

## Part III

# Medicaid Reviews

<b>Medicaid Prescription Drug Reviews .....</b>	<b>51</b>
Patient Safety and Quality of Care—Claims for and Use of Atypical Antipsychotic Drugs Prescribed to Children in Medicaid (New).....	51
Drug Pricing—Calculation of Average Manufacturer Prices .....	51
Drug Pricing—State Maximum Allowable Cost Programs .....	52
Drug Pricing—Manufacturer Compliance With AMP Reporting Requirements .....	52
Drug Pricing—Drugs Purchased Under Retail Discount Generic Programs .....	52
Manufacturer Rebates—States Collection of Rebates on Physician-Administered Drugs (New) .....	53
Manufacturer Rebates—States’ Collection of Supplemental Rebates (New).....	53
Manufacturer Rebates—Impact of the Deficit Reduction Act of 2005 on Rebates for Authorized Generic Drugs .....	53
Manufacturer Rebates—Zero-Dollar Unit Rebate Amounts.....	54
Manufacturer Rebates—New Formulations of Existing Drugs .....	54
Manufacturer Rebates—States’ Efforts and Experiences With Resolving Rebate Disputes .....	54
Manufacturer Rebates—Federal Share of Rebates .....	54
<b>Home, Community, and Personal Care Services.....</b>	<b>55</b>
Home Health Services—Duplicate Payments by Medicare and Medicaid (New) .....	55
Home Health Services—Screenings of Health Care Workers .....	55
Home Health Services—Provider Compliance and Beneficiary Eligibility .....	55
Home Health Services—Homebound Requirements .....	56
Medicaid Waivers—Quality of Care Provided Through Waiver Programs.....	56
Medicaid Waivers—Supported Employment Services (New).....	56
Medicaid Waivers—Adult Day Health Care Services (New) .....	56
Medicaid Waivers—Unallowable Room and Board Costs (New).....	57
School-Based Services—Students With Special Needs .....	57
Community Residence Rehabilitation Services .....	57
Continuing Day Treatment Mental Health Services.....	57
Personal Care Services—Compliance With Payment Requirements .....	58
<b>Other Medicaid Services, Equipment and Supplies.....</b>	<b>58</b>
Nursing Facility Services—Communicable Disease Care (New) .....	58
Dental Services for Children—Inappropriate Billing (New) .....	59
Dental Services for Children—Billing Patterns in Five States (New) .....	59
Hospice Services—Compliance With Reimbursement Requirements.....	59
Family Planning Services—Claims for Enhanced Federal Funding .....	59
Transportation Services—Compliance With Federal and State Requirements.....	60
Health-Care-Acquired Conditions—Prohibition on Federal Reimbursements .....	60
Medical Equipment and Supplies—Potential Savings From the Competitive Bidding Program (New) .....	60
Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Selected Items (New) .....	60

Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Blood-Glucose Test Strips (New).....	61
Medical Equipment and Supplies—States’ Efforts To Control Costs for Disposable Incontinence Supplies (New).....	61
<b>State Management of Medicaid .....</b>	<b>61</b>
State Use of Provider Taxes To Generate Federal Funding .....	61
State-Operated Facilities—Reasonableness of Payment Rates .....	62
State Upper-Payment-Limit-Related Supplemental Payments to Private Hospitals .....	62
State Use of Incorrect FMAP for Federal Share Adjustments (New) .....	62
State Allocation of Medicaid Administrative Costs.....	62
State Quarterly Expenditure Reporting on Form CMS-64—CMS Oversight .....	63
State Medicaid Monetary Drawdowns—Reconciliation With Form CMS-64 .....	63
State Reporting of Medicaid Collections on Form CMS-64 .....	63
State Actions To Address Vulnerabilities Identified During CMS Reviews .....	63
State Buy-In of Medicare Coverage—Eligibility Controls.....	64
State Medicaid Payments for Medicare Deductibles and Coinsurance (New) .....	64
State Cost Allocations That Deviate From Acceptable Practices (New) .....	64
State Recovery Audit Contractor Performance and Results (New).....	64
State Enrollment and Monitoring of Medical Equipment Suppliers (New) .....	65
State Determinations of Hospital Provider Eligibility and Program Participation (New) .....	65
State Compliance With Estate Recovery Provisions of the Social Security Act (New) .....	65
State Compliance With the Money Follows the Person Demonstration Program (New) .....	65
State Terminations of Providers Terminated by Medicare or by Other States .....	66
State Payments to Federally Excluded Providers and Suppliers .....	66
State Compliance With Federal Certified Public Expenditures Regulations .....	66
State Procedures for Identifying and Collecting Third-Party Liability Payments .....	66
State Collection and Verification of Provider Ownership Information .....	66
<b>Children’s Health Insurance Program for Medicaid-Eligible Individuals.....</b>	<b>67</b>
State Claims for Federal Reimbursement Under the Children’s Health Insurance Program for Medicaid-Eligible Individuals .....	67
State Compliance With Eligibility and Enrollment Notification and Review Requirements for the Children’s Health Insurance Program.....	67
<b>Medicaid Data Systems, Controls, and Claims Processing.....</b>	<b>67</b>
Early Review of the Transformed Medicaid Statistical Information System Pilot Project (New) .....	68
Claims With Inactive or Invalid Provider Identifier Numbers .....	68
Beneficiaries With Multiple Medicaid Identification Numbers .....	68
Use of the Public Assistance Reporting Information System To Reduce Instances of Payments by More Than One State .....	68
Management Information Systems Business Associate Agreements .....	69
Security Controls Over State Web-Based Applications.....	69
Security Controls at the Mainframe Data Centers That Process States’ Claims Data .....	69

**Medicaid Managed Care..... 70**

- Beneficiary Access to Medicaid Managed Care (New) ..... 70
- Beneficiary Grievances and Appeals Process (New)..... 70
- State Oversight of Provider Credentialing by Managed Care Entities ..... 70
- Managed Care Entities’ Marketing Practices..... 70
- Completeness and Accuracy of Managed Care Encounter Data ..... 71
- Program Integrity—Excluded Individuals Employed by Managed Care Networks ..... 71
- Program Integrity—Medicaid Managed Care Organizations’ Identification of Fraud and Abuse (New) ..... 72
- Program Integrity—Managed Care Organizations’ Use of Prepayment Review To Detect and Deter  
    Fraud and Abuse..... 72
- Medical Loss Ratio—Medicaid Managed Care Plans’ Refunds to States ..... 72

**Other Medicaid-Related Reviews .....72**

- Medicaid Overpayments—Credit Balances in Medicaid Patient Accounts ..... 73
- Payment Error Rate Measurement Program—Error Rate Accuracy and Health Information Security..... 73
- Nursing Home Minimum Data Set—Accuracy and CMS Oversight ..... 73
- Reviews of State Medicaid Fraud Control Units ..... 74

<https://oig.hhs.gov>

## Part III 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) 2013 address prescription drugs, long-term and community care, other services, program integrity and accountability, administration, information systems, and managed care.

