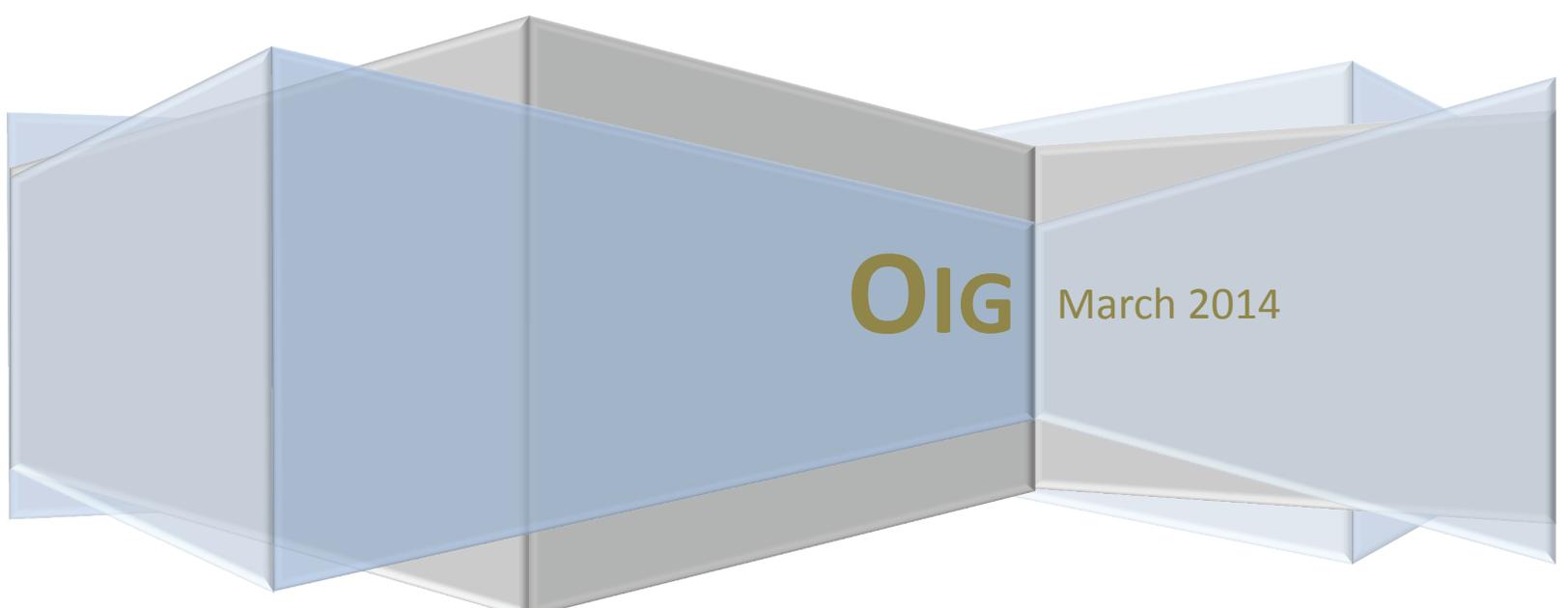


U.S. Department of Health and Human Services
Office of Inspector General

Medicaid Integrity Program Report for Fiscal Year 2013



OIG

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Contents

FY 2013 Funding for Medicaid Integrity Activities	1
Funding sources for Medicaid oversight	1
Oversight Activities	1
Allocation of Statutory Funding Streams	2
FY 2013 results from funding in multiple years	2
Information systems and data security	3
Transformed Medicaid Statistical Information System (T-MSIS)	3
State claims for the Federal share of Medicaid	4
Federal and State requirements for payment	4
Home health services	4
Rehabilitative services	4
School-based transportation services	5
Hospital Outlier Payments	5
Personal care services (PCS)	6
Traumatic brain injury (TBI) services	7
Assisted living facility (ALF)	7
State stewardship over policies and payments	8
Medicaid beneficiary identification numbers	8
Cost allocation methodologies and related issues	8
Unallowable administrative costs	10
Improper rates and reporting errors	10
Hospital eligibility issues	12
Identification of excluded providers	13
Identification of third-party liability for payment	13
Recovery of the Federal share of Medicaid overpayments	14
State oversight of provider reconciliations of credit balances	14
State recoveries of improper payments and refunds of the Federal share	15
CMS's recovery of OIG-identified overpayments	15

Medicaid Wasteful Policies and Practices	16
Payments for prescription drugs.....	16
Medicaid Federal upper limit (FUL) amounts	16
State Maximum Allowable Cost Programs.....	16
Payments for blood glucose test strips and other medical equipment and supplies.....	17
Beneficiary eligibility and access to care.....	18
Home Health Care Restrictions of Eligibility	18
Medicaid legal and investigative activities	19
OIG oversight of State Medicaid Fraud Control Units.....	19
MFCU funding and accomplishments in FY 2013	19
FY 2013 onsite reviews of MFCUs.....	19
Joint investigations with MFCUs	20
Other Medicaid-related criminal and civil actions.....	21
Exclusions from program participation.....	24
Appendixes	27
Appendix A – FY 2013 Medicaid Audit and Evaluation Reports	
Appendix B – OIG Priority Recommendations From Previous Fiscal Years	
Appendix C – FY 2014 Medicaid Work Plan	

Selected Acronyms and Abbreviations

ALF	assisted living facility
AMP	average manufacturer price
AWP	average wholesale price
CDT	continuing day treatment
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPE	certified public expenditure
CoP	Conditions of Participation
DOJ	Department of Justice
DSH	disproportionate share hospital
DRA	Deficit Reduction Act of 2005
DUR	drug utilization review
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FBI	Federal Bureau of Investigation
FBT	family-based treatment
FDA	Food and Drug Administration
FMAP	Federal Medical Assistance Percentage
FOIA	Freedom of Information Act
FFS	fee for service
FUL	Federal upper limit
HCBS	home- and community-based services
HCFAC	Health Care Fraud and Abuse Control
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IEP	individualized education plan
MCE	managed care entity
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
MIP	Medicaid Integrity Program
MSIS	Medicaid Statistical Information System
NCCI	National Correct Coding Initiative
NPI	national provider identifier
OIG	Office of Inspector General
OMB	Office of Management and Budget
PARIS	Public Assistance Reporting Information System
PCS	personal care services
PHP	partial hospitalization program
RCC	residential care center
RMS	random moment sampling
RMSS	random moment sampling system
RMTS	random moment time study
SAU	school administrative unit
UPL	upper payment limit

<http://oig.hhs.gov>

FY 2013 Funding for Medicaid Integrity Activities

Funding sources for Medicaid oversight

During fiscal year (FY) 2013, 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.”¹ 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)). The report is available on our Web site at: <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

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. The DRA, § 6034(c), 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 2013, MIP funds were still available but were fully expended by the end of the year.

Oversight Activities

Because there is an overlap among the HHS program oversight activities funded by HCFAC, MIP, and other sources, our work 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.

¹ Social Security Act, § 1817(k)(3)(A).

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.

Allocation of Statutory Funding Streams

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

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%
2013	\$213	\$0	\$73	\$2	\$75	30%

Note: Numbers have been updated for FY 2013 and are approximate because of rounding.

FY 2013 results from funding in multiple years

Our audit, evaluation, legal, and investigative work often requires more than a year to yield results. Investigative activities in particular may require multiple years to achieve convictions, sentencing, settlements, and/or exclusions. As a consequence, many of the results summarized in this document reflect OIG’s funding and work over multiple years that culminated in FY 2013. We have organized the FY 2013 output into the following categories:

- Information systems and data security
- State claims for the Federal share of Medicaid
- Recovery of the Federal share of Medicaid overpayments
- Medicaid wasteful policies and practices
- Beneficiary eligibility and access to care
- Legal and investigative activities

The appendixes provide lists of FY 2013 final audit and evaluation reports, priority recommendations carried forward from prior periods, and summaries of Medicaid work in progress and planned new starts in FY 2014.

The following audit, evaluation, and investigative results were previously reported in our *Semiannual Reports to Congress* during FY 2013.

Information systems and data security

Transformed Medicaid Statistical Information System (T-MSIS)

The Medicaid Statistical Information System (MSIS) is Medicaid's only nationwide Medicaid eligibility and claims database. The "transformed MSIS" (T-MSIS) is a continuation of past attempts by the Centers for Medicare & Medicaid Services (CMS) to improve the MSIS. The data are intended for use in analytical research, program integrity, planning, budgeting, and policy analyses associated with Medicaid. Our September 2013 report raised concerns about States' abilities to submit complete and accurate data to the T-MSIS. Evidence from our review indicates continued problems with completeness, accuracy, and other issues.

- *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System. OEI-05-12-00610. 2013 SEP.*

Establish a deadline for when national T-MSIS data will be available; ensure that States submit required T-MSIS data; and ensure that T-MSIS data are complete, accurate, and timely upon T-MSIS implementation.

See also:

- 2014 MAR—*High-Risk Security Vulnerabilities Identified During Reviews of Information Technology General Controls at State Medicaid Agencies. A-07-14-00433.*
- 2012 JUN—*Testimony of Ann Maxwell, Regional Inspector General for Evaluation and Inspections, Before the U.S. Senate Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid." (Testimony.)*
- 2009 AUG—*MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse, OEI-04-07-00240.*

State claims for the Federal share of Medicaid

The Federal Government and States share the cost of Medicaid. To receive a Federal share of Medicaid, States must ensure that in each instance, pertinent Federal and State standards, conditions, and other requirements must be met, including those pertaining to coverage specifications, quality of care, eligibility of beneficiaries, and provider qualifications. The Office of Inspector General's (OIG) Medicaid reviews of State claims for Federal reimbursement generally focus on whether one or more of such requirements were met and were appropriately documented prior to the States' submitting the claims for reimbursement.

Federal and State requirements for payment

Home health services

New York—Provider noncompliance. New York improperly claimed Federal reimbursement for home health services payments (about \$31.4 million Federal share) that were unallowable. In 15 percent of selected claims, we found one or more deficiencies including lack of physician review of plans of care, no plans of care, insufficient documentation, unallowable place of service, and insufficient staff training. The Social Security Act, § 1905(a)(7), authorizes home health services. Home health services are provided to beneficiaries at their places of residence pursuant to their physicians' orders and written plans of care that the physicians are to review every 60 days.

New York City—Provider noncompliance. The State improperly claimed Federal reimbursement for New York City home health services payments (about \$69.1 million Federal share) that were unallowable. We found a lack of physician review of plans of care and one instance in which a provider was unable to document that the service was provided.

- *New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies. A-02-11-01008. 2013 SEP.*
- *New York Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies in New York City. A-02-10-01022. 2012 NOV.*

New York should issue guidance to Medicaid home health agencies in the State on Federal and State requirements for physicians' orders and plans of care and refund the Federal share of unallowable payments to the Federal Government.

Rehabilitative services

New York—Provider noncompliance. New York improperly claimed Federal reimbursement for rehabilitative services payments (about \$27.5 million Federal share) that were unallowable. Our review of New York's family-based treatment (FBT) rehabilitation services for recipients between the ages of 5

and 19 found that 84 percent of selected claims had one or more deficiencies. The deficiencies occurred because FBT rehabilitation providers did not fully comply with State regulations, authorizing physicians were not familiar with applicable State regulations and program requirements, and the State did not adequately monitor providers for compliance with certain Federal and State requirements. The Social Security Act, § 1905(a)(13) and 42 CFR § 440.130(d) authorize optional rehabilitative services for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

- *New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services. A-02-10-01024. 2013 MAR.*

If New York does not close the FBT program,, it should provide guidance to the provider community on State regulations, provide guidance to physicians on State regulations and program requirements, and improve its monitoring and oversight to ensure compliance. New York should refund the Federal share of unallowable payments to the Federal Government.

