

Office of  
Inspector  
General

# Medicaid Integrity Program Report for Fiscal Year 2012



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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

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Office of Inspector General  
Medicaid Integrity Program Report for Fiscal Year 2012

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## Office of Inspector General Medicaid Integrity Program Report for Fiscal Year 2012

### FY 2012 Funding for Medicaid Integrity Activities

During fiscal year (FY) 2012, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) used funding from two sources to oversee the integrity of Medicaid activities: the Health Care Fraud and Abuse Control (HCFAC) program, created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Medicaid Integrity Program (MIP), created by the Deficit Reduction Act of 2005 (DRA). Following are descriptions of each funding source.

**Health Care Fraud and Abuse Control Program.** The HCFAC program was established by HIPAA to be under the joint direction of the Attorney General and the Secretary of HHS, acting through the Inspector General. Funds are appropriated in amounts that the Secretary and Attorney General jointly certify as necessary to finance antifraud activities, up to ceilings fixed by the legislation. Certain of these funds are, by law, set aside for OIG “activities ... with respect to Medicare and Medicaid.”<sup>1</sup> HIPAA also requires the Attorney General and the Secretary of HHS to submit a joint annual report to Congress identifying expenditures and accomplishments under the law (Social Security Act, § 1817(k)(5)). These reports are available on the Web sites of both agencies at: <http://www.oig.hhs.gov/publications/hcfac.asp> and <http://www.usdoj.gov/dag/pubdoc.html>.

Since FY 1997, the HCFAC program has been the primary source of funding for Medicare and Medicaid fraud investigations and prosecutions by OIG and the Department of Justice (DOJ). Beginning in FY 2009, OIG began receiving discretionary funding in support of HCFAC-related activities to provide additional resources for program integrity work.

**Medicaid Integrity Program.** Section 6034 of the DRA established the MIP, through which OIG received enhanced funding for fraud and abuse control activities “with respect to the Medicaid program” (section 6034(c)). This funding was provided annually from FY 2006 through FY 2010 in addition to OIG’s HCFAC resources and is available until expended. In FY 2012, MIP funds were still available. Specific DRA requirements that pertain to OIG are described in Appendix C.

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<sup>1</sup> Social Security Act, § 1817(k)(3)(A).

## Overlap in Oversight Activities

Because there is an overlap among the oversight activities funded by HCFAC, MIP, and other sources, our work relating to Medicaid may draw on funding from more than one source. For investigations and prosecutions, it is particularly difficult (sometimes impossible) to accurately segregate enforcement activities by funding stream. For example, even if we conduct an investigation exclusively with MIP funds, the prosecution of that case could draw upon DOJ's HCFAC funding and the matter would be reportable pursuant to the requirements of both HCFAC and MIP. An overlap could also occur when an investigation involves fraud in Medicaid and other Federal health care programs, such as Medicare, as is often the case. For these reasons, this document does not artificially divide accomplishments among funding sources; our Medicaid successes are typically the result of combined funding from available resources.

Our audit, evaluation, and investigation work often requires more than a year to yield results. As a consequence, many of the reviews and investigations summarized in this document reflect the results of our work over several years that culminated in FY 2012.

## Allocation of Statutory Funding Streams

Allocation of Statutory Funding Streams for  
 Medicaid Integrity Oversight, FY 2006 – FY 2012  
 (Dollars in Millions)

Fiscal Year	Funding Appropriated to OIG for Health Care Oversight		Estimated OIG Obligations for Medicaid Oversight		Estimated Total OIG Obligations for Medicaid Oversight	Estimated Percentage of OIG Health Care Oversight Obligations for Medicaid Integrity
	HIPAA/ HCFAC	MIP & Other	HIPAA/ HCFAC	MIP & Other		
2006	\$160	\$25	\$45	–	\$45	28 %
2007	\$166	\$25	\$25	\$29	\$53	28 %
2008	\$170	\$25	\$33	\$29	\$62	31 %
2009	\$196	\$81	\$34	\$31	\$65	29 %
2010	\$209	\$25	\$42	\$34	\$76	32%
2011	\$228	\$0	\$37	\$38	\$76	28%
2012	\$226	\$0	\$53	\$19	\$72	28%

Note: Numbers have been updated and are approximate because of rounding.

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

## FY 2012 Medicaid Activities and Results

Following are key Medicaid-related congressional testimonies, audit and evaluation reports, and investigative outcomes that were included in the OIG spring and fall *Semiannual Reports to Congress* for FY 2012. The *Semiannual Reports* summarize in 6-month increments significant OIG activities and outcomes related to at-risk HHS programs and management issues. The *Semiannual Reports* and corresponding audit and evaluation reports are available on OIG's Web site at <https://oig.hhs.gov>. (See Appendix A of this document for a complete list of Medicaid reports issued in FY 2012.)

### OIG Participation in FY 2012 Medicaid-Related Congressional Hearings

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**9-20-2012**

John Hagg, Director of Medicaid Audits, testified before two subcommittees of the U.S. House of Representatives Committee on Oversight and Government Reform on Medicaid payment rates for State-operated developmental centers in New York. [Testimony](#).



*John Hagg,  
Director, Medicaid Audits*

**6-14-2012**

Ann Maxwell, Regional Inspector General for Evaluation and Inspections, testified before the U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, on saving taxpayer dollars by curbing waste and fraud in Medicaid. [Testimony](#).



*Ann Maxwell,  
Regional Inspector General  
for Evaluation and  
Inspections*

**12-07-2011**

Gary Cantrell, Deputy Inspector General for Investigations, testified before the U.S. House of Representatives Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency and Financial Management, and Subcommittee on Health Care, District of Columbia, Census and the National Archives. Mr. Cantrell summarized OIG's efforts to combat Medicaid fraud. [Testimony](#)



*Gary Cantrell,  
Deputy Inspector General  
for Investigations*

## Medicaid-Related Beneficiary Safety and Quality-of-Care Issues

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As purchasers of health care, Medicare and Medicaid face challenges in ensuring quality of care for their beneficiaries. Despite increased attention to patient safety, administrative, civil, and criminal problems persist.

### Quality of Care for Waiver Program Beneficiaries

**Additional Federal Guidance, Onsite Reviews, Other Oversight Measures Needed.** Of 25 States we reviewed, 7 States did not have adequate systems to ensure the quality of care provided to beneficiaries of the States' home and community-based services (HCBS) waiver programs. Although the Centers for Medicare & Medicaid Services (CMS) renewed the waiver programs in all seven of these States, three did not adequately correct identified problems. Not only did the States fail to correct the problems before renewal of their programs, but also they had not adequately addressed the problems long after renewal. Also, CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care. States must operate their HCBS waiver programs in accordance with certain "assurances," including three related to quality of care. To meet these assurances, States must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Recommendations—CMS should provide additional guidance to States for meeting the required assurances, require States that do not meet one or more assurances to develop corrective action plans, require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits, develop a broader array of approaches to ensure compliance with each of the assurances, and make information about State compliance with the assurances available to the public. *Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs*. [OEI-02-08-00170](#). June 2012.

### Vaccines for Children Mismanaged in Storage

**Vulnerabilities in Vaccine Storage and Management Threaten Efficacy.** A June 2012 report revealed that providers in the Vaccines for Children (VFC) program exposed vaccines in storage to inappropriate temperatures, which could reduce vaccine potency and efficacy, increasing the risk that children are not provided with maximum protection against preventable diseases. The VFC program is a Medicaid benefit that provides free vaccines to eligible children. CMS delegates the program's implementation to the Centers for Disease Control and Prevention (CDC), which purchases VFC vaccines and distributes them to VFC providers. We found that vaccines stored by 76 percent of 45 selected providers were exposed to inappropriate temperatures for at least 5 cumulative hours. We also found expired vaccines stored together with nonexpired vaccines, increasing the risk of mistakenly administering the expired vaccine. The selected providers generally did not meet vaccine management requirements or maintain required documentation.

Recommendations—CDC should work with VFC grantees and providers to ensure that VFC vaccines are stored according to requirements; that expired vaccines are identified and separated from nonexpired vaccines; that grantees better manage providers' vaccine inventories; and that grantees meet oversight requirements. *Vaccines for Children Program: Vulnerabilities in Vaccine Management*. OEI-04-10-00430. June 2012.

## Nursing Home Services Found Worthless

**Georgia – Nursing Home Operator Sentenced to 20 Years for Providing Worthless Services.** Former nursing home operator George Houser was sentenced to 20 years of incarceration and ordered to pay \$6.7 million in restitution after being convicted of submitting claims to Medicare and Georgia Medicaid for services provided to residents that were so deficient the judge determined them to be “worthless.” During the trial, witnesses testified that there were food shortages, leaking roofs, virtually no nursing or housekeeping supplies, poor sanitary conditions, major staff shortages, and serious safety concerns at the three nursing homes that Houser and his wife owned and operated. This is the first time that a defendant has been convicted after a trial in Federal court of submitting claims for payment for worthless services.

## Medicaid Wasteful Spending

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The reports in this section describe the wasteful spending that occurs when Federal or State Medicaid laws, policies, and methodologies fail to ensure that program costs are consistent with efficiency and economy; reasonableness; and Medicaid's role as a high-volume, prudent insurer/payer in the health care marketplace.

### Developmental Centers—Excessive Daily Rates (New York)

**New York's Rate-Setting Methodology for State-Operated Developmental Center Reimbursement Was Inconsistent With Efficiency and Economy.** The Medicaid daily rate for 15 selected State-operated Intermediate Care Facilities (ICF) for individuals with intellectual and developmental disabilities (developmental centers) was more than nine times the average daily rate for all other State-operated and privately operated ICFs in State FY (SFY) 2009. If New York had used prior year actual costs as the starting point in its rate methodology instead of its current method, the Federal Government might have saved over \$700 million in reimbursements in SFY 2009. The daily rate for the selected developmental centers grew to \$4,116 per day in SFY 2009—the equivalent of \$1.5 million per year for one Medicaid beneficiary. The growth occurred because the State's rate-setting methodology significantly inflated the Medicaid daily rate for the developmental centers and CMS did not prevent the rate from increasing to its current levels.

Recommendation—CMS should ensure that New York's Medicaid daily rate methodology for State-operated developmental centers meets the Federal requirement that payment for services be consistent with efficiency and economy. On the basis of this report and previous audits of payments to public providers in other States, OIG reiterated in [testimony](#) before a congressional committee that payments to public providers should be limited to the actual cost of providing services. *Medicaid*

*Rates for New York State-Operated Developmental Centers May Be Excessive.* [A-02-11-01029](#). May 2012. [Testimony](#).

## Prescription Drugs—Multitier Strategy Would Fine-Tune Medicaid Pricing

**States' Pharmacy Reimbursement Methodologies Did Not Always Reflect Pharmacies' Actual Costs for Major Categories of Drugs.** States could better approximate pharmacies' actual costs of drugs by developing separate reimbursement methodologies for major categories of drugs, i.e., single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs. Numerous OIG reviews have found that the basis that States historically used for Medicaid drug reimbursements did not represent pharmacies' actual costs to acquire drug ingredients. As a result, States often have overreimbursed pharmacies for those costs. This review evaluated the relationships between three recognized pricing benchmarks and pharmacy invoice prices for Medicaid-reimbursed drugs and found variations depending on whether the drugs were brand-name or generic.

Recommendation—CMS should encourage States to use the results of this review when considering changes to pharmacy reimbursement methodologies, including methodologies for the major categories of drugs. *Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices.* [A-06-11-00002](#). October 2011.

## Prescription Drug Rebates—Medicaid Managed Care

**Some States Did Not Collect All the Manufacturer Rebates They Are Due.** The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) expanded the Medicaid rebate requirement to include drugs paid for through managed care organizations (MCOs). To realize the full savings under the expansion, States must implement processes to collect accurate drug utilization data from MCOs and invoice and collect rebate payments from manufacturers. Of 22 States we identified that paid for prescription drugs through MCOs during our period of review, 10 did not invoice manufacturers and collect the rebates they were due. The actions were not taken because, for example, States had to complete programming changes to the systems that process MCO claims.

Recommendation—CMS should follow up with the 10 States that had not collected rebates for drugs dispensed to Medicaid MCO beneficiaries and take action to enforce rebate collection if necessary. *States' Collection of Medicaid Rebates for Drugs Paid Through Medicaid Managed Care Organizations.* [OEI-03-11-00480](#). September 2012.