### Medicaid Prescription Drug Reviews

---

Acronyms and Abbreviations for Selected Terms Used in This Section:

AMP—average manufacturer price  
FUL—Federal upper limit  
MCO—managed care organization

State MAC—State Maximum Allowable Cost  
URA—unit rebate amount

#### **Patient Safety and Quality of Care—Claims for and Use of Atypical Antipsychotic Drugs Prescribed to Children in Medicaid (New)**

We will determine the extent to which children ages 18 and younger had Medicaid claims for atypical antipsychotic drugs during the selected timeframe. On the basis of medical record reviews, we will also determine the extent to which the atypical antipsychotic drug claims were for off-label uses and for indications not listed in one or more of the approved drug compendia. (*OEI; 07-12-00320; expected issue date: FY 2014; work in progress*)

#### **Drug Pricing—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 the Medicaid drug rebate program and for drug reimbursement. We will also determine whether the methodologies are consistent with statutes, regulations, and manufacturers' rebate agreements and the CMS *Drug Manufacturer Release(s)*. Several changes to the Medicaid drug rebate statute and to Medicaid reimbursement for multiple-source drugs involve revisions in the calculation of the AMP and the best price. The changes will affect amounts that pharmaceutical manufacturers report under the Medicaid drug rebate program and will affect the Federal upper limit (FUL) for drug reimbursement. (Deficit Reduction Act of 2005 (DRA), § 6001.) CMS uses the AMP and the best price to determine Unit Rebate Amounts (URA). Manufacturers must pay

rebates to States based on the URAs. (OAS; W-00-11-31202; various reviews; expected issue date: FY 2013; work in progress)

### **Drug Pricing—State Maximum Allowable Cost Programs**

We will review State Maximum Allowable Cost (State MAC) programs to determine how State MAC lists are developed, how State MAC prices are set, and how State MAC prices compare to the FUL amounts. This review will compare State MAC programs to determine which ones are most successful in reducing Medicaid expenditures. To take advantage of lower market prices for certain generic products, States use the FUL list and/or State MAC programs in determining reimbursement amounts. State MAC programs are designed to ensure that Medicaid pays appropriate prices for generic drugs. In 2004, a CMS-contracted study looked at State MAC programs in five States and found considerable variation between these programs and the FUL program. The study concluded that expansion of existing State MAC programs and implementation of new ones could contribute to cost containment efforts nationwide. (OEI; 03-11-00640; expected issue date: FY 2013; work in progress)

### **Drug Pricing—Manufacturer Compliance With AMP Reporting Requirements**

We will review manufacturer compliance with AMP reporting requirements and determine what percentage of manufacturers complied with the requirements in 2011. We will determine whether stepped-up enforcement actions by CMS and OIG are reflected in increased compliance by manufacturers. A previous OIG review found that in 2008 more than half of the drug manufacturers that were required to submit quarterly AMPs to CMS failed to comply with reporting requirements in at least one quarter. Manufacturers were even less likely to comply with monthly AMP reporting requirements, with more than three-fourths submitting late, incomplete, or no AMPs in at least 1 month of 2008. After the release of this report, CMS and the Office of Inspector General (OIG) worked to increase manufacturer compliance. Price-reporting obligations for certain drug manufacturers, including the obligation to report AMP data to CMS quarterly and monthly, are set forth in the Social Security Act, § 1927(b)(3), and 42 CFR §§ 447.510(a) and (d). (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **Drug Pricing—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. We will also examine CMS's policies and procedures for ensuring that Medicaid is billed properly under 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 require, with certain exceptions, that each State Medicaid agency's reimbursement for covered generic outpatient drugs without established upper limits 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. (42 CFR § 447.512.)

(OEI; 00-00-00000; expected issue date: FY 2014; new start)

**Manufacturer Rebates—States Collection of Rebates on Physician-Administered Drugs (New)**

We will determine whether States have established adequate accountability and internal controls for collecting Medicaid rebates on physician-administered drugs. We will assess States' processes for collecting national drug code information on claims for physician-administered drugs and subsequent processes for billing and collecting rebates. To be eligible for Federal matching funds, States are required to collect rebates on covered outpatient drugs. (Social Security Act, § 1927(a).) Pursuant to the Deficit Reduction Act of 2005 (DRA), States collect and submit data to CMS, including national drug codes that identify drug manufacturers, thereby allowing them to invoice manufacturers responsible for paying rebates. The DRA provision was phased in beginning January 1, 2006. Prior OIG audit and evaluation work identified concerns with certain States' implementation of the provision. (OAS; W-00-12-31400; various reviews; expected issue date: FY 2013; work in progress)

**Manufacturer Rebates—States' Collection of Supplemental Rebates (New)**

We will determine whether increases in the basic Federal minimum rebate amount required by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) are being collected from drug manufacturers by States. We will also determine the dollar amount of supplemental drug rebates States negotiated and collected between 2008 and 2011. State Medicaid agencies negotiate supplemental rebate agreements (SRA) with drug manufacturers to further reduce expenditures. Pursuant to SRAs, drug manufacturers agree to pay States rebates higher than (i.e., in addition to) the rebates required under the basic Federal rebate agreement. On the basis of annual rebate data, we estimated that between 2006 and 2011, SRAs saved Medicaid an additional \$1 billion per year, on average. Supplemental rebates might be reduced because manufacturers may be less willing to pay them because of the increases in the basic Federal rebates. (OEI; 03-12-00520; expected issue date: FY 2013; work in progress)

**Manufacturer Rebates—Impact of the Deficit Reduction Act of 2005 on Rebates for Authorized Generic Drugs**

We will review drug-pricing and rebate data that drug manufacturers report to State Medicaid agencies to determine the extent to which manufacturers are reporting pricing data and paying rebates for authorized generic drugs. Federal regulations define "authorized generics" 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. (42 CFR § 447.506.) We will also determine to what extent Medicaid rebates have changed since the implementation of certain provisions and whether the number of new authorized generics changed after implementation. 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 might increase the amount of rebates due from single-source drugs' primary manufacturers. Rebates to States from manufacturers are based in part on the difference between the AMP of a drug and the best price of the drug. (Social Security Act, § 1927.) The definition of "best price" was clarified to include the lowest

price available to any entity for any such drug sold under a new drug application. (DRA, § 6001.) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **Manufacturer Rebates—Zero-Dollar Unit Rebate Amounts**

We will determine whether States have procedures to track and collect drug rebates for drugs with zero-dollar URAs. We will determine each State's rebate collection rate for high-dollar drugs with zero-dollar URAs in the fourth quarter of 2010 and the first quarter of 2011. Previous OIG work found that States may not be collecting all possible drug rebates from manufacturers when CMS is unable to calculate URAs. URAs are based on pricing data reported by drug manufacturers. 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. If manufacturers have not reported the necessary data for the calculations, the URAs for such products are listed as \$0, i.e., zero-dollar URAs. In those cases, manufacturers are responsible for calculating URAs and the appropriate rebate payments for the drugs. (OEI; 03-11-00470; expected issue date: FY 2013; work in progress)

### **Manufacturer Rebates—New Formulations of Existing Drugs**

We will review drug manufacturers' compliance with Medicaid drug rebate requirements for drugs that are new formulations of existing drugs. We will also determine whether manufacturers have correctly identified all their drugs that are subject to a new provision in law. A recent change increases the additional rebate for drugs that are new formulations of existing drugs if certain conditions are met. (Social Security Act, § 1927(c)(2)(C), as amended by the Affordable Care Act, § 2501.) Manufacturers pay the additional rebate that is based on the existing drug if it is higher than the additional rebate that is based on the new formulation. (OAS; W-00-13-31451; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

