

Part II

Medicaid Program Reviews

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Part II

Medicaid Program Reviews

The Federal Government and States jointly administer, fund the cost of, and oversee the integrity of the Medicaid medical assistance program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. At the State level, State agencies administer their Medicaid programs in accordance with CMS-approved State plans.

Avoiding Waste in Medicaid Drug-Pricing and Payments

State Medicaid agencies lack information about pharmacies' costs to purchase drugs and/or fail to use available information about whether drugs are eligible for payment. As a result, payments to pharmacies often significantly exceed pharmacies' costs for the drugs and/or are made for drugs that are ineligible for Medicaid reimbursement.

Multitier Strategy Would Fine-Tune Medicaid Drug Pricing

States could better approximate pharmacies' invoice prices of drugs by developing separate reimbursement methodologies for major categories of drugs (single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs). Numerous Office of Inspector General (OIG) reviews have found that the basis that States historically used for Medicaid drug reimbursements did not represent pharmacies' actual costs to acquire drug ingredients (invoice prices), and as a result, States often have overreimbursed pharmacies for those costs. This review evaluated the relationships between three recognized pricing benchmarks and pharmacy invoice prices for Medicaid-reimbursed drugs and found variations depending on whether the drugs were brand-name or generic.

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

State Controls Over Medicaid Drug Expenditures Inadequate

Neither CMS nor the 14 States that we reviewed had adequate controls to ensure that all drug expenditures complied with Federal requirements. Cost savings to Medicaid could be realized by implementing several corrective actions that we outlined in our report.

Federal Medicaid funding is generally available for covered outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. The agreements require manufacturers to provide a list of all covered outpatient drugs to CMS quarterly. CMS includes these drugs on a quarterly Medicaid drug tape (list), makes adjustments for any errors, and sends the tape to the States. Manufacturers did not always provide information timely.

We found that the States generally did not use the quarterly Medicaid drug tapes (quarterly listings) that CMS provided to determine whether a drug was eligible for coverage and did not contact CMS to determine whether a drug was eligible for coverage if the drug was not on the tapes. The drug tapes indicate the drugs' termination dates, if applicable; specify whether the drugs are less than effective; and include information that the States use to claim rebates from manufacturers. The shortcomings we identified adversely affect the efficiency of the Medicaid outpatient prescription drug program.

(Recommendations—CMS should instruct States to ensure compliance with Federal requirements, appropriately report terminated drug expenditures to States, require that States use the reports to ensure compliance; and follow up as necessary. CMS should also work with manufacturers to ensure that they collect and submit complete and accurate information and take appropriate action if they are not timely in providing the information.)

Multi-State Review of Centers for Medicare & Medicaid Services Medicaid Drug Expenditure Controls. A-07-10-06003. October 2011. [Web Summary](#). [Full Text](#).

Identifying and Reducing Improper State Claims for Federal Reimbursement

States have considerable flexibility in designing and operating their Medicaid programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met.

Personal Care Services Improperly Claimed by the States of New Jersey and New Mexico

Federal law and regulations provide that personal care services (PCS) are generally furnished to individuals residing in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by each State. Other requirements may also apply based on State regulations.

- **New Jersey** – New Jersey improperly claimed an estimated \$145 million in Federal Medicaid reimbursement for PCS. Types of deficiencies in the claims we reviewed included lapses with authorizations, in-service education for personal care attendants, nursing supervision, documentation of services, nursing assessments, and certification of personal care attendants by the New Jersey Board of Nursing. New Jersey did not effectively monitor the PCS program for compliance with Federal and State requirements. (Recommendations—Refund \$145 million to the Federal Government and improve its monitoring of the PCS program to help ensure compliance with Federal and State requirements.) *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey*. A-02-09-01002. December 2011. [Web Summary](#). [Full Text](#).
- **New Mexico** – New Mexico improperly claimed about \$889,000 in Federal Reimbursement for PCS by a provider that did not always comply with certain Federal and State requirements. The deficiencies included lapses with attendant training, number of units claimed for attendant services, and prior approval for PCS provided by a legal guardian. (Recommendations—New Mexico should refund \$889,000 to the Federal Government and ensure that PCS providers maintain evidence that they comply with Federal and State requirements.) *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health*. A-06-09-00062. March 2012. [Web Summary](#). [Full Text](#).

