

Part III:
Medicaid Reviews

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Part III: Medicaid Reviews

The Federal and State Governments jointly fund Medicaid, a program that provides medical assistance to certain low-income individuals. The Federal share of a State's expenditures is called the Federal medical assistance percentage (FMAP). States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State.

Our continuing and new reviews of Medicaid in fiscal year (FY) 2012 address prescription drugs, long-term and community care, other services, program integrity and accountability, administration, information systems, and managed care.

Medicaid Prescription Drug Pricing, Reimbursement, and Rebates

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

AMP—AVERAGE MANUFACTURER PRICE	FUL—FEDERAL UPPER LIMIT
AWP—AVERAGE WHOLESALE PRICE	MCO—MANAGED CARE ORGANIZATION
CMS—CENTERS FOR MEDICARE & MEDICAID SERVICES	STATE MAC—STATE MAXIMUM ALLOWABLE COST
DRA—DEFICIT REDUCTION ACT OF 2005	URA—UNIT REBATE AMOUNT
FFP—FEDERAL FINANCIAL PARTICIPATION	WAC—WHOLESALE ACQUISITION COST
FMAP—FEDERAL MEDICAL ASSISTANCE PERCENTAGE	

Objectives and context for continuing and new *Work Plan* reviews of Medicaid follow.

Calculation of Average Manufacturer Prices

We will review selected drug manufacturers to evaluate methodologies they use to calculate the average manufacturer price (AMP) and the best price for the Medicaid drug rebate program and for drug reimbursement. We will also determine whether the methodologies are consistent with statutes, regulations, and manufacturers' rebate agreements and the Centers for Medicare & Medicaid Services (CMS) *Drug Manufacturer Release(s)*. Several changes to the Medicaid drug rebate statute and to Medicaid reimbursement for multiple-source drugs involve revisions in the calculation of the AMP and the best price. The changes will affect amounts that pharmaceutical manufacturers report under the Medicaid drug rebate program and will affect the Federal upper limit (FUL) for drug reimbursement. (Deficit Reduction Act of 2005 (DRA), § 6001.) CMS uses the AMP and the best price to determine unit rebate amounts (URA). Manufacturers must pay rebates to States based on the URAs. (OAS; W-00-11-31202; various reviews; expected issue date: FY 2012; new start)

Recalculation of Base-Date Average Manufacturer Prices

We will review changes to base-date AMPs and assess the impact of such changes on Medicaid rebates. We will examine manufacturers' rationales and supporting data for changes to base-date

AMPs. Manufacturers pay additional rebates for single-source drugs based on the difference between AMPs and base-date AMPs adjusted for inflation. (Social Security Act, § 1927(c).) To ensure that such rebates will not increase because of changes in AMPs, Federal regulations allow manufacturers to revise the base-date AMPs against which these inflationary measures are indexed. (42 CFR § 447.510(c).) Additional rebates paid by manufacturers reflect an integral and statutorily required aspect of the Medicaid drug rebate program. (DRA, § 6001.) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Federal Upper Payment Limit Drugs

We will review prescription drug claims to determine whether pharmacies have altered prescriptions to maximize reimbursements by avoiding certain dosage forms for drugs that have FULs on reimbursements. We will determine whether there has been manipulation of FULs. As a result of whistleblowers' actions, several pharmacies have admitted changing dosage forms for some commonly prescribed Medicaid drugs, thereby inflating reimbursements by avoiding FULs established on other dosage forms. The FULs for all multiple-source drugs were established by the Social Security Act, § 1927(e)(4). (OAS; W-00-12-31333; various reviews; expected issue date: FY 2012; new start)

State Maximum Allowable Cost Programs

We will review State Maximum Allowable Cost (State MAC) programs to determine how State MAC lists are developed, how State MAC prices are set, and how State MAC prices compare to the FUL amounts. This review will compare State MAC programs to determine which ones are most successful in reducing Medicaid expenditures. To take advantage of lower market prices for certain generic products, States use the FUL list and/or State MAC programs in determining reimbursement amounts. State MAC programs are designed to ensure that the Medicaid program pays appropriate prices for generic drugs. In 2004, a CMS-contracted study looked at State MAC programs in five States and found considerable variation between these programs and the FUL program. The study concluded that expansion of existing State MAC programs and implementation of new ones could contribute to cost containment efforts nationwide. (OEI; 03-11-00640; expected issue date: FY 2012; work in progress)