### **Manufacturer Rebates—States' Efforts and Experiences With Resolving Rebate Disputes**

We will review the causes of and resolutions to Medicaid rebate disputes and the methods States use to resolve them. In 2008, Medicaid spent approximately \$24 billion on prescription drugs and received approximately \$8 billion in rebates. Previous OIG reports have found large amounts in uncollected rebates. Federal law requires drug manufacturers to enter into drug rebate agreements as a prerequisite to coverage of their drugs under Medicaid State plans. (Social Security Act, § 1927(a).) (OEI; 05-11-00580; expected issue date: FY 2013; work in progress)

### **Manufacturer Rebates—Federal Share of Rebates**

We will review States' reporting of the Federal share of Medicaid rebate collections. We will determine whether States are correctly identifying and reporting the increases in rebate collections. Three new provisions in law should result in increased rebate payments by drug manufacturers to the States. The provisions will increase the minimum rebate percentages, increase the additional rebate on new formulations of existing drugs, and allow for rebates on drugs dispensed through Medicaid managed care organizations (MCO). (Social Security Act, §§ 1927(b) and (c), as amended by the Affordable Care Act, § 2501.) Any increase in rebate collections that results from these new provisions is not shared with

the States but is considered 100 percent Federal. (Social Security Act, § 1927(b)(1)(C).)  
(OAS; W-00-13-31450; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

## Home, Community, and Personal Care Services

Acronyms and Abbreviations for Selected Terms Used in This Section:

CDT—continuing day treatment  
FFP—Federal financial participation

HCBS—home and community-based services  
HHA—home health agency  
PCS—personal care services

### Home Health Services—Duplicate Payments by Medicare and Medicaid (New)

We will review Medicaid payments by States for Medicare-covered home health services to determine the extent to which both Medicare and Medicaid have paid for the same services. States are required to offer home health services to Medicaid beneficiaries who meet the States' criteria for nursing home coverage. (Social Security Act, § 1902(a)(10)(D).) Medicaid is the payer of last resort, paying only after all other third-party sources have met their legal obligation to pay. (Social Security Act, § 1902(a)(25).) (OAS; W-00-13-31305; various reviews; expected issue date: FY 2014; new start)

### Home Health Services—Screenings of 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. Examples of health screenings can include vaccinations for hepatitis and influenza. Home health agencies (HHA) provide health care services to Medicaid beneficiaries while visiting beneficiaries' homes. HHAs 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. (Social Security Act, §1891(a)(5).) 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; W-00-12-31387; various reviews; expected issue date: FY 2013; work in progress)

### Home Health Services—Provider Compliance and Beneficiary Eligibility

We will review HHA claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria. 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. The standards and conditions for HHAs' participation in Medicaid are at 42 CFR § 440.70 and 42 CFR pt. 484. (OAS; W-00-10-31304; W-00-11-31304; W-00-12-31304; various reviews; expected issue date: FY 2013; work in progress)

**Home Health Services—Homebound Requirements**

We will review CMS policies and practices for reviewing the sections of Medicaid State plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements for home health services. We will also identify the number of States that violate Federal regulations by inappropriately restricting eligibility for home health services to homebound recipients. States must ensure that the services available to any individual in a categorically or medically needy group are comparable to the services available to the entire group. (42 CFR § 440.240(b).) States may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of a beneficiary's diagnosis, type of illness, or condition. (42 CFR § 440.230(c).) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

**Medicaid Waivers—Quality of Care Provided Through Waiver Programs**

We will determine the extent to which Medicaid home and community-based services (HCBS) beneficiaries have service plans, receive the services in their plans, and receive services from qualified providers. Pursuant to the Social Security Act, § 1915(c), States are permitted to waive certain Medicaid requirements to provide a wide range of services to persons who would otherwise receive institutional care. In addition, States offering HCBS waiver programs must provide adequate planning for services and provide those services through qualified providers, as well as ensure the health and welfare of beneficiaries. Prior OIG work found vulnerabilities in State systems to ensure the quality of care provided to HCBS beneficiaries. (Social Security Act, §§ 1915 (c)(1) and 1902(a)(23).) (OEI; 02-11-00700; expected issue date: FY 2013; work in progress)

**Medicaid Waivers—Supported Employment Services (New)**

We will review Medicaid payments by States for supported employment services to determine whether such services were rendered in accordance with Federal and State requirements. With approval from CMS, States are authorized to waive certain Medicaid requirements, allowing a State to offer home and community-based services to State-specified target group(s) of Medicaid beneficiaries. (Social Security Act § 1915(c).) Supported employment helps individuals with the most significant disabilities to become competitively employed. Authorized services include vocational or job-related discovery or assessment, person-centered employment planning, job placement, training, and other workplace support services. (CMS Informational Bulletin, Sept. 16, 2011). Prior OIG work has identified significant unallowable Medicaid payments made by a State for supported employment services not covered under the waiver. (OAS; W-00-12-31463; various reviews; expected issue date: FY 2013; work in progress)

**Medicaid Waivers—Adult Day Health Care Services (New)**

We will review Medicaid payments by States for adult day care services to determine whether the payments complied with certain Federal and State requirements. Adult day health care programs provide health, therapeutic, and social services and activities to program enrollees. Beneficiaries enrolled in adult day health care programs must meet eligibility requirements, and services must be furnished in accordance with a plan of care. Medicaid allows payments for adult day health care

through various authorities, including HCBS waivers. (Social Security Act, § 1915, and 42 CFR § 440.180.) (OAS; W-00-12-31386; various reviews; expected issue date: FY 2013; work in progress)

### **Medicaid Waivers—Unallowable Room and Board Costs (New)**

We will determine whether selected State Medicaid agencies claimed Federal reimbursement for unallowable room and board costs for home and community-based services (HCBS) provided pursuant to the Social Security Act, § 1915(c). We will determine whether payments made by States for HCBS included the cost of room and board and the method used. Medicaid covers the cost of HCBS provided under a written plan of care to individuals in need of the services but does not allow for payment of room and board costs. (42 CFR §§ 441.301(b) and 441.310(a).) States may use various methods to pay for these services, such as a settlement process based on annual cost reports, or prospective rates with rate adjustments based on cost report data and cost trending factors. (OAS; W-00-13-31465; various reviews; expected issue date: FY 2014; new start)

### **School-Based Services—Students With Special Needs**

We will review Medicaid payments by States for school-based services to determine whether the costs claimed for such services are reasonable and properly allocated. Medicaid may pay for medical services provided to students with special needs pursuant to individualized education plans. (Social Security Act, § 1903(c).) Direct medical services may include physical therapy; occupational therapy; speech therapy; and nursing, personal care, psychological, counseling, and social work services. Some States use random moment time studies to develop school-based health service payment rates. Costs claimed must be reasonable and be allocated according to the benefit received. (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*.) (OAS; W-00-11-31391; W-00-12-31391; various reviews; expected issue date: FY 2013; work in progress)

### **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 FFP. Previous OIG work in one State found improperly claimed Medicaid reimbursement for individuals who were no longer residing in a community residence. To be allowable, costs must be authorized, or not prohibited, under State or local laws or regulations. (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Attachment A, § C.1.c.) (OAS; W-00-10-31087; W-00-11-31087; various reviews; expected issue date: FY 2013; work in progress)