## Improper State Claims for Federal Reimbursement

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States and the Federal Government jointly fund Medicaid. States sometimes inadvertently or inappropriately cause the Federal Government to pay more than its correct share of Medicaid costs. This condition typically occurs when States pay too much on the basis of improper billings by providers or suppliers. Billings are considered improper when, for example, required documentation in patients' medical files is missing or insufficient; the items or services billed were not medically necessary; the services were not provided; the billings contained errors, such as miscoding; or other

State or Federal requirements for payment were not met. States do not always readily identify such problems before claiming Federal reimbursement. States may also improperly claim Federal reimbursement for other types of costs, such as administrative costs, for which requirements are not met, or they may claim Federal reimbursement at the wrong rates. Following are reports issued in FY 2012 that revealed improper State claims for Federal reimbursement.

## HCBS Waivers—Room-and-Board Costs (South Carolina)

**Unallowable Room-and-Board Costs Claimed by South Carolina.** South Carolina improperly claimed about \$4.8 million (Federal share) of unallowable room-and-board costs under an HCBS intellectual and related disabilities waiver program. The State's controls were inadequate to ensure that applicable Federal law and State guidance were followed. The State did not detect errors or misstatements on local participating entities' cost reports. Also, the State did not prescribe a uniform format for the local entities to follow when preparing cost reports. Rather, each local entity prepared its cost reports in its own format, making it difficult to identify when unallowable costs were claimed.

**Recommendations—**South Carolina should refund to the Federal Government the improperly claimed \$4,832,975 Federal share. The State should remove room-and-board-related administrative and general costs from future waiver program cost reports, develop a uniform cost reporting process and require that participating entities follow the process, and strengthen cost report review procedures. *South Carolina Claimed Some Unallowable Room and Board Costs Under the Intellectual and Related Disabilities Waiver.* [A-04-11-04012](#). September 2012.

## HCBS Waivers—Noncompliant Providers (New Jersey, New York)

**Individual Plans of Care, Documentation, Insufficient Policies and Procedures.** Three reports revealed that claims for Federal reimbursement for Medicaid HCBS in New Jersey and New York were unallowable because they did not meet certain Federal and State requirements. Policies and procedures for overseeing and administering the waiver programs were not adequate to ensure that providers claimed reimbursement only for services actually provided and maintained all the required documentation to support the services billed and to ensure that waiver program services were provided to beneficiaries only when rendered pursuant to written plans of care. For example, at one provider, beneficiaries' plans of care were not reviewed by a physician every 60 days, as required.

- **Recommendations—New Jersey.** Refund to the Federal Government the estimated \$60,740,637 in improperly claimed Federal reimbursements; ensure that providers bill only for documented, allowable Community Care Waiver program services that are provided only to beneficiaries for whom there are completed and approved individual habilitation plans; and ensure and document that all beneficiaries approved for services have been assessed and certified to need the designated level of care. *Medicaid Payments for Services Under New Jersey's Section 1915c Community Care Waiver.* [A-02-10-01029](#). April 2012.
- **Recommendations—New York.** Refund to the Federal Government an estimated \$7,772,807 in improperly claimed Federal share reimbursements and strengthen policies and procedures to ensure that providers bill only for services actually provided, maintain the required documentation, and provide services pursuant to written plans of care. *New York Claimed Unallowable Costs for Services by NYC Providers Under the State's Developmental Disabilities Waiver Program.* [A-02-10-01027](#). August 2012.

- Recommendations—New York. Refund the improperly claimed \$8,177,970 Federal share and improve its monitoring of the reviewed provider and its other contracted home health providers to ensure compliance with Federal and State requirements. *Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP. A-02-10-01002.* April 2012.

## Personal Care Services—Documentation, Other Errors (New Mexico, New Jersey, Missouri)

**Inadequate Certifications, Inadequate Documentation, Other Errors Associated With Provider Claims to States.** New Mexico, New Jersey, and Missouri improperly claimed Federal reimbursement for personal care services claims submitted by providers that did not comply with certain Federal and State requirements; the claims were therefore ineligible for Federal reimbursement. Examples of personal care services include, but are not limited to, meal preparation, shopping, grooming, and bathing. The deficiencies included inadequate personal care attendant qualifications and certifications; lapses in authorizations, in-service education for personal care attendants, nursing supervision, documentation of services, nursing assessments, and certification; and various documentation deficiencies, including no documentation of supervisory visits, unsupported units of service claimed, no documentation of physician authorization, and lack of State approval for personal care services provided by certain caregivers. Personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases.

- Recommendations—New Mexico. Refund to the Federal Government the estimated \$404,817 Federal share paid for unallowable personal care services and ensure that personal care services providers maintain evidence that they complied with Federal and State requirements. *Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc. A-06-09-00117.* June 2012.
- Recommendations—New Mexico. Refund to the Federal Government the Federal share, estimated at \$4,483,492, of the State's payments for unallowable personal care services and ensure that personal care services providers maintain evidence that they comply with Federal and State requirements. *Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare. A-06-09-00063.* May 2012
- Recommendations—New Mexico. Refund \$889,000 to the Federal Government and ensure that personal care services providers maintain evidence that they comply with Federal and State requirements. *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health. A-06-09-00062.* March 2012.
- Recommendations—New Jersey. Refund an estimated \$774,274 to the Federal Government and direct the provider to ensure that all of its offices comply with Federal and State requirements. *New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Nurses, Inc., in Accordance With Federal and State Requirements. A-02-10-01001.* September 2012.
- Recommendations—New Jersey. Refund \$145 million to the Federal Government and improve its monitoring of the personal care services program to help ensure compliance with Federal and

State requirements. *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey*. [A-02-09-01002](#). December 2011.

- Recommendations—Missouri. Refund an estimated \$26,953,855 to the Federal Government, implement procedures to ensure that it adequately supports the costs claimed for personal care services and maintains the supporting documentation, and improves its policies and procedures for monitoring the personal care services program for compliance with Federal and State requirements. *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims*. [A-07-11-03171](#). September 2012.

Also see OIG Portfolio: *Personal Care Services*. [OIG 12-12-01](#). November 2012.

## Continuing Day Treatment Services Improperly Claimed (New York)

**State Monitoring Did Not Ensure Compliance.** More than half of the claims for continuing day treatment (CDT) services that we reviewed did not comply with one or more of New York State's requirements for payment, resulting in unallowable Federal reimbursements. CDT is a form of clinic services performed by nonhospital providers that New York includes among its licensed outpatient programs. Providers did not properly document the type of CDT services billed, recipients' clinical progress, and/or recipients' contacts with outpatient program staff. Although the State conducts periodic onsite monitoring, its monitoring program did not ensure that providers complied with all State requirements.

Recommendations—New York should refund \$84.4 million to the Federal Government, work with the State Office of Mental Health to issue guidance to providers regarding State requirements for claiming Medicaid reimbursement for CDT services, and work with the State office to improve its monitoring of the CDT program to ensure compliance with State requirements. *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State Audit*. [A-02-09-01023](#). October 2011.

## Adult Mental Health Rehabilitation (New Jersey)

**Guidance, Monitoring Needed To Curb Deficiencies.** New Jersey improperly claimed Federal reimbursement for adult mental health rehabilitation claims that were unallowable because community residence rehabilitation providers failed to comply with Federal and State requirements. We found the following seven types of deficiencies: provider staff did not meet education and training requirements; service plan requirements were not met; the providers' staffing levels were not consistent with the required level of care or the provider claimed a higher level of care than was recommended; weekly progress notes were not documented; a registered nurse did not conduct a face-to-face visit within the required time period; services were not documented, supported, or allowable; and nursing assessment requirements were not met.

Recommendations—New Jersey should refund to the Federal Government an estimated \$30,589,719 in improper Federal reimbursements, give community residence rehabilitation providers guidance to help ensure that they comply with Medicaid State plan requirements, and improve monitoring of providers' claims to ensure compliance with Federal and State requirements. *Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey*. [A-02-09-01028](#). May 2012.

## Nonemergency Medical Transportation Services Improperly Claimed (New York)

### **New York's Policies and Procedures Did Not Ensure That Providers Complied With Requirements.**

States are required to ensure necessary transportation for Medicaid beneficiaries to and from providers. Providers in New York did not comply with Federal and State requirements for ordering, documenting, providing, and claiming such services, and New York City's social services district's quality assurance mechanism did not ensure that services were properly provided.

- Recommendations—New York State. Refund \$13.5 million to the Federal Government; strengthen policies and procedures to ensure compliance with requirements for ordering, documenting, and claiming transportation services; and require the New York State social services districts to strengthen their quality assurance mechanism to ensure that services are properly provided. *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York State.* A-02-09-01024. February 2012.
- Recommendations—New York City. Refund an estimated \$17 million to the Federal Government; resolve \$2.9 million set aside for further analysis; and strengthen policies, procedures, and quality controls. *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York City.* A-02-08-01017. November 2011.

## Family Planning—Pharmacy and Sterilization Claims (North Carolina, Wyoming, Oregon)

**Documentation, Other Requirements Not Met.** Reviews of North Carolina, Wyoming, and Oregon Medicaid revealed that the States did not always claim Medicaid family planning reimbursement for pharmacy and sterilization costs in accordance with Federal and State requirements. States furnish family planning services and supplies to individuals of childbearing age who are eligible under the State Medicaid plan and who desire such services and supplies. The Federal Government is authorized to reimburse States for expenditures in family planning services at a 90-percent enhanced rate. Claims lacked supporting documentation, and the States' controls did not ensure that costs were claimed pursuant to Federal and State requirements. Also, services provided under Oregon's Expansion Project for certain categories of individuals were unallowable for Federal reimbursement in their entirety.

- Recommendations—North Carolina. Refund to the Federal Government the pharmacy claim amounts (estimated at \$1,383,713) and sterilization claim amounts (estimated at \$3,665) that were improperly reimbursed at the enhanced rate for family planning, improve its controls to ensure that it claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning, and ensure that sterilization consent forms are completed in accordance with Federal regulations. *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement For Some Medicaid Services That Were Not Family Planning.* A-04-10-01089. June 2012.
- Recommendations—Wyoming. Refund \$1,348,942 in improper Federal reimbursements, review costs for inpatient sterilization procedures for quarterly reporting periods after our audit period and refund any overpayments, and strengthen internal controls to ensure that costs for Medicaid family planning sterilization procedures are claimed in accordance with Federal and State requirements. *Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs.* A-07-11-01100. August 2012.

- Recommendations—Oregon. Refund an estimated \$1.7 million to the Federal Government, resolve \$3 million set aside for further analysis, limit income eligibility in accordance with Federal requirements, verify clients' incomes and Social Security numbers, and strengthen controls to prevent and detect duplicate claims.) *Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project*. [A-09-11-02010](#). January 2012.

## Therapy Services—Payments Exceeded State Limits

**Improper Payments Easily Preventable.** A relatively low number of claims for therapy services were paid improperly; however, most of the errors that occurred were easily preventable. Medicaid law allows States to provide optional services—such as physical; occupational; and speech, hearing, and language (speech) therapy—through their Medicaid State plans. States may establish limits on the amount, duration, and scope of the Medicaid services they will cover, as long as each service is sufficient to reasonably achieve its purpose. State-established limits include the number of therapy services, hours of therapy services, or total dollar amount the Medicaid program will pay for each beneficiary during a certain period. All of the eight States that we selected for indepth review had safeguards to prevent payments in excess of State limits. Despite the safeguards, we identified improperly paid therapy services claims totaling approximately \$744,000 in six of the eight States. Additional claims that were potentially improper were identified in three of the eight States. Several States reported improving their program integrity safeguards to address our findings.

Recommendations—CMS should work with States to prevent Medicaid payments for therapy services in excess of State limits and follow up on the inappropriate claims identified in our review. *Medicaid Payments for Therapy Services in Excess of State Limits*. [OEI-07-10-00370](#). March 2012.

## Prescription Drugs—State Controls Over Drug Expenditures Inadequate

**Neither CMS Nor the 14 States Reviewed Had Adequate Controls To Ensure That Drug Expenditures Complied With Federal Requirements for Payment.** Cost savings to Medicaid could be realized by implementing several corrective actions that we outlined. Federal Medicaid funding is generally available for covered outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. The agreements require manufacturers to provide a list of all covered outpatient drugs to CMS quarterly. CMS includes the drugs on a quarterly Medicaid drug tape (list), makes adjustments for any errors, and sends the tape to the States. We found that manufacturers did not always provide information in a timely manner to CMS, and States generally did not use the quarterly drug tapes to determine whether a drug was eligible for coverage and did not contact CMS to determine whether a drug was eligible for coverage if it was not on the tapes. The drug tapes indicate the drugs' termination dates (if applicable), specify whether the drugs are less than effective, and include information that the States use to claim rebates from manufacturers.