Appropriateness of Federal Upper Limit Amounts (New)

We will compare FUL amounts under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) methodology to an estimate of pharmacy acquisition costs for selected drugs. The Office of Inspector General (OIG) has a long history of examining FULs for generic drugs paid under Medicaid. Numerous reports found that a previous method for calculating FULs (150 percent of the lowest average wholesale price (AWP) or wholesale acquisition cost (WAC) caused Medicaid to overpay substantially. Our previous FUL reports consistently recommended that CMS work with Congress to ensure that FULs more accurately represent pharmacy acquisition costs. A revised method that set FULs at 250 percent of the lowest AMP was enacted by the DRA; however, it was never implemented because of an injunction imposed by the Federal District Court of the District of Columbia. A recent law changed the FUL calculation to no less than 175 percent of the average AMP. (Affordable Care Act, § 2503.) CMS implemented this latest change to the calculation in 75 Fed. Reg. 69591 (November 15, 2010). (OEI; 03-11-00650; expected issue date: FY 2012; work in progress; Affordable Care Act)

Update of Manufacturer Compliance With AMP Reporting Requirements (New)

We will review manufacturer compliance with AMP reporting requirements and determine what percentage of manufacturers complied with AMP reporting requirements in 2011. We will assess whether stepped-up enforcement actions by CMS and OIG are reflected in increased compliance by manufacturers. A previous OIG review found that in 2008 more than half of the drug manufacturers that were required to submit quarterly AMPs to CMS failed to comply with reporting requirements in at least one quarter. Manufacturers were even less likely to comply with monthly AMP reporting requirements, with more than three-fourths submitting late, incomplete, or no AMPs in at least 1 month of 2008. After the release of this report, CMS and OIG worked to increase manufacturer compliance. Price-reporting obligations for certain drug manufacturers, including the obligation to report AMP data to CMS quarterly and monthly, are set forth in the Social Security Act, § 1927(b)(3), and 42 CFR §§ 447.510(a) and (d). (OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Medicaid Drug Claims

We will review the accuracy of States' submissions of Medicaid drug claims to CMS for reimbursement. We will determine whether the tape that CMS provides to States includes all covered drugs and indicates drugs' termination dates, if applicable. We will also determine whether reimbursements are correct and are supported for the drugs claimed. A drug manufacturer must have a rebate agreement with CMS to have its outpatient drugs covered under Medicaid. (Social Security Act, § 1927(a)(1).) Under the drug rebate program, CMS provides States with a quarterly Medicaid drug tape that should list all covered outpatient drugs and indicate a drug's termination date, if applicable. CMS instructs States to use the tape to verify coverage of the drugs for which they claim reimbursement. (OAS; W-00-10-31203; W-00-11-31203; various reviews; expected issue date: FY 2012; work in progress)

Compound Drug Claims

We will review a State agency's Medicaid claims for compound drugs to determine whether the drugs' components complied with Federal requirements for reimbursement and collection of rebates. We will identify claimed drug components that are not eligible for Medicaid coverage and determine whether accountability and controls were established for collecting eligible drug component rebates. Compound drugs are custom blended by pharmacists from bulk ingredients based on doctors' prescriptions. For payments to be available under Medicaid or Part B of Medicare, Federal law requires manufacturers to enter into and have in effect rebate agreements with the Secretary of Health & Human Services (HHS) (except that the Secretary may authorize a State to enter directly into agreements with a manufacturer) and meet certain other requirements. (Social Security Act, § 1927.) States may then claim Federal financial participation (FFP) and report drug utilization to the manufacturers for rebates. CMS requires States to use a drug tape that lists all drugs covered by rebate agreements to determine whether the drugs they purchase are eligible for Medicaid coverage. (CMS's *Medicaid Drug Rebate Program State Release No. 130*.) CMS outlined States' responsibility for preventing claims for terminated drugs in its *Medicaid Drug Rebate Program State Release No. 19*. (OAS; W-00-12-31317; various reviews; expected issue date: FY 2012; work in progress)

