
Work Plan Part III: Medicaid Reviews

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Note: Selected acronyms and abbreviations of terms, titles, organizations, and laws used in the Work Plan are spelled out in Appendix B.

Medicaid Reviews

The Federal and State Governments jointly fund Medicaid, a program that provides medical assistance to certain low-income individuals. The Federal share of a State's expenditures is called the Federal medical assistance percentage (FMAP). 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.

Our continuing and new reviews of Medicaid in Fiscal Year (FY) 2011 address payments related to hospitals, long-term and community care, prescription drugs, other services, Medicaid administration, and information systems controls.

Medicaid Hospitals

Hospital Outlier Payments

We will review State Medicaid payments for hospital outliers, which are cases that incur extraordinarily high costs. Some States make supplemental Medicaid payments for hospital outliers based on methodologies similar to Medicare methodologies. Prior Office of Inspector General (OIG) work involving Medicare claims for hospital outliers identified vulnerabilities in the Medicare payment methodology. The Social Security Act, § 1886(d)(5)(A), provides for supplemental Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for outlier cases. We will determine whether similar vulnerabilities exist in Medicaid State agencies' methods of computing inpatient hospital cost outlier payments. The review is a followup to work involving Medicaid outlier payments.

(OAS; W-00-10-31069; W-00-11-31069; various reviews; expected issue date: FY 2011; work in progress)

Provider Eligibility for Medicaid Reimbursement

We will review whether States appropriately determined provider eligibility for Medicaid reimbursement. The Code of Federal Regulations (CFR) at 42 CFR § 440.10 requires hospital providers to meet Medicare program participation requirements to receive Medicaid funding. Various State regulations may extend the Federal requirement to cover other provider types, such as medical equipment and supplies or home health. We have previously found significant unallowable Medicaid payments to hospitals that did not meet Medicare program eligibility requirements as part of the disproportionate share hospital (DSH) program.

(OAS; W-00-10-31301; W-00-11-31301; various reviews; expected issue date: FY 2011; work in progress)

Supplemental Payments to Private Hospitals

We will review Medicaid supplemental payments by States to private hospitals. States are permitted to make payments under their approved plans to hospitals up to the applicable aggregate upper payment limit (UPL), and many States use this flexibility to make lump-sum supplemental payments based on the difference between the ordinary rate and the UPL. Federal regulations at 42 CFR § 447.272 define the UPL for inpatient hospital services as a reasonable estimate of the maximum amount that would be paid for Medicaid services under Medicare payment principles. Federal funds are not available for Medicaid payments that exceed the limits. The regulation at 42 CFR § 447.253(i) requires the Medicaid agency to pay “for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.” Prior OIG work involving supplemental payments to public facilities found errors. We will determine whether errors exist involving supplemental payments to private facilities.

(OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2011; work in progress)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services

We will review State controls to detect potentially excessive Medicaid payments to institutional providers for inpatient and outpatient services. Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.a, says that to be allowable, costs must be necessary and reasonable for the proper and efficient performance and administration of Federal awards. Section C.1.c of the circular says that costs must be authorized, or not prohibited, under State or local laws or regulations. The Social Security Act, § 1903(d)(2)(A), and regulations at 42 CFR pt. 433, subpart E, provide for the Centers for Medicare & Medicaid Services (CMS) to adjust quarterly payments to States to account for overpayments and underpayments by States to providers. Prior OIG work involving Medicare inpatient and outpatient claims found that many excessive payments to the hospitals were attributable to billing errors on the submitted claims, such as inaccuracies in diagnosis codes, admission codes, discharge codes, procedure codes, charges, Healthcare Common Procedure Coding System (HCPCS) codes, and number of units billed. We will determine whether similar vulnerabilities exist in State agencies’ controls for detecting potentially excessive Medicaid payments.

(OAS; W-00-09-31127; W-00-10-31127; W-00-11-31127; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Home, Community, and Nursing Home Care

Community Residence Rehabilitation Services

We will review Medicaid payments for beneficiaries who reside in community residences for people who have mental illnesses to determine whether States improperly claimed Federal financial participation (FFP). OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal*

Governments, establishes cost principles for State and local governments. Attachment A, § C.1.c., of the circular states that to be allowable, costs must be authorized, or not prohibited, under State or local laws or regulations. Previous OIG work in one State found improperly claimed Medicaid reimbursement for individuals who were no longer residing in a community residence.

(OAS; W-00-08-31087; W-00-09-31087; W-00-10-31087; W-00-11-31087; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments to Continuing Day Treatment Providers

We will review Medicaid payments to continuing day treatment (CDT) providers in one State. CDT providers render an array of services to those who have mental illnesses on a relatively long-term basis. A CDT provider bills Medicaid on the basis of the number of service hours rendered to a beneficiary. OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.c., provides that to be allowable, costs must be authorized, or not prohibited, under State or local laws or regulations. One State's regulations require that a billing for a visit/service hour be supported by documentation indicating the nature and extent of services provided. A State commission found that more than 50 percent of the service hours billed by CDT providers could not be substantiated. We will follow up on the commission's findings and determine whether Medicaid payments to CDT providers in that State are adequately supported.

(OAS; W-00-09-31128; W-00-11-31128; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Home Health Agency Claims

We will review home health agency (HHA) claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria. Federal regulations at 42 CFR § 440.70 and 42 CFR pt. 484 set standards and conditions for HHAs' participation. Providers must meet criteria, such as minimum number of professional staff, proper licensing and certification, review of service plans of care, and proper authorization and documentation of provided services. A doctor must determine that the beneficiary needs medical care at home and prepare a plan for that care. The care must include intermittent (not full-time) skilled nursing care and may include physical therapy or speech-language pathology services.

(OAS; W-00-09-31304; W-00-10-31304; W-00-11-31304; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments for Personal Care Services

We will review Medicaid payments for personal care services (PCS) to determine whether States have appropriately claimed the FFP. Pursuant to the Social Security Act, § 1905(a)(24), Medicaid covers PCS only for those who are not inpatients or residents of hospitals, nursing facilities, institutions for mental diseases (IMD), or intermediate care facilities for those with mental retardation. PCS must be authorized by a physician or (at the option of the State)

otherwise authorized in accordance with a plan of treatment, must be provided by someone who is qualified to render such services and who is not a member of the individual's family, and must be furnished in a home or other location. The Deficit Reduction Act of 2005 (DRA), § 6087, further allowed States, beginning January 1, 2007, to pay individuals for self-directed personal assistance services for the elderly and disabled, including PCS that could be provided by a family member.

(OAS; W-00-09-31035; W-00-10-31035; W-00-11-31035; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Hospice Services

We will review Medicaid payments for hospice services to determine whether the services were provided in accordance with Federal reimbursement requirements. Pursuant to the Social Security Act, § 1905(o)(1)(A), Medicaid may cover hospice services for terminally ill recipients. Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patient's illness and death. CMS's *State Medicaid Manual*, Pub. 45, § 4305, says the individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. In FY 2009, Medicaid payments for hospice services totaled more than \$2.2 billion. We will also conduct a medical review of claims for a sample of Medicaid recipients receiving hospice care to determine that services were reasonable and necessary.