### **Continuing Day Treatment Mental Health Services**

We will review Medicaid payments to continuing day treatment (CDT) providers in one State to determine whether Medicaid payments by the State to CDT providers in that State are adequately supported. 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. 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. To be allowable, costs must be authorized, or not prohibited, under State or local laws or regulations. (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.c.) (OAS; W-00-11-31128; W-00-12-31128; various reviews; expected issue date: FY 2013; work in progress)

### **Personal Care Services—Compliance With Payment Requirements**

We will review Medicaid payments by States for personal care services (PCS) to determine whether States have appropriately claimed the FFP. Medicaid covers PCS only for those who are not inpatients or residents of hospitals, nursing facilities, institutions for mental diseases, or intermediate care facilities for individuals with developmental disabilities. (Social Security Act, § 1905(a)(24).) 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. Beginning January 1, 2007, States are allowed to pay individuals for self-directed personal assistance services for the elderly and disabled, including PCS that could be provided by a family member. (DRA, § 6087.) (OAS; W-00-10-31035; W-00-11-31035; W-00-12-31035; various reviews; expected issue date: FY 2013; work in progress)

## Other Medicaid Services, Equipment and Supplies

---

### Acronyms and Abbreviations for Selected Terms Used in This Section:

EPSDT—Early and Periodic Screening, Diagnostic, and Treatment (services)

FFP—Federal financial participation  
OMB—Office of Management and Budget

### **Nursing Facility Services—Communicable Disease Care (New)**

We will review claims by nursing facilities for communicable disease care to determine whether they complied with Federal and State requirements. We will also examine patient safety consequences associated with nursing homes' failure to comply with related communicable disease requirements. Nursing facilities are required to establish and maintain infection control programs designed to provide safe, sanitary, and comfortable environments and to help prevent the development and transmission of diseases and infections. The facilities' infection control programs, under which they investigate, control, and prevent infections, decide what procedures, such as isolation, should be applied to individual residents and maintain records of incidents and corrective actions related to infections. (42 CFR § 483.65). A prior audit indicated that States are paying nursing facilities for unallowable claims related to communicable disease care. (OAS; W-00-13-31466; various reviews; expected issue date: FY 2014; new start)

### **Dental Services for Children—Inappropriate Billing (New)**

We will review Medicaid payments by States for dental services to determine whether States have properly claimed Federal reimbursement. 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. (Social Security Act, §§ 1905(a)(4)(B) and 1905(r).) Federal regulations define “dental services” as diagnostic, preventative, or corrective procedures provided by or under the supervision of a dentist. (42 CFR § 440.100.) 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. Prior work indicates that some dental providers may be inappropriately billing for services. (OAS; W-00-10-31135; W-00-11-31135; W-00-12-31135; various reviews; expected issue date: FY 2013; work in progress)

### **Dental Services for Children—Billing Patterns in Five States (New)**

We will review billing patterns of pediatric dentists and their associated clinics in five selected States. Medicaid covers comprehensive dental care for approximately 30 million low-income children through the EPSDT benefit. Under EPSDT, States must cover dental services and dental screening services for children. OIG investigations have identified numerous vulnerabilities with pediatric dental care, particularly with the care provided by certain for-profit dental chains. (OEI; 02-12-00330; expected issue date: FY 2014; work in progress)

### **Hospice Services—Compliance With Reimbursement Requirements**

We will determine whether Medicaid payments by States for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) 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 patients’ illness and death. An individual, having been certified as terminally ill, may elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS’s *State Medicaid Manual*, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than \$816 million. (OAS; W-00-11-31385; W-00-12-31385; various reviews; expected issue date: FY 2013; work in progress)

### **Family Planning Services—Claims for Enhanced Federal Funding**

We will review family planning services in several States to determine whether States improperly claimed enhanced Federal funding for such services and the resulting financial impact on Medicaid. Previous OIG work found improper claims for enhanced funds for family planning services. States may claim Federal reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. (Social Security Act, § 1903(a)(5).) (OAS; W-00-10-31078; W-00-11-31078; W-00-12-31078; various reviews; expected issue date: FY 2013; work in progress)

**Transportation Services—Compliance With Federal and State Requirements**

We will review Medicaid payments by States to providers for transportation services to determine the appropriateness of the payments for such services. Federal regulations require States to ensure necessary transportation for Medicaid beneficiaries to and from providers. (42 CFR § 431.53.) Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. (OAS; W-00-11-31121; W-00-12-31121; various reviews; expected issue date: FY 2013; work in progress)

**Health-Care-Acquired Conditions—Prohibition on Federal Reimbursements**

We will determine whether selected States made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions. As of July 1, 2011, Federal payments to States under the Social Security Act, § 1903, are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions. (Affordable Care Act, § 2702.) Federal regulations prohibiting Medicaid payments by States for services related to health-care-acquired conditions and provider-preventable conditions are at 42 CFR § 447.26. (OAS; W-00-13-31452; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

**Medical Equipment and Supplies—Potential Savings From the Competitive Bidding Program (New)**

We will determine cost savings for Medicare and Medicaid that could result from expanded use of competitive bidding for medical equipment and supplies. Medicare has authority to expand beyond the largest metropolitan statistical areas currently covered by the Medicare's competitive bidding program. (Social Security Act, § 1847(a)(1)(B)(i).) Use of payment rates established through competitive bidding could result in costs savings for State Medicaid programs, which establish their own payment rates for medical equipment and supplies. (Social Security Act, § 1902(a)(30)(A).) (OEI; 06-12-00470; 00-00-0000; expected issue date: FY 2014; work in progress)

**Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Selected Items (New)**

We will determine whether opportunities exist for lowering Medicaid payments for selected items of medical equipment and supplies. We will also determine the amount of Medicaid savings that could be achieved for selected items through the use of rebates, competitive bidding, or other means. Prior work found that State Medicaid programs negotiated rebates with manufacturers that reduced net payments for home blood-glucose test strips. Similarly, CMS reduced Part B rates of payment in selected areas through competitive bidding. (OAS; W-00-12-31390; various reviews; expected issue date: FY 2013; new start)

### **Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Blood-Glucose Test Strips (New)**

We will determine whether opportunities exist for lowering payments for home blood-glucose test strips provided under the Medicaid program. We will also review the rebates that some States collected on test strips to determine whether the States properly reimbursed the Federal share of the rebates. Prior work found that State Medicaid programs negotiated rebates with manufacturers that reduced net payments for test strips. Similarly, CMS reduced Part B rates of payment in selected areas through competitive bidding. We will determine the amount of Medicaid savings that could be achieved through a reduction in payments for blood-glucose test strips through rebates, competitive bidding, or other means. (OAS; W-00-12-31390; W-00-13-31390; various reviews; expected issue date: FY 2013; work in progress and new start)

### **Medical Equipment and Supplies—States' Efforts To Control Costs for Disposable Incontinence Supplies (New)**

We will review the extent to which State Medicaid programs have implemented measures aimed at controlling costs for disposable incontinence supplies. We will also determine the cost savings created by these measures and the potential cost savings for States that have not yet implemented them. A State Medicaid plan must provide for the inclusion of home health services (and related supplies) to Medicaid beneficiaries who meet the States' criteria for nursing home coverage. (Social Security Act, § 1902(a)(10)(D).) Federal regulations state that medical supplies, equipment, and appliances suitable for use in the home are required home health services. (42 CFR § 440.70(b)(3).) (OEI; 07-12-000710 expected issue date: FY 2014; work in progress)