Medicaid Claims for Drugs Purchased Under Retail Discount Generic Programs

We will review Medicaid claims for generic drugs to determine the extent to which large chain pharmacies are billing Medicaid the usual and customary charges for drugs provided under their retail discount generic programs. We will also examine CMS's policies and procedures for

ensuring that Medicaid is billed properly under retail discount generic programs. The discount programs typically offer selected generic drugs to anyone with a prescription for \$4 for a 30-day supply or \$10 for a 90-day supply. Federal regulations require, with certain exceptions, that each State Medicaid agency's reimbursement for covered generic outpatient drugs without established upper limits not exceed (in the aggregate) the lower of the estimated acquisition cost for drugs, plus a reasonable dispensing fee, or the provider's usual and customary charge to the public for the drugs. (42 CFR § 447.512.) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

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

We will review drug-pricing and rebate data that drug manufacturers report to State Medicaid agencies to determine the extent to which manufacturers are reporting pricing data and paying rebates for authorized generic drugs. We will also determine to what extent Medicaid rebates have changed since the implementation of certain provisions and whether the number of new authorized generics changed after implementation. CMS stated in its 2007 final rule on Medicaid prescription drugs that best-price calculations must now include the prices available to secondary manufacturers of authorized generic drugs. The change in definition has the potential to increase the amount of rebates due from single-source drugs' primary manufacturers. Federal regulations define "authorized generics" as versions of brand-name drugs produced and/or marketed with the consent of the original brand manufacturers and marketed under the brand manufacturers' original drug applications. (42 CFR § 447.506.) Rebates to States from manufacturers are based in part on the difference between the AMP of a drug and the best price of the drug. (Social Security Act, § 1927.) The definition of "best price" was clarified to include the lowest price available to any entity for any such drug sold under a new drug application. (DRA, § 6001.) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Zero-Dollar Unit Rebate Amounts

We will determine whether States are effectively collecting drug rebates from manufacturers for drugs with zero-dollar URAs. We will determine the financial impact of zero-dollar URAs and examine possible causes for States not receiving required rebates from manufacturers. Previous OIG work found that States may not be collecting all possible drug rebates from manufacturers when CMS is unable to calculate URAs. URAs are based on pricing data reported by drug manufacturers. At the end of every quarter, CMS calculates URAs for drugs included in the Medicaid drug rebate program and provides the amounts to State Medicaid agencies. If and when manufacturers have not reported the necessary data for the calculations, the URAs for such products are listed as \$0, i.e., zero-dollar URAs. Even so, Medicaid requires States to work with manufacturers to determine the appropriate rebates for the drugs. (OEI; 03-11-00470; expected issue date: FY 2012; work in progress)

States' Efforts and Experiences With Resolving Rebate Disputes

We will review the causes of and resolutions to Medicaid rebate disputes and the methods States use to resolve such disputes. In 2008, Medicaid spent approximately \$24 billion on prescription drugs and received approximately \$8 billion in rebates. Previous OIG reports have found large amounts in uncollected rebates. Federal law requires drug manufacturers to enter into drug rebate agreements as a prerequisite to coverage of their drugs under Medicaid State plans. (Social Security Act, § 1927(a).) (OEI; 05-11-00580; expected issue date: FY 2012; work in progress)

States' Collection of Rebates for Drugs Paid by Managed Care Organizations (New)