(OAS; W-00-11-31385; various reviews; expected issue date: FY 2011; new start. OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Adult Day Care Services for Elderly Individuals Who Have Chronic Functional Disabilities

We will review Medicaid payments to providers for adult day care services. The Social Security Act, § 1929(a)(7), allows Medicaid payments for adult day care services through home and community care for elderly individuals who have chronic functional disabilities. We will determine whether Medicaid payments to providers for adult day care health services were in compliance with Federal and State regulations.

(OAS; W-00-11-31386; various reviews; expected issue date: FY 2011; new start)

Medicaid Adult Day Health Service

We will review adult day health services reimbursed by Medicaid programs in select States. The Social Security Act, § 1915(c)(4)(B), allows Medicaid payments for adult health services through home- and community-based waiver programs. Previous Federal and State reviews of Medicaid adult day health services found problems with reimbursement systems and questionable billings. Additionally, CMS and State Medicaid programs do not receive information about the individual services provided to beneficiaries because reimbursement is based on bundled payment rates. We will describe the services provided, review the qualifications of providers, and assess the appropriateness of documentation.

(OEI; 09-07-00500; expected issue date: FY 2011; work in progress)

Appropriateness of Level of Care Determinations for Home- and Community-Based Services Waiver Recipients

We will review the States' eligibility evaluation process for Medicaid home- and community-based services (HCBS) waiver recipients. Medicaid HCBS waiver programs allow States to provide alternative HCBS services for individuals who would otherwise need nursing home care. The enrollment of Medicaid beneficiaries in HCBS waivers increased dramatically in recent years, rising more than 60 percent between 1999 and 2006. Regulations at 42 CFR § 441.302(c) and 42 CFR § 441.352(c), require States to assess whether each potential waiver recipient meets criteria for the level of care provided by a nursing home. We will determine the extent to which States are following Federal regulations for assessing the level of care of HCBS recipients and whether level-of-care assessments are appropriate.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

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

We will review States' and CMS's oversight of HCBS waiver programs. Medicaid HCBS waiver programs allow States to provide alternative services for those who otherwise would require care in nursing homes. In accordance with 42 CFR § 441.302, States must provide assurances that necessary safeguards have been taken to protect the health and welfare of recipients. However, a 2003 Government Accountability Office (GAO) review found that CMS and States did not provide adequate oversight of HCBS waivers. We will determine the extent to which States monitor the quality of care given to participants in HCBS waiver programs for the aged and disabled. We will also determine the extent to which CMS oversees States' efforts to ensure the quality of care provided under such waiver programs.

(OEI; 02-08-00170; expected issue date: FY 2011; work in progress)

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

We will review the extent to which assisted living facilities (ALFs) provide HCBS to their Medicaid-eligible residents. ALFs may receive Medicaid funding through the HCBS waiver program under the Social Security Act, § 1915(c). Regulations at 42 CFR § 441.302 require States to provide CMS with assurances that necessary safeguards have been taken to protect the health and welfare of HCBS recipients. We will determine how States and CMS ensure that ALFs are meeting provider standards, that plans of care are established and followed by ALFs, and that ALFs meet other Federal requirements for HCBS services.

(OEI; 09-08-00360; expected issue date: FY 2011; work in progress)

CMS Oversight of Accuracy of Nursing Home Minimum Data

We will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. The Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act require nursing homes to conduct accurate comprehensive assessments for residents using an instrument that includes the MDS. Regulations at 42 CFR § 483.20 specify the requirements of

the assessment instrument. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. CMS implemented a skilled nursing facility prospective payment system (SNF PPS) based on MDS data in July 1998 and began posting MDS-based quality performance information on its Nursing Home Compare Web site in 2002. About half of the States base their Medicaid payment systems on MDS data. We will also review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Transparency Within Nursing Facility Ownership

We will review ownership structures at investor-owned nursing homes. Nursing facilities are increasingly being purchased by private equity or other for-profit investor firms. Prior OIG work showed that after the facility purchase, in some cases, new owners created a complex web of ownership that essentially left the operators of the nursing facility with no assets.

Determination of which entity is legally liable for patient care can be difficult because of the ownership structure. After the facility purchase in some cases, new owners have reduced staffing levels and taken other cost-cutting measures that increase profit at the expense of quality of care. We will determine which investor-owned entities are benefiting from Medicaid reimbursement and study the effects of ownership changes on the care received by beneficiaries.

(OAS; W-00-11-31130; various reviews; expected issue date: FY 2011; new start)

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

We will examine how States administer and use civil monetary penalties (CMP) imposed on nursing homes that fail to meet Medicare and Medicaid health and safety requirements. The Social Security Act, § 1919(h)(2)(A)(ii), requires that States use CMP funds they collect to ensure the safety of residents of penalized nursing homes. We will identify amounts that States have received as a result of imposing CMPs, determine what policies and procedures States have to ensure that CMP funds are allocated appropriately to meet Federal requirements, and determine how and to what extent CMS oversees States' use of CMP funds.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

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

We will review Medicaid incentive payments by States to nursing facilities based on the facilities' quality-of-care performance measures. The Social Security Act, § 1919(h)(2)(F), authorizes States to establish programs to reward nursing facilities—through public recognition, incentive payments, or both—that provide the highest quality care to their Medicaid-eligible residents. We will determine whether States have sufficient controls to assess nursing facilities' quality-of-care performance measures and determine whether incentive payments were in accordance with program requirements.

(OAS; W-00-10-31331; W-00-11-31331; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Waiver Administrative Costs

We will review the reasonableness of Medicaid HCBS waiver program administrative costs. The Federal share of Medicaid matches most administrative expenditures at the 50-percent rate if the expenditures are for the “proper and efficient” administration of the Medicaid program. The Social Security Act, § 1915(c), authorizes the HCBS waiver program, which permits States to furnish arrays of services that help Medicaid beneficiaries to live in the community and avoid institutionalization. Some States have contracted with nonprofit groups to administer waiver programs. Because CMS’s methodology for reviewing waiver applications does not examine administrative costs, it may be possible that States have claimed the Federal share of contracted administrative costs in amounts exceeding Medicaid’s actual average administrative costs. We will determine whether States’ contractual arrangements with nonprofit entities for administration of HCBS waiver programs are economical.

(OAS; W-00-10-31332; W-00-11-31332; various reviews; expected issue date: FY 2011; work in progress)

Health Screenings of Medicaid Home Health Care Workers

We will review health-screening records of Medicaid home health care workers to determine whether the workers were screened in accordance with Federal and State requirements. Home health agencies provide home health care services to Medicaid beneficiaries on a visiting basis in beneficiaries’ homes. Pursuant to the Social Security Act, §1891(a)(5), a home health care agency must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted standards that apply to personnel providing services within such an agency. The Federal requirements for home health services are found at 42 CFR § 440.70, 441.15, and 441.16 and at 42 CFR pt 484. Other applicable requirements are found in State and local regulations.

(OAS; W-00-11-31387; various reviews; expected issue date: FY 2011; new start)

Medicaid Prescription Drugs

Calculation of Average Manufacturer Prices

We will review selected drug manufacturers to evaluate methodologies they use to calculate the average manufacturer price (AMP) and the best price for Medicaid drug rebate program and Medicaid drug reimbursement purposes. We will determine whether the methodologies are consistent with applicable statutes, regulations, and manufacturers’ rebate agreements and CMS’s *Drug Manufacturer Releases*. Section 6001 of the DRA makes several changes to the Medicaid drug rebate statute and to Medicaid reimbursement for multiple-source drugs. The changes involve revisions in the calculation of the AMP and the best price that will affect amounts that pharmaceutical manufacturers report under the Medicaid drug rebate program

and will affect the FUL for drug reimbursement. CMS uses the AMP and the best price to determine a unit rebate amount (URA). Manufacturers must pay rebates to States based on the URAs.