Continuing Day Treatment Services Improperly Claimed by New York

More than half of the claims for continuing day treatment (CDT) services that we reviewed did not comply with one or more of New York State's requirements for payment, resulting in unallowable Federal reimbursements estimated at about \$84.4 million. CDT is a form of clinic services performed

by nonhospital providers that New York includes among its licensed outpatient programs.

Providers did not properly document the type of CDT services billed, recipients' clinical progress, and/or recipients' contacts with outpatient program staff. Although the State conducts periodic onsite monitoring, its monitoring program did not ensure that providers complied with all State requirements.

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

Nonemergency Medical Transportation Services Improperly Claimed by New York

States are required to ensure necessary transportation for Medicaid beneficiaries to and from providers. Pursuant to New York State regulations, nonemergency medical transportation (NEMT) services may be delivered through the use of an ambulance, an ambulette, a taxicab, or livery service; prior authorization must be obtained; a medical practitioner's order justifying the beneficiary's use of NEMT services must be documented in the beneficiary's medical record; and a transportation provider must notify the New York Department of Motor Vehicles within 10 days of the date on which an ambulette driver commences employment.

- **New York** – New York improperly claimed an estimated \$13.5 million in Federal Medicaid reimbursement for NEMT services. The deficiencies occurred because New York State's policies, procedures, and mechanisms for overseeing the Medicaid program did not ensure that providers complied with Federal and State requirements for ordering, documenting, providing, and claiming such services.

(Recommendations—Refund \$13.5 million to the Federal Government; strengthen policies and procedures to ensure compliance with requirements for ordering, documenting, and claiming NEMT services; and require the New York State social services districts to strengthen their quality assurance mechanism to ensure that NEMT services are properly provided.) *Review of Medicaid Payments for Nonemergency*

Medical Transportation Services Claims Submitted by Providers in New York State. A-02-09-01024. February 2012. [Web Summary](#). [Full Text](#).

- **New York City** – During a 1-year period, New York improperly claimed Federal reimbursement for almost 1 million NEMT claims for services in New York City. We set aside for further analysis additional New York City NEMT claims that may also have been noncompliant. New York’s policies and procedures did not ensure that providers complied with Federal and State requirements for ordering, documenting, and claiming NEMT services, and New York City’s social services district’s quality assurance mechanism did not ensure that NEMT services were properly provided. (Recommendations—Refund an estimated \$17 million to the Federal Government; resolve \$2.9 million set aside for further analysis; and strengthen policies, procedures, and quality controls.) *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York City.* A-02-08-01017. November 2011. [Web Summary](#). [Full Text](#).

Family Planning Services Improperly Claimed by Oregon

Oregon improperly claimed \$1.7 million for unallowable Federal reimbursement for its Family Planning Expansion Project (Expansion Project) costs over a 3-year period.

States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the Medicaid State plan and desire such services and supplies. Services include those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. Oregon established the Expansion Project for certain categories of individuals who were not eligible for regular Medicaid under the State plan. Because Expansion Project clients are not eligible for the regular Medicaid program, services provided under the Expansion Project are unallowable for Federal reimbursement in their entirety.

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

Medicare Deductibles and Coinsurance for Dual Eligible Individuals Incorrectly Claimed by Nebraska

Various groups of low-income individuals who are entitled to Medicare are also eligible for full or partial Medicaid benefits. These individuals are referred to as “dual eligibles.” States may pay some or all of dual eligible individuals’ Medicare deductibles and copayments pursuant to Federal regulations and their Medicaid State Plans.

After the Medicare contractor pays a Medicare claim for a dual eligible individual and assesses the Medicare deductibles and coinsurance, the contractor forwards the claim information to the State’s Medicaid program. According to the guidelines in its State plan, the State determines whether to pay part or all of the Medicare deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. The States claim the payments for Federal reimbursement.

- **Medicare Part A** – Nebraska did not follow the documented and approved State plan that was in effect during our audit period as a result, 60 of the 100 claims in our sample were improperly paid during FY 2009. These discrepancies occurred because the State did not compare the Medicare payments to the State Medicaid plan rate. (Recommendation—Refund an estimated \$5.5 million to the Federal Government.) *Review of Nebraska’s Medicaid Payments for Dual Eligible Individuals’ Medicare Part A Deductibles and Coinsurance*. A-07-11-03161. February 2012. [Web Summary](#). [Full-Text](#).
- **Medicare Part B** – For 68 of the 100 claims in our sample, Nebraska did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan. These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so. (Recommendation—Refund an estimated \$5.6 million to the Federal Government.) *Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance*. A-07-11-03168. February 2012. [Web Summary](#). [Full Text](#).