Recommendations—CMS should require States to review and reject all current and prior claims for terminated drugs. It should instruct States to develop and implement controls to ensure that drug expenditures claimed for Federal reimbursement comply with all Federal requirements, report terminated drug expenditures to States quarterly, and require States to use the reports to ensure compliance. CMS should also work with drug manufacturers to ensure that the information on the quarterly drug tapes is complete and accurate and take appropriate action against manufacturers if they do not provide timely information, develop policies and procedures to inform States

immediately when a drug has been terminated, and instruct States to claim expenditures only for drugs dispensed before the termination dates. *Multi-State Review of Centers for Medicare & Medicaid Services Medicaid Drug Expenditure Controls*. [A-07-10-06003](#). October 2011.

## Part B Premiums—Claims for State-Paid Premiums (Nevada)

### **Documentation and Eligibility Issues Associated With State's Improper Part B Premium Payments.**

Nevada did not always comply with Federal requirements when claiming Federal reimbursement for Medicare Part B program premiums that it paid on behalf of Medicaid beneficiaries. Federal law allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows a participating State Medicaid program to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in Part B and to pay the monthly premiums on their behalf. The State may then claim the monthly premium expenditures for Federal reimbursement. We identified numerous improper State claims for Federal reimbursement and set aside additional amounts for resolution involving public welfare additions (i.e., individuals added to a State's buy-in list on the basis of a Social Security Administration notice to CMS that the individuals appear to be eligible for Medicaid).

Recommendations—Nevada should refund to the Federal Government \$194,891 (Federal share) of unallowable Part B premiums claimed, identify any portion of the \$878,263 in Part B premiums claimed for public welfare additions that was unallowable and refund the Federal share, identify the Part B premiums for which the State did not have adequate supporting documentation and refund the Federal share, delete ineligible individuals from the buy-in program and refund the Federal share of the Part B premiums claimed, identify ineligible individuals added through the public welfare addition procedure and take appropriate corrective action, establish procedures to reduce the number of erroneous public welfare additions, and ensure that it can support the Federal share claimed for each Part B premium. *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries*. [A-09-11-02024](#). July 2012.

## Medicare Deductibles and Coinsurance—State Plan Rates (Montana, Nebraska)

**Lack of Policies and Procedures Fostered Noncompliance.** Montana and Nebraska did not always claim Medicaid payments for Medicare deductibles and coinsurance for services whose payments are limited to State Medicaid plan rates in accordance with Federal requirements and the approved State plan. The States did not compare the Medicare payment to the State Medicaid plan rate because they did not have policies and procedures requiring them to do so.

- Recommendations—Montana (Part B). Refund to the Federal Government an estimated \$1,113,789 in unallowable Medicaid payments and develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance. *Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services*. [A-07-11-03172](#). June 2012.
- Recommendation—Nebraska (Part A). Refund an estimated \$5.5 million to the Federal Government. *Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance*. [A-07-11-03161](#). February 2012.

- Recommendation—Nebraska (Part B). Refund an estimated \$5.6 million to the Federal Government.) *Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance. A-07-11-03168*. February 2012.

## Administrative Costs—Unallowable Provider Training Costs (Pennsylvania)

**Training Activities Did Not Qualify as Administrative Costs.** Pennsylvania did not comply with Federal requirements when it claimed Medicaid administrative costs for the Pennsylvania Restraint Reduction Initiative (Initiative). The claimed costs were for training nursing home providers and not for administering the Medicaid program. CMS explicitly prohibits claiming provider training as Medicaid administrative costs. Accordingly, Pennsylvania's claims for Federal reimbursement of Initiative costs for SFYs 1996-1997 through 2010-2011 as administrative costs were unallowable. In 1996, Pennsylvania launched the Initiative to train nursing home providers to reduce the use of physical restraints in compliance with Federal regulations. The Initiative subsequently introduced provider training to address other quality-of-life issues in nursing homes.

Recommendations—Pennsylvania should refund \$3,001,536 in Federal funds for unallowable administrative costs, refund the Federal share of unallowable Initiative costs claimed as administrative costs after our audit period, and discontinue all future claims of such costs. *Pennsylvania Claimed Medicaid Administrative Costs for Provider Training Under Its Restraint Reduction Initiative. A-03-11-00209*. July 2012.

## Administrative Costs—Unallowable Salaries, Operating Costs, Other Issues (New Jersey)

**Policy, Procedures Lacking; Calculations, Documentation Noncompliant.** In FYs 2005 and 2006, New Jersey included unallowable salaries and operating costs in the cost pool used to compute its Medicaid administrative claim. The State improperly claimed Federal Medicaid reimbursement for the cost of Medicaid administrative activities performed by staff of contracted community mental health providers. In addition, the contractor that computed the Medicaid costs assigned Medicaid-reimbursable random moment time study (RMTS) codes to workers' activities that were not allowable or could not be documented as related to Medicaid and performed an RMTS that deviated from acceptable statistical sampling practices. Also, the State used Medicaid eligibility rates that could not be documented. Similar issues were found in FY 2007.

- Recommendations—New Jersey 2005, 2006. Refund \$22.5 million to the Federal Government, maintain supporting documentation for Medicaid-reimbursable activities, ensure that future calculations follow acceptable cost principles and CMS requirements, and maintain supporting documentation for Medicaid eligibility rates used in computations. *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006. A-02-08-01009*. March 2012.
- Recommendations—New Jersey 2007. Refund \$5 million to the Federal Government, resolve \$8 million in Medicaid administrative costs set aside for further analysis, establish policies and procedures to follow acceptable statistical sampling practices, and maintain supporting documentation for rates used. *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Year 2007. A-02-07-01050*. November 2011.

## Improper Claims for Individuals Concurrently Enrolled in Medicaid and the Children’s Health Insurance Program (Alabama)

**Alabama Improperly Claimed the Federal Share for Concurrently Enrolled Individuals.** The Children’s Health Insurance Program (CHIP) allows States to provide health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. Alabama improperly claimed the Federal share of CHIP costs for individuals who had Medicaid or other health insurance coverage from October 1, 2009, through September 30, 2010. States may not claim a Federal share of CHIP costs for individuals who are concurrently enrolled in CHIP and Medicaid or who have other health insurance coverage. Alabama’s internal controls were not adequate to prevent or promptly correct concurrent enrollments. The errors occurred because State policy allowed for a coordination of benefits between CHIP and other health insurance coverage.

**Recommendations—**We recommend that Alabama refund \$1.5 million for the Federal share of costs claimed on behalf of individuals who were concurrently enrolled in CHIP and Medicaid, refund \$153,000 (Federal share) for costs claimed on behalf of individuals enrolled in CHIP who had other health insurance coverage, develop additional policies and procedures to prevent or promptly recoup CHIP payments made on behalf of individuals who are identified as enrolled concurrently in Medicaid, and revise the current policy that allows for a coordination of benefits between CHIP and other health insurance coverage. *Alabama Improperly Claimed Federal Funds for Children’s Health Insurance Program Enrollees Who Had Medicaid or Other Health Insurance Coverage.* [A-04-11-08008](#). September 2012.

## Improper Quarterly Statements and Adjustments

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States’ failure to report accurate data or make required quarterly adjustments may also cause the Federal Government to pay more than its correct share of Medicaid costs. States report Medicaid expenditures to CMS on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The report must be submitted to CMS within 30 days after the end of each quarter. This form shows Medicaid expenditures for the quarter being reported and any prior-period adjustments. It accounts for overpayments, underpayments, and refunds received by the State.

### Adjustments Made at Improper Rate (Maine)

**Incorrect Rate Applied to Adjustments.** Maine did not always use the correct Federal share percentage when processing claim adjustments reported on the Form CMS-64. The Federal Government reimbursed Maine \$166 million (Federal share) for 1 million Medicaid claims that the State originally paid and subsequently adjusted through the Form CMS-64 for calendar years 2005 through 2009. Of that amount, \$9,179,777 was incorrect. Errors occurred when the State subsequently processed entirely new claims, including the adjustment amounts, as current expenditures at the current rate.

**Recommendations—**Maine should refund to the Federal Government \$9,179,777 it improperly claimed for Medicaid claim adjustments and ensure that it processes future adjustments using the correct rate. *Maine Did Not Always Make Correct Medicaid Claim Adjustments.* [A-01-12-00001](#). July 2012.

## Calculation, Documentation Errors (Virgin Islands)

**Calculations Improper and Documentation Not Properly Retained.** The U.S. Virgin Islands claimed Federal Medicaid reimbursement for expenditures that were improperly calculated because employees lacked policies and procedures for correctly preparing the Form CMS-64. The amounts claimed were not adequately documented by reported expenditures. Supporting documentation could not be located because a record retention policy had not been established.

Recommendations—The Virgin Islands should refund to the Federal Government \$393,316 in improperly calculated expenditures and establish policies and procedures for correctly preparing Form CMS-64. *Review of Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in the U.S. Virgin Islands for the Quarter Ended September 30, 2009.* [A-02-11-01004](#). April 2012.

## Adjustments for Excess Contractor Profits (Texas)

**Federal Share Understated and Required Project Approvals Not Obtained.** A review of Form CMS-64 reports that Texas submitted to CMS revealed that Texas did not correctly report a Medicaid Management Information System (MMIS) contractor's profits that were in excess of the 11 percent allowed by the contract. The State's calculation erroneously understated the Federal share of the excess profits.

Although other sampled MMIS expenditures Texas claimed for Federal reimbursements were allowable and were claimed at the appropriate reimbursement rates, Texas did not obtain required prior approvals from CMS for two projects in the sample. The projects included designing, developing, and operating the MMIS. Federal regulations require States to seek prior approval from CMS to claim Federal reimbursement for MMIS project costs estimated to exceed certain thresholds. We also identified 16 other projects, which were not in the sample, that did not have the required approvals.

Recommendations—Texas should refund \$2,634,568 related to the Federal share of excess contractor profits; obtain retroactive approval for the projects that did not have the required prior Federal approval from CMS; and ensure that prior approval is obtained on future projects, as required by Federal regulations. *Texas Did Not Report Excess Contractor Profits in Accordance With Federal Regulations.* [A-06-10-00062](#). August 2012.

## Adjustments for State Collections of Overpayments (Delaware)

**Collections Understated and Federal Share Miscalculated.** Delaware did not comply with Federal requirements to report all Medicaid overpayment collections. State officials said that they believed the overpayments had been netted out of reported Medicaid expenditures but did not provide support for such adjustments. The State did not properly report its collections for Medicaid overpayments because it did not develop and implement effective internal controls to ensure accurate reporting on Form CMS-64. Also, Delaware reported on Form CMS-64 collections for overpayments that it identified as recoveries resulting from fraud and abuse investigations but calculated a Federal share based on an incorrect rate. Using the correct rate, the State should have reported a higher Federal share.

Recommendations—Delaware should include \$16,272,518 of unreported Medicaid overpayment collections on the next Form CMS-64 and refund \$10,080,378 to the Federal Government, identify and report any unreported Medicaid overpayments collected before and after our audit period, account for the incorrectly calculated Federal share for the collections resulting from fraud and abuse investigations by refunding \$2,391, apply the correct rate when reporting Medicaid overpayments on Form CMS-64, and develop and implement internal controls that will enable the State to correctly report and refund the Federal share of Medicaid overpayments on Form CMS-64. *Delaware Did Not Comply With Federal Requirements To Report All Medicaid Overpayment Collections.* [A-03-11-00203](#). June 2012.

## Overpayments Not Fully Reported (New Jersey)

**Not All Overpayments Are Correctly Reported.** For Federal FYs 2008 and 2009, New Jersey did not report Medicaid overpayments totaling \$2.8 million (\$1.4 million Federal share) in accordance with Federal requirements. Federal law requires the State to refund the Federal share of Medicaid overpayments at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment. Of the 180 overpayments we reviewed, 14 were only partially reported or not reported on Form CMS-64. The remaining 166 were reported correctly. The State also did not report all Medicaid provider overpayments within the 60-day time requirement. The State did not properly report these overpayments because it had not developed and implemented policies to ensure that overpayments were reported correctly on Form CMS-64.