(OAS; W-00-11-31202; various reviews; expected issue date: FY 2011; new start)

Recalculation of Base Date Average Manufacturer Prices

We will review changes to base date AMPs and assess the impact of such changes on Medicaid rebates. Section 6001 of the DRA made numerous changes and clarifications to the definition and use of the AMP. The Social Security Act, § 1927(c), requires that manufacturers pay additional rebates for single-source drugs based on the difference between AMPs and base date AMPs adjusted for inflation. To ensure that such rebates would not increase because of changes in AMPs, Federal regulations at 42 CFR § 447.510(c) allow manufacturers to revise the base date AMPs against which these inflationary measures are indexed. Because additional rebates paid by manufacturers reflect an integral and statutorily required aspect of the Medicaid drug rebate program, we will examine manufacturers' rationales and supporting data for changes to base date AMPs.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Medicaid Drug Claims

We will review the accuracy of States' submission of Medicaid drug claims to CMS for reimbursement. Pursuant to the Social Security Act, § 1927(a)(1), a drug manufacturer must have a rebate agreement with CMS to have its outpatient drugs covered under Medicaid. Under the drug rebate program, CMS provides States with a quarterly Medicaid drug tape that should list all covered outpatient drugs and indicate a drug's termination date, if applicable. CMS guidance instructs States to use the tape to verify coverage of the drugs for which they claim reimbursement. We will determine whether the tape that CMS provides to States includes all covered drugs and indicates drugs' termination dates, if applicable. We will also determine whether reimbursements to States are correct and are supported for the drugs claimed.

(OAS; W-00-10-31203; various reviews; expected issue date: FY 2011; work in progress)

Federal Upper Payment Limit Drugs

We will review prescription drug claims to determine whether pharmacies have altered prescriptions to maximize reimbursements by avoiding certain dosage forms for drugs that have Federal Upper Limits (FUL) on reimbursements. The Social Security Act, § 1927(e)(4), establishes FULs for all multiple-source drugs. As a result of whistleblowers' actions, several pharmacies have admitted changing dosage forms for some commonly prescribed Medicaid drugs, thereby inflating reimbursements by avoiding FULs established on other dosage forms. We will determine whether there has been manipulation of FULs.

(OAS; W-00-11-31333; various reviews; expected issue date: FY 2011; new start)

Pharmacy Prescription Drug Claims

We will review the appropriateness of Medicaid pharmacy prescription drug claims for selected State Medicaid agencies. CMS's *State Medicaid Manual*, Pub. No. 45, pt. 2, §§ 2497 and 2500, requires that States report actual expenditures on the Medicaid Quarterly Expenditure Report (Form CMS-64) and maintain supporting documentation. We will determine whether States accurately reported Medicaid expenditures for prescription drugs and whether the claims related to the expenditures were adequately supported by pharmacy records.

(OAS; W-00-09-31318; W-00-10-31318; W-00-11-31318; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Pharmacy Reimbursement

We will review drug acquisition costs for pharmacies participating in the Medicaid program. Federal regulations at 42 CFR § 447.512 provide that drugs for which no upper limits have been established are reimbursed at the lower of usual and customary charges or estimated acquisition costs (EAC) plus a dispensing fee. States have historically based EACs on a discount average wholesale price (AWP). In previous work, we have reported that reimbursements for prescription drugs significantly exceeded EACs. As of October 2011, the AWP will not be available for States to use in setting reimbursement. We will compare actual pharmacy acquisition costs to other potential benchmark prices, such as the wholesale acquisition cost (WAC) and the AMP to determine what effects the lack of AWP data will have on State Medicaid programs.

(OAS; W-00-11-31388; various reviews; expected issue date: FY 2011; new start)

Medicaid Payments for Drugs Not Approved for Use by Children

We will review Medicaid paid claims to determine whether payments were for drugs not approved for children by the Food and Drug Administration (FDA). The Social Security Act, §1905(a), provides that State Medicaid plans may cover prescription drugs. Pursuant to the Social Security Act, §§ 1927(k)(3) and 1927(k)(6), Medicaid will pay for an outpatient drug if it is prescribed for indications approved by FDA or supported by the drug compendia listed in section 1927(g)(1). We will examine drug services paid for children under age 18 in 2007 by reviewing States' Medicaid and Children's Health Insurance Program (CHIP) paid claims files.

(OAS; W-00-11-31131; various reviews; expected issue date: FY 2011; new start)

Medicaid Third-Party Liability for Prescription Drug Payments

We will review a State's controls to determine whether third-party providers are billed for Medicaid fee-for-service (FFS) prescription drug claims before Medicaid pays. Pursuant to the Social Security Act, § 1902(a)(25), participating States must "take reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the [Medicaid] plan." The Office of the Auditor General for one State identified almost \$30 million in drug claims during a 2-year period that may have been the responsibility of a third-party insurance payer. We will review the State's process for identifying and billing third-party payers.

(OAS; W-00-10-31134; W-00-11-31134; various reviews; expected issue date: FY 2011; work in progress)

Compound Drugs

We will review whether a State agency's Medicaid claims for compound drugs (custom-blended by pharmacists from bulk ingredients based on doctors' prescriptions) and the drugs' components complied with Federal requirements for reimbursement and collection of rebates. The Social Security Act, § 1927, generally requires manufacturers to have a rebate agreement with CMS for States to claim the FFP and report drug utilization to the manufacturers for rebates. The CMS Medicaid Drug Rebate Program State Release No. 130 requires States to use the CMS drug tape, which lists all drugs covered by rebate agreements pursuant to the Social Security Act, § 1927(a)(1), to determine whether drugs they purchase are eligible for Medicaid coverage. CMS's Medicaid Drug Rebate Program State Release No. 19 outlines States' responsibility for preventing claims for terminated drugs. We will identify claimed drug components that are not eligible for Medicaid coverage and determine whether accountability and controls were established for collecting eligible drug component rebates.

(OAS; W-00-10-31317; various reviews; expected issue date: FY 2011; work in progress)

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

We will review required drug-pricing and rebate data reported by drug manufacturers to State Medicaid agencies to determine the extent to which manufacturers are reporting pricing data and paying rebates for authorized generic drugs. "Authorized generics" are defined by regulations at 42 CFR § 447.506 as versions of brand-name drugs produced and/or marketed with the consent of the original brand manufacturers and marketed under the brand manufacturers' original drug applications. Rebates to States from manufacturers pursuant to the Social Security Act, § 1927, are based in part on the difference between the AMP of a drug and the best price of the drug. Section 6001 of the DRA clarified the definition of "best price" to include "the lowest price available to any entity for any such drug that is sold under a new drug application." CMS stated in its 2007 final rule on Medicaid prescription drugs that best price calculations must now include the prices available to secondary manufacturers of authorized generic drugs. The change in definition has the potential to increase the amount of rebates due from single-source drugs' primary manufacturers. We will also determine to what extent Medicaid rebates have changed since the implementation of the DRA and whether the number of new authorized generics changed after the implementation of the DRA provisions.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Collection of Medicaid Rebates for Physician-Administered Drugs

We will review State Medicaid agencies' policies and practices to determine the extent to which they are collecting drug manufacturers' rebates for physician-administered drugs. Section 6002 of the DRA, requires States to collect utilization and coding information for single-source drugs and 20 multiple-source drugs that have the highest dollar volume of physician-administered

drugs dispensed. States must collect such information as is necessary to obtain the manufacturers' rebates. Previous OIG work determined that most States had not collected rebates for physician-administered drugs. We will also estimate the savings that could result if all States were to collect the rebates.