School-based transportation services

New Hampshire—provider calculation errors and incorrect State guidance to providers. New Hampshire improperly claimed Federal reimbursement for school-based transportation services payments (about \$2.7 million Federal share) that were unallowable. The payments were made to school administrative units (SAUs). Of 115 items in a random sample, 78 items had 1 or more transportation services associated with school-based transportation services that were not reimbursable by Medicaid. The deficiencies occurred because the SAUs calculated costs on the basis of incorrect mileage, billed costs that exceeded the amount detailed in the supporting documentation, or had inadequate or no supporting documentation. In addition, New Hampshire issued incorrect guidance to SAUs on the basis of its misunderstanding of Federal requirements and did not adequately monitor the claims submitted by SAUs. The Social Security Act, §1903(c), permits Medicaid payment for medical services provided to children through a child’s individualized education plan (IEP).

- *New Hampshire Did Not Always Correctly Claim Medicaid Payments for School-Based Transportation Services. A-01-11-00008. 2012 OCT.*

New Hampshire should strengthen its oversight of the New Hampshire Medicaid to Schools program to ensure that claims for school-based transportation services comply with Federal and State requirements and issue new guidance on school-based transportation that is consistent with Federal requirements. New Hampshire should also refund the Federal share of unallowable payments to the Federal Government and work with CMS to review Medicaid payments made to SAUs after our audit period and refund any overpayments.

Hospital Outlier Payments

Wisconsin and Indiana—Provider data entry errors. In separate reviews, we found that Wisconsin and Indiana claimed Federal reimbursement for unallowable high-dollar outlier payments (about \$2.1 million Federal share) that the States made to hospitals for inpatient services. The hospitals had submitted

incorrect charges, which they attributed to data entry errors. In Wisconsin, 22 percent of the high-dollar payments we reviewed were unallowable; in Indiana, 92 percent were unallowable. When hospitals' charges exceed thresholds, the States make what is known as outlier payments. Outlier payments are intended to protect hospitals against large financial losses associated with high-cost cases and generally result in unusually high-dollar Medicaid payments.

- *Wisconsin Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable. A-05-11-00037. 2013 JUN.*
- *Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable. A-05-11-00040. 2013 SEP.*

Wisconsin and Indiana should use the results of the audits in their provider education activities related to data entry procedures and refund the Federal share of unallowable payments to the Federal Government.

Personal care services (PCS)

OIG PCS Portfolio—Provider noncompliance and inconsistent program policies. A November 2012 OIG Portfolio report summarized the results of over 20 reports pertaining to PCS. With regard to quality of care and beneficiary safety, we reported that program safeguards intended to ensure medical necessity, patient safety, and quality were often ineffective. We also reported inconsistent standards for, and monitoring of, the qualifications of PCS attendants and problematic provider billing practices. PCS cover nonmedical services supporting activities of daily living, which may include bathing, dressing, light housework, meal preparation, and transportation. (See OIG's November 2012 [Spotlight](#) on PSC services, available on our Web site at <http://oig.hhs.gov>.)

- *Medicaid—Personal Care Services Portfolio—Trends, Vulnerabilities, and Recommendations for Improvement. OIG 12-12-01. 2012 NOV.*

CMS should establish minimum Federal PCS attendant qualification standards applicable to all PCS reimbursed by Medicaid; require States to either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier; require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants; and issue operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants. CMS should also issue guidance to States regarding adequate prepayment controls, consider whether additional controls are needed to ensure that PCS are allowable and are actually provided, and take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

Maryland—Provider noncompliance. Maryland improperly claimed Federal reimbursement for PCS payments (about \$10.8 million Federal share) that were unallowable. Our April 2013 report revealed deficiencies related to unqualified PCS attendants, unapproved or missing plans of care, unauthorized services, and undocumented services.

- *Maryland Improperly Claimed Personal Care Services Provided Under Its Medicaid Home and Community-Based Services Waiver for Older Adults. A-03-11-00201. 2013 APR.*

Maryland should work with the State's Department of Aging to improve controls over PCS claims to ensure compliance and refund the Federal share of unallowable payments to the Federal Government.

See also:

- *West Virginia Improperly Claimed Some Personal Care Services Under Its Medicaid State Plan. A-03-11-00204. 2012 OCT.*

Traumatic brain injury (TBI) services

New York—provider noncompliance and program management deficiencies. New York improperly claimed Federal reimbursement for TBI payments (about \$54 million Federal share) that were unallowable because the services were provided to beneficiaries not qualified for nursing home level of care and/or services were not documented and/or were not provided in accordance with a plan of care. Some eligibility assessments were conducted by uncertified individuals and/or were not properly documented. Additional TBI payments were potentially unallowable; however the data were insufficient to determine beneficiary eligibility for such services.

- *New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements. A-02-10-01043. 2013 MAY.*

New York should require its contracted development centers to ensure and document that all beneficiaries approved for TBI services have been assessed by certified individuals and are eligible for the services, require adequate training for assessors on the Federal and State requirements, require providers to ensure that they document the services billed and claim reimbursement only for allowable ones, refund the Federal share of unallowable payments to the Federal Government, and work with CMS to resolve other claims for which payment may have been unallowable.

Assisted living facility (ALF)

Seven States—Provider noncompliance, ineffective oversight. We found that 77 percent of beneficiaries in seven selected States received home- and community-based services (HCBS) in ALFs that were cited for one or more deficiencies with regard to State licensure or certification requirements. Other deficiencies involved missing or insufficient plans of care. As part of a 35-State review, we specifically analyzed seven selected States with the highest numbers of beneficiaries receiving HCBS in ALFs: Georgia, Illinois, Minnesota, New Jersey, Oregon, Texas, and Washington. ALFs are State-regulated and -monitored residential long-term-care options that provide or coordinate oversight and services to meet the residents' individualized scheduled needs, on the basis of the residents' assessments and service plans and their unscheduled needs as they arise.² We did not attempt to identify the payment amounts associated with the deficiencies.

² Assisted Living Workgroup, *Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging, 2003.*

- *Home and Community-Based Services in Assisted Living Facilities.* [OEI-09-08-00360](#). 2012 DEC.

CMS should issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS.

State stewardship over policies and payments

This section describes gaps and vulnerabilities in States' program oversight and management practices that inappropriately inflate State and/or Federal costs of Medicaid.

Medicaid beneficiary identification numbers

New York—Systems interface deficiency. New York improperly claimed Federal reimbursement for payments (about \$7.3 million Federal share) to managed care organizations (MCOs) that were unallowable because the payments were duplicative. Some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification number, and New York's eligibility systems did not identify the potential beneficiary matches between the systems. We reviewed payments New York made to different MCOs for the same beneficiary and found that MCOs received duplicate monthly Medicaid payments for the beneficiaries. We also found that New York made eligibility errors.

- *New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers.* [A-02-11-01006](#). 2013 APR.

New York should ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State and require local departments of social services to ensure that applicants provide valid SSNs when required and maintain documentation to support eligibility determinations. New York should refund the Federal share of unallowable payments to the Federal Government.

See also:

- *2014 JAN—New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care.* [A-02-12-01007](#).
- *2012 MAY—Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive.* [A-02-11-01029](#).
- *2014 MAR—Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive.* [A-02-13-01008](#).

Cost allocation methodologies and related issues

Wisconsin—State noncompliance. Wisconsin improperly claimed Federal reimbursement for payments (about \$22.8 million Federal share) to residential care centers (RCCs) that were unallowable because the State used a noncompliant cost allocation methodology and used estimates that it could not adequately support. The State also claimed unsupported administrative costs as an add-on to the RCC service costs.

Wisconsin had contracted with a consultant to develop initiatives to target new revenues that might be available to the State.

- *Wisconsin Improperly Claimed Federal Medicaid Reimbursement for Most Residential Care Center Payments. A-05-07-00036. 2013 SEP.*

Wisconsin should work with CMS to identify payment and allocation methodologies for claiming allowable Medicaid RCC costs and refund the unallowable amounts to the Federal Government.

Arizona—State noncompliance. Arizona improperly claimed Federal reimbursement for Medicaid school-based administrative costs (about \$11.6 million Federal share) that were unallowable because the random moment timestudies (RMTS) methodology that Arizona used to allocate costs to Medicaid was not fully consistent with Federal requirements and the State did not always maintain the required supporting documentation. Also, the 2004 State guide included incorrect guidance that allowed its contractor to discard sample items. We set aside an additional \$18.8 million for CMS resolution. Federal regulations provide that random moment sampling (RMS), which uses RMTS, is an acceptable method for allocating costs to Federal awards when employees work on multiple activities. The methodology must meet acceptable statistical sampling standards, including that the results must be statistically valid.

- *Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs. A-09-11-02020. 2013 JAN.*

Arizona should strengthen controls to ensure that all required documentation to support the RMTS methodology is maintained and the RMTS methodology is consistent with Federal requirements. Also, Arizona should refund to the Federal Government the unallowable school-based administrative costs, work with CMS to determine the allowability of the amount we set aside for further analysis, and refund to the Federal Government any amount determined to be unallowable. We also recommend that Arizona review periods after our audit period and make appropriate financial adjustments for any unallowable school-based administrative costs claimed.

Florida—State noncompliance. Florida improperly claimed Federal reimbursement for administrative costs (about \$2.2 million Federal share) that were unallowable because RMS observation forms were not completed as specified and the RMS coordinator's review did not detect the noncompliance. As a result, the Medicaid administrative costs were overstated. Further, an additional \$20 million was questionable because of several vulnerabilities that we identified in the RMS statistical sampling methods. Florida claimed a 50-percent Federal share for the Medicaid portion of the administrative costs of the State's Agency for Persons With Disabilities (APD), including costs allocated on the basis of APD's quarterly random moment sampling (RMS). These and other deficiencies are addressed by the recommendations below.

- *Florida Claimed Some Medicaid Administrative Costs That Did Not Comply With Program Requirements. A-04-10-00076. 2013 MAR.*

Florida should require APD to amend its cost allocation plan to ensure that APD's RMS gives appropriate consideration to all hours worked by employees, properly accounts for invalid responses and nonresponses, and requires observation forms to include the sampled position numbers. Florida also should refund the unallowable amount to the Federal Government; ensure that APD follows pertinent

procedures defined in its cost allocation plan and work with CMS to determine what portion of the remaining Federal share of costs was allowable under Federal requirements.

Unallowable administrative costs

Pennsylvania—State noncompliance. Pennsylvania improperly claimed Federal reimbursement for administrative costs of the Pennsylvania Regional Housing Coordinator Initiative (about \$1.9 million Federal share) that were unallowable because the services did not directly relate to the administration of Medicaid services. The claimed costs represented indirect services, such as the provision of information, referrals, training, and technical assistance, to support housing programs, including programs that provided housing services to Medicaid beneficiaries.

- *Pennsylvania Claimed Unallowable Medicaid Administrative Costs for the Regional Housing Coordinator Initiative. A-03-11-00210. 2012 DEC.*

Pennsylvania should discontinue all future claims for Regional Housing Coordinator Initiative costs, refund the Federal funds claimed for unallowable Initiative costs, and refund the Federal share of unallowable Initiative costs claimed after our audit period.

Improper rates and reporting errors

California—Services not eligible for the enhanced rate for family planning. California improperly claimed Federal reimbursement (about \$5.7 million Federal share) for services at a 90-percent enhanced rate for family planning when they should have been claimed at the regular rate. The difference between the 90-percent rate and the regular rate was unallowable. The 90-percent rate was unallowable because the primary purpose of the visits was not family planning, the charges were for followup visits properly reimbursed at the regular rate, or the supporting documentation was insufficient. We also found claims that contained either no procedure code or a procedure code that was not approved by CMS for reimbursement at the 90-percent rate.

- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County. A-09-11-02040. 2012 DEC.*

California should establish billing procedures to ensure that only services whose primary purpose is family planning are claimed for reimbursement at the 90-percent enhanced rate, and should establish Medicaid Management Information System edits to ensure that family planning claims meet Federal and State requirements for reimbursement at the 90-percent enhanced rate and at the regular rate for followup visits. Also, California should refund the unallowable Federal enhanced reimbursement to the Federal Government.

Arkansas—Services not eligible for the enhanced rate for family planning. Arkansas improperly claimed Federal reimbursement (about \$1.9 million Federal share) for services at a 90-percent enhanced rate for family planning when they should have been claimed at the regular rate. The difference between the 90-percent rate and the regular rate was unallowable. The payments were inappropriate

because they exceeded limits specified in the State's allocation methodology and resulted from the State's errors in compiling the family planning expenditures and from errors in the computer programming used to identify costs, i.e., infant delivery costs were incorrectly classified as family planning expenditures as a result of the programming errors.

- *Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010. A-06-11-00022. 2013 JAN.*

Arkansas should review its pertinent computer programming; submit documentation to CMS supporting the reasonableness of the percentages used in allocations; and establish review procedures to ensure that expenditures are correctly compiled, assigned, and claimed. Arkansas should also refund to the Federal Government the family planning Federal share, work with CMS to determine the allowable portion of the family planning Federal share that it received for allocated sterilization costs, review the claim-level data of quarters that we did not analyze, identify infant delivery costs incorrectly classified, and refund overpayments to the Federal Government.

Missouri—State errors in reporting payments for family planning services. Missouri improperly claimed Federal reimbursement for costs of Medicaid family planning sterilization procedures (about \$1.5 million Federal share) that were unallowable. The amount claimed was overstated because of two types of errors the State made on the Form CMS-64. The excess Federal reimbursement occurred because the State agency's adjustment process—which was designed to identify costs for family planning sterilization procedures—was ineffective.

- *Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010. A-07-12-01117. 2013 JUN.*

Missouri should ensure that future expenditures for family planning sterilization procedures are correctly claimed to CMS, refund the Federal share of payments we estimated to be unallowable, review family planning sterilization procedures for quarterly reporting periods after our audit period, and refund the Federal share of any unallowable payments.

Missouri—Errors in reporting payments for intermediate care facility (ICF) services. Missouri improperly claimed Federal reimbursement for State-operated intermediate care facilities payments (about \$7.2 million Federal share) that were unallowable because Missouri claimed the same payments twice—during the quarter ended December 2010 and again during the quarter ended March 2011. Missouri's controls did not specify that the State perform reconciliations of payments to claimed costs to ensure that it did not claim duplicate or unsupported Medicaid payments on its CMS-64 report.

- *Missouri Claimed Unallowable Medicaid Payments for Individuals With Intellectual and Developmental Disabilities in Intermediate Care Facilities. A-07-12-03180. 2013 JUN.*

Missouri should develop and implement sufficient internal controls and procedures, including those pertaining to reconciliations of payments to claimed costs, and refund the Federal share of payments we estimated to be unallowable.

See also:

- *Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010. A-07-12-01118. 2014 JAN.*

Hospital eligibility issues

Disproportionate share hospitals

New Jersey—State noncompliance. New Jersey improperly claimed disproportionate share (DSH) payments (about \$50 million Federal share) for five hospitals that did not meet Federal eligibility requirements for such payments during our audit period. For a hospital to receive DSH payments, the State must properly classify the hospital as a DSH. New Jersey stated that it claimed DSH payments for the hospitals because it misinterpreted Federal regulations on DSH eligibility. Under the DSH program, the State agency is required to make special payments to hospitals that serve a disproportionate share of low-income and/or uninsured patients. The State did not ensure that the hospitals were eligible for DSH before claiming the amounts for Federal reimbursement.

- *The New Jersey Department of Human Services Claimed Medicaid Disproportionate Share Hospital Payments to Five Hospitals That Did Not Meet Federal Eligibility Requirements. A-02-09-01017. 2012 NOV.*

New Jersey should ensure that all hospitals designated as DSHs meet Federal eligibility requirements for DSH payments. The State should also refund the Federal share of unallowable payments to the Federal Government.

State-Owned Psychiatric Hospitals

Missouri—State noncompliance. Our review of one of Missouri's nine State-owned psychiatric hospitals found that the State improperly claimed Federal reimbursement (about \$21.3 million Federal share). The reimbursement was unallowable because the selected State-owned hospital did not demonstrate compliance with the special Medicare Conditions of Participation (CoP). For States to claim Federal Medicaid reimbursement for inpatient psychiatric services and DSH payments to psychiatric hospitals, the hospitals' inpatient services must meet the Federal definition of such services. The definition includes that the providers demonstrate compliance with the basic Medicare CoP generally applicable to all hospitals and two special Medicare CoP applicable to psychiatric hospitals. The State did not ensure that the State-owned facility was eligible for Federal reimbursement for inpatient psychiatric services and DSH payment.

- *Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children's Psychiatric Hospital. A-05-12-00050. 2013 JUN*

Indiana—State noncompliance. Indiana improperly claimed Federal reimbursement for payments (about \$12.8 million Federal share) for two of its six State-owned psychiatric hospitals. For a different review period, Indiana also improperly claimed Federal reimbursement for payments (about \$7.5 million Federal share) for a third State-owned psychiatric hospital. Our reviews found that the State-owned facilities did not demonstrate the required compliances with CoP. Indiana did not ensure that its

facilities were eligible for Federal Medicaid reimbursement before claiming reimbursement for inpatient psychiatric services.

- *Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Evansville State Hospital. A-05-12-00041. 2013 JUN.*
- *Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Logansport State Hospital. A-05-12-00042. February 2013.*
- *Indiana Improperly Claimed Federal Reimbursement for Most Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Evansville Psychiatric Children's Center. A-05-12-00040. 2013 MAY.*

Missouri and Indiana should ensure that Federal reimbursement for the subject payments to psychiatric hospitals is claimed only if the hospitals can demonstrate compliance with the basic and special Medicare CoP, refund the Federal share of the improperly claimed amount to the Federal Government, and work with CMS to resolve other claims for which payment may have been unallowable.

Identification of excluded providers

California—State noncompliance. California improperly claimed Federal reimbursement for payments (about \$1.2 million Federal share) that were unallowable because the items or services provided were associated with excluded providers. The State did not implement policies and procedures to determine whether excluded providers were listed on claims. OIG may exclude certain individuals and entities from participation in federally funded health care programs, including Medicaid. With a limited exception for certain emergency care, such programs should not pay for items or services to the excluded provider, to anyone who employs or contracts with the excluded provider, or to any hospital or other provider where the excluded provider furnished items or services during the period of exclusion.

- *California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers. A-09-11-02016. 2013 APR.*

California should ensure that it does not pay for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to monitor agencies that enroll providers or process Medicaid claims to ensure compliance with CMS guidance that reviews be conducted monthly to identify excluded providers and determine whether any providers (i.e., furnishing, ordering, or prescribing) listed on claims are excluded and deny those claims. California should refund the Federal share of payments we estimated to be unallowable and work with CMS to resolve other claims for which payments may have been unallowable.

Identification of third-party liability for payment

Pursuant to our review, States estimated that about \$4 billion remained at risk of not being recovered because Medicaid paid for costs that were the responsibility of other payers. Medicaid is intended to be

the payer of last resort. Millions of Medicaid beneficiaries have additional health insurance through third-party sources, such as Medicare, TRICARE, or other Government or private payers. Improved State processes and congressional action seem to have had some positive effect, but continued vigilance is needed. States continue to report longstanding challenges when trying to identify other insurance coverage. The recommendations in our January 2013 report should help States better identify liable third parties, recover improper Medicaid payments, and return the Federal share of the payments to the Federal Government.

■ *Medicaid Third-Party Liability Savings Increased, But Challenges Remain.* [OEI-05-11-00130](#). 2013 JAN.

CMS should work with States to address longstanding challenges working with third parties to identify insurance coverage and recover payments, address States' challenges with 1-year timely filing limits for Medicare and TRICARE, and strengthen enforcement mechanisms designed to deal with uncooperative third parties.

See also:

- *North Carolina Medicaid Overpaid Hospitals for Some Inpatient Services That Medicare Paid.* [A-04-11-06137](#). 2013 MAY.
- *South Carolina Medicaid Overpaid Hospitals for Some Inpatient Services That Medicare Paid.* [A-04-11-06145](#). 2014 FEB.

Recovery of the Federal share of Medicaid overpayments

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR pt. 225 (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). Pursuant to 2 CFR § App. A, C.1.c., to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.

State oversight of provider reconciliations of credit balances

North Carolina. State and provider noncompliance with overpayment requirements. One method for identifying overpayments is to examine credit balances in provider accounts. Our review in North Carolina identified overpayments associated with unresolved credit balances at selected providers totaling about \$10,000 (about \$7,000 Federal share). On the basis of the results, we estimated that North Carolina could realize a Statewide recovery of at least \$1.2 million (at least \$902,000 Federal share) from our review period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts. The selected providers reviewed did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed.

■ *Noninstitutional Providers in North Carolina Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency.* [A-04-11-04016](#). 2012 NOV.

North Carolina should realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments to the State. Also, North Carolina should refund the Federal share of the overpayments we identified to the Federal Government and enhance its efforts to recover the additional overpayments we estimated from our review period.

See also:

- *Georgia—Acute Care Hospitals in Georgia Did Not Always Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency.* [A-04-12-04021](#). 2013 FEB.
- *Missouri—Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency.* [A-07-11-03169](#). 2013 JAN.
- *California—Noninstitutional Providers in California Did Not Always Reconcile Invoice Records With Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments,* [A-09-12-02047](#). 2013 JUL.

State recoveries of improper payments and refunds of the Federal share

Florida. Noncompliance with collection and reporting requirements. Our audit covered nearly \$22.3 million (about \$12.2 million Federal share) in State-identified Medicaid overpayments for ineligible individuals during the period July 1, 2007, through June 30, 2010. Of this amount, the State collected almost \$2.5 million (\$1.4 million Federal share) but had not collected nearly \$19.8 million (\$10.8 million Federal share). The State did not return the Federal share of either the collected or uncollected amounts to CMS. In addition, the State collected more than \$1.5 million (about \$850,000 Federal share) of overpayments subsequent to our audit period, from July 1, 2010, through June 30, 2012, that it did not report to CMS.

- *Florida Medicaid: Millions in Overpayments Not Refunded.* [A-04-11-08007](#). 2013 MAR.

Florida should improve coordination to report State-identified Medicaid overpayments and collections. It should refund the Federal share of amounts collected during our audit period and during the 2 fiscal years following our audit period. It should work with CMS to determine whether it should refund the Federal share of recipient overpayments identified but not collected.

CMS's recovery of OIG-identified overpayments

As of December 2012, CMS had not collected \$225.6 million of \$1.2 billion in Medicaid overpayments to States that OIG had identified. When CMS concurs with a recommendation to collect overpayments, it may sustain (agree to collect or offset) either the entire amount or a different amount. If the overpaid State agrees in writing with OIG or CMS to refund the overpayment, the State should refund it to the Federal Government. If the State does not agree, CMS should follow other procedures to resolve the OIG recommendations.

- *Medicaid overpayments—The Centers for Medicare & Medicaid Services Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected. A-05-11-00071. 2013 FEB.*

CMS should review and address delays in resolving OIG audit recommendations and promptly pursue corrective actions, maintain adequate documentation to support the collection of overpayments in accordance with OMB Circular A-50 and CMS Standard Operating Procedures, educate the States about their responsibility to report overpayments on the correct line of the CMS-64 to improve oversight of the reporting process, and collect the remaining amount we identified as due the Federal Government.