## State Management of Medicaid

---

#### Acronyms and Abbreviations for Selected Terms Used in This Section:

CPE—certified public expenditures

MIP—Medicaid Integrity Program

Form CMS-64—Quarterly Medicaid Statement of Expenditures

RAC—recovery audit contractor

### **State Use of Provider Taxes To Generate Federal Funding**

We will review State health-care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable Federal requirements. Our work will focus on the mechanism States use to raise revenue through provider taxes and determine the amount of Federal funding generated. Previous OIG work has raised concerns about States' use of health-care-related taxes. Many States finance a portion of their Medicaid spending by imposing taxes on health care providers. Health-care-related taxes are defined by Federal regulations that set forth the standard for permissible health-care-related taxes. (42 CFR §§ 433.55 and 433.68.) (OAS; W-00-12-31455; various reviews; expected issue date: FY 2013; work in progress)

### **State-Operated Facilities—Reasonableness of Payment Rates**

We will determine whether Medicaid payment rates to State-operated facilities are reasonable and are in accordance with Federal and State requirements. We will determine in selected States the extent to which payments to providers may be excessive. Payments for services must be consistent with efficiency, economy, and quality of care. (Social Security Act, §1902(a)(30)(A).) Federal regulations state that a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. (2 CFR § 225, Appendix A, § C. 2.) (OAS; W-00-12-31398; various reviews; expected issue date: FY 2013; work in progress)

### **State Upper-Payment-Limit-Related Supplemental Payments to Private Hospitals**

We will review supplemental payments by States to private hospitals to determine whether errors exist involving such payments. Federal funds are not available for Medicaid payments that exceed applicable upper payment limits (UPL). Prior OIG work involving supplemental payments to public facilities found errors. Federal regulations 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. (42 CFR § 447.272.) States are permitted to make payments under their approved plans to hospitals up to the applicable aggregate UPL, and many States use this flexibility to make lump-sum supplemental payments based on the difference between the ordinary rate and the UPL. Medicaid agencies pay for inpatient hospital and long-term-care services using rates determined in accordance with methods and standards specified in their approved State plans. (42 CFR § 447.253(i).) (OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2013; work in progress)

### **State Use of Incorrect FMAP for Federal Share Adjustments (New)**

We will review States' Medicaid claims records to determine whether the States used the correct Federal Medical Assistance Percentage (FMAP) when processing claim adjustments reported on the Medicaid Quarterly Expenditure Report (Form CMS-64). We reviewed the claim adjustments reported on Form CMS-64 for one State and determined that it did not use the correct FMAP for the majority of adjustments. The Federal Government is required to reimburse a State at the FMAP rate in effect at the time the expenditure was made (Social Security Act, §1903(a)(1).) (OAS; W-00-12-31460; various reviews; expected issue date: FY 2013; work in progress)

### **State Allocation of Medicaid Administrative Costs**

We will review administrative costs claimed by several States to determine whether they were properly allocated and claimed or directly charged to Medicaid. Prior reviews in one State noted problems with the State's administrative costs. The Federal share of Medicaid administrative costs is typically 50 percent, with enhanced rates for specific types of costs. Federal cost sharing for the proper and efficient administration of Medicaid State plans is provided by the Social Security Act, § 1903(a)(7). Administrative costs are 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; W-00-12-31123; various reviews; expected issue date: FY 2013; work in progress)

### **State Quarterly Expenditure Reporting on Form CMS-64—CMS Oversight**

We will examine CMS's oversight of State quarterly expenditure reporting on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). We will also identify opportunities to improve the accuracy of such reporting. Previous OIG and Government Accountability Office (GAO) studies have shown significant inaccuracies in the reporting of State expenditures, thus affecting the Federal reimbursement match. The Form CMS-64 is a detailed accounting of expenditures that the Federal Government uses to reimburse States under Title XIX of the Social Security Act. Federal regulations require each State to submit the Form CMS-64 as a report of actual quarterly expenditures. (42 CFR § 430.30(c).) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **State Medicaid Monetary Drawdowns—Reconciliation With Form CMS-64**

We will review the Medicaid monetary drawdowns that States received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the States on the Form CMS-64. States draw monetary advances against a continuing letter of credit certified to the Secretary of the Treasury in favor of the State payee throughout a quarter. (42 CFR § 430.30(d)(4).) After the end of each quarter, States must submit the Form CMS-64, which shows the disposition of Medicaid funds used to pay for actual medical and administrative expenditures for the reporting period. (42 CFR § 430.30(c).) The amounts reported on the Form CMS-64 should reconcile the monetary advances for a quarter. (OAS; W-00-12-31456; various reviews; expected issue date: FY 2013; work in progress)

### **State Reporting of Medicaid Collections on Form CMS-64**

We will determine whether States accurately captured Medicaid collections on their Form CMS-64, as well as returned the correct Federal share related to those collections. Previous OIG work revealed multiple errors in compiling collection amounts on the Form CMS-64, particularly errors related to the calculation of the Federal share returned. The States should report collections on lines 9a-9e of the Form CMS-64. These collections decrease the total expenditures reported for the period. (42 CFR §§ 433.154 and 433.320.) Instructions for line 9 indicate that States should compute the Federal share of collections at the rate at which CMS matched the original expenditures. (CMS's *State Medicaid Manual*, § 2500.1(B).) (OAS; W-00-12-31457; various reviews; expected issue date: FY 2013; work in progress)

### **State Actions To Address Vulnerabilities Identified During CMS Reviews**

We will review corrective actions that State Medicaid agencies have implemented to address the findings and recommendations from State Medicaid program integrity reviews conducted by CMS. We will determine why States have not implemented all corrective actions, examine the followup CMS performed to ensure that corrective actions were taken by States, and examine the evidence CMS reviews to ensure that corrective actions were implemented. As part of the Medicaid Integrity Program (MIP), CMS conducts a triennial review of each State's program integrity functions to assess their effectiveness and compliance with Federal requirements. CMS issues to the State a final report of findings and recommendations and requires the State to provide a corrective action plan within 30 days

of the report issuance. The MIP was established by the Deficit Reduction Act of 2005 (DRA), § 6034. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **State Buy-In of Medicare Coverage—Eligibility Controls**

We will review States' Medicaid buy-in programs for Medicare Part B to 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. States may enroll dual-eligible beneficiaries in Part B. States that operate buy-in programs pay the Part B premium for each dual-eligible individual that they enroll in Part B. (Social Security Act, § 1843, and 42 CFR §§ 407.40 through 407.42.) (OAS; W-00-10-31220; W-00-11-31220; W-00-12-31220; various reviews; expected issue date: FY 2013; work in progress)

### **State Medicaid Payments for Medicare Deductibles and Coinsurance (New)**

We will determine whether States claimed Federal reimbursement for Medicaid payments for Medicare deductibles and coinsurance in excess of amounts authorized in the State plans. State Medicaid plans require coordination of Medicaid with Medicare and provide methods and standards for claim payments. Claims payment is based on the eligibility group of a dual-eligible individual and a comparison between Medicare's payment and the State Medicaid plan rate. (Social Security Act, § 1902(a)(10)(E), § 1902(n)(2), and § 1902(a)(30)(A), and State plan Supplement 1 to Attachment 4.19-B). Prior OIG audits found problems with Medicaid payments for Medicare deductibles and coinsurance. (OAS; W-00-13-31464; various reviews; expected issue date: FY 2014; new start)