(OEI; 03-09-00410; expected issue date: FY 2011; work in progress)

Medicaid Claims for Drugs Purchased Under Retail Discount Generic Programs

We will review Medicaid claims for generic drugs to determine the extent to which large chain pharmacies are billing Medicaid the usual and customary charges for drugs provided under their retail discount generic programs. The discount programs typically offer selected generic drugs to anyone with a prescription for \$4 for a 30-day supply or \$10 for a 90-day supply. Federal regulations at 42 CFR § 447.512 require, with certain exceptions, that each State Medicaid agency's reimbursement for covered generic outpatient drugs without established upper limits may not exceed (in the aggregate) the lower of the estimated acquisition cost for drugs, plus a reasonable dispensing fee, or the provider's usual and customary charge to the public for the drugs. We will also examine CMS's policies and procedures for ensuring that Medicaid is billed properly under retail discount generic programs.

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

Review of Medicaid Policies and Oversight Activities Related to 340B Entities

We will review States' policies and oversight activities for reimbursements related to the 340B Drug Discount program (340B). The 340B Program provides for sales of drugs at or below established ceiling prices to 340B covered entities that provide health care to certain disadvantaged individuals. The Veterans Health Care Act of 1992 established the 340B Drug Program in section 340B of the Public Health Service Act (PHS Act). We will also examine States' activities to identify claims for 340B-purchased drugs.

(OEI; 05-09-00321; expected issue date: FY 2011; work in progress)

High-Cost HIV/AIDS Drugs

We will review Medicaid payments for high-cost human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) drugs to determine the amount Medicaid could save by using centralized purchasing and dispensing programs. During recent audits of the Federal AIDS Drug Assistance Program (ADAP), we identified one State that had purchased all ADAP drugs through a single contracted wholesale drug company and dispensed the drugs to ADAP-eligible participants through State-contracted pharmacies. Our preliminary analysis indicates that the centralized approach produced significant savings.

(OAS; W-00-10-31334; W-00-11-31334; various reviews; expected issue date: FY 2011; work in progress)

Reporting Lowest Accepted Reimbursement Rates

We will review one State's use of a provision in its prescription drug reimbursement agreements that requires pharmacies to report their lowest accepted reimbursement rates from

nongovernmental payers for each drug. The State's Medicaid program then reimburses pharmacies at the lower of those rates or 11 percent below the AWP for the drug. We will determine whether the State's use of the provision has resulted in significant savings for the State's Medicaid program and whether other State Medicaid programs could benefit from implementing similar provisions in their reimbursement agreements.

(OAS; W-00-11-31336; various reviews; expected issue date: FY 2011; new start)

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

We will review whether States are effectively collecting drug rebates from manufacturers for drugs with zero-dollar URAs. At the end of every quarter, CMS calculates URAs for drugs included in the Medicaid drug rebate program and provides the amounts to State Medicaid agencies. URAs are based on pricing data reported by drug manufacturers. Previous OIG work found that States may not be collecting all possible drug rebates from manufacturers when CMS is unable to calculate URAs. This occurs if and when manufacturers have not reported the necessary data for the calculations. The URAs for such products are listed as \$0, i.e., zero-dollar URAs. However, States are still required to work with manufacturers to determine the appropriate rebates for the drugs. We will determine the financial impact of zero-dollar URAs and examine possible causes for States not receiving required rebates from manufacturers.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Drug Pricing in State Maximum Allowable Cost Programs

We will review State Maximum Allowable Cost programs to determine how maximum allowable cost lists are developed, how maximum allowable cost prices are set, and how maximum allowable cost prices compare to the FUL amounts. To take advantage of lower market prices for certain generic products, States use the FUL list and/or State maximum allowable cost programs in determining reimbursement amounts. State maximum allowable cost programs are designed to ensure Medicaid programs pay appropriate prices for generic drugs. In 2004, a CMS-contracted study looked at maximum allowable cost programs in five States and found considerable variation between these programs and the FUL program. The study concluded that expansion of existing maximum allowable cost programs and implementation of new ones could contribute to cost containment efforts nationwide. This study will compare State maximum allowable cost programs to determine which State maximum allowable cost programs are most successful in reducing Medicaid expenditures.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Efforts and Experiences With Resolving Medicaid Rebate Disputes

We will review the causes of and resolutions to Medicaid rebate disputes. The Social Security Act, § 1927(a), requires a drug manufacturer to enter into a drug rebate agreement as a prerequisite to coverage of its drugs under Medicaid State plans. In 2008, the Medicaid program spent approximately \$24 billion on prescription drugs and received approximately \$8 billion in rebates. Previous OIG reports have found large amounts of money in uncollected

rebates. This study will follow up on previous work done by OIG and will describe both the causes of rebate disputes, as well as methods States use to address rebate disputes.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Changes in Prices for Medicaid Brand-Name Drugs

We will review annual price increases for brand-name prescription drugs used by Medicaid beneficiaries. According to a recent report released by AARP, the rate of increase in published prices for brand-name drugs has been substantially higher than the overall rate of inflation, which has raised concerns among members of Congress. Because most States base their Medicaid reimbursement amounts on published prices, disproportionate price increases could create fraud vulnerabilities and lead to excessive Medicaid spending. The study will determine how price increases for brand-name drugs affect Medicaid payment amounts.

(OEI; 03-10-00260; expected issue date: FY 2011; work in progress)

Other Medicaid Services

Medicaid Dental Services

We will review Medicaid payments for dental services to determine whether States have properly claimed the FFP. Pursuant to the Social Security Act, §§ 1905(a)(4)(B) and 1905(r), dental services are required for most Medicaid-eligible individuals under age 21 as a component of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit. Federal regulations at 42 CFR § 440.100 define “dental services” as diagnostic, preventative, or corrective procedures provided by or under the supervision of a dentist. Services include the treatment of teeth and the associated structure of the oral cavity and disease, injury, or impairment that may affect the oral cavity or general health of the recipient. In 2007, Medicaid costs for dental services totaled more than \$3 billion.

(OAS; W-00-10-31135; W-00-11-31135; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments for Physical, Occupational, and Speech Therapy Services

We will review the extent to which payments for Medicaid physical, occupational, and speech therapy services comply with State standards and limits on coverage. Pursuant to the Social Security Act, § 1905(a), and regulations at 42 CFR § 440.110, States may provide physical, occupational, and speech therapy services to Medicaid beneficiaries. Previous OIG studies found that some therapy services provided under Medicare were billed incorrectly. Through a review of selected States, we will determine whether Medicaid has similar program integrity issues.

(OEI; 07-10-00370; expected issue date: FY 2011; work in progress)

Rehabilitative Services

We will review claims for rehabilitative services to determine whether the services were provided in accordance with State and Federal guidelines. The Social Security Act, § 1905(a)(13), and regulations at 42 CFR § 440.130 define “rehabilitative services” and require that they be recommended by a physician or other licensed practitioner of the healing arts for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Previous OIG reviews found a significant number of services claimed that were not eligible for reimbursement.