Medicaid Wasteful Policies and Practices

Wasteful spending occurs when Federal or State Medicaid laws, policies, methodologies, and practices fail to ensure that program costs are consistent with efficiency and economy; reasonableness; and Medicaid's role as a high-volume, prudent payer in the health care marketplace. Actions to reduce Medicaid costs through changes in policies and practices generally provide mutual benefit to States and the Federal Government.

Payments for prescription drugs

Medicaid Federal upper limit (FUL) amounts

We found that FUL amounts based on average manufacturer prices (AMPs) were 61 percent lower than FUL amounts based on published prices, e.g., average wholesale price (AWP) at the median. AMP-based FULs exceeded sampled pharmacy acquisition costs by 43 percent in the aggregate.

- *Analyzing Changes to Medicaid Federal Upper Limit Amounts. OEI-03-11-00650. 2012 OCT.*

CMS should complete the implementation of the post-Affordable Care Act AMP-based FUL amounts for drug reimbursements.

State Maximum Allowable Cost Programs

States may achieve additional cost savings by using different Maximum Allowable Cost (MAC) pricing formulas and inclusion criteria. For example, we estimated that by using Wyoming's methodology as a model, 39 of 45 States could have saved about \$483 million on their Medicaid generic drug costs in the first half of 2011. The use of more aggressive pricing formulas and inclusion criteria could achieve additional cost savings.

- *Medicaid Drug Pricing in State Maximum Allowable Cost Programs. OEI-03-11-00640. 2013 AUG.*

CMS should complete the implementation of the post-Affordable Care Act FUL amounts and encourage States to reevaluate their Maximum Allowable Cost pricing programs for additional cost-saving opportunities.

Payments for blood glucose test strips and other medical equipment and supplies

New York. For a 1-year audit period, we estimated that the New York Medicaid program could have saved an additional \$5.9 million (36 percent) on diabetes test strips through competitive bidding.

- *The New York State Manufacturer Rebate Program Significantly Reduced Medicaid Costs for Home Blood-Glucose Test Strips But Could Achieve Additional Reductions.* [A-02-11-01042](#). 2013 JUL.
-

New Jersey. For a 1-year audit period, we estimated that fee-for-service savings of \$1.8 million to \$2.7 million and managed care savings of \$3.1 million to \$4.5 million during the same period could be achieved. Our recommendations could result in a reduction of 46 to 68 percent in the price of test strips paid under the New Jersey Medicaid fee-for-service program and a reduction of 49 to 70 percent in the price paid by the Medicaid MCOs.

- *New Jersey Medicaid Program Could Achieve Savings by Reducing Home Blood-Glucose Test Strip Prices.* [A-02-12-01010](#). 2013 SEP.
-

Illinois. For one State fiscal year (SFY), we estimated that Illinois could have saved an additional \$8.5 million. On average, Medicare's rates were about 40 percent less than the State's Medicaid rates.

- *Illinois Significantly Reduced Medicaid Costs for Home Blood-Glucose Test Strips But Could Achieve Additional Reductions.* [A-05-12-00009](#). 2013 MAY.
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Ohio. For a 1-year audit period, the Ohio Medicaid program could have saved an estimated \$3 million on selected durable medical equipment items. We estimated that the State agency's cost could have been reduced to about \$7.4 million (from \$10.5 million).

- *The Ohio Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment and Supplies.* [A-05-12-00038](#). 2013 APR.
-

Texas. If Texas had used Medicare's competitive bidding payment amounts for the Dallas/Fort Worth area during the 1-year review period, it could have saved about \$2 million (State and Federal shares combined) on 30 selected medical equipment and supplies items.

- *Medicaid DMEPOS Costs May be Exceeding Medicare Costs in Competitive Bidding Areas.* [OEI-06-13-00470](#). 2013 SEP.

Recommendations from the above reports:

- New York should establish a competitive bidding program similar to that in the Medicare program for the purchase of test strips.
- New Jersey should establish a competitive bidding program similar to that in the Medicare program for the purchase of test strips, reduce the Medicaid fee-for-service reimbursement rate for test strips to be comparable to the average retail price, or work with Medicaid MCOs to adjust payment rates for test strips to the average retail price or to Medicare competitive payment rates.
- Illinois should lower the net cost of test strips through changes to its provider reimbursement rates.
- Ohio should establish competitive bidding that functions similar to Medicare’s Competitive Bidding Program for the purchase of selected durable medical equipment and supply items.
- Texas. Further analysis is needed to better understand the full potential of limiting Federal reimbursement for State Medicaid spending on medical equipment and supplies to Medicare payment rates.

See also:

- *The California Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment.* [A-09-13-02028](#). 2014 MAR.
- *OIG Spotlight article. “Diabetes Test Strips.”* 2014 MAR.
- *State Medicaid Agencies Can Significantly Reduce Medicaid Costs for Diabetic Test Strips.* [A-05-13-00033](#). 2014 MAR.
- *The Minnesota Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment and Supplies.* [A-05-13-00015](#). 2014 JAN.
- *State Medicaid Program Efforts to Control Costs for Disposable Incontinence Supplies.* [OEI-07-12-00710](#). 2014 JAN.

Beneficiary eligibility and access to care

Home Health Care Restrictions of Eligibility

We identified 11 States with policies in their Medicaid State Plans or other written policy documents that improperly restrict eligibility for the mandatory home health benefit to homebound individuals: Alabama, Arkansas, Indiana, Montana, Nebraska, New Mexico, North Dakota, Pennsylvania, South Dakota, Utah, and West Virginia. The report encourages CMS to finalize its pertinent regulation, after which it could consider issuing guidance specific to home health services and homebound eligibility

restrictions, explaining why such restrictions are improper. In July 2000, CMS released a State Medicaid Director letter stating that although Medicare requires beneficiaries to be homebound to qualify for home health services, imposing a homebound requirement on Medicaid home health benefits violates CMS's interpretation of Medicaid regulations related to "amount, duration, and scope of services" and "comparability of services." In July 2011, CMS published a Notice of Proposed Rulemaking to codify its interpretation, but it remains to be implemented. (76 Fed. Reg. 41032, 41033, and 41038 (July 12, 2011)). The report did not include formal recommendations to CMS.

- *Some States Improperly Restrict Eligibility for Medicaid Mandatory Home Health Services.* [OEI-07-13-00060](#). 2013 JUL.

Medicaid legal and investigative activities

OIG oversight of State Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. HHS OIG oversees MFCUs and administers grants that provide Federal funding for Unit operations. The Federal Government reimburses 75 percent of the costs of operating a Unit; the States contribute the remaining 25 percent. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities.

MFCU funding and accomplishments in FY 2013

In FY 2013, combined Federal and State expenditures for the operation of 50 MFCUs (including 1 in Washington, DC), totaled about \$231.5 million. The MFCUs employed 1,912 individuals. Collectively, in FY 2013, MFCUs reported 15,590 investigations, of which 12,366 were related to Medicaid fraud and 3,224 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,588 individuals, including 1,197 for fraud and 391 for patient abuse and neglect, including patient funds cases. In total, 1,341 criminal actions were reported in FY 2013, of which 991 were related to Medicaid fraud and 350 were related to patient abuse and neglect, including patient funds cases. Civil judgments and settlements for FY 2013 totaled 879 and monetary recoveries in civil cases totaled over \$1.5 billion. (*Medicaid Fraud Control Units FY 2013 Annual Report*. [OEI-06-13-00340](#). Appendix C. 2014 MAR.) See also Medicaid Fraud Control Units 2013 Statistics [Interactive Map](#) and [Chart](#) on our Web site.

FY 2013 onsite reviews of MFCUs

OIG has developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the [MFCU performance standards](#), most recently revised in June 2012, may be found on the OIG Web site. Periodically—approximately every 5 years—OIG conducts an in-depth onsite review of each Unit to evaluate its operations as related to the 12 performance standards and to assess compliance with laws,

regulations, and OIG policy guidance. OIG issued reports of onsite reviews of the following MFCUs during FY 2013. The full reports are available on our Web site.

- *Arkansas State Medicaid Fraud Control Unit: 2013 Onsite Review. OEI-06-12-00720. 2013 SEP.*
- *Idaho State Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-09-12-00220. 2013 APR.*
- *Illinois State Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-07-12-00510. 2013 JUN.*
- *Louisiana State Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-09-12-00010. 2012 DEC.*
- *New Hampshire Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-02-12-00180. 2012 OCT.*
- *New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review. OEI-02-13-00020. 2013 SEP.*
- *South Carolina State Medicaid Fraud Control Unit: 2011 Onsite Review. OEI-09-11-00610. 2012 OCT.*
- *Tennessee State Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-06-12-00370. 2013 APR.*

Joint investigations with MFCUs

Following are examples of OIG's joint investigations with MFCUs that reached conclusion in FY 2013.

California—Physician. According to court documents, Tustin Hospital paid marketers to recruit patients and transport them to the facility. Dr. Kenneth Thaler admitted the patients; then he and the hospital billed Medicare for inpatient services, even when such services were not medically necessary. Thaler admitted that many of the recruited patients had been coached to recite false symptoms and that he falsified medical records to justify the admissions of some patients. On average, Thaler admitted approximately 60 patients per month to the hospital. Thaler was sentenced to 1 year and 1 day in prison and ordered to pay about \$11 million in restitution after pleading guilty to conspiracy to receive kickbacks. This was a joint investigation with the Internal Revenue Service, the FBI, and the Bureau of Medi-Cal Fraud and Elder Abuse.

California—Hospital chief financial officer. Vincent Rubio was Chief Financial Officer of a hospital in Tustin, California. According to court documents, Rubio oversaw the issuance of checks to companies owned by co-conspirators for the referral of recruited beneficiaries admitted to the hospital. The hospital executed sham "consultant" contracts with these companies to conceal the fact that the hospital was making kickback payments to them for the referrals. The hospital then billed Medicare and Medi-Cal for hospital stays and related services provided to the recruited beneficiaries, including admissions that were medically unnecessary. Medicare and Medi-Cal paid the hospital more than \$10.5 million in reimbursement for these false claims. Rubio was sentenced to 8 months of home confinement and ordered to pay about \$10.6 million in restitution after pleading guilty to charges of conspiracy to pay kickbacks for patient referrals, causing an act to be done, and subscription to false tax returns. This was a joint investigation with the Internal Revenue Service, the Federal Bureau of Investigation (FBI), and the California MFCU.

Idaho—Optometrist. Christopher Card was a licensed optometrist who owned, managed, and provided care at Total Vision, P.A. According to the plea agreement, Card fraudulently billed Medicaid, Medicare, and other health care benefit programs for false diagnoses, including glaucoma, acquired color deficiency (color blindness), tension headaches, macular degeneration, treatment of eye injuries, and

removal of foreign objects from the eye. Card also billed for testing that did not occur and for testing results that were falsified or altered. Eighteen patients identified in the original indictment were diagnosed by Card as having glaucoma or glaucoma-related conditions. All were subsequently examined by other doctors, and only one patient was found to have glaucoma or glaucoma-related diseases. The patients named in the original indictment represented only a fraction of those for whom Card falsely billed health insurance companies. Card was sentenced to 3 years in prison and ordered to pay \$1 million in restitution and a \$100,000 fine after pleading guilty to charges of executing a scheme to defraud health care benefit programs. This was a joint investigation with the FBI, the Idaho Medicaid Fraud and Program Integrity Unit, and the Railroad Retirement Board OIG.