Recommendations—New Jersey should include unreported Medicaid overpayments of \$2,812,968 on the CMS-64, refund \$1,406,486 to the Federal Government, and develop and implement policies to ensure that future Medicaid overpayments are reported on the correct Form CMS-64 in accordance with Federal requirements. *New Jersey Generally Reported Medicaid Overpayments in Accordance With Federal Regulations.* [A-02-10-01009](#). September 2012.

## Federal Share of Collections Improperly Retained (Multiple States)

**Federal Share of Medicaid Collections To Be Recalculated in 35 States.** We identified 35 States that improperly retained the Federal share of collections (e.g., from overpayments to providers), which reduce States' expenditures in calculating the Federal share. Effective with the quarter ending December 31, 2008, the American Recovery and Reinvestment Act of 2009 (Recovery Act) temporarily increased the percentage of State Medicaid expenditures paid by the Federal Government. When CMS calculated the additional funding for the first Recovery Act quarter, it did not include States' collections in that calculation. As a result, States improperly retained increased funding. CMS retroactively provided additional Federal funds for the first Recovery Act quarter by applying the increased percentage to expenditures each State had already submitted. A CMS official stated that recalculating the Federal share of collections using the Recovery Act rate was the States' responsibility.

Recommendations— CMS should recoup from 35 States \$25,012,996 in retained funding; review States' Federal share calculations for collections reported in subsequent Recovery Act quarters and recoup any overpayments related to the Recovery Act rate; and emphasize that States should calculate the Federal share of collections for which they originally received amounts calculated at higher, fixed-reimbursement percentages using those same percentages. *States Inappropriately*

*Retained Federal Funds Related to Medicaid Collections for the First Recovery Act Quarter.* [A-06-11-00064](#). June 2012.

## Improper Reporting of Overpayments and Collections (Illinois, Oklahoma)

**Errors Found in the Reporting of Overpayments and Collected Amounts.** Pursuant to Federal law and the “applicable credit” provisions of Office of Management and Budget Circular A-87, the Federal share of recovered overpayments or other collections must be credited to the Federal award in the quarter in which they are collected. Two reports below demonstrate State errors in the reporting of uncollected overpayments (Illinois) and collected amounts (Oklahoma). Illinois did not report 24 of the 27 overpayments we reviewed because of its unwritten policy of reporting overpayments not involving fraud or abuse when the provider appeals process was completed, rather than at the end of the 60-day period following discovery. Oklahoma did not properly report collections associated with probate amounts and with fraud and abuse collections. Oklahoma inappropriately subtracted probate collection amounts from its worksheet calculation because State officials incorrectly believed that probate collections were associated with adjusted claims and wanted to avoid duplicate reporting. Also, the State did not report the entire amount of its fraud and abuse collections. In other instances, the State underreported and overreported the Federal share of collections and applied incorrect share percentages.

- Recommendations—Illinois. Include the unreported Medicaid overpayments we identified in its quarterly report to CMS, refund an estimated \$9 million to the Federal Government, and ensure that future Medicaid overpayments that are in the appeals process are reported in accordance with Federal requirements. *Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64.* [A-05-11-00052](#). January 2012.
- Recommendations—Oklahoma. Refund an estimated \$14.8 million to the Federal Government; resolve \$435,000 in unsupported adjusted claims we set aside for further analysis; ensure that documentation requirements are met; and establish review procedures to ensure that collections are correctly compiled, assigned, and reported. *Review of Oklahoma Collections for the Medical Assistance Program for Calendar Years 2004 Through 2009.* [A-06-10-00057](#). January 2012.

## Managed Care—Federal Share of Excess Capitation Payments (Pennsylvania)

**Poor Controls, Commingling of Funds Affect Federal Share Adjustments.** Pennsylvania did not develop and implement effective internal controls to identify and return to the Federal Government the Federal share of excess managed care capitation payments recouped from counties' Risk and Contingency and Reinvestment funds. Pennsylvania recouped excess capitation payments from 12 of 24 counties we reviewed but did not refund the full Federal share in accordance with Federal requirements. Also, the State was unable to identify the amount of State-only funds recouped from Philadelphia County because the county's reinvestment account commingled excess capitation payments for both Federal Medicaid and State General Assistance enrollees.

Recommendations—Pennsylvania should refund \$7,950,454 Federal share of excess capitation payments returned by Philadelphia County and develop procedures to ensure that it refunds the Federal share of excess capitation payments recouped from the Risk and Contingency and

Reinvestment funds. *Pennsylvania Did Not Refund the Full Federal Share of Recouped Excess Capitation Payments From the Medicaid Behavioral HealthChoices Program.* [A-03-10-00204](#). June 2012.

## Medicaid Fraud and Abuse

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Medicaid faces multiple challenges in preventing and detecting fraud, including identifying questionable patterns of billing, overpayments, and high rates of improper payments. Federal and State Medicaid agencies monitor fraud through data analysis, audits, and investigations.

### Medicaid Integrity Contractors' Performance Hindered

CMS defined three types of Medicaid Integrity Contractors (MIC) to perform the program integrity activities mandated in the DRA and to identify additional fraud, waste, and abuse—*Review MICs*, *Audit MICs*, and *Education MICs*. Review MICs review State Medicaid claims data and identify potential overpayments. Audit MICs audit specific providers and identify overpayments. Education MICs educate providers and beneficiaries on program integrity issues.

- **Review MICs' Performance Hindered by Poor Data.** For the Review MICs that we examined, analytical assignments under the task orders did not result in recommendations of specific audit leads or identification of potential fraud leads. MICs identified problems with CMS's information technology infrastructure data that limited their ability to accurately complete data analysis assignments. Because data were missing or inaccurate, the MICs inaccurately identified potential overpayments and may have overlooked some potential overpayments. States invalidated more than one-third of the potential overpayments in samples the MICs provided. CMS reported several initiatives underway to improve the data the MICs use.

Recommendations—CMS should improve the quality of data that Review MICs can access for data analysis and require Review MICs to recommend specific audit leads. *Early Assessment of Review Medicaid Integrity Contractors.* [OEI-05-10-00200](#). February 2012.

- **Audit MICs' Performance Hindered Because Audit Targets Were Poorly Identified.** Few of the audits assigned to Audit MICs from January through June 2010 identified overpayments. Of the 370 audits assigned to Audit MICs, 81 percent either did not identify overpayments or were unlikely to identify them. Audit targets were misidentified because of data problems and because State program policies were applied incorrectly. The problematic audit targets caused MICs to duplicate efforts. Audit MICs reported spending significant preaudit time evaluating algorithms, reanalyzing system data, and ensuring the accurate application of State policies during audit target selection. According to CMS's data, an average of 3 months elapsed between the date CMS assigned audits to Audit MICs and the dates Audit MICs began the audits.

Recommendation—CMS should increase collaboration among Audit and Review MICs, CMS, and States to eliminate duplication of efforts and improve target selections in States that opt not to partner in collaborative audits. *Early Assessment of Audit Medicaid Integrity Contractors.* [OEI-05-10-00210](#). March 2012.

- **Status of Previously Identified Audit Targets Provided.** Our April 2012 addendum report provides information and insights on 161 of 244 audit targets that CMS had assigned to Audit MICs. We

found that as of February 1, 2012, Audit MICs had completed 127 of the 161 assigned audits of providers. An average of 10 months elapsed between the dates CMS assigned the audits to Audit MICs and the dates the Audit MICs reported their findings to CMS. Twenty-five of the completed audits identified overpayments, totaling \$285,629. The remaining 102 completed audits found no overpayments. Thirty-four of the assigned audits had not been completed and were ongoing. The report does not contain recommendations. *Status of 244 Provider Audits Identified Using Review Medicaid Integrity Contractor Analysis*. [OEI-05-10-00201](#).

## Managed Care—Employment of Excluded Individuals

**Few Excluded Individuals Found in Medicaid Managed Care.** Of 248,869 individuals employed by 500 sampled providers, we identified 16 individuals who were excluded from participation in Federal health care programs. Exclusions are typically imposed on the basis of convictions for program-related fraud, patient abuse, or license revocations. Incorrect names and failure of contractors to follow procedures contributed to the employment of the excluded individuals. Most providers reported using a variety of safeguards to ensure that they do not employ excluded individuals. But providers said that costs and resource burdens posed challenges in executing those safeguards. Seven percent of providers in the 12 selected Medicaid managed care entities (MCE) do not check the exclusions status of their employees; most of these providers lacked knowledge regarding exclusions. The report does not contain recommendations. *Excluded Individuals Employed by Providers Enrolled in Medicaid Managed Care Entities*. [OEI-07-09-00632](#). September 2012.

A prior report recommended that CMS periodically remind States of their obligation to ensure that no excluded providers receive Medicaid payments. *Excluded Providers in Medicaid Managed Care Plans*. [OEI-07-09-00630](#). February 2012.

## Managed Care—Fraud and Abuse Concerns Remain Despite Safeguards

**Despite Safeguards, MCEs Remain Concerned About the Prevalence of Fraud.** CMS, States, and Medicaid MCEs said that services billed but not rendered are their primary concern with respect to fraud and abuse in Medicaid managed care. Other concerns include rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries. All MCEs in our sample reported taking steps to meet Federal program integrity requirements, and all States in our sample reported taking steps to oversee MCEs' fraud and abuse safeguards. Even so, they remained concerned about the prevalence of fraud.

**Recommendations—**CMS should require that State contracts with MCEs include a method to verify with beneficiaries whether they received services billed by providers. CMS could require States to implement one of several options we described. We also recommend that CMS update guidance to reflect concerns expressed by MCEs and States and share best practices and innovative methods that States and MCEs have applied. *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*. [OEI-01-09-00550](#). December 2011.

## State Medicaid Fraud Control Unit Onsite Reviews

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OIG oversees the operation and performance of State Medicaid Fraud Control Units (MFCUs or Unit). MFCUs are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. MFCUs investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. In FY 2011, HHS awarded \$156.7 million in Federal grant funds to 50 MFCUs (including 1 in Washington, DC), which employed a total of 1,833 individuals. OIG certifies, and annually recertifies, each MFCU. OIG collects information about MFCU operations and assesses whether they comply with statutes, regulations, and OIG policy. OIG also analyzes MFCU performance on the basis of 12 published performance standards and recommends program improvements, where appropriate.

For three State reviews, OIG found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

- **New York MFCU.** From FYs 2008 through 2010, the New York Unit filed criminal charges against more than 400 defendants, obtained over 400 convictions, and was awarded more than \$750 million in recoveries. Unit managers, staff, and stakeholders cited a number of noteworthy practices, including the Unit's approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology. Our report includes findings and recommendations with respect to staff size, training, written guidance and agreements, and file maintenance. *Medicaid New York State Medicaid Fraud Control Unit: 2011 Onsite Review.* [OEI-02-11-00440](#). June 2012.
- **Missouri MFCU.** For FYs 2008 through 2010, the Missouri Unit reported recoveries of \$135 million, 13 convictions, and 36 civil settlements. The Unit exercised proper fiscal controls over its resources. The Unit expanded its definition of referrals and changed its process for closing older cases during FYs 2008 through 2010. The report includes findings and recommendations with respect to training, documentation, and records oversight. *Medicaid Missouri State Medicaid Fraud Control Unit: 2011 Onsite Review.* [OEI-07-11-00750](#). July 2012.
- **Kansas MFCU.** For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions. The Unit increased referrals through education and outreach efforts. Our report includes findings and recommendations with respect to internal controls, reporting, training, documentation, and reviews. *Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review.* [OEI-07-12-00200](#). September 2012.

## Joint Investigations With State Medicaid Fraud Control Units

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Following are highlights of the outcomes of OIG's joint investigations with MFCUs that were concluded in FY 2012.

**Virginia – Psychiatric Counseling and Treatment of Adolescents.** Universal Health Services, Inc. (UHS), and its subsidiaries, Keystone Education and Youth Services, LLC, and Keystone Marion, LLC, d/b/a

Keystone Marion Youth Center UHS, agreed to pay over \$6.85 million to resolve allegations that it submitted false and fraudulent claims to Medicaid. Between October 2004 and March 2010, the entities allegedly provided substandard psychiatric counseling and treatment to adolescents in violation of Medicaid requirements. The United States alleged that UHS falsely represented Keystone Marion Youth Center as a residential treatment facility providing inpatient psychiatric services to Medicaid-enrolled children when in fact it was a juvenile detention facility. The United States further alleged that neither a medical director nor licensed psychiatrist provided the required direction for psychiatric services or for the development of initial or continuing treatment plans. The settlement further resolved allegations that the entities filed false records or statements to Medicaid when they filed treatment plans that falsely represented the level of services that would be provided to the patients.