(OAS; W-00-11-31389; various reviews; expected issue date: FY 2011; new start)

Medicaid Medical Equipment

We will review Medicaid payments for medical supplies and equipment to determine whether the equipment and/or supplies billed were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines. Federal regulations at 42 CFR pt. 440 and various provisions of CMS’s *State Medicaid Manual* provide rules and guidance about necessary medical supplies and equipment for home health services; physical therapy services; occupational therapy services; services for individuals with speech, hearing, and language disorders; and home- or community-based services.

(OAS; W-00-11-31390; various reviews; expected issue date: FY 2011; new start)

Family Planning Services

We will review family planning services in several States to determine whether enhanced Federal funding was improperly claimed for such services and the resulting financial impact on the Medicaid program. Pursuant to the Social Security Act, § 1903(a)(5), States may claim Medicaid reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. Prior OIG work found improper claims for enhanced funds for family planning services.

(OAS; W-00-09-31078; W-00-10-31078; W-00-11-31078; various reviews; expected issue date: FY 2011; work in progress)

Medicaid School-Based Services

We will review Medicaid services provided in schools to determine whether payments for school-based health services complied with laws and regulations. The Social Security Act, § 1903(c), permits Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act of 2004 (IDEA) through a child’s plan or family plan. States are permitted to use their Medicaid programs to help pay for certain health care services, such as physical and speech therapy, delivered to children in schools. Schools also may receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach, application assistance, and coordination and monitoring of health services. OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, permits in certain circumstances the use of substitute systems for allocation of salaries and wages to Federal

awards to be used in place of activity reports when employees work on multiple activities or cost objectives. Prior OIG reviews of school-based services found significant unallowable payments.

(OAS; W-00-11-31391; various reviews; expected issue date: FY 2011; new start)

Medicaid Payments for Transportation Services

We will review payments to providers for transportation services. Federal regulations at 42 CFR § 431.53 require States to ensure necessary transportation for Medicaid beneficiaries to and from providers. Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. We will determine the appropriateness of State Medicaid agencies' payments for transportation services.

(OAS; W-00-09-31121; W-00-10-31121; W-00-11-31121; various reviews; expected issue date: FY 2011; work in progress)

Payments to Terminated and/or Excluded Medicaid Providers and Suppliers

We will review Medicaid payments to providers and suppliers to determine the extent to which payments were for services provided during periods of termination or exclusion from the Medicaid program. Pursuant to the Social Security Act, §§ 1128 and 1128A, excluded and/or terminated providers and suppliers are not permitted to receive payments for services provided after the effective program termination date or during periods of exclusion.

(OAS; W-00-10-31337; W-00-11-31337; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Claims With Inactive or Invalid Physician Identifier Numbers

We will review Medicaid claims to determine the extent to which State agencies have controls in place to identify claims associated with inactive or invalid unique physician identifier numbers (UPIN), including claims for services alleged to have been provided after the dates of the referring physicians' deaths. In a prior OIG review, we found instances in which Medicare had paid durable medical equipment (DME) claims with inactive or invalid UPINs for the referring physicians. In 2009, the Senate Permanent Subcommittee on Investigations, Committee on Homeland Security and Governmental Affairs, reported that a substantial volume of Medicare-paid DME claims contained UPINs of deceased physicians. Given the vulnerabilities identified in the Medicare program, we will review State Medicaid programs to determine whether States have controls in place to identify claims with inactive or invalid UPINs.

(OAS; W-00-11-31338; various reviews; expected issue date: FY 2011; new start)

Medicaid Administration

Contingency Fee Payment Arrangements

We will review the extent to which State Medicaid agencies have contracted with consultants through contingency fee payment arrangements and the impact the arrangements have had on the submission of questionable or improper claims to the Federal Government. Some State Medicaid agencies use consulting firms to help identify ways to maximize Federal Medicaid reimbursement. In some cases, States pay the consulting firms a percentage of the increase in Federal Medicaid funding. OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, precludes the claiming of the costs of such contingency fee arrangements from the Federal Government. Prior OIG work in one State found that improper claims had been submitted by the State as a result of a contingency fee payment arrangement.

(OAS; W-00-07-31045; W-00-08-31045; W-00-09-31045; W-00-11-31045; various reviews; expected issue date: FY 2011; work in progress)

Early Results From Medicaid Integrity Contractors

We will review the progress of CMS's Medicaid Integrity Contractors (MICs) in completing program integrity tasks outlined in their contracts. Section 6034 of the DRA established the Medicaid Integrity Program (MIP) in the Social Security Act, § 1936. An integral part of MIP is the program integrity work that will be performed by MICs. MICs are tasked with preventing and detecting Medicaid fraud, waste, and abuse through the review of the actions of individuals or entities furnishing items or services under the Medicaid program. CMS began awarding contracts in April 2008 and subsequently awarded contracts covering CMS's 10 regions. We will also examine the results of the MICs' work.

(OEI; 05-10-00200, 05-10-00210; expected issue date: FY 2011; work in progress)

State Oversight of Provider Credentialing by Medicaid Managed Care Plans

We will review how States ensure that Medicaid managed care plans follow a structured process for credentialing and recredentialing of providers. Regulations at 42 CFR 438.214, require States to ensure that managed care plans serving the Medicaid population implement written policies and procedures for selection and retention of providers. Each managed care plan must also document its process for credentialing and recredentialing providers that have signed contracts or participation agreements. Plans may not employ or contract with providers excluded from participation in Federal health care programs. We will also examine how CMS ensures that States comply with requirements for provider credentialing by Medicaid managed care plans.

(OEI; 09-10-00270; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Entities' Marketing Practices

We will review State Medicaid agencies' oversight policies, procedures, and activities to determine the extent to which States monitor Medicaid managed care entities' (MCEs) marketing practices and compliance with Federal and State contractual marketing

requirements. The Social Security Act, § 1932(d)(2), provides that no marketing materials may be distributed by Medicaid MCEs without first obtaining States' approval. The regulations at 42 CFR § 438.104, permit States to impose additional requirements in contracts with MCEs about marketing activities. We will also determine the extent to which CMS ensures States' compliance with Federal requirements involving Medicaid MCE marketing practices.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Excluded Providers in Medicaid Managed Care Entities

We will review the extent to which OIG excluded individuals and entities contracted with selected MCEs to provide services and the extent to which OIG-excluded individuals were employed by entities that provide services through MCEs' provider networks in 2009.

Pursuant to the Social Security Act, §§ 1128, 1156, and 1892, HHS and OIG have authority to exclude individuals and entities from all Federal health care programs. The Social Security Act, § 1862(e)(1), and regulations at 42 CFR § 1001.1901(b), preclude Medicare or any other Federal health care program from paying for any items or services furnished, ordered, or prescribed by an excluded individual or entity, except under specific limited circumstances (e.g., the individual or entity provides an emergency item or service or the items or services are furnished, ordered, or prescribed pursuant to a waiver obtained from OIG). The payment prohibition applies to the excluded individual or entity, anyone who employs or contracts with the excluded individual or entity, and any hospital or other provider through which the excluded individual or entity provides services. Recent State Medicaid program integrity reviews by CMS's Medicaid Integrity Group have identified provider enrollment, including the employment of excluded providers, as one of the most common vulnerabilities. We will also determine the extent to which safeguards are in place to prevent excluded individuals and entities from participating in Medicaid managed care provider networks.