We will determine whether Medicaid managed care organizations (MCO) are providing State Medicaid agencies with the utilization data needed to collect rebates for drugs used by Medicaid MCOs enrollees. This review will determine whether States have procedures to verify the accuracy of the utilization data provided by Medicaid MCOs, whether and how States are invoicing manufacturers for these rebates, whether States are collecting these rebates from manufacturers, and what procedures States have to track rebate collection for drugs dispensed to Medicaid MCO enrollees. Medicaid rebate requirements were expanded to include drugs dispensed to MCO enrollees. Medicaid MCOs are required to report enrollees' drug utilization data to the State for the purpose of collecting rebates from manufacturers. (Affordable Care Act, § 2501.) CMS has provided guidance through State Medicaid Director Letters to States on implementation of this provision. Although the Congressional Budget Office has estimated this requirement would reduce expenditures by \$3.7 billion over a 5-year period, States and manufacturers have expressed concerns about how this requirement will be implemented. (OEI; 03-11-00480; expected issue date: FY 2012; work in progress)

Federal Share of Rebates (New)

We will review States' reporting of the Federal share of Medicaid rebate collections. We will determine whether States are correctly identifying and reporting the increases in rebate collections. Three new provisions in law should result in increased rebate payments by drug manufacturers to the States. The provisions will increase the minimum rebate percentages, increase the additional rebate on new formulations of existing drugs, and allow for rebates on drugs dispensed through Medicaid MCOs. (Social Security Act, §§ 1927(b) and (c), as amended by the Affordable Care Act, § 2501.) Any increase in rebate collections that results from these new provisions is not shared with the States but is considered 100 percent Federal. (Social Security Act, § 1927(b)(1)(C).) (OAS; W-00-12-31450; various reviews; expected issue date: FY 2012; new start; Affordable Care Act)

Rebates on New Formulations (New)

We will review drug manufacturers' compliance with Medicaid drug rebate requirements for drugs that are new formulations of existing drugs. We will also determine whether manufacturers have correctly identified all their drugs that are subject to a new provision in law. A recent change increases the additional rebate for drugs that are new formulations of existing drugs if certain conditions are met. (Social Security Act, § 1927(c)(2)(C), as amended by the Affordable Care Act, § 2501.) Manufacturers pay the additional rebate that is based on the existing drug if it is higher than the additional rebate that is based on the new formulation. (OAS; W-00-12-31451; various reviews; expected issue date: FY 2012; new start; Affordable Care Act)

Home, Community, and Personal Care Services

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

ALF—ASSISTED LIVING FACILITIES
 CDT—CONTINUING DAY TREATMENT
 FFP—FEDERAL FINANCIAL PARTICIPATION

HCBS—HOME- AND COMMUNITY-BASED SERVICES
 HHA—HOME HEALTH AGENCY
 PCS—PERSONAL CARE SERVICES

Home Health Services: Screenings of Health Care Workers

We will review health-screening records of Medicaid home health care workers to determine whether the workers were screened in accordance with Federal and State requirements. Examples of screenings can include vaccinations for hepatitis and influenza. Home health agencies provide health care services to Medicaid beneficiaries while visiting beneficiaries' homes. Home health care agencies must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted standards that apply to personnel providing services within such an agency. (Social Security Act, §1891(a)(5).) The Federal requirements for home health services are found at 42 CFR §§ 440.70, 441.15, and 441.16 and at 42 CFR pt 484. Other applicable requirements are found in State and local regulations. (OAS; W-00-11-31387; various reviews; expected issue date: FY 2012; new start)

Home Health Services: Agency Claims

We will review home health agency (HHA) claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria. Providers must meet criteria such as minimum number of professional staff, proper licensing and certification, review of service plans of care, and proper authorization and documentation of provided services. A doctor must determine that the beneficiary needs medical care at home and prepare a plan for that care. The care must include intermittent (not full-time) skilled nursing care and may include physical therapy or speech-language pathology services. The standards and conditions for HHA's participation in Medicaid are at 42 CFR § 440.70 and 42 CFR pt. 484. (OAS; W-00-10-31304; W-00-11-31304; various reviews; expected issue date: FY 2012; work in progress)

Home Health Services: Homebound Requirements (New)

We will review CMS policies and practices for reviewing the sections of Medicaid State plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements for home health services. We will also identify the number of States that violate Federal regulations by inappropriately restricting eligibility for home health services to homebound recipients. States must ensure that the services available to any individual in a categorically or medically needy group are comparable to the services available to the entire group. (42 CFR § 440.240(b).) States may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of a beneficiary's diagnosis, type of illness, or condition. (42 CFR § 440.230(c).) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Home- and Community-Based Services: Federal and State Oversight of Quality of Care