**North Carolina – Nonemergency Dialysis-Patient Ambulance Transports.** Thomas Hunter and Janet Johnson-Hunter, owners and operators of Coastline Care, Inc., an ambulance and medical transport company, entered into a settlement agreement for \$950,178. The settlement resolved allegations that, between January 2002 and October 2006, the Hunters submitted Medicare and Medicaid claims for nonemergency dialysis-patient ambulance transports that were not medically necessary because the patients could walk and/or were not bedridden. Specifically, the Hunters allegedly instructed employees to omit the true condition of patients from the ambulance call reports when they did not meet Medicare and Medicaid reimbursement requirements. As part of the settlement, Janet Johnson-Hunter agreed to an exclusion from Federal health care programs of 15 years on the basis of her conviction on charges of conspiracy to make false statements relating to health care matters. In the criminal case, she was sentenced to 2 years and 4 months of incarceration and ordered to pay \$475,089 in restitution.

**Pennsylvania – Attendant Care Services.** Octavia Durham and her daughter, Anneikkia Durham Smith, were sentenced for their roles in a Medicaid fraud scheme. A relative of the pair who was a Medicaid beneficiary received attendant care services from Durham pursuant to the Medicaid Commerce Waiver Program. An initial investigation by the Pennsylvania MFCU revealed that the beneficiary suffered from ulcers, bed sores, dehydration, and malnutrition and had missed numerous medical appointments. A doctor who examined him in June 2009 recommended that the beneficiary be immediately taken to an emergency room. On a number of Durham's attendant timesheets, Smith signed on behalf of the beneficiary, verifying Durham's hours and services provided. Numerous timesheets and claims submitted to Medicaid included hours that Durham allegedly provided care when in fact Durham was employed elsewhere or was out of town or when the beneficiary was hospitalized or was in a nursing home. Durham was sentenced to between 11.5 months to 23 months of incarceration and ordered to pay \$128,000 in restitution. Smith was ordered to pay \$38,614 of this amount jointly and severally with Durham and was sentenced to a 7-year term of probation. This was a joint investigation with the MFCU of the Pennsylvania Attorney General's Office and the Montgomery County District Attorney's Office.

**New York – Stark Law and Anti-Kickback Statute Issues.** Good Samaritan Hospital Medical Center (Good Samaritan) and South Bay OB/GYN (South Bay) agreed to pay \$1.75 million to resolve their liability under the Civil Monetary Penalties Law (CMPL). Good Samaritan and South Bay disclosed that Good Samaritan paid salary and benefits under a contract for clinical teaching, administrative, and supervisory services to five physicians associated with South Bay. The salary and benefits were above fair market value and violated the Stark Law and the Anti-Kickback Statute. This case was resolved jointly with New York State's Office of Medicaid Inspector General.

## Other Medicaid-Related Cases and Settlements

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### Pharmaceutical Companies

**Massachusetts – GlaxoSmithKline: Marketing and Promotion Practices.** In the largest health care fraud settlement in U.S. history, the pharmaceutical company GlaxoSmithKline (GSK) entered into a global criminal, civil, and administrative settlement and agreed to pay \$3 billion to resolve its liability for its marketing and promotion practices associated with several drugs. In three False Claims Act settlement agreements, the United States alleged that GSK promoted several drugs, including Paxil, Wellbutrin, Advair, Lamictal, and Zofran for off-label uses and paid kickbacks to induce the prescription of certain drugs; improperly promoted the drugs Avandia, Advandmet, and Avandaryl with false and misleading statements about the drugs' safety; and violated the requirements of the Medicaid drug rebate program. As part of the settlement, GSK also entered into a 5-year corporate integrity agreement (CIA) with OIG that includes enhanced compliance provisions designed to promote accountability and transparency in GSK's business practices. In addition, the CIA requires that GSK maintain its "Patient First" program, which is designed to compensate sales representatives on the basis of the quality of services they provide to physicians instead of the volume of sales in their territories. GSK also must establish and maintain a financial recoupment program for executives.

The investigation involved collaboration across several Government agencies, including the Food and Drug Administration (FDA), the Federal Bureau of Investigation, the Defense Criminal Investigative Service, the Office of Personnel Management, the Department of Veterans Affairs, the Department of Labor, TRICARE, and the U.S. Postal Service. In addition, GSK entered into separate Medicaid-related settlement agreements with multiple States.

**Massachusetts – Merck, Sharp & Dohme: Marketing and Promotion Practices.** Pharmaceutical company Merck, Sharp & Dohme (Merck) agreed to pay over \$628 million to resolve allegations that it violated the False Claims Act by improperly marketing and promoting the drug Vioxx. Between May 1999 and September 2004, Merck allegedly promoted Vioxx improperly for the treatment of rheumatoid arthritis; made statements about the cardiovascular safety of Vioxx that were inaccurate, misleading, and inconsistent with the FDA-approved labeling for the drug; and made false statements about the safety of Vioxx to State Medicaid agencies. The settlement agreement is part of a global criminal, civil, and administrative settlement under which Merck paid a total of \$950 million plus interest; pleaded guilty to a misdemeanor violation of the Food, Drug, and Cosmetic Act; and entered into a comprehensive 5-year CIA with OIG. In addition, Merck is expected to enter into separate Medicaid-related settlement agreements with 44 States.

**New Jersey – McKesson Corporation: Accuracy of Reported Drug Prices.** McKesson Corporation, a distributor of pharmaceuticals and medical supplies, agreed to pay \$187 million plus interest to resolve allegations that it inflated pricing information for its prescription drugs. The United States alleged that McKesson provided inflated average wholesale pricing figures—up to 25-percent markups—to First Data Bank, a publisher of discount pricing. First Data Bank's information was used by State Medicaid programs to determine reimbursements and fee schedules for McKesson's prescription drugs. As a result of McKesson's alleged provision of artificially inflated wholesale pricing, State Medicaid programs reimbursed higher amounts for prescription medications than should have been paid between August 2001 and December 2009. In addition, McKesson agreed to

pay over \$151 million to 29 States and the District of Columbia to resolve its liability to the States affected by the alleged price manipulation scheme.

**New Jersey – Sandoz: Timeliness of Reporting Required Drug Price Data.** Sandoz, a pharmaceutical company, agreed to pay \$230,000 to resolve its potential liability under the CMPL. Specifically, the Government contended that Sandoz failed to submit in a timely manner pricing data required under the Medicaid Drug Rebate Program.

## Pharmacists

**Massachusetts – HIV/AIDS Drugs Billed to Medicaid but Not Provided.** Pharmacist Aloysius Nsonwu was excluded from Federal health care programs for a minimum of 15 years after his convictions in Federal and State courts for conspiracy to defraud the Government with respect to claims, Medicaid false claims, larceny by false pretenses, and conspiracy. According to court documents, between approximately December 2004 and February 2010, Nsonwu paid customers to bring in their Medicare and Medicaid cards so he could submit false claims for HIV/AIDS medications without dispensing the medications. Many of these individuals were not HIV positive. In addition, Nsonwu obtained valid prescriptions from Medicaid beneficiaries who were HIV positive, but instead of dispensing their medications, he paid them in cash for the prescriptions. Nsonwu was sentenced to 4 years and 1 day of incarceration and ordered to pay approximately \$555,500 in restitution on his State conviction. He was also ordered to pay approximately \$147,700 in restitution on his Federal conviction. In addition, his license to practice as a pharmacist was revoked by the Massachusetts State Board of Pharmacy.

**Indiana – False Prescriptions and Money Laundering.** John Love, controlling member and pharmacist for the Terre Haute Prescription Shop (THPS), was sentenced to 4 years and 3 months of incarceration and ordered to pay \$3.5 million in restitution for his role in a health care fraud and money laundering scheme. Between January 2006 and September 2010, Love used his position at the pharmacy to carry out a scheme to defraud the Indiana Medicaid Program. Love entered false prescriptions in the THPS computer billing system, which, in turn, billed the Indiana Medicaid Program.

**Massachusetts – Kickbacks and False Claims.** Ernest Melvin McGee, assistant pharmacist of Codman Square Pharmacy (Codman), along with Codman's owner, Amadiogwu Onujiogu, solicited paper prescriptions from customers in exchange for illegal kickbacks and submitted false claims to Medicare and Medicaid. McGee and Onujiogu targeted customers with HIV/AIDS and/or psychiatric disorders, such as depression and bipolar disorder—conditions that require expensive prescriptions. Many of the beneficiaries they recruited were drug addicts or homeless persons. McGee was sentenced to 12 months and 1 day of incarceration and was ordered to pay \$292,635 and \$60,037 in restitution to Medicaid and Medicare, respectively, for his role in the health care fraud scheme. Onujiogu was convicted on the same charge and sentenced to 15 months of incarceration.

## Drug Trafficking

**Florida – Illegal Possession, Intent To Distribute, and Distribution.** Paul Wagner, Jr., a private citizen, was sentenced to 7 years and 2 months of incarceration for possession with intent to distribute, as well as for distributing the Schedule II drug oxycodone. Wagner was part of a fraud scheme that

entailed obtaining paper oxycodone prescriptions from a physician who prescribed the controlled substances to Medicare and Medicaid beneficiaries, despite lack of medical necessity. Wagner then assisted in filling the prescriptions and trafficking the drugs to street dealers.

## Hospitals

**Georgia – Claims for Allegedly Unnecessary and Dangerous Procedures.** Satilla Health Services, Inc., d/b/a Satilla Regional Medical Center (Satilla), agreed to pay \$840,000 to resolve its liability under the False Claims Act. The agreement resolves allegations that Satilla submitted claims to Medicare and Medicaid for medically unnecessary and dangerous endovascular procedures performed by a physician for the medical center's heart center that caused serious injury to 37 patients. Satilla entered into an agreement with another company to purchase Satilla, which will result in a new board of directors, new administrators, and a new compliance program at the medical center.

## Personal Care Services

**Minnesota – Personal Care Assistant Services.** John Alemoh Momoh, owner and operator of Hopecare Service, Inc. (Hopecare), was sentenced to 2 years of incarceration and ordered to pay \$656,876 in restitution to Medicaid for claims submitted for personal care assistant (PCA) services. Between May 2007 and March 2008, Momoh submitted false claims with respect to the number of PCA service hours provided to Medicaid beneficiaries. Momoh also submitted false claims to Medicaid for services that were not rendered, were provided by an unqualified individual, and were not medically necessary.

**Virginia – Services Rendered by Untrained Personal Care Aides.** Health Care of Virginia, LLC (HCV), a home health agency, was ordered to pay \$323,420 in restitution for health care fraud. The company allegedly submitted claims to the Virginia Medicaid program for services rendered by untrained personal care aides. The investigation indicated that HCV falsified training certificates and patient assessments. Two other defendants pleaded guilty for their roles in the scheme and have been sentenced.

## Nursing Homes

**Tennessee – Enteral (Nutrition) Therapy Goods and Services.** Vanguard Healthcare Ancillary Services, LLC; Vanguard Healthcare, LLC; and Vanguard Healthcare Services, LLC (collectively, Vanguard) agreed to pay \$2 million as a part of a settlement agreement to resolve allegations of false claims and illegal kickbacks. Between March 1998 and September 2008, Vanguard allegedly submitted claims to Medicare for enteral (nutrition) therapy goods and services that were also billed to the Tennessee and Mississippi Medicaid programs. Vanguard allegedly failed to disclose the relationship between its long-term-care facilities (which billed Tennessee and Mississippi Medicaid for the enteral therapy goods and services) and Vanguard Healthcare Ancillary Services (which billed Medicare Part B for the same goods and services). Vanguard also allegedly submitted claims to Medicare for certain free items, namely pumps used to deliver nutritional products and intravenous poles used in the administration of enteral therapy that Vanguard had received at no cost from a third-party supplier in an effort to induce referrals.

## Clinics

**New Jersey – Billing for Services Not Provided.** The Center for Lymphatic Disorders, LLC (CLD), was ordered to pay \$3 million in restitution as a result of a guilty plea to third-degree health care claims fraud by office manager Farah Houtan. Between January 2004 and June 2007, Houtan billed Medicare and Medicaid for services not provided to patients. CLD staff allegedly submitted claims for surgical procedures but in fact provided physical therapy services, which have a lower reimbursement rate.