Maine –Podiatrist. John Perry was a licensed podiatrist who owned and operated Atlantic Foot & Ankle, P.A., in Portland, Maine. According to court records, Perry prescribed controlled substances, including oxycodone, knowing that these substances were being further distributed by his co-conspirators. Perry would charge up to \$500 or more for each oxycodone prescription. Perry wrote prescriptions without any medical purpose; in the names of people to whom he never provided medical care; and in exchange for money and other controlled and illegal substances, including cocaine, for his personal use. Perry also wrote prescriptions with no legitimate medical purpose outside his medical office, including at bars and a strip club. Perry fabricated patient charts in his office to cover his improper prescriptions and then submitted false claims for these prescriptions to MaineCare. Perry was sentenced to 8 years of imprisonment and ordered to pay \$7,580 in restitution and a \$900 fine after pleading guilty to charges of conspiracy to possess with intent to distribute oxycodone; health care fraud, aiding and abetting; and unlawful distribution of oxycodone. This was a joint investigation with the Drug Enforcement Administration, the FBI, and the Maine MFCU.

Other Medicaid-related criminal and civil actions

The following are other examples of FY 2013 criminal and civil actions involving Medicaid. Medicaid investigations sometimes involve other programs as well, such as Medicare, and may involve multiple investigative resources, such as FBI and State and local enforcement entities.

Connecticut—Drug abuse counselor. According to published reports, Alan Bradley was a certified alcohol and drug abuse counselor who obtained the Medicaid identification numbers of various Medicaid clients and used the identification numbers to submit hundreds of claims to Connecticut's Department of Social Services. The claims alleged that Bradley provided 75- to 80-minute individual psychotherapy sessions to these Medicaid clients at his office in Norwalk, Connecticut. However, hundreds of the counseling sessions never occurred, and during the time for which he billed Medicare for many of them, Bradley was actually living and attending school in Florida. Bradley was sentenced to 2 years in prison and ordered to pay nearly \$152,000 in restitution after pleading guilty to charges of health care fraud. In addition to receiving his sentencing, Bradley was suspended from participating in the Medicaid program.

District of Columbia—Owner/officer of advocacy center. According to the indictment, Jacqueline Wheeler was part-owner and chief executive officer of the Health Advocacy Center, Inc. (HAC), in Washington, DC, which purportedly was an advocate for improving health care delivery to the community. About October 2002, HAC entered into an agreement with District of Columbia Medicaid to provide health care services to DC Medicaid beneficiaries. Wheeler owned two apartments that were rented by HAC patients who had alcohol and/or drug addictions. Wheeler's employees transported many of the patients to HAC, where they often slept, watched television, and occasionally received drug

and alcohol counseling. From these visits, Wheeler submitted more than \$6 million in claims to D.C. Medicaid for manual therapy and other services that did not meet Medicaid requirements for payment. Wheeler was sentenced to 6 years and 3 months of incarceration and ordered to pay about \$3.1 million in restitution after being convicted of charges related to health care fraud.

Florida—Community mental health centers. Health Care Solutions Network, Inc. (HCSN), operated community mental health centers in Florida (HCSN-FL) and North Carolina (HCSN-NC). These facilities allegedly provided partial hospitalization program (PHP) services to individuals suffering from mental illness. According to court documents, HCSN-FL personnel fabricated patient medical records to support false and fraudulent billing to Medicare and to Florida Medicaid. A majority of the fabricated notes were created at the HCSN-FL facility for patients admitted to the PHP HCSN-NC facility. The defendants either submitted, or caused the submission of, about \$56 million in false and fraudulent claims. As of FY 2013, 12 defendants had been sentenced for their roles in the health care fraud scheme—Wondera Eason, Paul Layman, Dana Gonzalez, Gema Pampin, Alexandra Haynes, Armando Gonzalez, John Theon, Daniel Martinez, Serena Joslin, Ivon Perez, Raymond Rivero, and Sarah Keller were sentenced to a combined 70 years of incarceration and ordered to pay \$186 million in joint and several restitution.

Illinois—Bogus personal care services assistant. According to the indictment, Cynthia Harmon and Daniel Geary defrauded the State of Illinois Medicaid program by falsely claiming and taking payments for personal assistant services that were not actually performed. Between February and March 2012, Geary purportedly provided personal care services to Harmon, a Medicaid recipient, at her home. However, Harmon was incarcerated during the time that the services were claimed to have been provided. Geary completed home services time sheets falsely stating that he performed 44.5 hours of personal assistant services for Harmon; he then billed Medicaid for the hours and received \$821 in reimbursement. Geary and Harmon were each sentenced to time served (4 months and 25 days for Harmon and 4 months and 11 days for Geary) and ordered to pay \$421 after pleading guilty to false statements relating to health care matters.

Indiana—Owner of day care service. Carol Woodard owned Gideon's Gate, which purportedly provided tutoring and day care services to indigent and school-age children. Woodard admitted that she executed a scheme to defraud Indiana Medicaid by filing more than 2,400 illegitimate reimbursement claims for psychological services that she had not performed. Woodard conspired with a previously convicted defendant, who provided Medicaid recipients' personal identifiers to Woodward, which she then used in false billings. Woodard was sentenced to 6 years and 8 months of incarceration and ordered to pay more than \$1.9 million in restitution after pleading guilty to health care fraud.

Iowa—Dentist. Dennis Schuller practiced dentistry in Cedar Rapids, Iowa. According to court records, Schuller allegedly billed Medicaid from August 2008 through June 2010 for exams performed by a hygienist as though a dentist had performed the exams. He billed for medically unnecessary procedures—for individual x-rays when whole mouth x-rays had been performed, for occlusal guards (mouth guards) that were not medically necessary, and for the use of desensitizing medication on patients when this medication was not medically necessary. Schuller agreed to pay \$100,000 to settle allegations that he submitted, or caused to be submitted, false claims for payment to Medicaid.

Michigan—Pharmacy owner. According to the indictment, Babubhai Patel was a licensed pharmacist who either owned or controlled 26 pharmacies in Michigan. Patel concealed his ownership and control over many of his pharmacies through the use of straw owners. Patel offered and paid kickbacks, bribes, and other inducements to prescribers in exchange for their writing fraudulent prescriptions for patients

with Medicare, Medicaid, and private insurance and directing the patients to fill their prescriptions at one of Patel's pharmacies. Patel and his pharmacists billed Medicare and other insurers for dispensing the medications, despite the fact that the medications were medically unnecessary and/or had not been provided. Since January 2009, Patel's pharmacies dispensed approximately 250,000 doses of Oxycontin, 4.6 million doses of Vicodin, 1.5 million doses of Xanax, and 6,100 pint bottles of codeine cough syrup. Patel's pharmacies falsely billed Medicare and Medicaid approximately \$57.8 million for medications purportedly provided to beneficiaries over the course of the scheme. Patel was sentenced to 17 years in prison and ordered to pay \$18.9 million in restitution, joint and several. By the end of FY 2013, 26 defendants had been convicted for their roles in the widespread scheme to defraud Medicare and Medicaid. Nineteen additional defendants were awaiting sentencing.

Minnesota—Beneficiary. James and Cynthia Hood fraudulently applied for several types of government benefits, including Medicaid and Social Security. According to court records, the Hoods, along with their three children, moved to Minnesota from Louisiana in 2005 after Hurricane Katrina. From January 2006 to April 2011, the couple stole approximately \$480,000 in State and Federal Medicaid benefits and Social Security benefits. During the application process for these benefits, Cynthia Hood made false statements, including that she did not have any assets and that she lived separately from her husband. However, investigators determined that she had substantial assets and lived with her husband James Hood and that James Hood had investments worth over \$11 million. James Hood was sentenced to 3 years and 6 months of imprisonment after pleading guilty to charges of theft of public money, health care fraud, and mail fraud. Cynthia Hood was sentenced to 3 years of probation after pleading guilty to false statements for use in determining rights to a Social Security benefit and mail fraud. Both were ordered to pay \$483,312 in restitution, joint and several, and were fined \$500,000.

New York—Mental health facility. Westchester County Health Care Corporation (WCHCC) WCHCC operates the freestanding mental health facility Westchester Behavioral Health Center (BHC). From August 2001 through June 2010, WCHCC allegedly submitted false certifications to Medicaid stating that claims for services at BHC complied with applicable regulations. WCHCC allegedly billed for professional services by uncredentialed nurse practitioners; billed for services rendered without required progress notes, physician signatures, or other supporting records; billed for hospital stays without the required certification or recertification of medical necessity; routinely failed to collect copayments from psychiatric inpatients to induce use of services; and offered potential kickbacks to private-practice physicians in return for patient referrals. The investigation also revealed that BHC allegedly billed Medicaid for psychiatric services without creating or maintaining treatment plans and progress notes. WCHCC agreed to pay \$7 million to resolve allegations that it violated the FCA.

Texas—State Employee fraud. The investigation revealed that Texas Medicaid's Medical Transportation Program (MTP) employees obtained the Medicaid numbers and personally identifiable information of Medicaid recipients, including friends and family members, to submit false MTP claims for transportation services that had not been provided or were unnecessary. According to the indictment, the defendants fraudulently obtained reimbursement checks, cashed the checks, and either kept the money or divided it among the co-conspirators. Several other defendants were previously sentenced in this case. In total, 19 defendants were ordered to pay more than \$247,000 in restitution and fines and were sentenced to a combined 6 years of incarceration. Juanita Leyva, Arlene Rodriguez, Edward Devally, Leticia Orosco, Michelle Aguilar, Patricia Cortez, and Loretta Cortez all were sentenced on charges related to the scheme. As a result of the investigation, a new MTP director was appointed, the program was restructured, and new policies were put in place.

Texas—Beneficiary/recruiter fraud. According to court documents, Robert Baker was a Medicare beneficiary who, from March 2007 through April 2012, visited Adom Rehabilitation Services, Inc., and Healthcare and Wellness Medical Clinic, Inc. These clinics purportedly provided medical services, such as physical therapy, diagnostic testing, and mental health services. However, Baker did not have a medical need for the services; rather he would allow his Medicare benefits to be billed in exchange for cash. Baker also was paid cash to recruit Medicare and Medicaid beneficiaries to the clinics. The owners and operators of the medical clinics then submitted claims to Medicare for payment using Medicare information from Baker and his co-conspirators. The owner and operator of the clinics, along with two clinic employees, were previously sentenced for their roles in the scheme. Baker was sentenced to 1 year and 6 months of incarceration and ordered to pay \$173,653 in restitution, joint and several, after pleading guilty to conspiracy to violate the anti-kickback statute.

Texas—Bogus physical therapist. According to court documents, Godwin Nzeocha worked for City Nursing Services of Texas, Inc., where he signed his name as the provider of physical therapy services on City Nursing patient files, including blank treatment data forms, progress notes, and daily physical therapy records. However, Nzeocha was not licensed, trained, or otherwise qualified to provide physical therapy to patients. During the time Nzeocha worked at City Nursing, the company billed Medicare and Medicaid approximately \$3 million for physical therapy services that had not been provided. Nzeocha, who was an OIG Most Wanted Fugitive, was arrested by Nigerian authorities in 2011 and extradited to the United States in June 2012 to face health care fraud charges. Nzeocha was sentenced to 9 years and 1 month of incarceration and ordered to pay more than \$26 million in restitution, joint and several, after pleading guilty to charges of conspiracy to commit health care fraud and money laundering.

Exclusions from program participation

OIG may exclude individuals and entities from participation in Medicare, Medicaid, and all other Federal health care programs for many reasons, some of which include program-related convictions, patient abuse or neglect convictions, licensing board disciplinary actions, or other actions that pose a risk to beneficiaries or programs. (Social Security Act, § 1128, § 1156, and other statutes.) Exclusions are generally based on referrals from Federal and State agencies. We work with these agencies to ensure the timely referral of convictions and licensing board and administrative actions. In FY 2013, OIG excluded 3,214 individuals and entities from participation in Federal health care programs. Searchable exclusion lists are available on OIG's Web site at: <http://exclusions.oig.hhs.gov/>

The following are examples of program exclusions in FY 2013.