We will review CMS and State oversight of home- and community-based services (HCBS) waiver programs to determine the extent to which CMS oversees States' efforts to ensure the quality of care provided under such waiver programs. We will also determine the extent to which States monitor the quality of care given to participants in HCBS waiver programs for the aged and disabled. Medicaid HCBS waiver programs allow States to provide alternative services for those who otherwise would require care in nursing homes. States must provide assurances that necessary safeguards have been taken to protect the health and welfare of recipients. (42 CFR § 441.302.) However, a 2003 Government Accountability Office (GAO) review found that CMS and States did not provide adequate oversight of HCBS waivers. (OEI; 02-08-00170; expected issue date: FY 2012; work in progress)

Home- and Community-Based Services: Federal and State Oversight of Assisted-Living Facilities

We will determine the extent to which assisted-living facilities (ALF) provide HCBS to their Medicaid-eligible residents. We will also determine how States and CMS ensure that ALFs are meeting provider standards, plans of care are established and followed by ALFs, and ALFs meet other Federal requirements for HCBS services. Federal regulations require States to provide CMS with assurances that necessary safeguards have been taken to protect the health and welfare of HCBS recipients. (42 CFR § 441.302.) ALFs may receive Medicaid funding through the HCBS waiver program pursuant to the Social Security Act, § 1915(c). (OEI; 09-08-00360; expected issue date: FY 2012; work in progress)

Home- and Community-Based Services: Vulnerabilities in Providing Services (New)

We will determine the extent to which HCBS waiver participants have plans of care, receive the services in their plans, and receive services from qualified providers. We will also identify recipient concerns about the quality of care they receive. Medicaid HCBS allow States to provide care in the home or community for individuals who would otherwise require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded (Social Security Act, § 1915(c)(1).) States offering HCBS waiver programs must provide adequate planning for services and provide those services through qualified providers, as well as ensure the health and welfare of participants. (Social Security Act, §§ 1915 (c)(1) and 1902(a)(23).) (OEI; 02-11-00700; expected issue date: FY 2013; work in progress)

Home- and Community-Based Services: Waiver Program Administrative Costs

We will determine the reasonableness of Medicaid HCBS waiver program administrative costs. We will also determine whether States' contractual arrangements with nonprofit entities for administration of HCBS waiver programs are economical. The HCBS waiver program permits States to furnish arrays of services that help Medicaid beneficiaries to live in the community and avoid institutionalization. (Social Security Act, § 1915(c).) Some States have contracted with nonprofit groups to administer waiver programs. Because CMS's methodology for reviewing waiver applications does not examine administrative costs, it may be possible that States have claimed the Federal share of contracted administrative costs in amounts exceeding Medicaid's actual average administrative costs. The Federal share of Medicaid matches most administrative expenditures at the 50-percent rate if the expenditures are for the "proper and efficient" administration of Medicaid. (OAS; W-00-11-31332; various reviews; expected issue date: FY 2012; work in progress)

Home- and Community-Based Services: Adult Day Care Services for Elderly Individuals Who Have Chronic Functional Disabilities

We will determine whether Medicaid payments to providers for adult day care services complied with Federal and State regulations. Medicaid allows payments for elderly individuals with chronic functional disabilities, through HCBS waiver programs. (Social Security Act, § 1929(a)(7).) (OAS; W-00-11-31386; various reviews; expected issue date: FY 2012; new start)

Community Residence Rehabilitation Services

We will review Medicaid payments for beneficiaries who reside in community residences for people who have mental illnesses to determine whether States improperly claimed FFP. Previous OIG work in one State found improperly claimed Medicaid reimbursement for individuals who were no longer residing in a community residence. To be allowable, costs must be authorized, or not

prohibited, under State or local laws or regulations. (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Attachment A, § C.1.c.) (OAS; W-00-09-31087; W-00-10-31087; W-00-11-31087; various reviews; expected issue date: FY 2012; work in progress)