### **State Cost Allocations That Deviate From Acceptable Practices (New)**

We will review public assistance cost allocation plans and processes for selected States to determine whether the States claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems (RMSS) that deviated from acceptable statistical sampling practices. RMSSs must be documented so as to support the propriety of the costs assigned to Federal awards. (OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, Attachment A, §C.1.j.) A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan (45 CFR § 95.517(a).) Prior OIG reviews of school-based and community-based administrative claims found significant unallowable payments when payments were based on RMSS. (OAS; W-00-12-31467; various reviews; expected issue date: FY 2014; work in progress)

### **State Recovery Audit Contractor Performance and Results (New)**

We will review the early performance and results of Recovery Audit Contractors (RAC) in State Medicaid programs. States were required to establish programs to contract with RACs to audit Medicaid payments by the end of 2010. (Affordable Care Act, § 6411.) The RACs were initially established to conduct postpayment reviews to identify Medicare overpayments and underpayments. The Affordable Care Act expanded the use of RACs to Medicaid. Previous OIG and GAO work identified problems with Medicare RACs' process for identifying and reporting potential fraud and with CMS's handling of vulnerabilities identified by RACs. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

**State Enrollment and Monitoring of Medical Equipment Suppliers (New)**

We will review State Medicaid agencies' processes for enrolling and monitoring medical equipment suppliers. We will conduct site visits to determine whether such suppliers complied with their State Medicaid agencies' enrollment standards. In a recent OIG review of Medicaid medical equipment suppliers, more than 15 percent of the suppliers failed to meet at least one enrollment standard. (OAS; W-00-12-31468; various reviews; expected issue date: FY 2014; work in progress; Affordable Care Act)

**State Determinations of Hospital Provider Eligibility and Program Participation (New)**

We will determine whether States appropriately determined hospital providers' eligibility for Medicaid reimbursement. Hospital providers are required to meet Medicare program participation requirements to receive Medicaid funding. (42 CFR § 440.10.) Previous reviews have found significant unallowable Medicaid payments to hospitals that did not meet Medicare program eligibility requirements as part of the disproportionate share hospital (DSH) program, which assists hospitals serving a high proportion of low-income patients. (OAS; W-00-12-31301; W-00-13-31301; various reviews; expected issue date: FY 2013; work in progress)

**State Compliance With Estate Recovery Provisions of the Social Security Act (New)**

We will determine whether States complied with requirements for recoveries from deceased Medicaid beneficiaries' estates. We will also determine whether States properly reported any such recoveries on Form CMS-64. States must, with certain exceptions, recoup medical assistance costs from the estates of deceased beneficiaries who were institutionalized. (Social Security Act, § 1917(b)(1).) 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. Beneficiaries' estates include the real and personal property in the estates under the State's probate laws. (Social Security Act, § 1917(b)(4).) CMS requires that the amounts collected from deceased Medicaid beneficiaries' estates be reported on Form CMS -64 as reductions to total Medicaid expenditures. (CMS's *State Medicaid Manual*, Pub. No. 45, pt. 2, § 2500.1.) (OAS; W-00-12-31113; W-00-13-31113; various reviews; expected issue date: FY 2013; work in progress)

**State Compliance With the Money Follows the Person Demonstration Program (New)**

We will review selected States' compliance with the Money Follows the Person (MFP) rebalancing demonstration program. The MFP program was authorized by the Deficit Reduction Act of 2005 (DRA), § 6071, and was extended by the Affordable Care Act, § 2403. The MFP program was designed to assist States in rebalancing their long-term-care systems and to help Medicaid enrollees transition from institutions to the community. The MFP program is authorized through September 30, 2016, at up to \$4 billion. We will determine whether States followed applicable requirements for participating in the MFP program, such as providing qualified services to eligible participants. (OAS; W-00-12-31461; various reviews; expected issue date: FY 2013; work in progress)

### **State Terminations of Providers Terminated by Medicare or by Other States**

We will review States' compliance with a new requirement that State Medicaid agencies terminate providers that have been terminated under Medicare or by another State. We will determine whether such providers are terminated by all States, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify obstacles States face in complying with the termination requirement. This new requirement became effective January 1, 2011. (Social Security Act, § 1902(a)(39), as amended by the Affordable Care Act, § 6501.) (Affordable Care Act, § 6401(b)(2).) (OEI; 06-12-00030; expected issue date: FY 2014; work in progress; Affordable Care Act)

### **State Payments to Federally Excluded Providers and Suppliers**

We will review Medicaid payments by States to providers and suppliers to determine the extent to which payments were made for services rendered during periods of exclusion from Medicaid. Excluded providers and suppliers are not permitted to receive payments for services rendered during periods of exclusion. (Social Security Act, §§ 1128, 1128A, and 1156, and 42 CFR § 1001.1901.) (OAS; W-00-11-31337; W-00-12-31337; various reviews; expected issue date: FY 2013; work in progress)

### **State Compliance With Federal Certified Public Expenditures Regulations**

We will determine whether States are complying with Federal regulations for claiming certified public expenditures (CPE), which are normally generated by local governments as part of their contribution to the coverage of Medicaid services. States may claim CPEs to provide the States' shares in claiming Federal reimbursement as long as the CPEs comply with Federal regulations and are being used for the required purposes. (42 CFR § 433.51 and 45 CFR § 95.13.) (OAS; W-00-12-31110; various reviews; expected issue date: FY 2013; work in progress)

### **State Procedures for Identifying and Collecting Third-Party Liability Payments**

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. Many Medicaid beneficiaries may have additional health insurance through third-party sources, such as employer-sponsored health insurance. OIG work in 2006 described problems that State Medicaid agencies had in identifying and collecting third-party payments. States are to take all reasonable measures to ascertain the legal liabilities of third parties with respect to health care items and services. (Social Security Act, § 1902(a)(25).) The DRA, § 6035, clarified the provision for entities defined as third-party payers. (OEI; 05-11-00130; expected issue date: FY 2013; work in progress)

### **State Collection and Verification of Provider Ownership Information**

We will determine the extent to which State Medicaid agencies and CMS collect and verify required ownership information for enrolled providers. Federal regulations require Medicaid and Medicare providers to disclose ownership information, such as the name, address, and date of birth of each person with an ownership or control interest in the provider. (42 CFR § 455.104.) We will also review States' and CMS' practices for collecting and verifying provider ownership information and determine whether

States and CMS had comparable provider ownership information for providers enrolled in both Medicaid and Medicare. (OEI; 04-11-00590, 04-11-00591, 04-11-00592; expected issue date: FY 2013; work in progress)

## Children’s Health Insurance Program for Medicaid-Eligible Individuals

---

Acronyms and Abbreviations for Selected Terms Used in This Section:

CHIP—Children’s Health Insurance Program

FFP—Federal financial participation

### State Claims for Federal Reimbursement Under the Children’s Health Insurance Program for Medicaid-Eligible Individuals

