Medicaid Program

The Federal Government and States 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. Many States contract with managed care organizations (MCOs) to provide or coordinate comprehensive health services.

Protecting an expanding Medicaid program from fraud, waste, and abuse takes on a heightened urgency as the program continues to grow in spending and in the number of people it serves. Our continuing and new reviews of Medicaid in FY 2015 address: prescription drugs; billing, payment, reimbursement, quality, and safety of home health services, community-based care, and other services, equipment, and supplies; State management of Medicaid; information system controls and security; and Medicaid managed care.

Planning for FY 2015 and beyond may include examinations of beneficiary eligibility determinations and FMAP assignments, data and methodologies used to ensure program integrity, and inefficient payment policies or practices—targeting areas prone to payment errors. Going forward, OIG expects to expand its portfolio examining protections to ensure quality of care and access to services, as well as work examining drug diversion and abuse.

Medicaid Prescription Drug Reviews

Acronyms and Abbreviations for Selected Terms:

ACA—Affordable Care Act
AMP—average manufacturer price
CMS—Centers for Medicare & Medicaid Services
CPI-U—consumer price index for urban consumers
DRA—Deficit Reduction Act
DUR—drug utilization review
MCO—managed care organization
NDA—new drug application

State and Manufacturer Compliance With Medicaid Requirements

➢ States' use of Medicaid drug utilization review to reduce the inappropriate dispensing of opioids

We will review the education and enforcement actions that States have taken on the basis of information generated by their drug utilization review (DUR) programs related to inappropriate dispensing and potential abuse of prescription opiates. We also will review State oversight of MCOs' DUR programs and any resulting actions related to inappropriate dispensing of opiates. States are required to establish DUR programs to receive the Federal share of Medicaid payments. (42 CFR § 456.703.) DUR involves, among other functions, ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implementing corrective action when needed. (OEI; 05-13-00550; expected issue date: FY 2016)

➢ Manufacturer compliance with AMP reporting requirements

We will determine whether manufacturer compliance with average manufacturer price (AMP) reporting requirements has changed since 2008 and identify actions that CMS has taken to improve compliance with AMP reporting requirements. Manufacturer-reported AMPs play a critical role in Federal cost containment strategies for prescription drugs. 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). 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. (OEI; 03-14-00150; expected issue date: FY 2016)

➢ States' collection of rebates on physician-administered drugs

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. Prior OIG work identified concerns with States' collection and submission of data to CMS, including national drug codes that identify drug manufacturers, thus allowing States to invoice the manufacturers responsible for paying rebates. (Deficit Reduction Act of 2005 (DRA).) To be eligible for Federal matching funds, States are required to collect rebates on covered outpatient drugs administered by physicians. (Social Security Act, § 1927(a).) (OAS; W-00-12-31400; W-00-13-31400; W-00-14-31400; various reviews; expected issue date: FY 2015)

➢ States' collection of rebates for drugs dispensed to Medicaid MCO enrollees

We will determine whether the States are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid MCOs. Drugs dispensed by Medicaid MCOs were excluded from this requirement until March 23, 2010. Section 2501 (c) of the ACA expanded the rebate requirement to include drugs dispensed to MCO enrollees. Medicaid MCOs are required to report enrollees' drug utilization to the State for the purpose of collecting rebates from manufacturers. (OAS; W-00-14-31483; W-00-15-31483; various reviews; expected issue date: FY 2015; ACA)

➢ **NEW** Manufacturer rebates – Federal share of rebates

We will review States' reporting of the Federal share of Medicaid rebate collections to determine whether States are correctly identifying and reporting the increases in rebate collections. Section 2501 of the Affordable Care Act increased the Medicaid drug rebates (both single source and multiple source drugs) for Medicaid outpatient drugs and required that those additional rebate amounts attributable to the increase be given solely to the Federal Government. (OAS; W-00-15-31450; various reviews; expected issue date: FY 2016; new start; ACA)