Medicaid Administrative Costs Improperly Claimed by New Jersey

Federal law permits States to claim Federal reimbursement for 50 percent of the costs of administrative activities necessary for the proper and efficient administration of the State Medicaid plan (Medicaid administration).

Allowable claims must be directly related to the Medicaid State plan or waiver services and may not include the overhead costs of a provider facility or the operating costs of an agency whose purpose is other than the administration of the Medicaid program. States' methodologies for distinguishing administrative activities eligible for Federal financial participation (FFP) should conform to CMS guidelines and the State's cost allocation plan.

- **FY 2007** – New Jersey's Medicaid administrative claim for Federal reimbursement exceeded the State's Medicaid administrative costs. New Jersey's Medicaid contractor included unallowable costs in the cost pool used to compute the claim. Also, the contractor performed a random moment time study (RMTS) that deviated from acceptable statistical sampling practices and applied Medicaid eligibility rates that were not documented by the State agency, affecting the accuracy of the costs claimed and the validity of the RMTS used to allocate the costs.

(Recommendations—Refund \$5 million to the Federal Government, resolve \$8 million in Medicaid administration costs set aside for further analysis, establish policies and procedures to follow acceptable statistical sampling practices, and maintain supporting documentation for rates used.) *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Year 2007*. A-02-07-01050. November 2011. [Web Summary](#). [Full Text](#).

- **FYs 2005 and 2006** – New Jersey included unallowable salaries and operating costs in the cost pool used to compute its Medicaid administrative claim. The State improperly claimed Federal Medicaid reimbursement for the cost of Medicaid administration activities performed by staff of contracted community mental health providers. In addition, the contractor that computed the Medicaid costs assigned Medicaid-reimbursable RMTS codes to workers' activities that were not allowable or could not be documented as related to Medicaid and performed an RMTS that deviated from acceptable statistical sampling practices. Also, New Jersey used Medicaid eligibility rates that could not be documented. These errors occurred because the State did not establish adequate policies and procedures to ensure compliance with Federal requirements.

(Recommendations—Refund \$22.5 million to the Federal Government, maintain supporting documentation for Medicaid-reimbursable activities, ensure that future calculations follow acceptable cost principles and CMS requirements, and maintain supporting

documentation for Medicaid eligibility rates used in computations.)
*Review of Medicaid Administrative Costs Claimed by New Jersey for State
Fiscal Years 2005 and 2006.* A-02-08-01009. March 2012.
[Web Summary.](#) [Full Text.](#)

Improper Claims for Therapy Services in Excess of State Limits Easily Preventable

A relatively low number of claims for therapy services were paid in excess of State limits; however, most of the errors that occurred were easily preventable. All of the eight States that we selected for indepth review had safeguards to prevent payments in excess of State limits. Despite the safeguards, we identified improperly paid therapy services claims totaling approximately \$744,000 in six of the eight States. Additional claims that were potentially improper were identified in three of the eight States. Several States reported improving their program integrity safeguards to address our findings.

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

Problems With States' Reporting of Medicaid Overpayments and Collections

States have 60 days from the discovery of Medicaid overpayments to providers to recover, or attempt to recover, overpayments before the Federal share of the overpayments must be refunded to CMS. States must refund the Federal share of overpayments to CMS by the end of the 60-day periods following the dates of discovery, whether or not the States have recovered the overpayments from the providers. Providing appeal rights to providers does not extend the dates of discovery.

Pursuant to Federal law and the “applicable credit” provisions of Office of Management and Budget (OMB) Circular A-87, the Federal share of recovered overpayments or other collections must be credited to the Federal award in the quarter in which they are collected. The examples below demonstrate State errors in the reporting of uncollected overpayments (Illinois) and collected amounts (Oklahoma).