We will assess the appropriateness of a State’s claims for federal financial participation (FFP) under the State’s Children’s Health Insurance Program (CHIP) program for individuals who were enrolled in the State’s Medicaid 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 Medicaid. 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. (Social Security Act, § 2105(c)(6)(B).) (OAS; W-00-11-31314; W-00-12-31314; various reviews; expected issue date: FY 2013; work in progress)

### State Compliance With Eligibility and Enrollment Notification and Review Requirements for the Children’s Health Insurance Program

We will review State compliance with the CHIP eligibility and enrollment notification and review requirements. We will also determine whether beneficiaries remain enrolled during reviews of suspension or after termination of enrollment. Federal regulations contain requirements relating to applicant and enrollee protections. (42 CFR pt. 457, subpart K.) Requirements include, among other things, that eligibility determinations be timely and be in writing, 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. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

## Medicaid Data Systems, Controls, and Claims Processing

---

Acronyms and Abbreviations for Selected Terms Used in This Section:

MMIS—Medicaid Management Information System

MSIS—Medicaid Statistical Information System

NPI—National Provider Identifier

PARIS—Public Assistance Reporting Information System

PHI—protected health information

### **Early Review of the Transformed Medicaid Statistical Information System Pilot Project (New)**

We will review CMS's implementation of the Transformed Medicaid Statistical Information System (T-MSIS) pilot project. Much of the efforts around Medicaid program integrity at a national level rely on the use of the Medicaid Statistical Information System (MSIS), which is a database of Medicaid claims and encounter information collected from States by CMS. MSIS data are used by Medicaid Integrity Contractors and other Federal and law enforcement agencies to identify and pursue providers that are defrauding States and the Federal Government. Timely, accurate, and comprehensive Medicaid data are necessary for program integrity oversight and the identification of potential fraud, waste, and abuse. CMS is implementing a pilot project, called T-MSIS, to begin collecting higher quality timely data. T-MSIS is scheduled for national implementation in 2014. We will also determine whether the pilot project is achieving results that will make the new T-MSIS database useful for detecting fraud, waste, and abuse. *(OEI; 05-12-00610; expected issue date: FY 2013; work in progress)*

### **Claims With Inactive or Invalid Provider Identifier Numbers**

Given the vulnerabilities identified in the Medicare program, 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 National Provider Identifiers (NPI), 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 medical equipment and supplies claims with inactive or invalid NPIs 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 medical claims contained NPIs of deceased physicians. *(OAS; W-00-11-31338; various reviews; expected issue date: FY 2013; work in progress)*

### **Beneficiaries With Multiple Medicaid Identification Numbers**

We will review duplicate payments made by States on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and States' 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. *(OAS; W-00-11-31374; W-00-12-31374; various reviews; expected issue date: FY 2013; work in progress)*

### **Use of the Public Assistance Reporting Information System To Reduce Instances of Payments by 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. 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. PARIS is a computer matching and information exchange system operated by the Administration for Children and 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. Federal law requires States' Medicaid eligibility determination systems to provide data matching through PARIS. (Social Security Act, § 1903, as amended by the Qualifying Individual Program Supplemental Funding Act of 2008 (QI).) (OEI; 09-11-00780; expected issue date: FY 2013; work in progress)

### **Management Information Systems Business Associate Agreements**

We will review CMS's oversight activities related to data security requirements of State Medicaid Management Information Systems (MMIS), which process and pay claims for Medicaid benefits. We will determine whether business associate agreements have been properly executed to protect beneficiary information, including safeguards implemented pursuant to Federal standards. 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 established minimum requirements for contracts with business associates to protect the security of electronic-protected health information. (Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rules at 45 CFR pt. 164, subpart C.) (OAS; W-00-13-41015; various reviews; expected issue date: FY 2013; new start)

### **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 to determine whether they contain any vulnerabilities that could affect the confidentiality, integrity, and availability of the Medicaid claims' protected health information (PHI). Electronic claims transactions may contain PHI as defined under regulations that also define "health plan" to include Medicaid. (45 CFR § 160.103.) 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. We will use an application security assessment tool in conducting this review. (OAS; W-00-13-41016; various reviews; expected issue date: FY 2013; new start)

### **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. We will focus on security controls, 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. The Office of Management and Budget (OMB) requires that agencies implement and maintain programs to ensure that adequate security is provided for all agency information that is collected, processed, transmitted, stored, or disseminated in general support systems and major applications. OMB also established a minimum set of controls to be included in Federal automated information security programs. (OMB Circular A-130, *Management of Federal Information Resources*, Appendix III.) (OAS; W-00-12-40019; W-00-13-40019; various reviews; expected issue date: FY 2013; work in progress and new start)

## Medicaid Managed Care

---

Acronyms and Abbreviations for Selected Terms Used in This Section:

MCE—managed care entities

MSIS—Medicaid Statistical Information System

MCO—managed care organizations

OMB—Office of Management and Budget

### **Beneficiary Access to Medicaid Managed Care (New)**

We will review how extensive managed care provider networks are for Medicaid managed care beneficiaries. According to Federal regulations (42 CFR §§ 438.202-210), States must ensure that managed care plans maintain and monitor a network of providers that is sufficient to provide adequate access to all Medicaid services. In establishing and maintaining this network, managed care plans must consider the anticipated Medicaid enrollment, the expected utilization of services, the number and types of providers accepting new patients, and the geographic location of providers and beneficiaries. We will also describe State standards for primary and specialty care and will determine beneficiaries' access to certain primary and specialty care providers. *(OEI; 02-11-00320; expected issue date: FY 2014; work in progress)*

### **Beneficiary Grievances and Appeals Process (New)**

We will review the extent to which States monitor Medicaid managed entities' (MCE) grievances and appeals systems for compliance with Federal requirements. States are required to provide an opportunity for a fair hearing to any beneficiary whose Medicaid claim for assistance is denied or not acted upon promptly. (Social Security Act, § 1902(a)(3).) Medicaid MCEs are required to establish internal grievance procedures under which beneficiaries, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical services. (Social Security Act, § 1932(b)(4).) CMS promulgated more detailed requirements at 42 CFR Part 438, Subpart F. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

### **State Oversight of Provider Credentialing by Managed Care Entities**

We will determine how States ensure that Medicaid MCEs (specifically managed care organizations) prepaid inpatient health plans, and prepaid ambulatory health plans comply with credentialing and recredentialing requirements. We will also determine how CMS ensures that States comply with provider credentialing requirements. Each entity must document its process for credentialing and recredentialing providers and not discriminate against providers that serve high-risk populations or specialize in high-cost treatment. Federal regulations require States to ensure that entities serving the Medicaid population implement written policies and procedures for selection and retention of providers. (42 CFR 438.214.) *(OEI; 09-10-00270; expected issue date: FY 2013; work in progress)*

### **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 MCEs' marketing practices and compliance with Federal and

State contractual marketing requirements. We will also determine the extent to which CMS ensures States' compliance with Federal requirements involving Medicaid MCE marketing practices. No marketing materials may be distributed by Medicaid MCEs without first obtaining States' approval. (Social Security Act, § 1932(d)(2).) States are permitted to impose additional requirements in contracts with MCEs about marketing activities. (42 CFR § 438.104.) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **Completeness and Accuracy of Managed Care Encounter Data**