➢ **NEW** Analysis of generic price increases compared to price index

We will analyze generic drug prices over a period of time to determine whether prices increased more than the increases in inflation as measured by the consumer price index for urban consumers (CPI-U). Under the Medicaid drug rebate program, manufacturers are required to pay an additional rebate when the AMP for a brand-name drug increases more than the CPI-U increases. Generally,

the amount of the additional rebate is based on the amount that the drug's reported AMP exceeds its inflation-adjusted baseline AMP (Social Security Act, § 1927(c)(2)). There is no similar inflation-based rebate provision for generic drugs. Our review will quantify any potential savings from requiring an inflation-based additional rebate for generic drugs. (OAS; W-00-15-31501; expected issue date: FY 2016)

➢ NEW Treatment of authorized generic drugs

We will review drug manufacturers' treatment of sales of authorized generics in their calculation of AMP for the Medicaid drug rebate program. We will determine whether manufacturers included sales of authorized generics to secondary manufacturers in their AMP calculations. An authorized generic drug is one that the manufacturer holding the title to the original new drug application (NDA) permits another manufacturer to sell under a different national drug code. Provisions in 42 CFR §§ 447.506(b) provide that the manufacturer holding title to the original NDA of the authorized generic drug must include the sales of this drug in its AMP only when such drugs are being sold by the manufacturer directly to a wholesaler. Manufacturers that also include the sales of an authorized generic to a secondary manufacturer could lower AMP and consequently a lower rebate to be paid to the State. (OAS; W-00-15-31499; expected issue date: FY 2016)

State Claims for Federal Reimbursement

➢ Medicaid payments for multiuse vials of Herceptin

We will review States' claims for the Federal share of Medicaid payments for the drug Herceptin, which is used to treat breast cancer, to determine whether providers properly billed the States for the drug. We will determine whether providers' claims to States were complete and accurate and were billed in accordance with the regulations of the selected States. Prior OIG audits of Herceptin have shown provider noncompliance with Medicare billing requirements. Similar issues may occur in Medicaid. (OAS; W-00-14-31476; various reviews; expected issue date: FY 2015)

Home Health Services and Other Community-Based Care

Acronyms and Abbreviations for Selected Terms Used in This Section:

CDT—continuing day treatment
CMS—Centers for Medicare & Medicaid Services
HCBS—home and community-based services
HHA—home health agency
OMB—Office of Management and Budget

Billing and Payments

➢ Adult day health care services

We will review Medicaid payments by States for adult day care services to determine whether providers complied with Federal and State requirements. Adult day health care programs provide health, therapeutic, and social services and activities to program enrollees. Beneficiaries enrolled

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 home and community-based services (HCBS) waivers. (Social Security Act, § 1915, and 42 CFR § 440.180.) Prior OIG work shows that these payments do not always comply with State and Federal requirements. (OAS; W-00-12-31386; W-00-13-31386; various reviews; expected issue date: FY 2015)

➢ Continuing day treatment mental health services

We will review Medicaid payments to continuing day treatment (CDT) mental health services providers to determine whether their claims were adequately supported. Our review will follow up on a State commission's findings of unsubstantiated claims. CDT providers render an array of services to people with mental illnesses. CDT providers bill Medicaid on the basis of the number of hours of services rendered to beneficiaries. 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 in that State could not be substantiated. 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-00-13-31128; W-00-14-31128; various reviews; expected issue date: FY 2015)

State Claims for Federal Reimbursement

➢ Room and board costs associated with HCBS waiver program payments

We will determine whether selected States claimed Federal reimbursement for unallowable room and board costs associated with services provided under the terms and conditions of HCBS waiver programs. We will determine whether HCBS payments included the costs of room and board and identify the methods the States used to determine the amounts paid. Medicaid covers the cost of HCBS provided under a written plan of care to individuals in need of such services but does not allow for payment of room and board costs. (42 CFR §§ 441.301(b) and 441.310(a).) HCBS are provided pursuant to the Social Security Act, § 1915(c). States may use various methods to pay for such 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; W-00-14-31465; various reviews; expected issue date: FY 2015)

Quality of Care and Safety of Beneficiaries

➢ Home health services—Screenings of health care workers

We will review health-screening records of Medicaid home health agency (HHA) health care workers to determine whether they were screened in accordance with Federal and State requirements. Health screenings for home health care workers include vaccinations, such as those for hepatitis and influenza. HHAs provide health care services to Medicaid beneficiaries while the home health care workers are 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 Part 484. Other applicable requirements are found in State and local regulations. (OAS; W-00-11-31387; various reviews; expected issue date: FY 2015)