(OEI; 07-09-00630; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Fraud and Abuse Safeguards

We will review Medicaid managed care organizations' (MCO) fraud and abuse safeguards. Regulations at 42 CFR § 438.608 require Medicaid MCOs to have administrative and management arrangements or procedures, including mandatory compliance plans, that are designed to guard against fraud and abuse. We will also review State Medicaid agencies' oversight plans and procedures to determine the extent to which States monitor MCOs' fraud and abuse program safeguards for compliance with Federal requirements. Finally, we will review CMS's plans and procedures for overseeing States' compliance with these requirements.

(OEI; 01-09-00550; expected issue date: FY 2011; work in progress)

Use of Prepayment Review To Detect and Deter Fraud and Abuse in Medicaid Managed Care

We will review the extent to which Medicaid MCOs use prepayment reviews to detect and deter fraud and abuse. Regulations at 42 CFR § 438.608 require Medicaid MCOs to have administrative and management arrangements or procedures that are designed to guard

against fraud and abuse and that include mandatory compliance plans and provisions for internal monitoring and auditing. Prepayment reviews can serve as effective fraud and abuse safeguards because they occur during the claims-processing phase prior to claim payment. We will also examine the results of prepayment reviews, challenges the MCOs addressed in developing and implementing such programs, and lessons learned by MCOs about them. *(OEI; 00-00-00000; expected issue date: FY 2012; new start)*

Medicaid Administrative Costs

We will review administrative costs claimed by several States. The Social Security Act, § 1903(a)(7), provides Federal cost sharing for the proper and efficient administration of Medicaid State plans. The Federal share of Medicaid administrative costs is typically 50 percent, with enhanced rates for specific types of costs. Prior reviews in one State noted problems with the State's administrative costs. We will determine whether administrative costs in additional States were properly allocated or directly charged to the Medicaid program and claimed in accordance with OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, and State requirements. *(OAS; W-00-10-31123; W-00-11-31123; various reviews; expected issue date: FY 2011; work in progress)*

Impact on the Medicaid Program of Certified Public Expenditures

We will determine whether States are complying with Federal regulations for claiming certified public expenditures (CPE). CPEs are normally generated by local governments as part of their contribution to the coverage of Medicaid services. States may claim CPEs to provide the State's share in claiming Federal reimbursement as long as the CPEs comply with Federal regulations at 42 CFR § 433.51 and 45 CFR 95.13 and the CPEs are being used for the required purposes. *(OAS; W-00-11-31110; various reviews; expected issue date: FY 2011; new start)*

Medicaid Management Information System Costs

We will review Medicaid Management Information System (MMIS) costs in selected States to determine whether costs allocated to Medicaid are allowable. The Social Security Act, § 1903(a)(3), as implemented by regulations at 42 CFR pt. 433, subpart C, provides FFP in State expenditures for the design, development, or installation of mechanized claims-processing and information retrieval systems and for the operation of certain systems. Reviews of Medicaid Managed Information System (MMIS) costs have not been performed by OIG in recent years. *(OAS; W-00-10-31312; W-00-11-31312; various reviews; expected issue date: FY 2011; work in progress)*

State Buy-In of Medicare Coverage

We will review States' Medicaid buy-in programs of Medicare Part B. States may enroll dual-eligible beneficiaries in the Medicare Part B program. The Social Security Act, § 1843, and regulations at 42 CFR §§ 407.40 through 407.42 require States that operate buy-in programs to pay the Medicare Part B premium for each dual-eligible individual that they enroll in

Medicare Part B. We will determine whether States have adequate controls to ensure that Medicare premiums are paid only for individuals eligible for State buy-in coverage of Medicare services.

(OAS; W-00-10-31220; W-00-11-31220; various reviews; expected issue date: FY 2011; work in progress)

State Agency Oversight of Medical Loss Ratio Experience Adjustment

We will review the accuracy of experience adjustment reports provided by managed care plans to State agencies under Title XIX and Title XXI. Medical contracts between State agencies and managed care plans may contain a provision requiring a minimum percentage of total costs to be expended on medical expenditures (medical loss ratio). The experience adjustment reports provide the costs that a managed care plan has incurred throughout the year and calculate whether the medical loss ratio threshold has been met. If the medical loss ratio threshold is not met, the managed care plan is to refund the State agency a percentage of the premiums paid. OMB Circular A-87 requires State Agencies to properly report expenditures and to apply any applicable credits. We will review State Agencies' oversight and validation of experience adjustment reports and assess whether managed care plans accurately reported medical costs and properly adjusted when the medical loss ratio thresholds were not met. Prior OIG work found deficiencies because the wrong capitation amount was used when calculating the experience adjustment.

(OAS; W-00-11-31372; various reviews; expected issue date: FY 2011; new start)

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

We will review States' procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries to determine the extent to which States' efforts have improved since our last review in 2006. The Social Security Act, § 1902(a)(25), requires States to take all reasonable measures to ascertain the legal liabilities of third parties with respect to health care items and services. Section 6035 of the DRA clarified the provision for entities defined as third-party payers. Many Medicaid beneficiaries may have additional health insurance through third-party sources, such as employer-sponsored health insurance. Previous OIG work detailed problems that State Medicaid agencies had in identifying and collecting third-party payments. We will examine changes to State laws and Medicaid procedures and determine whether such changes have improved States' identification of third-party liabilities.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States Reporting of Program Income From Third-Party Reimbursements

We will review States' compliance with the requirement that they accurately report all program income from third-party reimbursements. Federal regulations at 42 CFR §433.140(c) require that if a State receives FFP for Medicaid payments for which it receives third-party reimbursement, the State is to pay the Federal Government a portion of the reimbursement, determined in accordance with the FMAP for that State. One third-party recovery vendor noted on its Web site that it recovered over \$1 billion in 1 year for various health care programs and

disbursed the recoveries to State clients. Prior OIG reviews indicated that States are using such third-party collection contractors and receiving reimbursements for claims that had previously been paid partially with Federal funds.

(OAS; W-00-10-31376; W-00-11-31376; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Credit Balances

We will review providers to determine whether there are Medicaid overpayments in patient accounts with credit balances. The Social Security Act, § 1902(a)(25); Federal regulations at 42 CFR pt. 433, subpart D; various State laws; and CMS's *State Medicaid Manual*, Pub. No. 45, pt. 3, § 3900.1, require that Medicaid be the payer of last resort and that providers identify and refund overpayments received. Prior OIG work has found Medicaid overpayments in patients' accounts with credit balances.