We will determine the extent to which Medicaid managed care encounter data included in Medicaid Statistical Management Systems (MSIS) submissions to CMS accurately represent all services provided to beneficiaries. We will also determine the extent to which CMS acted to enforce Federal requirements that Medicaid managed care encounter data be included in MSIS. A prior OIG review of 2007 data found that although all 40 States with Medicaid managed care were collecting encounter data and most of those States used the data, only 25 States included the data in their MSIS submissions to CMS. Of the 25 States that included encounter data in their MSIS submissions, the MSIS files containing encounter data varied by service (e.g., inpatient, pharmacy, long-term care) and eligibility, as did the data elements reported in each file. Federal law requires States and MCEs to submit data elements deemed necessary by the Secretary for use in program integrity, program oversight, and administration. (Affordable Care Act, § 6504.) Federal Medicaid matching funds for the operation of an MSIS are authorized pursuant to the Social Security Act, § 1903(a)(3)(B). Such matching funds can be withheld from States that fail to submit required Medicaid data, including encounter data. (Social Security Act, §§ 1903(m)(2)(A) and 1903(r)(1).) (OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act)

### **Program Integrity—Excluded Individuals Employed by Managed Care Networks**

We will determine the extent to which OIG-excluded individuals were employed by entities that provide services through MCE provider networks in 2009. 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. The Department of Health and Human Services (HHS) and OIG have authority to exclude individuals and entities from all Federal health care programs pursuant to the Social Security Act, §§ 1128, 1156, and 1892. Medicaid and any other Federal health care programs are precluded from paying for any items or services furnished, ordered, or prescribed by an excluded individual or entity, except under specific limited circumstances. (Social Security Act, § 1862(e)(1), and 42 CFR § 1001.1901(b).) 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. (OEI; 07-09-00632; expected issue date: FY 2013; work in progress)

### **Program Integrity—Medicaid Managed Care Organizations’ Identification of Fraud and Abuse (New)**

We will determine whether managed care organizations (MCO) identified and addressed potential fraud and abuse incidents in 2011. We will also describe how States oversee MCOs’ efforts to identify and address fraud and abuse. All MCOs are required to have processes to detect, correct, and prevent fraud, waste, and abuse. However, the Federal requirements surrounding these activities are general in nature (42 CFR § 438.608), and MCOs vary widely in how they deter fraud, waste, and abuse. A prior OIG report found that over a quarter of the MCOs surveyed did not report a single case of suspected fraud and abuse to their State Medicaid agencies in 2009. The report also found that although MCOs and States are taking steps to address fraud and abuse in managed care, they remain concerned about their prevalence. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **Program Integrity—Managed Care Organizations’ Use of Prepayment Review To Detect and Deter Fraud and Abuse**

We will determine the extent to which Medicaid MCOs use prepayment reviews to detect and deter fraud and abuse. We will also examine the results of MCO prepayment reviews, the challenges addressed in developing and implementing the prepayment programs, and lessons MCOs learned about them. Federal regulations 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. (42 CFR § 438.608.) Prepayment reviews can serve as effective fraud and abuse safeguards because they occur during the claims processing phase before claim payment. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### **Medical Loss Ratio—Medicaid Managed Care Plans’ Refunds to States**

We will review managed care plans with contract provisions that require a minimum percentage of total costs to be expended for medical expenditures (medical loss ratio) to determine whether a refund was made to the State agency when the minimum medical loss ratio threshold was not met. Prior OIG work found that, although the minimum medical loss ratios were not met, the managed care plans did not make the required refund to the State agency. State Agencies must properly report expenditures and apply any applicable credits. (OMB Circular A-87.) (OAS; W-00-11-31372; W-00-12-31372; various reviews; expected issue date: FY 2013; work in progress)

## **Other Medicaid-Related Reviews**

---

#### Acronyms and Abbreviations for Selected Terms Used in This Section:

FFS—fee for service

MDS—Minimum Data Set

MFCU—Medicaid Fraud Control Unit

PERM—Payment Error Rate Measurement (process)

PPS—prospective payment system

SNF—skilled nursing facility

**Medicaid Overpayments—Credit Balances in Medicaid Patient Accounts**

We will review patient accounts of providers to determine whether there are Medicaid overpayments in accounts with credit balances. Previous OIG work found Medicaid overpayments in patients' accounts with credit balances. Medicaid is the payer of last resort and providers are to identify and refund overpayments received. (Social Security Act, § 1902(a)(25); 42 CFR pt. 433, subpart D; various State laws; and CMS's *State Medicaid Manual*, Pub. No. 45, pt. 3, § 3900.1.) (OAS; W-00-11-31311; W-00-12-31311; various reviews; expected issue date: FY 2013; work in progress)

**Payment Error Rate Measurement Program—Error Rate Accuracy and Health Information Security**

We will review CMS's implementation of the Payment Error Rate Measurement (PERM) process to determine whether it has produced valid and reliable error rate estimates for Medicaid and Children's Health Insurance Program (CHIP) fee for service, managed care, and eligibility. We will also review the physical and data security of health information transmitted by various States for use in the PERM. We will also verify CMS's actions to implement recommendations from a March 2010 OIG review. Annually, Federal agencies must develop statistically valid estimates of improper payments under programs with a significant risk of erroneous payments, including Medicaid and CHIP. (Improper Payments Elimination and Recovery Act of 2011 (IPERA) and OMB's implementation of IPERA.) CMS developed the PERM process to comply with IPERA. The process includes conducting FFS, managed care, and eligibility reviews. (42 CFR, pt. 431, subpart Q.) OMB's instructions on protecting sensitive information and reporting incidents involving potential and confirmed breaches of personally identifiable information (PII) are provided by OMB Memorandums M-06-16 and M-07-16. OIG has oversight and monitoring responsibilities related to CMS's error rate process pursuant to the Chief Financial Officers Act of 1990. (OAS; W-00-13-40046; various reviews; expected issue date: FY 2013; new start)

**Nursing Home Minimum Data Set—Accuracy and CMS Oversight**

We will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. We will also review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. Nursing homes must conduct accurate comprehensive assessments for residents using an instrument that includes the MDS. (Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act.) Federal regulations specify the requirements of the assessment instrument. (42 CFR § 483.20.) CMS implemented a skilled nursing facility (SNF) prospective payment system (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. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

### Reviews of State Medicaid Fraud Control Units

We will review the overall management, operations, and performance of selected Medicaid Fraud Control Units (MFCU). We will also determine the extent to which a State MFCU operates in accordance with the 12 published performance standards and identify effective practices and areas for improvement in the MFCU's management and operations. The Secretary has delegated to OIG the responsibility for administering the MFCU grants and providing oversight and guidance to the MFCUs. Part of that oversight responsibility, as required by 42 CFR § 1007.15(d), includes certifying and then annually recertifying every State MFCU. The Social Security Act, §1902(a)(61), required the Secretary to establish performance standards that could be used in evaluating a MFCU's performance for recertification purposes; the 12 standards were published at 59 Fed. Reg. 49080. Periodically, OIG conducts an in depth, on-site review of each State MFCU as part of the recertification process. (OEI; 00-00-00000; various reviews; expected issue date: FY 2013; work in progress)

---

The [Work Plan](#) is one of OIG's three core publications. The [Semiannual Report to Congress](#) summarizes OIG's most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. The annual [Compendium of Unimplemented Recommendations](#) (Compendium) describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.