Other Medicaid Services, Equipment, and Supplies

Acronyms and Abbreviations for Selected Terms:

ACA—Affordable Care Act
CFC—Community First Choice
CMS—Centers for Medicare & Medicaid Services
EPSDT—Early and Periodic Screening, Diagnostic, and Treatment (services)
FMAP—Federal medical assistance percentage
LTSS—long-term services and support

Policies and Practices

➢ Medical equipment and supplies—Opportunities to reduce Medicaid payment rates for selected items

We will determine whether opportunities exist for lowering Medicaid payments for some medical equipment and supplies. We will also determine the amount of Medicaid savings that could be achieved for selected items through 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-00-13-31390; W-00-15-31390; various reviews; expected issue date: FY 2015)

Billing and Payments

➢ Transportation services—Compliance with Federal and State requirements

We will determine the appropriateness of Medicaid payments by States to providers for transportation 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-00-13-31121; various reviews; expected issue date: FY 2015)

➢ Health-care-acquired conditions—Prohibition on Federal reimbursements

We will determine whether selected States made Medicaid payments for hospital care associated with 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 are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions. (Social Security Act, § 1903, and ACA, § 2702.) Federal regulations prohibit Medicaid payments by States for services related to health-care-acquired conditions and for provider-preventable conditions as defined by CMS or included in the Medicaid State Plan. (42 CFR § 447.26.) (OAS; W-00-14-31452; various reviews; expected issue date: FY 2015; ACA)

State Claims for Federal Reimbursement

➢ Dental services for children—Inappropriate billing

We will review Medicaid payments by States for dental services to determine whether States have properly claimed Federal reimbursement. Prior OIG work indicated that some dental providers may be inappropriately billing for services. 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. (OAS; W-00-13-31135; various reviews; expected issue date: FY 2015)

➢ 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-00-13-31078; W-00-14-31078; W-00-15-31078; various reviews; expected issue date: FY 2015)

➢ Community First Choice State plan option under the Affordable Care Act

We will review Community First Choice (CFC) payments to determine whether the payments are proper and allowable. The ACA, section 2401, added section 1915(k) to the Social Security Act, a new Medicaid State plan option that allows States to provide statewide home and community-based attendant services and support to individuals who would otherwise require an institutional level of care. States taking up the option will receive a 6-percent increase in their FMAP for CFC services. To be eligible for CFC services, beneficiaries must otherwise require an institutional level of care and meet financial eligibility criteria. (OAS; W-00-15-31495; expected issue date: FY 2016; ACA)

➢ Payments to States under the Balancing Incentive Program

We will review expenditures the States claimed under the Balancing Incentive Program (BIP) to ensure that they were for eligible Medicaid long-term services and support (LTSS) and determine whether the States used the additional enhanced Federal match in accordance with § 10202 of the ACA. Under the BIP, eligible States can receive either a 2-percent or 5-percent increase in their FMAP for eligible Medicaid LTSS expenditures. Funding to States under the BIP cannot exceed $3 billion over the program's 4-year period (i.e., October 1, 2011, through September 30, 2015). To receive payments, participating States agree to make structural changes to increase access to noninstitutional LTSS. Additionally, the States must use the additional Federal funding to provide new or expanded offerings of non-institutional LTSS. (OAS; W-00-15-31482; various reviews; expected issue date: FY 2016; ACA)

Quality of Care and Safety of Beneficiaries

➢ Access to pediatric dental care for children enrolled in Medicaid

We will review billing patterns of pediatric dentists and their associated clinics in selected States and describe the extent to which children enrolled in Medicaid received dental services in these States. In recent years, a number of dental providers and chains have been prosecuted for providing unnecessary dental procedures and causing harm to Medicaid children. In addition, children's access to dental services has been a longstanding Medicaid problem. Medicaid covers comprehensive dental care for approximately 37 million low-income children through the EPSDT benefit. Under EPSDT, States must cover dental services and dental screening services for children. (OEI; 02-14-00490; various reviews; expected issue date: FY 2016)