## Medical Equipment and Supplies

**Texas – Billing for Items Not Provided.** James Reese, Lia St. Junius, Brenda Lopez, Lily Johnson, and others of The Mobility Store (TMS), a medical equipment and supply company, took part in a scheme that fraudulently billed braces to Medicare and Medicaid as orthotic devices. As a result, Medicare reimbursed TMS at a rate many times the actual cost of the braces. Reese, Junius, Lopez, and Johnson were sentenced to 15 years, 11 years and 3 months, 3 years and 7 months, and 2 years and 9 months of incarceration, respectively, for their roles in the scheme. Additionally, Johnson was ordered to pay \$4 million in restitution, jointly and severally, and Lopez, Reese, and St. Junius were each ordered to pay \$8.6 million, jointly and severally.

**Florida – Unauthorized Oxygen-Therapy-Related Testing and Falsification.** Benjamin Bane (B. Bane), owner and operator of two medical equipment and supply companies that provided oxygen therapy in central and west Florida, and two managers, Greg Bane (G. Bane) and Tracy Bane (T. Bane), were sentenced to incarceration and ordered to pay restitution for participating in a scheme to defraud Medicare and Medicaid. Although medical equipment and supply companies are expressly prohibited by Medicare regulations from performing the qualifying tests to establish medical necessity for home oxygen, B. Bane allegedly instructed his employees to perform such tests; falsify test results; and alter information on office computers, such as the beneficiary's name and the procedure date. The qualifying test results were then provided to either one of two pulmonary diagnostics companies to appear as though they had been performed by an independent diagnostic testing facility in accordance with Medicare regulations, thus making them appear eligible for reimbursement. B. Bane was sentenced to 12 years of incarceration and ordered to pay \$7 million in restitution, jointly and severally. G. Bane and T. Bane were sentenced to 3 years and 6 months of incarceration, respectively, for their roles in the scheme, and both were ordered to pay \$7 million in restitution, jointly and severally.

**California – Kickback-Related Solicitation and Sale of Beneficiary Information Used in False Billings of Medicare and Medi-Cal.** Mariya Bagdasaryan, owner of Goldberg Medical Supply, was sentenced to 3 years and 1 month of incarceration and ordered to pay \$576,803 in restitution for one count of health care fraud. Between October 2007 and December 2008, Bagdasaryan defrauded Medicare and Medi-Cal by paying kickbacks to marketers to solicit beneficiary information with promises of free medical equipment and supplies. Bagdasaryan then sold the beneficiary information to a Medicare billing service, which, in turn, sold some of the information to a fraudulent medical equipment and supply company called True Care Medical Supply (True Care). True Care submitted claims to Medicare falsely representing that it had supplied medical equipment and supplies to beneficiaries. Bagdasaryan received the longest possible prison term, partly because of a conviction in 2002 for the same offense. In January 2011, True Care's owner, Edgar Srappyan, was sentenced to 3 years and 1 month of incarceration and ordered to pay over \$330,000 in restitution.

**Tennessee – Diabetic Testing Supplies.** AmMed Direct, LLC (AmMed), agreed to pay \$18 million to resolve allegations that it violated the False Claims Act. From September 2008 to January 2010, AmMed, a supplier of diabetic testing supplies and other medical equipment and supplies, allegedly billed Medicare and Tennessee Medicaid for diabetic testing supplies sold to beneficiaries through telephone cold calls, in violation of the Social Security Act, 1834(a)(17), which prohibits unsolicited telephone contact by suppliers. AmMed advertised and offered free cookbooks without any mention of diabetic testing supplies or without stating that AmMed was a medical equipment and supply company. When beneficiaries called to claim the cookbook, AmMed allegedly sold them diabetic testing supplies and submitted claims to Medicare and Tennessee Medicaid. The settlement also resolves AmMed’s alleged failure to refund Medicare and Medicaid for supplies that were returned to the company. AmMed disclosed the unpaid refunds to the Government during the investigation.

## Laboratories

**Indiana – Unnecessary Blood Tests and Other Improprieties.** Medway Diagnostic Laboratories operator Munir Chaudhry and Physician Adolph Yaniz were each sentenced after health care fraud convictions. The Government contended that, between January 2008 and February 2009, Chaudhry worked with Yaniz to perform unnecessary blood tests on Yaniz’s patients and billed Medicare and Medicaid for the services. Chaudhry also paid the monthly rent for the medical practice in exchange for Yaniz’s sending all his patients’ specimens to Medway Diagnostic Laboratories for analysis. Yaniz admitted that he knowingly dispensed hydrocodone and alprazolam to patients who had no medical need for the medications. Yaniz was sentenced to 5 years of incarceration and ordered to pay restitution of \$71,577. As part of his plea agreement, Yaniz agreed to forfeit his medical license. He further agreed to a lifetime ban from participating in any Federal or State-funded health care program. Chaudhry was sentenced to 2 years and 3 months of incarceration and ordered to pay \$31,000 in restitution, jointly and severally.

## Managed Care Companies

**Florida, Illinois – Multiple Violations Alleged.** WellCare Health Plans, Inc., a company that provides managed health care services, agreed to pay \$137.5 million to the Federal Government and nine States to resolve four lawsuits involving alleged violations of the False Claims Act. The Government alleged that WellCare falsely retained payments from Florida Medicaid, Florida Healthy Kids, and Illinois Medicaid for behavioral health services; falsely retained payments from Florida Medicaid for newborns; submitted falsely inflated performance data for call centers; knowingly permitted Florida Medicaid to rely on overpriced encounter data for future premium rate setting and other uses; operated a sham Special Investigative Unit that failed to properly audit WellCare providers; upcoded risk scores for Medicare plans; and engaged in sales and marketing abuses, including “cherry picking” of healthy patients to avoid future costs. Five former WellCare executives, including former chief executive officer Todd Farha, were indicted in March 2011. In addition to agreeing to the settlement, WellCare entered into a 5-year CIA with enhanced oversight and reporting obligations.

**California – Allegations of Misrepresenting Information Affecting Reimbursements.** SCAN Health Plan, Senior Care Action Network, and Scan Group (collectively, SCAN) agreed to pay \$322 million to resolve allegations that it violated the False Claims Act. SCAN is a Medicare Advantage (i.e., Medicare Part C) plan, which is focused on providing services to beneficiaries who are dually eligible for Medicare and Medicaid. The United States alleged that SCAN provided misleading information about

beneficiaries' diagnoses, resulting in inflated capitation payments, and improperly retained overpayments.

<http://oig.hhs.gov>

## Appendix A

# Medicaid Reports Issued in FY 2012

The majority of reports listed in this appendix are available on the Office of Inspector General (OIG) Web site at <https://oig.hhs.gov>. To access the reports, query on the report number shown after each title. Reports not posted to the Web site may be requested through the Freedom of Information Act (FOIA). To make a request under FOIA, please use the following link: <https://oig.hhs.gov/foia/submit.asp>.

## Audit Reports

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### Medicaid Hospitals

- *Utah Did Not Always Correctly Claim Medicaid Costs for Selected High-Dollar Outpatient Claims Audit, A-07-11-04177*
- *Review of Costs Claimed for Selected High-Dollar Outpatient Services in the Colorado Medicaid Program During the Period January 1, 2007, Through December 31, 2009, A-07-11-04178*
- *Missouri Did Not Always Correctly Claim Medicaid Costs for Selected High Dollar Outpatient Claims Audit, A-07-11-04180*

### Medicaid Home, Community, and Nursing Home Care

- *Massachusetts Generally Complied With Federal and State Requirements for Medicaid Payments to Wingate Healthcare, A-01-11-00010*
- *Massachusetts Medicaid Payments to Alliance Health of Massachusetts, Inc., Did Not Always Comply With Federal and State Requirements, A-01-12-00003*
- *Massachusetts Medicaid Payments to Diocesan Healthcare Facilities Did Not Always Comply With Federal and State Requirements, A-01-12-00004*
- *Massachusetts Medicaid Payments to Cedar Hill Health Care Center Did Not Always Comply With Federal and State Requirements, A-01-12-00008*
- *Massachusetts Medicaid Payments to Redstone Rehabilitation and Nursing Center Did Not Always Comply With Federal and State Requirements, A-01-12-00007*
- *Massachusetts Medicaid Payments to Newton Health Care Center Did Not Always Comply With Federal and State Requirements, A-01-12-00013*
- *Massachusetts Medicaid Payments to Calvin Coolidge Nursing and Rehabilitation Center for Northampton Did Not Always Comply With Federal and State Requirements, A-01-12-00012*
- *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey, A-02-09-01002*

- *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State Audit, A-02-09-01023*
- *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007, A-02-09-01034*
- *New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Nurses, Inc., in Accordance With Federal and State Requirements, A-02-10-01001*
- *Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services -- Manhattan LTHHCP Audit, A-02-10-01002*
- *New York Claimed Some Unallowable Costs for Services by New York City Providers Under the State's Developmental Disabilities Waiver Program, A-02-10-01027*
- *Review of Medicaid Payments for Services Under New Jersey's Section 1915(c) Community Care Waiver Program From January 1, 2005, Through December 31, 2007, A-02-10-01029*
- *Review of Personal Care Services Under Maryland's Medicaid State Plan, A-03-11-00200*
- *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program, A-03-11-00205*
- *South Carolina Claimed Some Unallowable Room-and-Board Costs Under the Intellectual and Related Disabilities Waiver, A-04-11-04012*
- *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health, A-06-09-00062*
- *Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Health Care, A-06-09-00063*
- *Review of New Mexico Medicaid Personal Care Services Provided by Coordinated Home Health Care, A-06-09-00064*
- *Review of Louisiana Medicaid Personal Care Services Provided by American Pride Caregivers, LLC, A-06-09-00107*
- *Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc., A-06-09-00117*
- *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services, A-07-11-03171*
- *Federal Survey Requirements Not Always Met for Three California Nursing Homes Participating in the Medicare and Medicaid Programs, A-09-11-02019*

## Medicaid Prescription Drug Claims

- *Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices, A-06-11-00002*
- *Multi-State Review of the Centers for Medicare & Medicaid Services' Medicaid Drug Expenditures, A-07-10-06003*

- *Review of Prescribed Drug Costs in the Colorado Medicaid Family Planning Program, A-07-11-01095*

## Other Medicaid Services

- *Review of Medicaid Payments for School-Based Health Services Made to Manchester, New Hampshire, A-01-10-00014*
- *Rhode Island Did Not Always Comply With State Requirements on Medicaid Payments for Hospice Services, A-01-11-00005*
- *Rhode Island Hospice General Inpatient Claims and Payments Did Not Always Meet Federal and State Requirements, A-01-12-00002*
- *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York City, A-02-08-01017*
- *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York State, A-02-09-01024*
- *Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers In New Jersey, A-02-09-01028*
- *Review of Medicaid Payments to Excluded or Terminated Durable Medical Equipment Suppliers in Florida During Calendar Year 2009, A-04-11-07020*
- *Ohio Medicaid Costs for Home Blood-Glucose Test Strips Could Be Reduced by Approximately 50 Percent, A-05-11-00098*
- *Indiana Reduced Medicaid Costs for Home Blood-Glucose Test Strips by Approximately 50 Percent Using Manufacturer Rebates, A-05-12-00011*
- *Review of North Dakota's Medicaid Fee Schedule Rates for Home Blood Glucose Test Strips, A-05-12-00019*
- *Review of Costs for Inpatient Services in the Colorado Medicaid Family Planning Program, A-07-11-01097*
- *Review of Colorado Direct Medical Service and Specialized Transportation Costs for the Medicaid School Health Services Program for State Fiscal Year 2008, A-07-11-04185*
- *Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project, A-09-11-02010*
- *Hawaii Claimed Unallowable Medicaid Reimbursement for Nonemergency Medical Transportation Services Furnished by Taxi Providers, A-09-11-02047*

## Medicaid Administration

- *Maine Did Not Always Make Correct Medicaid Claim Adjustments, A-01-12-00001*
- *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Year 2007, A-02-07-01050*

