payments. The rule was to take effect on January 1, 2008. However, in December 2007, a Federal district court issued a preliminary injunction prohibiting CMS from implementing the new FULs. While this prohibition is in effect, CMS continues to calculate FUL amounts based on the previous formula (i.e., 150 percent of the lowest published price). The Patient Protection and Affordable Care Act (P.L. No. 111-148), § 2503, changes the basis of the FUL amount to that of AMP which could reduce Medicaid payment for multiple source drugs. However, further analysis is required to determine the effect of the change.

Section 6031: Encouraging the Enactment of State False Claims Acts

Effective January 1, 2007, this section provides a financial incentive for States to enact false claims acts (FCA) that establish liability to the States for the submission of false or fraudulent claims to the States' Medicaid programs. If a State's FCA is determined to meet certain enumerated requirements, the Federal share of Medicaid recoveries under the State FCA will be reduced by 10 percent, increasing the State's share by 10 percent.

Specifically, for a State to be eligible for the 10-percent increase in its share of false claims recoveries, the State law relating to false and fraudulent claims must be determined by OIG, in consultation with the Attorney General, to meet the following criteria: it establishes liability to the State for false or fraudulent claims described in the FCA with respect to Medicaid expenditures; it contains provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA; it contains a requirement for filing an action under seal for 60 days with review by the State Attorney General; and it contains a civil penalty that is not less than the amount authorized by the FCA. Following are OIG's related actions:

- On August 21, 2006, OIG published in the Federal Register (71 Fed. Reg. 48552) its guidelines for evaluating State FCAs under the requirements of section 6031 of the DRA. This notice was developed in consultation with the Department of Justice's (DOJ) Civil Division. In the notice, OIG invited the States to request review of their FCAs.
- During FY 2008, OIG provided written responses to 10 States and approved 4 of the State laws—those passed by California, Georgia, Indiana, and Rhode Island—for the DRA incentive. OIG made these determinations in consultation with DOJ's Civil Division.
- During FY 2009, OIG provided written responses to three States and approved two of the State laws—those passed by Wisconsin and Michigan—for the DRA incentive. OIG made these determinations in consultation with DOJ's Civil Division. The response letters are published on OIG's Web site at <http://www.oig.hhs.gov>.

Section 6034: Medicaid Integrity Program

This section establishes the Medicaid Integrity Program (MIP) and requires the Secretary to enter into contracts to enhance the capacity of CMS to conduct oversight of Medicaid expenditures. The program's activities include: review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made; audit of claims for payment for items or services furnished or for administrative services rendered; and education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

The section further establishes that from FY 2006 through FY 2010, \$25 million shall be appropriated to OIG for the Medicaid activities of OIG in addition to any other amounts appropriated or made available for Medicaid oversight. Such funds shall remain available until expended. This section also requires OIG to identify to Congress the use and effectiveness of OIG's use of such funds no later than 180 days after the end of each FY. This document responds to that requirement for FY 2009.

Appendix E: Acronyms and Abbreviations

The following is a list of selected acronyms and abbreviations used in this publication.

AMP	average manufacturer price
AoA	Administration on Aging
ASPE	Assistant Secretary for Planning and Evaluation
CDPAP	Consumer Directed Personal Assistance Program
CIA	corporate integrity agreement
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CoP	Conditions of Participation
CSA	Controlled Substances Act, included in the Comprehensive Drug Abuse Prevention and Control Act of 1970, P.L. No. 91-513
CY	calendar year
DEA	Drug Enforcement Administration
DME	durable medical equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005, P.L. No. 109-171
DSH	disproportionate share hospital
FCA	False Claims Amendments Act of 1986, P.L. No. 99-562
FDA	Food and Drug Administration
FDCA	Federal Food, Drug, and Cosmetic Act of 1938, P.L. No. 75-717
FMAP	Federal Medical Assistance Percentage
FUL	Federal upper limit
FY	fiscal year
HCFAC	Health Care Fraud and Abuse Control Program
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
LTC	long-term care
MCO	managed care organization
MFA	Medicaid fraud and abuse funds
MFCU	Medicaid Fraud Control Unit
MHASA	mental health assessment and service agencies
MIP	Medicaid Integrity Program
MIPPA	Medicare Improvements for Patients and Providers Act of 2008, P.L. No. 110-275
MSIS	Medicaid Statistical Information System
NAMFCU	National Association of MFCUs

NEMT	nonemergency medical transportation
OAS	Office of Audit Services
OEI	Office of Evaluation and Inspections
OIG	Office of Inspector General
PCS	personal care services
PTH	parathyroid hormone
TANF	Temporary Assistance for Needy Families
TCM	targeted case management
UCCP	uncompensated care pool
UPL	upper payment limit