➢ Medicaid beneficiary transfers from group homes and nursing facilities to hospital emergency rooms

We will review the rate of and reasons for transfer from group homes or nursing facilities to hospital emergency departments. High occurrences of emergency transfers could indicate poor quality of care. Prior OIG work examined transfers to hospital emergency departments, raising concerns about the quality of care provided in some nursing facilities. There is congressional interest in this area. (OAS; W-00-15-31040; various reviews; expected issue date: FY 2015)

State Management of Medicaid

Acronyms and Abbreviations for Selected Terms:

ACA—Affordable Care Act
CHIP—Children's Health Insurance Program
CMS—Centers for Medicare & Medicaid Services
CPE—certified public expenditures
FFP—Federal financial participation
FMAP—Federal medical assistance percentage
Form CMS-64—Quarterly Medicaid Statement of Expenditures
MIP—Medicaid Integrity Program
MFCU—Medicaid Fraud Control Unit
OMB—Office of Management and Budget
RMSS—random moment sampling systems

How States Fund Their Medicaid Programs

➢ 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 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. Federal regulations define and set forth the standard for permissible health-care-related taxes. (42 CFR §§ 433.55 and 433.68.) (OAS; W-00-14-31455; various reviews; expected issue date: FY 2015)

➢ State compliance with Federal Certified Public Expenditures regulations

We will determine whether States are complying with Federal regulations for claiming Certified Public Expenditures (CPEs), 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-00-14-31110; various reviews; expected issue date: FY 2015)

State Claims for Federal Reimbursement

➢ State cost allocations that deviate from acceptable practices

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. Prior OIG reviews of school-based and community-based administrative claims found significant unallowable payments when payments were based on RMSS. Such systems 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 Federal financial participation (FFP) for costs associated with a program only in accordance with its approved cost allocation plan (45 CFR § 95.517(a).) (OAS; W-00-13-31467; W-00-14-31467; various reviews; expected issue date: FY 2015)

➢ Enhanced Federal Medical Assistance Percentage

We will review States' Medicaid claims to determine whether the States correctly applied enhanced FMAP payment provisions of the ACA. The ACA, § 2001, authorized the use of an FMAP of 100 percent for individuals who are newly eligible because of Medicaid expansion. In addition, the ACA, § 2012, required that Medicaid payments to primary care providers be at least those of the Medicare rates in effect for calendar years 2013 and 2014. (OAS; W-00-14-31480; W-00-15-31480; various reviews; expected issue date: FY 2015; ACA)

➢ Medicaid eligibility determinations in selected States

We will determine the extent to which selected States made inaccurate Medicaid eligibility determinations. We will examine eligibility inaccuracy for Medicaid beneficiaries in selected States that expanded their Medicaid programs pursuant to the ACA and in States that did not. We will also assess whether and how the selected States addressed issues that contributed to inaccurate determinations. For some States, we will calculate a Medicaid eligibility error rate and determine the amount of payments associated with beneficiaries who received incorrect eligibility determinations. The ACA, § 2001, required significant changes affecting State processes for Medicaid enrollment, modified criteria for Medicaid eligibility, and authorized the use of an enhanced FMAP of 100 percent for newly eligible individuals. (OAS; W-00-14-31140; W-00-15-31140; various reviews; and OEI; 06-14-00330; expected issue date: FY 2016; ACA)

State Adjustments of Federal Reimbursement

➢ 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 Quarterly Medicaid Statement of Expenditures (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 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 Form CMS-64 should reconcile the monetary advances for a quarter. (OAS; W-00-13-31456; various reviews; expected issue date: FY 2015)

➢ State reporting of Medicaid collections on Form CMS-64

We will determine whether States accurately captured Medicaid collections on Form CMS-64 and returned the correct Federal share related to those collections. Previous OIG work revealed multiple errors in compiling collection amounts on Form CMS-64, particularly errors related to the calculation of the Federal share returned. Collections decrease the total expenditures reported for the period. (42 CFR §§ 433.154 and 433.320.) States should compute the Federal share of collections at the rate at which the Federal Government matched the original expenditures. (CMS's *State Medicaid Manual*, § 2500.1(B).) (OAS; W-00-14-31457; various reviews; expected issue date: FY 2015*)*