Florida—Chiropractor. Joseph Burrell Wagner, Jr., a chiropractor, billed, and caused bills to be sent to, Medicare, Medicaid, and private insurers for services that were rendered by him or his staff as though they were medical doctors. Wagner used the name of a medical doctor to fraudulently bill for services that had never been performed or provided by the medical doctor. In addition, he conspired with others to distribute and dispense schedule III and IV controlled substances. As a licensed chiropractor, Wagner was not permitted to prescribe, distribute, or dispense controlled substances. As a result of these crimes, Wagner was sentenced to 15 years and 8 months of incarceration and ordered to pay more than \$2 million in restitution. The Florida Board of Chiropractic Medicine ordered the relinquishment of Wagner's license to practice as a chiropractor. Wagner was excluded for a minimum period of 40 years on the basis of his convictions for health care fraud; conspiracy to illegally distribute and dispense, and cause to be distributed and dispensed, schedule III and IV controlled substances; and aiding and abetting transactional money laundering.

Florida—Pain clinic owner/operator. From November 2007 to about September 2011, Juan De Dios Gomez owned and operated a pain clinic for the purpose of obtaining false prescriptions for oxycodone and oxymorphone for beneficiaries of Medicare, Medicaid, and private health care prescription drug insurance plans. The drugs were not medically necessary. Gomez would offer kickbacks, bribes, and inducements to beneficiary recruiters so they would bring beneficiaries to his pain clinic. The court sentenced Gomez to more than 16 years of incarceration and ordered him to pay \$15 million in restitution. Gomez was excluded for a minimum of 50 years on the basis of his convictions for conspiracy to possess with intent to distribute oxycodone and oxymorphone, attempt to possess with intent to distribute oxycodone, and conspiracy to commit health care fraud.

Louisiana—Clinic owner. Vadim Mysak, was an owner, manager, and technician of several medical clinics. Mysak and his co-conspirators were involved in a scheme to defraud Medicare and Medicaid through fraudulent billing for diagnostic tests that were not medically necessary or had not been performed. On the basis of this scheme, Mysak was convicted on charges of conspiracy to commit health care fraud and conspiracy to commit money laundering. He was sentenced to 4 years and 1 month of incarceration and ordered to pay more than \$6 million in restitution, joint and several. Mysak was excluded for a minimum period of 25 years on the basis of his conviction. Mysak was also excluded from participation in Medicaid by the Louisiana Department of Health and Hospitals.

Washington—Physician. Alfred Chan was a medical doctor who specialized in hematology and oncology. He and his wife Judy operated the Alfred H. Chan, M.D., P.C., Clinic in Lakewood, Washington, until the clinic closed in February 2011. According to court documents, the Chans allegedly defrauded Medicare, Medicaid, and other Federal health care programs by intentionally submitting false and inaccurate claims for medications and services. Specifically, the Chans allegedly billed for quantities of drugs greater than those actually administered to patients, overstated chemotherapy drug infusion times, and double-billed for medications. They also falsified the patient charts to support the fraudulent billing. Chan agreed to pay \$3.1 million to resolve allegations under the FCA. As a result of this conduct, Chan agreed to be excluded for a period of 15 years. In January 2012, Chan's license to practice as a physician and surgeon in the State of Washington was indefinitely suspended.

<http://oig.hhs.gov>

Appendixes

Appendix A – FY 2013 Medicaid Audit and Evaluation Reports

Appendix B – OIG Priority Recommendations From Previous Fiscal Years

Appendix C – FY 2014 Medicaid Work Plan

<http://oig.hhs.gov>

Appendix A

Fiscal Year 2013 audit and evaluation reports

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>.

Medicaid hospital audits

- *New Jersey Department of Human Services Claimed Medicaid Disproportionate Share Hospital Payments to Five Hospitals That Did Not Meet Federal Eligibility Requirements, A-02-09-01017.*
- *New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements, A-02-11-01038.*
- *North Carolina Medicaid Overpaid Hospitals for Some Inpatient Services That Medicare Paid, A-04-11-06137.*
- *Georgia—Acute Care Hospitals in Georgia Did Not Always Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency, A-04-12-04021.*
- *Wisconsin Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable, A-05-11-00037.*
- *Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable, A-05-11-00040.*
- *Indiana Improperly Claimed Federal Reimbursement for Most Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Evansville Psychiatric Children’s Center, A-05-12-00040.*
- *Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Evansville State Hospital, A-05-12-00041.*
- *Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Logansport State Hospital, A-05-12-00042.*
- *Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children’s Psychiatric Hospital, A-05-12-00050.*
- *Oklahoma Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Children’s Recovery Center, A-05-12-00052.*
- *Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010, A-07-12-01121.*

Medicaid home, community, and nursing home care audits

- *Massachusetts Medicaid Payments to Millbury Health Care Center Did Not Always Comply With Federal and State Requirements, A-01-12-00010.*
- *Rhode Island's Managed Care Contract Settlements With Neighborhood Health Plan of Rhode Island Did Not Always Comply With Federal and State Requirements, A-01-12-00011.*
- *Massachusetts Medicaid Payments to Essex Park Rehabilitation and Nursing Center Did Not Always Comply With Federal and State Requirements, A-01-12-00015.*
- *Massachusetts Medicaid Payments to Weymouth Health Care Center Did Not Always Comply With Federal and State Requirements, A-01-12-00016.*
- *Massachusetts Medicaid Payments to Healthbridge Management Did Not Always Comply With Federal and State Requirements, A-01-13-00001.*
- *Medicaid Hospice General Inpatient Payments to Home and Hospice Care of Rhode Island Did Not Always Meet Federal and State Requirements, A-01-13-00002.*
- *Massachusetts Medicaid Payments to Golden Living Centers Did Not Comply with Federal and State Requirements, A-01-13-00007.*
- *New York Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies in New York City, A-02-10-01022.*
- *New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies, A-02-11-01008.*
- *Maryland Generally Complied With Requirements for Medicaid Payments Made to Multi-Medical Center for Nursing Facility Services, A-03-11-00151.*
- *Maryland Improperly Claimed Personal Care Services Provided Under Its Medicaid Home and Community-Based Services Waiver for Older Adults, A-03-11-00201.*
- *West Virginia Improperly Claimed Some Personal Care Services Under Its Medicaid State Plan, A-03-11-00204.*
- *Virginia—Nursing Facilities in Virginia Generally Reconciled Account Records With Credit Balances and Reported the Associated Medicaid Overpayments to the State Agency, A-03-11-00211.*
- *Wisconsin Improperly Claimed Federal Medicaid Reimbursement for Most Residential Care Center Payments, A-05-07-00036.*
- *Illinois Did Not Always Properly Claim Medicaid Reimbursement for Hospice Claims, A-05-12-00029.*
- *Louisiana—Review of Louisiana Medicaid Personal Care Services Provided by Immaculate Heart of Mary-PCS Audit, A-06-09-00106.*
- *Missouri—Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency, A-07-11-03169.*
- *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims Submitted by The Whole Person, Incorporated, A-07-11-03170.*

- *Washington State Claimed a Small Amount of Unallowable Medicaid Reimbursement for Home Health Services That Exceeded the Maximum Allowable Number of Reimbursable Visits, A-09-12-02056.*

Medicaid prescription drug claims audits

- *Oklahoma Complied With the Federal Medicaid Requirements for Billing Manufacturers for Rebates for Physician-Administered Drugs, A-06-12-00059.*
- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County, A-09-12-02077.*

Other Medicaid services audits

- *New Hampshire Did Not Always Correctly Claim Medicaid Payments for School-Based Transportation Services, A-01-11-00008.*
- *Maine Improperly Claimed Medicaid Payments for School-Based Health Services Submitted by Portland School Department, A-01-11-00011.*
- *Massachusetts Generally Implemented Recommendations From Prior Review of Claims for Hospital Outpatient Clinical Laboratory Services, A-01-12-00005.*
- *Connecticut Generally Implemented Recommendations From Prior Review of Medicaid Payments for Clinical Laboratory Services, A-01-12-00014.*
- *New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services, A-02-10-01024.*
- *New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury Waiver Program Did Not Comply With Certain Federal and State Requirements, A-02-10-01043.*
- *New York State Manufacturer Rebate Program Significantly Reduced Medicaid Costs for Home Blood-Glucose Test Strips But Could Achieve Additional Reductions, A-02-11-01042.*
- *New Jersey Medicaid Program Could Achieve Savings By Reducing Home Blood Glucose Test Strip Prices, A-02-12-01010.*
- *Maryland Claimed Costs for Unallowable Room and Board and Other Residential Habilitation Costs Under Its Community Pathways Waiver Program, A-03-12-00203.*
- *North Carolina—Noninstitutional Providers in North Carolina Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency, A-04-11-04016.*
- *Florida Generally Ensured That Providers Complied With Selected State Durable Medical Equipment Enrollment Requirements, A-04-12-07034.*
- *Tennessee Incorrectly Reported Costs for Individuals With Intellectual and Developmental Disabilities, A-04-12-08016.*
- *Ohio Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment and Supplies, A-05-12-00038.*

- *Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010, A-06-11-00022.*
- *Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010, A-07-12-01117.*
- *Missouri Claimed Unallowable Medicaid Payments for Individuals With Intellectual and Developmental Disabilities in Intermediate Care Facilities, A-07-12-03180.*
- *California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers, A-09-11-02016.*
- *Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs, A-09-11-02020.*
- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County, A-09-11-02040.*
- *Hawaii Did Not Adequately Monitor Implementation of Some Risk-Sharing Contract Provisions for the QUEST Expanded Medicaid Managed Care Program, A-09-11-02054.*
- *California—Noninstitutional Providers in California Did Not Always Reconcile Invoice Records With Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments, A-09-12-02047.*

Medicaid administration audits

- *New Jersey's Medicaid Expenditure Claim Was Supported by Actual Recorded Expenditures, A-02-10-01013.*
- *New Jersey Did Not Always Claim Medicaid Reimbursement for Medicare Part B Premiums in Accordance with Federal Requirements, A-02-10-01025.*
- *New York State Made Unallowable Medicaid Managed Care Payments For Beneficiaries Assigned Multiple Medicaid Identification Numbers, A-02-11-01006.*
- *New York Complied With Federal Requirements to Report Federal Overpayment Collections for the Quarter Ended September 30, 2011, A-02-12-01020.*
- *Pennsylvania Claimed Unallowable Medicaid Administrative Costs for the Regional Housing Coordinator Initiative, A-03-11-00210.*
- *Florida Claimed Some Medicaid Administrative Costs That Did Not Comply With Program Requirements, A-04-10-00076.*
- *Florida Medicaid: Millions in Overpayments Not Refunded, A-04-11-08007.*
- *Kentucky Substantially Met Money Follows the Person Program Requirements, A-04-12-06152.*
- *Alabama Received Millions in Unallowable Performance Bonus Payments Under the Children's Health Insurance Program Reauthorization Act, A-04-12-08014.*
- *The Centers for Medicare & Medicaid Services Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected, A-05-11-00071.*

- *Texas Did Not Always Comply With Federal and State Requirements Regarding the Medicare Buy-In Program, A-06-10-00070.*
- *Arkansas Generally Supported Its Claim for Federal Medicaid Reimbursement, A-06-10-00098.*
- *Iowa Did Not Properly Pay Some Medicare Part A and Part B Deductibles and Coinsurance, A-07-12-03178.*