(OAS; W-00-10-31311; W-00-11-31311; various reviews; expected issue date: FY 2011; work in progress)

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

We will review eligibility data from the Public Assistance Reporting Information System (PARIS) to determine the extent to which States use PARIS to identify Medicaid recipients who are simultaneously receiving Medicaid benefits in more than one State. PARIS is a computer matching and information exchange system operated by the Administration for Children & Families (ACF). Using States' eligibility data, PARIS identifies those who concurrently receive benefits from Medicaid and other means-tested programs, such as food stamps, in more than one State. The Qualifying Individual Program Supplemental Funding Act of 2008 (QI) amended the Social Security Act, § 1903, to require that States' Medicaid eligibility determination systems provide data matching through PARIS. We will also determine the extent to which States investigate instances in which recipients are receiving Medicaid benefits in more than one State simultaneously and recover Medicaid payments for recipients determined to be ineligible.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Duplicate Medicaid Payments for Beneficiaries With Multiple Medicaid Identification Numbers

We will review duplicate payments on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and procedures for preventing such payments. A preliminary data match has identified a significant number of individuals who were assigned more than one Medicaid identification number and for whom multiple Medicaid payments were made for the same period. The Improper Payments Information Act of 2002 (IPIA) states that a duplicate payment is an improper payment. We will determine whether duplicate Medicaid payments were made by State agencies on behalf of beneficiaries who were assigned more than one Medicaid identification number.

(OAS; W-00-10-31374; W-00-11-31374; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Payments for Deceased Beneficiaries

We will review capitation payments that States make to MCOs for deceased beneficiaries. Pursuant to the Social Security Act, § 1915(b), CMS grants waivers to States allowing them to contract with MCOs. Under the waiver authority, the MCOs receive capitated payments to provide services to certain target groups of Medicaid-eligible beneficiaries. Prior reviews of the Medicare Advantage (MA) program have found improper capitation payments for deceased beneficiaries. We will review States' and CMS's oversight of capitated payments to determine the accuracy of payments subsequent to enrollees' deaths.

(OAS; W-00-11-31392; various reviews; expected issue date: FY 2011; new start)

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

We will review States' compliance with requirements for recoveries from deceased Medicaid beneficiaries' estates. Pursuant to the Social Security Act, § 1917(b)(1), States must, with certain exceptions, recoup medical assistance costs from the estates of deceased beneficiaries who were institutionalized. States generally can recover medical assistance costs of inpatient stays at nursing facilities, intermediate care facilities for persons with intellectual disabilities, or other medical institutions. States may opt to recover costs of other services covered under the States' Medicaid plans if the individuals were 55 or older when the services were provided. The Social Security Act, § 1917(b)(4), requires States at a minimum to recover assets that pass through probates governed by States' laws. CMS's *State Medicaid Manual*, Pub. No. 45, pt. 2, § 2500.1, requires that the amounts collected from deceased Medicaid beneficiaries' estates be reported on the Medicaid Quarterly Expenditure Report (Form CMS-64) as reductions to total Medicaid expenditures. We will determine whether States complied with applicable requirements in making estate recoveries and properly reported any such recoveries on the Form CMS-64.

(OAS; W-00-09-31113; W-00-10-31113; W-00-11-31113; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Services to Incarcerated Juveniles

We will review States' compliance with Federal rules that prohibit Federal funding for medical services provided to incarcerated juveniles. The Social Security Act, § 1905(a)(28)(A), prohibits Federal funding for services provided to inmates of a public institution (except patients in medical institutions). Federal regulations at 42 CFR § 435.1010 define "inmate of a public institution" as "a person who is living in a public institution." The regulations define "public institution" as "an institution that is the responsibility of a governmental unit over which a governmental unit exercises administrative control." Previous work found unallowable claims for medical services provided to incarcerated juveniles. We will determine whether selected States have improperly claimed Federal funding for medical services provided to incarcerated juveniles.

(OAS; W-00-07-31222; W-00-11-31222; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Citizenship Documentation Requirements

We will review the eligibility status of Medicaid beneficiaries to ensure that States are meeting the new citizenship documentation requirements. As of July 1, 2006, all U.S. citizens who apply for Medicaid or renew their Medicaid eligibility must prove their citizenship by presenting, among other possible documents, a U.S. passport or the combination of a U.S. birth certificate and an identification document. States that provide Medicaid eligibility to individuals claiming U.S. citizenship who have not provided documentation to prove their citizenship may not claim Federal matching funds for Medicaid-covered services to those individuals. The new requirement was mandated by section 6036 of the DRA. The Children's Health Insurance Program Reauthorization Act of 2009, § 211, also provides a new optional State process for verifying citizenship. We will determine whether States implemented the citizenship documentation requirement and document the amount of payments on behalf of individuals not meeting the new citizenship documentation requirements.

(OAS; W-00-10-31224; W-00-11-31224; various reviews; expected issue date: FY 2011; work in progress)

Payment Error Rate Measurement: Fiscal Year 2008 Error Rate

We will review certain aspects of CMS's Medicaid Payment Error Rate Measurement (PERM) process for determining the FY 2008 Medicaid FFS payment error rate. The IPIA and the OMB implementation of that Act in memorandum M-06-23 require Federal agencies to annually develop a statistically valid estimate of improper payments under programs with a significant risk of erroneous payments. CMS contracted with an independent medical review organization to perform a random independent review of its PERM contractor's payment determinations for 250 Medicaid FFS claims. We will evaluate this CMS initiative, which was designed to ensure the accuracy of the 2008 reported error rate. We will determine whether the independent medical review organization met its contractual obligations to CMS and will analyze the organization's review. We will also evaluate the methodology and medical review determinations underlying the error rate testing conducted by the PERM contractor.

(OAS; W-00-10-40045; W-00-11-40045; expected issue date: FY 2011; work in progress)

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

We will review CMS's PERM process to determine whether the PERM has produced valid and reliable error rate estimates for Medicaid and Children's Health Insurance Program (CHIP) FFS, managed care, and eligibility. The IPIA and OMB's implementation of that Act in memorandum M-06-23 require Federal agencies annually to develop statistically valid estimates of improper payments under programs with a significant risk of erroneous payments. Medicaid and CHIP have been identified as programs with significant risks and programs for which OMB has requested improper payment information. To comply with the IPIA, CMS

developed the PERM. The PERM process includes conducting FFS, managed care, and eligibility reviews pursuant to Federal regulations at 42 CFR, pt. 431, subpart Q. As part of OIG's oversight and monitoring responsibilities of CMS's error rate process, we will review CMS's implementation of the PERM process for Medicaid and CHIP. We will also review the physical and data security of health information that is transmitted by States or contractors for use in the PERM process to assess compliance with OMB Memorandums M-06-16 and M-07-16, which provide guidance on protecting sensitive information and reporting incidents involving potential and confirmed breaches of personally identifiable information (PII). We will also review CMS's corrective actions in response to recommendations in OIG's March 2010 report on the California Department of Health Care Services' FY 2007 PERM universes. We will verify actions taken by CMS to implement our recommendations.

(OAS; W-00-11-40046; various reviews; expected issue date: FY 2011; new start)

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

We will review compliance in one State with PERM requirements for reviewing eligibility in its Medicaid and CHIP programs. The IPIA and OMB's implementation of that act in memorandum M-06-23 require Federal agencies annually to develop statistically valid estimates of improper payments under programs with significant risk of erroneous payments. To comply with the IPIA, CMS developed the PERM program. The PERM process includes conducting FFS, managed care, and eligibility reviews pursuant to regulations at 42 CFR pt. 431, subpart Q. As part of the PERM program, CMS requires States to have an independent review performed of Medicaid and CHIP eligibility determinations to assess whether the State is in compliance with the State's eligibility requirements and has properly documented its eligibility determinations. As part of OIG's oversight and monitoring responsibilities under the Chief Financial Officers Act of 1990 (CFO Act) related to CMS's error rate process, we will review implementation of the PERM process for Medicaid and CHIP in one State.