➢ State use of incorrect FMAP for Federal share adjustments

We will review States' Medicaid claims records to determine whether the States used the correct FMAP when processing claim adjustments reported on 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-00-14-31460; various reviews; expected issue date: FY 2015)

State Program Integrity Activities and Compliance With Federal Requirements

➢ 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 its Medicaid Integrity Program (MIP) activities, 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 DRA, § 6034. (OEI; 00-00-00000; expected issue date: FY 2016)

➢ State terminations of providers terminated by Medicare or by other States

We will review States' compliance with a new requirement that they terminate their Medicaid program providers that have been terminated under Medicare or by a Medicaid program of another State. We will determine whether such providers are terminated by all State Medicaid programs in which they are enrolled, 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. The new requirement became effective January 1, 2011. (Social Security Act, § 1902(a)(39), as amended by the ACA, § 6501.) (OEI; 06-12-00030; expected issue date: FY 2015; ACA)

➢ Recovering Medicaid overpayments—Credit balances in Medicaid patient accounts

We will review providers' patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances. Previous OIG work found Medicaid overpayments in patients' accounts with credit balances. Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed, such as when a provider receives a duplicate payment for the same service from the Medicaid program or another third party payer. In such cases, the provider should return the overpayment to the Medicaid program. When there is more than one payer, Medicaid is the payer of last resort. (Social Security Act, § 1902(a)(25); 42 CFR Part 433, Subpart D; various State laws; and CMS's *State Medicaid Manual*, Pub. No. 45, Part 3, § 3900.1.) (OAS; W-00-13-31311; various reviews; expected issue date: FY 2015)

➢ State and CMS collection and verification of provider ownership information

We will determine the extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. We will also review States' and CMS's practices for collecting and verifying provider ownership information. Finally, we will test the accuracy and completeness of ownership information by comparing ownership information sampled providers gave to CMS to enroll in Medicare to the ownership information the same providers gave to OIG and to the States to enroll in Medicaid. 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 controlling interest in the provider entity. (see e.g., 42 CFR § 455.104 and 42 CFR § 420.206.) (OEI; 04-11-00590, 04-11-00591; expected issue date: FY 2015)

➢ States' experiences with enhanced provider screening

We will review States' use of enhanced screenings that assess risk for fraud, waste, and abuse for moderate- and high-risk enrolling and revalidating Medicaid providers and suppliers. We will also determine the results of States' efforts to prevent risky providers and suppliers from participating in Medicaid before and after the implementation of enhanced screenings. The ACA, § 6402, requires enhanced screening for providers and suppliers seeking initial enrollment, reenrollment, or revalidation in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). States are responsible for employing screening and revalidation procedures for their Medicaid and CHIP providers. (OEI; 05-13-00520; expected issue date: FY 2016; ACA)

➢ Provider payment suspensions during pending investigations of credible fraud allegations

We will review payments to providers with allegations of fraud deemed credible by States. We will also review States' processes for suspending payments. FFP in Medicaid is not available for items or services furnished by an individual or entity when the State has failed to suspend payments during a period when there is a credible allegation of fraud. (Social Security Act, § 1903(i)(2), as amended by the ACA, § 6402(h)(2).) Upon determinations that allegations of fraud are credible, States must suspend all Medicaid payments to the providers, unless the States have good cause to not suspend payments or to suspend payment only in part. (42 CFR § 455.23(a).) States are required to make fraud referrals to Medicaid Fraud Control Units (MFCUs) or to appropriate law enforcement agencies in States with no certified MFCUs. (42 CFR § 455.23(d).) We will determine whether select Medicaid State agencies are in compliance with these provisions. (OAS; W-00-14-31473; various reviews; expected issue date: FY 2015; and OEI; 09-14-00020; expected issue date: FY 2015; ACA)