Medicaid information technology audits

- *Audit of IT Controls for USB devices at Ochsner Medical Center, A-06-12-00017.*
- *Audit of IT Controls for USB devices at Saint Francis Hospital, A-06-12-00020.*
- *Review of General Controls at North Dakota Department of Human Services, A-07-11-00368.*
- *Audit of General Controls for Medicaid Eligibility Determinations and Claims Processing at the North Dakota Information Technology Department, A-07-12-00372.*
- *Audit of IT Controls for USB Devices at Mercy Health, A-07-12-00400.*
- *Audit of IT Controls for USB Devices at Cox Health, A-07-12-00401.*
- *Audit of IT Controls for USB Devices at BJC HealthCare, A-07-12-00402.*
- *Review of LA Care's information system general controls over its Medi-Cal managed-care claims processing system, A-09-12-03001.*
- *IT Audit - Audit of IT controls over USB devices at Georgetown Hospital, A-18-12-30070.*

State Medicaid Fraud Control Unit (MFCU) evaluations

- *Arkansas Medicaid Fraud Control Unit: 2013 Onsite Review, OEI-06-12-00720.*
- *Idaho State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-09-12-00220.*
- *Illinois State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-07-12-00510.*
- *Louisiana State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-09-12-00010.*
- *New Hampshire State Medicaid Fraud Control Unit: 2012 Onsite Review. OEI-02-12-00180.*
- *New Jersey State Medicaid Fraud Control Unit: 2013 Onsite Review, OEI-02-13-00020.*
- *South Carolina State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-09-11-0061.*
- *Tennessee State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-06-12-00370.*

Other program evaluation reports

- *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System, OEI-05-12-00610.*
- *Analyzing Changes to Medicaid Federal Upper Limit Amounts, OEI-03-11-00650.*

- *Medicaid Drug Pricing in State Maximum Allowable Cost Programs, OEI-03-11-00640.*
- *Medicaid Third-Party Liability Savings Increased, But Challenges Remain, OEI-05-11-00130.*
- *Medicaid DMEPOS Costs May Be Exceeding Medicare Costs in Competitive Bidding Areas, OEI-06-13-00470.*
- *Home and Community-Based Services in Assisted Living Facilities, OEI-09-08-00360.*
- *Some States Improperly Restrict Eligibility for Medicaid Mandatory Home Health Services, OEI-07-13-00060.*
- *Most States Anticipate Implementing Eligibility and Enrollment Requirements by 2014, OEI-07-10-00530.*

Appendix B

Priority Medicaid recommendations from previous fiscal years

The priority Medicaid recommendations below are carried forward from final reports issued prior to fiscal year (FY) 2013. The full reports are available on the Office of Inspector General's (OIG) Web site at www.oig.hhs.gov. The recommendations were designated as priorities in OIG's March 2014 *Compendium of Priority Recommendations*, which covers all HHS programs through FY 2013 and is also available on the OIG Web site at <http://oig.hhs.gov/reports-and-publications/compendium/>.

Federal share of Medicaid—Ensure that State claims and practices do not inappropriately inflate Federal reimbursements.

Key OIG Report

Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers. A-03-00-00216. 2001 SEP.

Specific Recommendations

- The Centers for Medicare & Medicaid Services (CMS) should provide States with definitive guidance for calculating the Federal upper payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data and
- require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the Federal share generated by the original payment.

Medicaid drug pricing—Assist States to better align drug reimbursements with pharmacy acquisition costs.

Key OIG Reports

Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices. A-06-11-00002. 2011 OCT.

Replacing Average Wholesale Price: Medicaid Drug Payment Policy. OEI-03-11-00060. 2011 JUL.

Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products. A-06-02-00041. 2002 SEP.

Specific Recommendations

- CMS should provide the results of this review to States for their use when they consider changes to their pharmacy reimbursement methodologies, including those for single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs.
- CMS should develop a national benchmark that accurately estimates acquisition costs and encourage States to use it in determining Medicaid reimbursement for prescription drugs.
- CMS should encourage States to adopt a multitiered payment system to bring pharmacy reimbursement more in line with the actual acquisition cost of drug products.

Ensure that Medicaid Information Systems are fully functional.

Key OIG Report

Medicaid Managed Care Encounter Data: Collection and Use. [OEI-07-06-00540](#). 2009 MAY.

Specific Recommendation

- CMS should enforce existing Federal requirements that States include encounter data in Medicaid Statistical Information System (MSIS) submissions.

Address Medicaid managed care fraud and abuse concerns.

Key OIG Report

Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards. [OEI-01-09-00550](#). 2011 DEC.

Specific Recommendations

- CMS should require that State contracts with managed care entities (MCEs) include methods to verify with beneficiaries whether services billed by providers were received and
- update guidance to reflect concerns expressed by MCEs and States.

Medicaid home- and community-based care settings—Ensure that service providers comply with quality and safety requirements.

Key OIG Reports

Medicaid—Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs. [OEI-02-08-00170](#). 2012 JUN.

Specific Recommendations

- CMS should provide additional guidance to states to help ensure that they meet the 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 is renewed and develop detailed protocols for such visits, and
- make information about state compliance with the assurances available to the public.

Prevention—Ensure that States improve utilization of preventive screening services for eligible children.

Key OIG Report

Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services. [OEI-05-08-00520](#). 2010 MAY.

Specific Recommendations

- CMS should require States to report vision and hearing screenings,
- collaborate with States and providers to develop effective strategies to encourage beneficiary participation in 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 screenings and providers' delivery of complete medical screenings.

Appendix C

Medicaid projects in OIG's FY 2014 Work Plan

The projects below represent the objectives of work in progress and planned new starts for fiscal year (FY) 2014. The objectives were extracted from the Office of Inspector General's (OIG) FY 2014 *Work Plan*, published in January 2014. Pertinent context information and citations for each project are available in the complete *Work Plan*, which is available on OIG's Web site at:

<http://oig.hhs.gov/reports-and-publications/workplan/index.asp#current>.

Medicaid Prescription Drug Reviews

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

Compliance With Requirements. We will review the education and enforcement actions States have taken on the basis of information generated by their drug utilization review (DUR) programs related to inappropriate dispensing and potential abuse of prescription opiates. (OEI; 05-13-00550; expected issue date: FY 2014; work in progress)

- **States' methods for resolving rebate disputes with manufacturers**

Compliance With Requirements—We will review the causes of and resolutions to Medicaid rebate disputes with manufacturers and the methods States use to resolve them. (OEI; 05-11-00580; expected issue date: FY 2014; work in progress)

- **Manufacturer compliance with AMP reporting requirements**

Compliance With Requirements. We will review manufacturer compliance with average manufacturer price (AMP) reporting requirements and determine what percentage of manufacturers complied with the requirements. We will also determine whether stepped-up enforcement actions by the Centers for Medicare & Medicaid Services (CMS) and OIG are reflected in increased compliance by manufacturers. (OEI; 03-14-00150; expected issue date: FY 2015; work in progress)

- **States' collection and reporting of rebates**

Compliance With Requirements. We will determine whether the increased amount of manufacturer rebates for brand-name and generic drugs were collected by States and reported to the Federal Government, as required. We will also determine the amount of supplemental drug rebates that States collected during a selected period. (OEI; 03-12-00520; expected issue date: FY 2014; work in progress; Affordable Care Act)

- **Rebates for new formulations of existing drugs**

Compliance With Requirements. 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 of their drugs that are subject to a recent change in law. (OAS; W-00-14-31451; various reviews; expected issue date: FY 2015; new start; Affordable Care Act)

- **States collection of rebates on physician-administered drugs**

Compliance With Requirements. 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; W-00-13-31400; W-00-14-31400; various reviews; expected issue date: FY 2014; work in progress)

- **Medicaid payments for multiuse vials of Herceptin (new)**

State Claims—We will review States' claims for the Federal share of Medicaid payments for the drug Herceptin, which is used to treat breast cancer, to determine whether providers properly billed the States for the drug. We will determine whether providers' claims to States were complete and accurate and were billed in accordance with the regulations of the selected States. (OAS; W-00-14-31476; various reviews; expected issue date: FY 2014; new start)

- **Atypical antipsychotic drugs prescribed for children in Medicaid**

Quality of Care and Safety. We will determine the extent to which Medicaid claims for atypical antipsychotic drugs were for treatment of children aged 18 years and younger. We will determine, on the basis of medical record reviews, the extent to which the atypical antipsychotic drug claims were for uses and indications not listed in one or more of the approved drug compendia. We will also determine the extent to which the medical reviews identified concerns about the treatment of the children with the prescribed drugs related to dosage, duration of treatment, indications for use, monitoring, side effects, reactions to combinations of drugs (polypharmacy), and patient age. (OEI; 07-12-00320; expected issue date: FY 2014; work in progress)

Home Health Services and Other Community-Based Care

- **Home health services—provider and beneficiary eligibility**

Billing and Payments. We will review home health agency (HHA) claims to State Medicaid programs to determine whether the billing providers met applicable criteria to provide home health services to Medicaid beneficiaries. We will also determine whether the beneficiaries met the criteria to receive such services. (OAS; W-00-12-31304; various reviews; expected issue date: FY 2015; work in progress)

- **Adult day health care services**

Billing and Payments. We will review Medicaid payments by States for adult day care services to determine whether the providers complied with Federal and State requirements. (OAS; W-00-12-31386; W-00-13-31386; various reviews; expected issue date: FY 2014; work in progress)

- **Continuing day treatment mental health services**

Billing and Payments. We will review Medicaid payments to continuing day treatment (CDT) mental health services providers to determine whether their claims were adequately supported. Our review will follow up on a State Commission's findings of unsubstantiated claims. (OAS; W-00-12-31128; W-00-13-31128; various reviews; expected issue date: FY 2014; work in progress)

- **Room and board costs associated with home- and community-based services (HCBS) program payments**

State Claims—We will determine whether selected States claimed Federal reimbursement for unallowable room and board costs associated with services provided under home- and community-based services (HCBS) programs. We will determine whether HCBS payments included the costs of room and board and identify the methods the States used to determine the amounts paid. (OAS; W-00-13-31465; various reviews; expected issue date: FY 2014; work in progress)

- **Home health services—Screenings of health care workers**

Quality of Care and Safety—We will review health-screening records of Medicaid HHAs' health care workers to determine whether they were screened in accordance with Federal and State requirements. (OAS; W-00-11-31387; W-00-12-31387; various reviews; expected issue date: FY 2014; work in progress)

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

Policies and Practices. 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 rebates, competitive bidding, or other means. (OAS; W-00-13-31390; various reviews; expected issue date: FY 2014; new start)

- **Transportation services—Compliance with Federal and State requirements**

Billing and Payments. We will review Medicaid payments by States to providers for transportation services to determine the appropriateness of the payments for such services. (OAS; W-00-12-31121; W-00-13-31121; various reviews; expected issue date: FY 2015; work in progress)

- **Questionable billing for outpatient mental health services by Medicaid providers**

Billing and Payments. We will review State payments for Medicaid outpatient mental health services to identify questionable billing patterns. We will also review combined Medicaid and Medicare claims data to identify additional questionable billing patterns. (OEI; 07-13-00320; expected issue date: FY 2014; work in progress)

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

Billing and Payments. 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-00-14-31452; various reviews; expected issue date: FY 2015; new start; Affordable Care Act)

- **Dental services for children—Inappropriate billing**

State Claims. We will review Medicaid payments by States for dental services to determine whether States have properly claimed Federal reimbursement. (OAS; W-00-11-31135; W-00-12-31135; various reviews; expected issue date: FY 2014; work in progress)

- **Family planning services—Claims for enhanced Federal funding**

State Claims. 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-00-11-31078; W-00-12-31078; W-00-13-31078; various reviews; expected issue date: FY 2014; work in progress)

- **Access to pediatric dental care for children enrolled in Medicaid**

Quality of Care and Safety. We will review billing patterns of pediatric dentists and their associated clinics in selected States and describe the extent to which children enrolled in Medicaid received services from them. (OEI; 02-12-00330; 02-14-00120; various reviews; expected issue date: FY 2014; work in progress)

- **Utilization of preventive screening services for children enrolled in Medicaid (new)**