(OAS; W-00-10-40038; expected issue date: FY 2011; work in progress)

Children's Health Insurance Program Administrative Costs

We will review States' CHIP compliance with the 10-percent cap on administrative costs. The Social Security Act, § 2105(c)(2)(A), establishes a limit on administrative funds that are eligible for Federal matching equal to 10 percent of the amounts expended to provide child health assistance. Administrative expenditures include expenditures related to administration, outreach, and other child health assistance and initiatives. We will determine whether States have appropriately claimed administrative costs.

(OAS; W-00-09-31226; W-00-10-31226; various reviews; expected issue date: FY 2011; work in progress)

Dually Enrolled Beneficiaries in a State

We will review a State's claims for FFP under the State's CHIP program for individuals who were enrolled in the State's Medicaid program to determine the appropriateness of these claims.

Pursuant to the Social Security Act, § 2105(c)(6)(B), no payment shall be made to a State for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly under any other federally operated or financial health care insurance program. A previous OIG review of CHIP eligibility in one State for the first 6 months of 2005 indicated that the State had made some CHIP payments on behalf of individuals who were also enrolled in the Medicaid program.

(OAS; W-00-10-31314; various reviews; expected issue date: FY 2011; work in progress)

State Compliance With CHIP Eligibility and Enrollment Notification and Review Requirements

We will review State compliance with the CHIP eligibility and enrollment notification and review requirements. Regulations at 42 CFR pt. 457, subpart K, contains requirements relating to applicant and enrollee protections. It requires, among other things, that eligibility determinations be timely and be in writing and that the State ensure that an applicant or enrollee has an opportunity for an impartial review of eligibility denials and that the results of such reviews be timely and be in writing. We will also review whether beneficiaries remain enrolled during reviews of suspension or termination in enrollment.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Program Integrity Best Practices

We will review State Medicaid agencies' program integrity activities. We will examine State Medicaid program integrity policies and procedures required by Federal regulations at 42 CFR pt. 455 to identify best practices and verify which procedures are operating as intended. Ensuring Medicaid program integrity includes identifying payment risks, implementing actions to minimize the risks, and identifying and collecting overpayments and improper payments.

(OAS; W-00-11-31396; various reviews; expected issue date: FY 2011; new start)

Medicare and Medicaid Data Matching Project

We will review CMS's oversight and monitoring of the Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi task orders. Pursuant to the Social Security Act, § 1893, CMS began the Medi-Medi project in 2001 in partnership with the State of California to improve coordination of Medicare and Medicaid program integrity efforts. The objective of the project is to match Medicare and Medicaid data to proactively identify program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data individually. As of 2007, there were 10 active Medi-Medi Task Orders in the States of California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois. Federal regulations at 48 CFR §§ 42.1500 to 42.1503 provide policies and establish responsibilities for agencies to record and maintain contractor performance information. We will also determine the extent to which Medi-Medi contractors

identified potential fraud, waste, and abuse through the Medi-Medi project.
(OEI; 09-08-00370; expected issue date: FY 2011; work in progress)

Collection and Verification of Provider Ownership Information by State Medicaid Agencies

We will review State practices for collection and verification of Medicaid provider ownership information. The regulation at 42 CFR § 455.104 requires Medicaid providers to disclose the name and address of each person with an ownership or control interest in the provider. State Medicaid agencies cannot approve a provider participation agreement or contract with any entity that has not disclosed the required information, and payments to providers that have not disclosed the required information are not eligible for FFP. We will also assess the accuracy of the provider ownership information on file for a sample of providers to determine the effectiveness of State practices for Medicaid provider ownership information collection and verification.

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

Oversight of State Data Reporting

We will examine CMS's oversight of State quarterly expenditure reporting on Form CMS-64. CMS-64 is a detailed accounting of expenditures that the Federal Government uses to reimburse States under Title XIX of the Social Security Act. Regulations at 42 CFR §430.30(c) require each State to submit the CMS-64 as a report of actual quarterly expenditures. Previous OIG and GAO studies have shown significant inaccuracies in the reporting of State expenditures, which affects the Federal reimbursement match. We will also identify opportunities to improve the accuracy of State expenditure reporting.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Readiness to Comply With ACA Eligibility and Enrollment Requirements

We will review States' readiness to comply with new eligibility and enrollment requirements for the Health Insurance Exchange, Medicaid, CHIP, and health subsidy programs. Section 1413 of the Affordable Care Act requires the Secretary to establish a system for State residents to apply for enrollment and receive eligibility determinations for applicable programs. The States' eligibility systems must ensure that applicants who are eligible for Medicaid or CHIP are enrolled in these programs. We will also identify challenges and barriers that States report regarding the implementation of eligibility and enrollment systems. Finally, we will review the extent to which the Office of the National Coordinator for Health Information Technology (ONC) and CMS have provided guidance, technical assistance, and financial incentives to States to develop model eligibility and enrollment systems.

(OEI; 07-10-00530; expected issue date: FY 2012; work in progress)

Medicaid Information Systems and Data Security

OIG reviews the design, development, and maintenance of HHS computer-based systems by performing comprehensive audits of general and applications controls in accordance with applicable control requirements. Our work in progress and planned reviews deal with standards, security, controls, and oversight of the information systems that support Medicare and Medicaid payments and operations.

Medicaid Management Information Systems Business Associate Agreements

We will review CMS's oversight activities related to data security requirements of States' MMISs, which process and pay claims for Medicaid benefits. Business associates of States' MMISs typically include support organizations, such as data processing services and medical review services. State Medicaid agencies are among the covered entities that must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rules at 45 CFR pt. 164, subpart C, which establish minimum requirements for contracts with business associates to protect the security of electronic-protected health information. We will determine whether business associate agreements have been properly executed to protect beneficiary information, including safeguards implemented pursuant to HIPAA standards.

(OAS; W-00-11-41015; various reviews; expected issue date: FY 2011; new start)

Medicaid Security Controls Over State Web-Based Applications

We will review States' security controls over Web-based applications that allow Medicaid providers to electronically submit claims. The electronic transactions may contain protected health information as defined under HIPAA regulations at 45 CFR § 160.103, which also define "health plan" to include Medicaid programs. Thus Medicaid programs must comply with the security standards set forth at 45 CFR pt. 164, subpart C, which is known as the HIPAA Security Rule. Using an application security assessment tool, we will determine whether States' Web-based applications contain any vulnerabilities that could affect the confidentiality, integrity, and availability of the Medicaid claims' protected health information.

(OAS; W-00-11-41016; various reviews; expected issue date: FY 2011; new start)

Medicaid Security Controls at the Mainframe Data Centers That Process States' Claims Data

We will review security controls at States' mainframe data centers that process Medicaid claims data. OMB Circular A-130, *Management of Federal Information Resources*, Appendix III, paragraph A.3, states that agencies shall implement and maintain programs to ensure that adequate security is provided for all agency information collected, processed, transmitted, stored, or disseminated in general support systems and major applications. The appendix also establishes a minimum set of controls to be included in Federal automated information security programs. We will focus on security controls over States' mainframe computers, such as access controls over the mainframe operating system and security software. We will also review some limited

general controls, such as disaster recovery plans and physical security.
(OAS; W-00-10-40019; W-00-11-40019; *expected issue date: FY 2011; work in progress, new start*)