OIG Oversight of State Medicaid Fraud Control Units

➢ Reviews of State Medicaid Fraud Control Units

We will continue to conduct indepth onsite reviews of the management, operations, and performance of a sample of MFCUs. We will identify effective practices and areas for improvement in MFCU management and operations. As part of its responsibility for administering Federal grants to MFCUs, OIG provides oversight and guidance to MFCUs, assesses MFCU compliance with Federal regulations and policy, and evaluates MFCU performance under established performance standards. The onsite reviews are part of OIG's program of oversight for MFCUs that includes annual recertification, training, and collection and reporting of statistical information. (OEI; 00-00-00000; various reviews; expected issue date: FY 2015)

Medicaid Information System Controls and Security

Acronyms and Abbreviations for Selected Terms:

CMS—Centers for Medicare & Medicaid Services
MSIS—Medicaid Statistical Information System
NCCI—National Correct Coding initiative

Controls To Prevent Improper Medicaid Payments

➢ Duplicate payments for 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 identify States' procedures or other controls for preventing such payments. A preliminary data match 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. (OAS; W-00-14-31374; various reviews; expected issue date: FY 2015)

➢ National Correct Coding Initiative edits and CMS oversight

We will review selected States' implementation of National Correct Coding initiative (NCCI) edits for Medicaid claims and describe CMS's oversight of NCCI edits. The NCCI consists of coding policies and automatic computer edits. The NCCI's original purpose was to promote correct coding of health care services provided to Medicare beneficiaries and to prevent payment for improperly coded services. Federal law required States to incorporate methodologies compatible with NCCI for Medicaid claims filed on or after October 1, 2010. (Social Security Act, § 1903(r), as amended by the ACA, § 6507.) States were permitted to deactivate some or all NCCI edits because of conflicts with State laws, regulations, administrative rules, payment policies, and/or the States' levels of operational readiness. (State Medicaid Director Letter #10-017.) As of April 1, 2011, lack of operational readiness was no longer a permissible basis for deactivation of the edits. (State Medicaid Director Letter #11-003.) After April 1, 2011, the only basis for deactivation is conflicts with State laws, regulations, administrative rules, and/or payments policies. (OAS; W-00-15-31459; various reviews; expected issue date: FY 2015; and OEI; 09-14-00440; expected issue date: FY 2016, ACA)

Controls To Ensure the Security of Medicaid Systems and Information

➢ CMS oversight of States' Medicaid information systems security controls

We will determine the adequacy of CMS's oversight of States' Medicaid system and information security controls, including the policies, technical assistance, and security and operational guidance provided to the States. For selected States, we will use OIG's automated assessment tools to assess controls for their information system networks, databases, Web-facing applications, logical access, and wireless access. We will also review general controls, such as disaster recovery plans and physical security. Prior OIG audits reported that States lack sufficient security features, potentially exposing Medicaid beneficiary health information to unauthorized access. State system controls for Medicaid data and transactions have not been consistently applied and have not been adequately monitored by CMS pursuant to Federal requirements for Automated Data Processing System Security and Review (45 CFR § 95.621(f).) CMS is responsible for ensuring that appropriate security controls have been implemented. (OAS; W-00-14-40019; W-00-15-40019; various reviews; expected issue date: FY 2015)

➢ **NEW** Completeness of data in Transformed Medicaid Statistical Information System: early implementation

We will determine whether States are submitting complete Transformed Medicaid Statistical Information System (T-MSIS) data. T-MSIS is designed to be a detailed national database of Medicaid and Children's Health Insurance Program information to cover a broad range of user needs, including program integrity. It is a continuation of CMS's past attempts to improve nationally available Medicaid data after OIG and others found that the data were not complete, accurate, or timely. (OEI; 05-15-00050; expected issue date: FY 2016)

Medicaid Managed Care

Managed care is a health delivery system that aims to maximize efficiency by negotiating rates, coordinating care, and managing the use of services. State Medicaid agencies contract with MCOs to provide comprehensive health services in return for a fixed, prospective payment (capitated payment) for each enrolled beneficiary.