Quality of Care and Safety. We will determine what steps CMS has taken to address OIG's recommendations to improve the provision of Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and what obstacles it faces in implementing these recommendations. We will also determine whether the underutilization of EPSDT services continues to be a challenge for children enrolled in Medicaid. (OEI, 05-13-00690; expected issue date: FY 2014; work in progress)

State Management of Medicaid

- **State use of provider taxes to generate Federal funding**

Funding Mechanisms. 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-00-13-31455; various reviews; expected issue date: FY 2014; work in progress)

- **State compliance with Federal Certified Public Expenditures regulations**

Funding Mechanisms. We will determine whether States are complying with Federal regulations for claiming Certified Public Expenditures (CPEs), which are normally generated by local governments as part of their contribution to the coverage of Medicaid services. (42 CFR § 433.51 and 45 CFR § 95.13.) (OAS; W-00-13-31110; various reviews; expected issue date: FY 2014; work in progress)

- **State allocation of Medicaid administrative costs**

State Claims—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-00-13-31123; various reviews; expected issue date: FY 2014; work in progress)

- **State-operated facilities—Reasonableness of payment rates**

State Claims—We will determine whether Medicaid payment rates to State-operated facilities are reasonable and the Federal share is claimed in accordance with Federal and State requirements. We will determine in selected States the extent to which payments to such providers may be excessive. (OAS; W-00-12-31398; W-00-13-31398; various reviews; expected issue date: FY 2014; work in progress)

- **State cost allocations that deviate from acceptable practices**

State Claims—We will review public assistance cost allocation plans and processes for selected States to determine whether the States claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems (RMSS) that deviated from acceptable statistical sampling practices. (OAS; W-00-13-31467; various reviews; expected issue date: FY 2015; work in progress)

- **Enhanced Federal Medical Assistance Percentage (new)**

State Claims. We will review States' Medicaid claims to determine whether the States correctly applied enhanced Federal Medical Assistance Percentage (FMAP) payment provisions of the Affordable Care Act. (OAS; W-00-14-31480; various reviews; expected issue date: FY 2015; new start; Affordable Care Act)

- **Medicaid eligibility enrollment—National error rates**

State Claims. We will determine the extent to which States improperly enrolled individuals in Medicaid programs who did not meet eligibility criteria and estimate national enrollment error rates. For FY 2014, the national enrollment error rates will be estimated for newly enrolled Medicaid beneficiaries in States that expanded their Medicaid programs pursuant to the Affordable Care Act and in States that did not. We will also identify issues that contributed to enrollment errors. (OEI; 00-00-0000; expected issue date: FY2015; new start; Affordable Care Act).

- **Medicaid eligibility determinations in selected States (new)**

State Claims. We will review Medicaid eligibility determinations in selected States. For each State selected, we will calculate a Medicaid eligibility error rate. We will focus on eligibility determinations

for beneficiaries who are newly eligible for Medicaid pursuant to the Affordable Care Act and beneficiaries who were eligible for Medicaid prior to the eligibility expansion. We will also determine the amount of payments associated with beneficiaries who received incorrect eligibility determinations. (OAS; W-00-14-31140; various reviews; expected issue date: FY 2015; new start; Affordable Care Act)

- **State Medicaid monetary drawdowns—Reconciliation with Form CMS-64**

State Adjustments—We will review the Medicaid monetary drawdowns that States received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the States on the Form CMS-64. (OAS; W-00-12-31456; W-00-13-31456; various reviews; expected issue date: FY 2014; work in progress)

- **State reporting of Medicaid collections on Form CMS-64**

State Adjustments. We will determine whether States accurately captured Medicaid collections on their Form CMS-64 and returned the correct Federal share related to those collections. (OAS; W-00-12-31457; W-00-13-31457; various reviews; expected issue date: FY 2014; work in progress)

- **Estate recoveries—Compliance and reporting of recovered costs**

State Adjustments—We will determine whether States complied with requirements to recover Medicaid costs from deceased Medicaid beneficiaries' estates. We will also determine whether States properly reported any such recoveries to CMS. (OAS; W-00-12-31113; W-00-13-31113; various reviews; expected issue date: FY 2014; work in progress)

- **State use of incorrect FMAP for Federal share adjustments (new)**

State Adjustments. We will review States' Medicaid claims records to determine whether the States used the correct FMAP when processing claim adjustments reported on the Form CMS-64. (OAS; W-00-14-31460; various reviews; expected issue date: FY 2015; work in progress)

- **State actions to address vulnerabilities identified during CMS reviews**

Program Integrity. We will review corrective actions that State Medicaid agencies have implemented to address the findings and recommendations from State Medicaid program integrity reviews conducted by CMS. We will determine why States have not implemented all corrective actions, examine the followup CMS performed to ensure that corrective actions were taken by States, and examine the evidence CMS reviews to ensure that corrective actions were implemented. (OEI; 00-00-00000; expected issue date: FY 2015; new start)

- **State terminations of providers terminated by Medicare or by other States**

Program Integrity. We will review States' compliance with a new requirement that they terminate their Medicaid program providers that have been terminated under Medicare or by another State Medicaid program. We will determine whether such providers are terminated by all State Medicaid programs in which they are enrolled, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify

obstacles States face in complying with the termination requirement. (OEI; 06-12-00030; expected issue date: FY 2014; work in progress; Affordable Care Act)

- **Recovering Medicaid overpayments—Credit balances in Medicaid patient accounts**

Overpayment Recovery. We will review providers' patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances. (OAS; W-00-12-31311; W-00-13-31311; various reviews; expected issue date: FY 2014; work in progress)

- **State collection and verification of provider ownership information**

Program Integrity—We will determine the extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. We will also review States' and CMS's practices for collecting and verifying provider ownership information and determine whether States and CMS had comparable provider ownership information for providers enrolled in both Medicaid and Medicare. (42 CFR § 455.104.) (OEI; 04-11-00590, 04-11-00591, 04-11-00592; expected issue date: FY 2015; work in progress)

- **States' experiences with enhanced provider screening**

Program Integrity. We will review States' progress toward rescreening or revalidating all Medicaid providers by 2016. We will assess how States are complying with the mandate to conduct enhanced screening; determine how many providers are enrolled in both Medicare and Medicaid; and determine whether States can use screenings from Medicare, other State Medicaid programs, and the Children's Health Insurance Program (CHIP). (OEI; 05-13-00520; expected issue date FY 2015; work in progress; Affordable Care Act)

- **Provider payment suspensions during pending investigations of credible fraud allegations (new)**

Program Integrity. We will review payments to providers with allegations of fraud deemed credible by States. We will also review States' suspension of payments processes. We will determine if select Medicaid State agencies are in compliance with required provisions. (OAS; W-00-14-31473; various reviews; expected issue date: FY 2015; new start; and OEI; 09-14-00020; expected issue date: FY 2015; work in progress; Affordable Care Act)

- **Reviews of State Medicaid Fraud Control Units**

Program Integrity. We will review the overall management, operations, and performance of a sample of Medicaid Fraud Control Units (MFCU). We will identify effective practices and areas for improvement in MFCU management and operations. (OEI; 00-00-00000; various reviews; expected issue date: FY 2014; work in progress).

- **States and Territories without Medicaid Fraud Control Units (new)**

Program Integrity. We will determine whether each of the U.S. territories, none of which currently operate a MFCU, have sought an exemption as part of their State Medicaid plan as required by section 1902(a)(61) of the Social Security Act. We will also determine whether North Dakota, the only State without a MFCU and which received an exemption in 1994, continues to operate under

the conditions that supported the State's exemption. (OEI; 00-00-00000; expected issue date: FY 2015; new start)

Medicaid Information System Controls and Security

- **Inactive or invalid provider identifier numbers**

Payment Controls. 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 (NPIs), including claims for services alleged to have been provided after the dates of the referring physicians' deaths.

(OAS; W-00-13-31338; various reviews; expected issue date: FY 2015; work in progress)

- **Duplicate payments for beneficiaries with multiple Medicaid identification numbers**

Payment Controls. We will review duplicate payments made by States on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and identify States' procedures or other controls for preventing such payments. (OAS; W-00-12-31374; W-00-13-31374; various reviews; expected issue date: FY 2014; work in progress)

- **States' use of PARIS data matching to reduce improper payments**

Payment Controls. We will review Public Assistance Reporting Information System (PARIS) enrollment data and determine the extent to which States use PARIS to prevent improper Medicaid payments made on behalf of beneficiaries who are simultaneously enrolled in more than one State. (OEI; 09-11-00780; expected issue date: FY 2014; work in progress)

- **National Correct Coding Initiative edits and CMS oversight (new)**

Payment Controls. We will review selected States' implementation of National Correct Coding initiative (NCCI) edits for Medicaid claims and describe CMS's oversight of NCCI edits. (OAS; W-00-13-31459; various reviews; expected issue date: FY 2014; work in progress; and OEI; 00-00-00000; expected issue date: FY 2015; work in progress, Affordable Care Act)

- **CMS oversight of States' Medicaid information systems security controls (new)**

System Security Controls. We will determine the adequacy of CMS's oversight of States' Medicaid system and information security controls, including the policies, technical assistance, and security and operational guidance provided to the States. For selected States, we will use OIG's automated assessment tools to assess controls for their information system networks, databases, Web-facing applications, logical access, and wireless access. We will also review general controls, such as disaster recovery plans and physical security. (OAS, W-00-13-40019; W-00-14-40019; various reviews; expected issue date: FY 2014; work in progress and new start)

Medicaid Managed Care

- **Medicaid managed care reimbursement (new)**

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

- **Medical loss ratio—Managed care plans' refunds to States**

Adjustments to State Payments. We will review managed care plans with contract provisions that require a minimum percentage of total costs to be expended for medical services (medical loss ratio) to determine whether a refund was made to the State agency when the minimum medical loss ratio threshold was not met. We will also determine whether plan expenses were properly classified as medical or administrative. (OAS; W-00-13-31372; various reviews; expected issue date: FY 2015; work in progress)

- **Completeness and accuracy of managed care encounter data**

Data Collection and Reporting. We will determine the extent to which complete Medicaid managed care encounter data are included in Medicaid Statistical Management Systems (MSIS). We will also identify factors that enable States and Medicaid managed care entities to collect and report MSIS encounter data or prevent them from performing these functions. Finally, we will assess CMS's oversight of the reporting of MSIS encounter data. (OEI; 07-13-00120; expected issue date: FY 2015; work in progress; Affordable Care Act)

- **Medicaid managed care entities' identification of fraud and abuse**

Program Integrity—We will determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents. We will also describe how States oversee MCOs' efforts to identify and address fraud and abuse. (OEI; 02-13-00640; expected issue date: FY 2015; new start)

- **Beneficiary access to services under Medicaid managed care**

Beneficiary Protections. We will review Medicaid managed care provider networks and describe the extent to which managed care beneficiaries have access to services. We will also describe State standards for ensuring access to primary and specialty care and will determine the extent to which States identify and address problems with access to care in their managed care plans. (OEI; 02-11-00320; 02-13-00670; expected issue date: FY 2014; work in progress; Affordable Care Act)

- **Medicaid managed care beneficiary grievances and appeals process**

Beneficiary Protections. We will review the extent to which States monitor Medicaid MCOs' grievances and appeals systems for compliance with Federal requirements. (OEI; 00-00-00000; expected issue date: FY 2014; new start)

- **Oversight of managed care entities' marketing practices**

Beneficiary Protections. We will review State Medicaid agencies' oversight policies, procedures, and activities to determine the extent to which States monitor Medicaid MCOs' marketing practices and compliance with Federal and State contractual marketing requirements. We will also determine the extent to which CMS ensures that States' comply with Federal requirements involving Medicaid MCO marketing practices. (OEI; 00-00-00000; expected issue date: FY 2015; new start)