- *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006, A-02-08-01009*
- *New Jersey Generally Reported Medicaid Overpayments in Accordance With Federal Regulations, A-02-10-01009*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in the U.S. Virgin Islands for the Quarter Ended September 30, 2009, A-02-11-01004*
- *Medicaid Rates for New York State Developmental Centers May Be Excessive, A-02-11-01029*
- *Review of Virginia's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries From January 2008 Through December 2009, A-03-10-00201*
- *Pennsylvania Did Not Refund the Full Federal Share of Recouped Excess Capitation Payments From the Medicaid Behavioral HealthChoices Program, A-03-10-00204*
- *Delaware Did Not Comply With Federal Requirements To Report All Medicaid Overpayment Collections, A-03-11-00203*
- *Pennsylvania Claimed Medicaid Administrative Costs for Provider Training Under Its Restraint Reduction Initiative, A-03-11-00209*
- *Maryland Claimed Medicaid Administrative Costs for Unallowable Remedial and Training Services, A-03-12-00204*
- *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning, A-04-10-01089*
- *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning, A-04-10-01091*
- *Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs, A-07-11-01100*
- *Alabama Improperly Claimed Federal Funds for CHIP Enrollees Who Had Medicaid or Other Health Insurance Coverage, A-04-11-08008*
- *Review of Michigan Medicaid Payments to Terminated Providers for Posttermination Services, A-05-10-00082*
- *Illinois Did Not Report All Medicaid Overpayments In Accordance With Federal Requirements, A-05-11-00044*
- *Michigan Did Not Perform Eligibility Redeterminations at Least Every 12 months for Wayne County Medicaid Beneficiaries, A-05-11-00045*
- *Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64, A-05-11-00052*
- *Review of Arkansas' Reporting Fund Recoveries for Federal and State Medicaid Programs on the CMS-64 Report for State Fiscal Year 2009, A-06-10-00051*
- *Review of Oklahoma Collections for the Medical Assistance Program for Calendar Years 2004 Through 2009, A-06-10-00057*

- *Texas Did Not Report Excess Contractor Profits in Accordance With Federal Regulations, A-06-10-00062*
- *States Inappropriately Retained Federal Funds for Medicaid Contractors for the First Recovery Act Quarter, A-06-11-00064*
- *Review of Kansas Medicaid Payments for the School District Administrative Claiming Program During the Period April 1, 2006, Through March 31, 2009, A-07-10-04168*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Colorado, A-07-11-02758*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Nebraska, A-07-11-02759*
- *Review of Nebraska's Medicaid Payments for Dual Eligible Individuals' Medicare Part A Deductibles and Coinsurance, A-07-11-03161*
- *Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance, A-07-11-03168*
- *Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance, A-07-11-03172*
- *Review of ARRA Medicaid Prompt Requirements in Nebraska, A-07-11-06019*
- *Colorado Did Not Always Identify or Prevent Excluded Providers From Participating in the Medicaid Program, A-07-11-06026*
- *Not All of Colorado's Claimed State CHIP Expenditures Were Allowable, A-07-12-02780*
- *Most of Missouri's Medicaid Expenditures for the Quarter Ended March 31, 2009, Were Adequately Supported and Allowable, A-07-12-03174*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Washington State, A-09-10-02013*
- *Arizona Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries, A-09-11-02009*
- *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries, A-09-11-02024*
- *Oregon's Internal Controls Were Substantially Adequate To Prevent Medicaid Payments to Excluded Providers, A-09-11-02042*
- *Contract Provisions for the Hawaii QUEST Expanded Access Risk Share Program Not Implemented, A-09-12-02006*

## Medicaid Information Technology

- *Information Technology General Controls Audit of the State of Ohio of Client Registry Information System - Enhanced (CRIS-E), A-05-10-00064*
- *Information Technology General Controls Audit of the State of Minnesota MMIS, A-05-11-00014*
- *Audit of OHCA's IT Controls, A-06-10-00081*

- *Audit of Arkansas IT Controls Over the Medicaid Program, A-06-11-00005*
- *Audit of Louisiana IT Controls Over the Medicaid Program, A-06-11-00020*
- *Audit of IT Controls for USB Devices at Children's Medical Center of Dallas, A-06-12-00016*
- *Audit of IT Controls for USB Devices at Presbyterian Hospital, A-06-12-00018*
- *Audit of IT Controls for USB Devices at Baptist Health Medical Center, A-06-12-00019*
- *Review of General Controls for Kansas Medicaid Eligibility Determinations at Policy Studies Incorporated, A-07-10-00346*
- *Review of CalOptima's Information System General Controls Over Its Medi-Cal Claims Processing System, A-09-11-03008*

## Evaluation and Inspection Reports

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- *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*, OEI-01-09-00550
- *Oversight of Quality of Care in Medicaid Home and Community-based Services Waiver Programs*  
OEI-02-08-00170
- *Medicaid New York State Medicaid Fraud Control Unit: 2011 Onsite Review*, OEI-02-11-00440
- *States Collection of Medicaid Rebates for Drugs Paid Through Medicaid Managed Care Organizations*, OEI-03-11-00480
- *Vaccines for Children Program: Vulnerabilities in Vaccine Management*, OEI-04-10-00430
- *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200
- *Early Assessment of Audit Medicaid Integrity Contractors*, OEI-05-10-00210
- *Status of 244 Provider Audits Identified Using Review Medicaid Integrity Contractor Analysis*,  
OEI-05-10-00201
- *Excluded Providers in Medicaid Managed Care Entities*, OEI-07-09-00630
- *Medicaid Payments for Therapy Services in Excess of State Limits*, OEI-07-10-00370
- *Missouri State Medicaid Fraud Control Unit: 2011 Onsite Review*, OEI-07-11-00750
- *Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review*, OEI-07-12-00200
- *Excluded Individuals Employed by Providers Enrolled in Medicaid Managed Care Entities*,  
OEI-07-09-00632
- *The Medicare-Medicaid (Medi-Medi) Data Match Program*, OEI-09-08-00370

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## Appendix B

# OIG Open Recommendations Carried Forward From Prior Fiscal Years

The Medicaid-related recommendations selected for this appendix were described in the December 2012 Edition of the Office of Inspector General's (OIG) *Compendium of Unimplemented Recommendations*. The recommendations, which are addressed to the Centers for Medicare & Medicaid Services (CMS), represent significant opportunities to improve program management and save tax dollars through legislative, regulatory, or administrative actions.

The recommendations below are aligned with four of the key management and performance challenges that OIG identified for the Department of Health and Human Services (HHS) at the close of fiscal year (FY) 2012.

- Identifying and Reducing Improper Payments
- Preventing and Detecting Fraud
- Ensuring Patient Safety and Quality of Care
- Avoiding Waste and Promoting Value

In many instances, CMS has made significant progress with regard to the prior-period items. More detail on the prior-period items in this appendix is provided in the Medicaid section of OIG's December 2012 *Compendium*, available on our Web site at <https://oig.hhs.gov>.

## Identify and Reduce Improper Payments

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**Improper Payments** *Home Health—Duplicate Medicaid and Medicare Home Health Payments – Medical Supplies and Therapeutic Services*

- OEI-07-06-00640 Continuing to monitor—We recommend that CMS ensure that Medicaid does not pay home health providers for nonroutine medical supplies and therapeutic services paid by Medicare. When Medicaid and Medicare cover particular supplies and services, Medicaid is the payer of last resort and Medicare should pay first for services provided to individuals who meet dual-eligibility requirements. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 124 ([Home Health—Prevent Duplicate Medicaid and Medicare Payments](#)).

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**Improper Payments** *Personal Care Services—Payments Made in Error for Personal Care Services During Institutional Stays*

- OEI-07-06-00620 Continuing to monitor—We recommend that CMS enforce Federal Medicaid payment policies that prohibit Medicaid reimbursement for personal care services (PCS) provided over a range of dates if the range includes dates on which the beneficiary was institutionalized and work with States to reduce erroneous Medicaid payments for PCS provided during institutional stays. Annual savings are

probable but not estimated. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 125 ([Personal Care Services—Enforce Policies Prohibiting Payments for Personal Care Services for Institutionalized Beneficiaries](#)).

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**Improper Payments**    *Personal Care Services—Inappropriate Claims for Medicaid Personal Care Services*

OEI-07-08-00430    Continuing to monitor—We recommend that CMS work with States to ensure that Medicaid claims for PCS provided by attendants with undocumented qualifications are not paid and take action regarding the inappropriately paid claims identified in our review. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 127 ([Personal Care Services—Ensure that Medicaid Claims Provided by Attendants With Undocumented Qualifications Are Not Paid.](#))

Also See:  
OEI-07-05-00250  
and OIG 12-12-01

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**Improper Payments**    *Medicaid Managed Care Encounter Data – Collection and Use*

OEI-07-06-00540    Continuing to monitor—We recommend that CMS enforce Federal requirements that States include managed care encounter data in Medicaid Statistical Information System (MSIS) submissions. The Affordable Care Act, § 6402(c), authorizes the Secretary to withhold Federal matching payments for States that fail to report enrollee encounter data in the MSIS. Encounter data are the primary records of Medicaid services provided to beneficiaries enrolled in capitated Medicaid managed care. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 131 ([Managed Care—Enforce Federal Requirements for Submitting Medicaid Managed Care Encounter Data](#)).

and  
OEI-04-07-00240

## Prevent and Detect Medicaid Fraud Ensure Patient Safety and Quality of Care

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**Quality of Care**    *Children— Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*

OEI-05-08-00520    Continuing to monitor—We recommend that CMS require States to report beneficiaries' vision and hearing screenings; collaborate with States and providers to develop effective strategies to encourage beneficiary participation in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings; and identify and disseminate promising State practices for increasing children's participation in EPSDT screenings and providers' delivery of complete medical screenings. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 129 ([Improve Medicaid Children's Utilization of Preventive Screening Services](#)).

See also:  
OEI-02-00-00362

## Avoid Waste and Promote Value

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<b>Wasteful Spending</b>	<b><i>Prescription Drugs—Replacing Average Wholesale Price: Medicaid Drug Payment Policy</i></b>
<a href="#">OEI-03-11-00060</a> and <a href="#">A-06-11-00002</a>	Continuing to monitor—We recommend that CMS develop a national benchmark that accurately reflects actual acquisition costs; encourage States to consider it when determining Medicaid reimbursement for prescription drugs; and enable States to develop different reimbursement benchmarks for single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 98 ( <a href="#">Prescription Drugs—Develop National Pharmacy Acquisition Cost Data as a Benchmark for Reimbursing Prescription Drugs</a> ).
<b>Wasteful Spending</b>	<b><i>Prescription Drugs—FDA’s Approval Status of Drugs Paid for by Medicaid</i></b>
<a href="#">OEI-03-08-00500</a> and <a href="#">OEI-03-08-00300</a>	Continuing to monitor—We recommend that CMS work with the Food and Drug Administration (FDA) to identify any potentially problematic Medicaid payments for drugs that have not been approved by FDA. We also recommend that FDA work with CMS and Congress to compel manufacturers to list all approved products with FDA before the products become eligible for Medicaid payment. Annual savings are probable. We estimated \$20 million quarterly on the basis of an analysis of 2007 fourth-quarter Medicaid expenditures. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 100 ( <a href="#">Prescription Drugs—Require Manufacturers To List All Approved Products With the Food and Drug Administration as a Requirement of Medicaid Eligibility</a> ).
<b>Wasteful Spending</b>	<b><i>Prescription Drugs—Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005</i></b>
<a href="#">A-06-06-00063</a>  See also: <a href="#">Advisory Bulletin</a>	Continuing to monitor—We recommend that CMS clarify specified terms and the treatment of certain aspects of determining average manufacturer prices (AMP) that we identified, address the various industry group concerns about AMP that we reported, and encourage States to analyze the relationship between AMP and pharmacy acquisition costs to ensure that Medicaid appropriately reimburses pharmacies. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 102 ( <a href="#">Prescription Drugs—Clarify and Improve Program Guidance to Drug Manufacturers on Average Manufacturer Price Issues</a> ).
<b>Wasteful Spending</b>	<b><i>Prescription Drugs—Need To Establish Connection Between the Calculation of Medicaid Drug Rebates and Reimbursement for Medicaid Drugs</i></b>
<a href="#">A-06-97-00052</a> See also: <a href="#">A-06-06-00063</a>	Continuing to monitor—We recommend that CMS seek legislation that would require Medicaid drug rebates and reimbursements to be developed using the same basis or review viable alternatives to the current program. Annual savings probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 104 ( <a href="#">Prescription Drugs—Establish a Connection Between the Calculations of Medicaid Drug Reimbursements and Rebates</a> ).