Acronyms and Abbreviations for Selected Terms:

ACA—Affordable Care Act
CMS—Centers for Medicare & Medicaid Services
GAO— Government Accountability Office
MCO—managed care organization
MSIS—Medicaid Statistical Information System
OMB—Office of Management and Budget

State Payments to Managed Care Entities

➢ Medicaid managed care reimbursement

We will review States' managed care plan reimbursements to determine whether MCOs are appropriately and correctly reimbursed for services provided. We will ensure that the data used to set rates are reliable and include only costs for services covered under the State plan as required by or costs of services authorized by CMS. (42 CFR §438.6(e).) Also, we will verify that payments made under a risk-sharing mechanism and incentive payments made to MCOs are within the limits set forth in Federal regulations. (42 CFR § 438.6(c)(5)(ii) and 42 CFR § 438.6(c)(5)(iii) and (iv).) Previous work by the GAO found that CMS's oversight of States' rate-setting required improvement and that States may not audit or independently verify the MCO-reported data used to set rates. (GAO-10-810.) (OAS; W-00-14-31471; various reviews; expected issue date: FY 2015)

➢ Medical loss ratio

We will review States and managed care plans without contract provisions that require a minimum percentage of total costs to be expended for medical services (medical loss ratio) to determine the extent of potential Medicaid program savings if the States had required Medicaid MCOs to meet the medical loss ratio standards established by the ACA. The ACA established standards for the amount of premium revenue that certain commercial health insurers and Medicare Advantage plans can spend on costs other than health care-related expenses and provide rebates to enrollees if the minimum standards are not met. While the standards established by the ACA do not apply to Medicaid, some States have applied similar standards to their contracts with Medicaid MCOs and require the MCOs to issue rebates to the appropriate Medicaid State agencies if the insurers do not meet minimum MLR standards. The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. (OAS; W-00-13-31372; various reviews; expected issue date: FY 2016)

➢ MCO payments for services after beneficiaries' deaths

We will identify Medicaid managed care payments made on behalf of deceased beneficiaries. We will also identify trends in Medicaid claims with service dates after beneficiaries' dates of death. Prior OIG reports have found that Medicare paid for services that purportedly started or continued after beneficiaries' dates of death. (OAS; W-00-15-31497; expected issue date: FY 2016)

➢ MCO payments for ineligible beneficiaries

We will identify Medicaid managed care payments made on behalf of beneficiaries that were not eligible for Medicaid. We will also identify trends in Medicaid claims within this population. Section 1903(m) of the Social Security Act authorizes payments to States for eligible Medicaid beneficiaries enrolled in an MCO. Prior OIG work has found that Medicaid paid for services that purportedly started or continued during periods when the beneficiary was not eligible for Medicaid. (OAS; W-00-15-31498; expected issue date: FY 2016)

Data Collection and Reporting

➢ State reporting of managed care encounter data

We will determine the extent to which complete Medicaid managed care encounter data are reported to the Medicaid Statistical Information System (MSIS). We will also identify factors that enable States and Medicaid managed care entities to collect and report MSIS encounter data or prevent them from performing these functions. Finally, we will assess CMS's oversight of the reporting of MSIS encounter data. 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 MCOs to submit data elements deemed necessary by the Secretary for use in program integrity, program oversight, and administration. (ACA, § 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; 07-13-00120; expected issue date: FY 2015; ACA)

Program Integrity in Managed Care

➢ Medicaid managed care entities' identification of fraud and abuse

We will determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents. We will also describe how States oversee MCOs' efforts to identify and address fraud and abuse. A prior OIG report revealed 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 MCOs and States are taking steps to address fraud and abuse in managed care and they remain concerned about their prevalence. 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. (OEI; 02-15-00260; expected issue date: FY 2016)

Beneficiary Protections in Managed Care

➢ Medicaid managed care beneficiary grievances and appeals process

We will review the extent to which States monitor Medicaid MCOs' 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 managed care entities 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).) (OEI; 00-00-00000; expected issue date: FY 2016)

➢ Oversight of 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 MCOs' marketing practices and compliance with Federal and State contractual marketing requirements. We will also determine the extent to which CMS ensures that States comply with Federal requirements involving Medicaid MCO marketing practices. No marketing materials may be distributed by Medicaid MCOs without first obtaining States' approval. (Social Security Act, § 1932(d)(2).) States are permitted to impose additional requirements in contracts with MCOs about marketing activities. (42 CFR § 438.104.) (OEI; 00-00-00000; expected issue date: FY 2016)