- **Illinois** – Illinois did not report 24 of the 27 overpayments we reviewed because of its unwritten policy of reporting overpayments not involving fraud or abuse when the provider appeals process was completed, rather than at the end of the 60-day period following discovery. (Recommendations—Include the unreported Medicaid overpayments we identified in its quarterly report to CMS, refund an estimated \$9 million to the Federal Government, and ensure that future Medicaid overpayments that are in the appeals process are reported in accordance with Federal requirements.) *Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64.* A-05-11-00052. January 2012. [Web Summary](#). [Full Text](#).
- **Oklahoma** – Oklahoma did not properly report collections associated with probate amounts and with fraud and abuse collections. The State inappropriately subtracted probate collection amounts from its worksheet calculation because State officials incorrectly believed that probate collections were associated with adjusted claims and wanted to avoid duplicate reporting. Also, the State did not report the entire amount of its fraud and abuse collections. In other instances, the State underreported and overreported the Federal share of collections and applied incorrect share percentages.

(Recommendations—Refund an estimated \$14.8 million to the Federal Government; resolve \$435,000 in unsupported adjusted claims we set aside for further analysis; ensure that documentation requirements are met; and establish review procedures to ensure that collections are correctly compiled, assigned, and reported. *Review of Oklahoma Collections for the Medical Assistance Program for Calendar Years 2004 Through 2009.* A-06-10-00057. January 2012. [Web Summary](#). [Full Text](#).)

Oversight of Medicaid Integrity Contractors

CMS defined three types of Medicaid Integrity Contractors (MIC) to perform the program integrity activities mandated in the Deficit Reduction Act of 2005 (DRA) and to identify additional fraud, waste, and abuse—Review MICs, Audit MICs, and Education MICs. Review MICs review State Medicaid claims data and identify potential overpayments. Audit MICs audit specific providers and identify overpayments. Education MICs educate providers and beneficiaries on program integrity issues.

Poor Data and Audit Targeting Hinder Contractor Performance

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

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

- **Audit MICs** – Performance was hindered because audit targets were poorly identified. Few of the audits assigned to Audit MICs from January through June 2010 identified overpayments. Of the 370 audits assigned to Audit MICs, 81 percent either did not identify overpayments or are unlikely to identify overpayments. Audit targets were misidentified because of data problems and because State program policies were applied incorrectly. The problematic audit targets caused MICs to duplicate efforts.

Audit MICs reported spending significant preaudit time evaluating algorithms, reanalyzing system data, and ensuring the accurate application of State policies during audit target selection. According to CMS's data, an average of 3 months elapsed between the date CMS assigned audits to Audit MICs and the date when Audit MICs began the audits.

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

Ensuring Program Integrity in Medicaid Managed Care

State Medicaid agencies contract with managed care entities (MCE) to provide comprehensive health services in return for capitated payments for each enrolled beneficiary. Two types of MCEs are subject to specific Federal program integrity requirements: managed care organizations (MCO) and prepaid inpatient health plans (PIHP). In 2000, CMS issued *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*. In the guidelines, CMS adapted general Medicaid definitions of "fraud" and "abuse" to the managed care environment and identified areas of concern.

Excluded Providers in Medicaid Managed Care Plans

We found that only a few of the providers that OIG had excluded from participation in Medicare were associated with the managed care provider networks we reviewed. We found 11 excluded providers enrolled in 4 of 12 Medicaid MCE provider networks. We recognize that the number of excluded providers that we identified is small. However, States may benefit from information regarding the failures that led to the inclusion of a few excluded providers in MCE provider networks. For example, two MCEs explained that excluded providers had joined their MCE networks through their acquisition of other MCEs or the providers had simply not been removed from the enrollment data when their last contracts expired or were terminated.

This report also describes the safeguards MCEs use to identify excluded providers. Federally funded programs, such as Medicaid managed care, are prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider or paying anyone who contracts with an excluded provider.

(Recommendation—CMS should periodically remind States of their obligation to ensure that no excluded providers receive Medicaid payments.)
Excluded Providers in Medicaid Managed Care Plans. OEI-07-09-00630. February 2012. [Web Summary](#). [Full Text](#).

Fraud and Abuse Concerns Remain Despite Safeguards.

MCEs reportedly took steps to oversee fraud and abuse safeguards, but they remained concerned about the prevalence of fraud. CMS, States, and Medicaid MCEs expressed that services billed but not rendered are their

primary concern with respect to fraud and abuse in Medicaid managed care. Other concerns include rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries.

All MCEs in our sample reported taking steps to meet Federal program integrity requirements, and all States in our sample reported taking steps to oversee MCEs' fraud and abuse safeguards. Even so, they remained concerned about the prevalence of fraud.

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

OEI-01-09-00550. December 2011. [Web Summary](#). [Full Text](#).