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<b>Wasteful Spending</b>	<b><i>Prescription Drug Rebates—States’ Collection of Medicaid Rebates for Physician-Administered Drugs</i></b>
<a href="#">OEI-03-09-00410</a> See also: <a href="#">A-06-10-00011</a> <a href="#">A-06-03-00048</a> <a href="#">OEI-03-02-00660</a>	Continuing to monitor—We recommend that CMS ensure that all States are accurately identifying and collecting rebates owed by manufacturers for these drugs, work with States to develop guidance for implementing system edits that increase the efficiency of physician-administered drug claim reviews, work with States to administer guidance to providers and Medicare contractors about the physician-administered drug rebate requirements, ensure that the crosswalk file (a CMS data file that links two types of commonly used drug codes) is complete and accurate and identifies rebateable physician-administered drugs, and take action against States that do not meet statutory requirements to collect rebates on physician-administered drugs. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 105 ( <a href="#">Prescription Drugs—Ensure That States Are Accurately Identifying and Collecting Rebates on Physician-Administered Drugs</a> ).
<b>Wasteful Spending</b>	<b><i>Prescription Drug Rebates—Review of Generic Drug Price Increases</i></b>
<a href="#">A-06-07-00042</a> See also: <a href="#">OEI-03-10-00320</a>	Continuing to monitor—We recommend that CMS seek legislative authority to extend the additional rebate provisions for brand-name drugs to generic drugs. Annual savings probable but not estimated. An August 2011 OIG report estimated that rebates reduced Medicaid’s expenditures for selected generic drugs by only 3 percent in 2009 (\$13.5 million out of \$449 million) compared to 45 percent for selected brand-name drugs. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 107 ( <a href="#">Prescription Drug Rebates—Extend the Additional Rebate Payment Provisions for Brand-Name Drugs to Generic Drugs</a> ).
<b>Wasteful Spending</b>	<b><i>340B Drugs—State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs</i></b>
<a href="#">OEI-05-09-00321</a> See also: <a href="#">OIG Testimony</a>	Continuing to monitor—We recommend that CMS inform States about tools they can use to identify claims for 340B-purchased drugs and that the Health Resources and Services Administration share 340B ceiling prices with States. Annual savings probable but not estimated. More detail is available in the <a href="#">Medicaid section</a> of OIG’s December 2012 <i>Compendium</i> , p. 109 ( <a href="#">Prescription Drugs—Improve the Policies and Information Available for State Medicaid Agencies To Oversee Reimbursements for 340B-Purchased Drugs</a> ).
<b>Wasteful Spending</b>	<b><i>Payments to Public Providers—Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers</i></b>
<a href="#">A-03-00-00216</a> See Also: <a href="#">A-02-11-01029</a> and OIG Testimony in <a href="#">2012</a> and <a href="#">2005</a>	Continuing to monitor—We recommend that CMS issue definitive guidance for calculating enhanced payment limits, which should include using facility-specific limits that are based on actual cost report data (with the effect of limiting enhanced payments to cost) and require that returns of Medicaid payments by a county or local government to the State be declared refunds of those payments and thus be used to offset the Federal share generated by the original payments. Annual savings probable. A January 2007 proposed rule that effectively addressed our concerns was estimated to result in \$120 million in savings during the first year and \$3.87 billion in savings over 5 years; however the final rule was vacated and withdrawn. ( <a href="#">75 Fed. Reg. 73972</a> , November 30, 2010.) More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 111 ( <a href="#">Payments to</a>

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

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<b>Wasteful Spending</b>	<b><i>Uncollected Refunds— Quarterly Credit Balance Reporting Requirements for Medicaid</i></b>
<a href="#">A-05-93-00107</a> and <a href="#">A-04-92-01023</a>	Continuing to monitor—We recommend that CMS establish a national Medicaid credit balance reporting mechanism similar to that used for Medicare Part A and require its regional offices to actively monitor the reporting mechanism that is established. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 114 ( <a href="#">Uncollected Refunds—Establish a National Medicaid Credit Balance Reporting Mechanism To Monitor Refundable Amounts in Providers’ Patient Accounts</a> ).
<b>Wasteful Spending</b>	<b><i>Third-Party Liability—Eight-State Review of the Ability of Noncustodial Parents To Contribute Toward the Medical Costs of Title IV-D Children That Were Paid Under the Medicaid Program</i></b>
<a href="#">A-01-03-02501</a> and <a href="#">A-01-03-02502</a>	Continuing to monitor—We recommend that CMS clarify third-party liability regulations to help State Medicaid agencies coordinate with States’ Title IV-D child support enforcement programs to collect Medicaid costs from noncustodial parents with the ability to contribute medical support; seek legislation that would allow States to accumulate medical support payments to offset Medicaid fee-for-service (FFS) costs for a reasonable period; determine whether more Federal funds are needed to help States interface their databases; implement a process to collect program costs from noncustodial parents; and as appropriate, provide funds for this purpose. Annual savings are probable but not estimated. On the basis of a pair of eight-State reviews, we estimated savings at \$99 million for Medicaid and \$14 million for the Children’s Health Insurance Program for the selected States over 2 years. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 116 ( <a href="#">Third-Party Liability—Ensure That States Collect From Noncustodial Parents With the Ability To Contribute Toward Their Children’s Medicaid or Children’s Health Insurance Program (CHIP) Costs</a> ).
<b>Wasteful Spending</b>	<b><i>Hospitals— Medicaid Hospital Outlier Payment Followup for Fiscal Years 2004 Through 2006</i></b>
<a href="#">A-07-10-04160</a>	Continuing to monitor—We recommend that CMS encourage all States that make Medicaid outlier payments to use the most recent cost-to-charge ratios to calculate those payments, reconcile them upon cost report settlement or use an alternative method to ensure that outlier payments are more closely aligned with actual costs, and amend their State plans accordingly. Annual savings are probable but not estimated. More detail is available in the Medicaid section of OIG’s December 2012 <i>Compendium</i> , p. 118 ( <a href="#">Hospital Payments—Encourage States To Update Hospital Outlier Payment Methodologies</a> ).
<b>Wasteful Spending</b>	<b><i>Adult Day Health Care—Medicaid Services Provided in an Adult Day Health Setting</i></b>
<a href="#">OEI-09-07-00500</a>	Continuing to monitor—We recommend that CMS specify what minimum services are required to qualify for Medicaid reimbursement of adult day health services, direct States to enforce supervision requirements for staff who provide therapy services in Medicaid adult day health centers, and take appropriate action with regard to the adult day health centers that did not respond to repeated data

requests. Annual savings probable but not estimated. More detail is available in the Medicaid section of OIG's December 2012 *Compendium*, p. 119 ([Adult Day Health Settings—Ensure That Services Provided Qualify for Medicaid Reimbursement](#)).

## Appendix C

# Fiscal Year 2013 Medicaid Work Plan

The audit and evaluation projects below were drawn from the Medicaid section of the Office of Inspector General (OIG) *Work Plan* for Fiscal Year (FY) 2013. In most instances, additional information, such as definitions of key terms and legal citations, is provided in the source *Work Plan*. For brevity, the summaries below include only the stated objectives.

## Prescription Drug Reviews

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

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 Centers for Medicare & Medicaid Services (CMS) Drug Manufacturer Release(s). (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 Federal Upper Limit (FUL) amounts. This review will compare State MAC programs to determine which ones are most successful in reducing Medicaid expenditures. (OEI; 03-11-00640; expected issue date: FY 2013; work in progress)

### ***Drug Pricing—Manufacturer Compliance With Average Manufacturer Price 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. (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. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

***Manufacturer Rebates—State's 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. (OAS; W-00-12-31400; various reviews; expected issue date: FY 2013; work in progress)

***Manufacturer Rebates—States' Collection of Supplemental Rebates***

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 that States negotiated and collected between 2008 and 2011. (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. 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. (Deficit Reduction Act of 2005, § 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 unit rebate amounts (URA). 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. (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. (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. (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. (OAS; W-00-13-31450; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

## Home, Community, and Personal Care Services

### ***Home Health Services—Duplicate Payments by Medicare and Medicaid***

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. (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. (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 home health agency (HHA) claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria. (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. (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. (OEI; 02-11-00700; expected issue date: FY 2013; work in progress)

### ***Medicaid Waivers—Supported Employment Services***

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. (OAS; W-00-12-31463; various reviews; expected issue date: FY 2013; work in progress)

### ***Medicaid Waivers—Adult Day Health Care Services***

We will review Medicaid payments by States for adult day care services to determine whether the payments complied with certain Federal and State requirements. (OAS; W-00-12-31386; various reviews; expected issue date: FY 2013; work in progress)

### ***Medicaid Waivers—Unallowable Room -and-Board Costs***

We will determine whether selected State Medicaid agencies claimed Federal reimbursement for unallowable room-and-board costs for HCBS-provided services 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 to make that calculation. (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 are properly allocated. (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 Federal financial participation (FFP). (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. (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 to determine whether States have appropriately claimed FFP. (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

***Nursing Facility Services—Communicable Disease Care***

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 care requirements. (OAS; W-00-13-31466; various reviews; expected issue date: FY 2014; new start)

***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. (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***

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 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. (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. (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. (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 payments for such 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. (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***

We will determine cost savings for Medicare and Medicaid that could result from expanded use of competitive bidding for medical equipment and supplies. (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***

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. (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***

We will determine whether opportunities exist for lowering payments for home blood-glucose test strips provided under Medicaid. We will also review rebates that some States collected on test strips to determine whether the States properly reimbursed the Federal share of the rebates. (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***

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 implemented them. (42 CFR § 440.70(b)(3).) (OEI; 07-12-000710 expected issue date: FY 2014; work in progress)

## State Management of Medicaid

***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. (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. (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 in such payments. Federal funds are not available for Medicaid payments that exceed applicable upper payment limits (UPL). (OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2013; work in progress)

***State Use of Incorrect Federal Medical Assistance Percentage for Federal Share Adjustments***

We will review States' Medicaid claims records to determine whether the States used the correct Federal Medical Assistance Percentage when processing claim adjustments reported on the Medicaid quarterly expenditure report (Form CMS-64). (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. (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 Form CMS-64. We will also identify opportunities to improve the accuracy of such reporting. (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 Form CMS-64. (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 Form CMS-64, as well as returned the correct Federal share related to those collections. (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 reviewed to ensure that corrective actions were implemented. (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. (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***

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. (OAS; W-00-13-31464; various reviews; expected issue date: FY 2014; new start)

***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 that deviated from acceptable statistical sampling practices. (OAS; W-00-12-31467; various reviews; expected issue date: FY 2014; work in progress)

***State Recovery Audit Contractor Performance and Results***

We will review the early performance and results of Recovery Audit Contractors in State Medicaid programs. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

***State Enrollment and Monitoring of Medical Equipment Suppliers***

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. (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***

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. (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***

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. (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***

We will review selected States' compliance with the Money Follows the Person (MFP) rebalancing demonstration program. 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. (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. (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, which are normally generated by local governments as part of their contribution to the coverage of Medicaid services. (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. (OEI; 05-11-00130; expected issue date: FY 2013; work in progress)

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

***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 FFP under the State's Children's Health Insurance Program (CHIP) program for individuals who were enrolled in the State's Medicaid program. (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. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

## Medicaid Data Systems, Controls, and Claims Processing

***Early Review of the Transformed Medicaid Statistical Information System Pilot Project***

We will review CMS's implementation of the Transformed Medicaid Statistical Information System (T-MSIS) pilot project. 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 Medicare, 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, including claims for services alleged to have been provided after the dates of the referring physicians' deaths. (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. (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 such instances and recover Medicaid payments for recipients determined to be ineligible. (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, 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. (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. (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. (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

***Beneficiary Access to Medicaid Managed Care***

We will review how extensive managed care provider networks are for Medicaid managed care 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***

We will review the extent to which States monitor Medicaid managed care entities' (MCE) grievances and appeals systems for compliance with Federal requirements. (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 (MCOs)) 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. (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. (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 (MSISs) 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. (OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act)

***Program Integrity—Medicaid Managed Care Organizations' Identification of Fraud and Abuse***

We will determine whether MCOs 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. (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. (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 that a minimum percentage of total costs 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. (OAS; W-00-11-31372; W-00-12-31372; various reviews; expected issue date: FY 2013; work in progress)

## Other Medicaid-Related Reviews

***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. (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 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. (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. (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. (OEI; 00-00-00000; various reviews; expected issue date: FY 2013; work in progress)

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