Continuing Day Treatment Providers

We will review Medicaid payments to continuing day treatment (CDT) providers in one State to determine whether Medicaid payments to CDT providers in that State are adequately supported. CDT providers render an array of services to those who have mental illnesses on a relatively long-term basis. A CDT provider bills Medicaid on the basis of the number of service hours rendered to a beneficiary. One State's regulations require that a billing for a visit/service hour be supported by documentation indicating the nature and extent of services provided. A State commission found that more than 50 percent of the service hours billed by CDT providers could not be substantiated. We will follow up on the commission's findings. To be allowable, costs must be authorized, or not prohibited, under State or local laws or regulations. (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.c.) (OAS; W-00-09-31128; W-00-11-31128; various reviews; expected issue date: FY 2012; work in progress)

Medicaid School-Based Services

We will review Medicaid payments for school-based services in selected States to determine whether the costs claimed for such services are reasonable and properly allocated. Medicaid may pay for medical services provided to students with special needs pursuant to individualized education plans. (Social Security Act, § 1903(c).) Direct medical services may include physical therapy; occupational therapy; speech therapy; and nursing, personal care, psychological, counseling, and social work services. Some States use random moment time studies to develop school-based health service payment rates. Costs claimed must be reasonable and allocated according to the benefit received. (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*.) (OAS; W-00-11-31391; various reviews; expected issue date: FY 2012; work in progress)

Personal Care Services

We will review Medicaid payments for personal care services (PCS) to determine whether States have appropriately claimed the FFP. Medicaid covers PCS only for those who are not inpatients or residents of hospitals, nursing facilities, institutions for mental diseases, or intermediate care facilities for those with mental retardation. (Social Security Act, § 1905(a)(24).) PCS must be authorized by a physician or (at the option of the State) otherwise authorized in accordance with a plan of treatment, must be provided by someone who is qualified to render such services and who is not a member of the individual's family, and must be furnished in a home or other location. Beginning January 1, 2007, States are allowed to pay individuals for self-directed personal assistance services for the elderly and disabled, including PCS that could be provided by a family member. (DRA, § 6087.) (OAS; W-00-09-31035; W-00-10-31035; W-00-11-31035; various reviews; expected issue date: FY 2012; work in progress)

Other Medicaid Services and Payments

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

DME—DURABLE MEDICAL EQUIPMENT

OMB—OFFICE OF MANAGEMENT AND BUDGET

HCBS—HOME- AND COMMUNITY-BASED SERVICES

UPL—UPPER PAYMENT LIMITS

NPI—NATIONAL PROVIDER IDENTIFIERS

Hospice Services: Compliance With Reimbursement Requirements

We will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients' illness and death. An individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS's *State Medicaid Manual*, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than \$816 million. (OAS; W-00-11-31385; various reviews; expected issue date: FY 2012; new start. OEI; 00-00-00000; expected issue date: FY 2013; new start)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services

We will review State controls to detect potentially excessive Medicaid payments to institutional providers for inpatient and outpatient services. Previous OIG work involving Medicare inpatient and outpatient claims found that many excessive payments to the hospitals were attributable to billing errors on the submitted claims, such as inaccuracies in diagnosis codes, admission codes, discharge codes, procedure codes, charges, Healthcare Common Procedure Coding System codes, and number of units billed. To be allowable, costs must be necessary and reasonable for the proper and efficient performance and administration of Federal awards. (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.a.) Costs must be authorized, or not prohibited, under State or local laws or regulations. (§ C.1.c.) CMS adjusts quarterly payments to States to account for overpayments and underpayments by States to providers. (Social Security Act, § 1903(d)(2)(A), and 42 CFR pt. 433, subpart E.) (OAS; W-00-11-31127; various reviews; expected issue date: FY 2012; work in progress)

Payments for Physical, Occupational, and Speech Therapy Services

We will determine the extent to which payments for Medicaid physical, occupational, and speech therapy services comply with State standards and limits on coverage. Previous OIG studies found that some therapy services provided under Medicare were billed incorrectly. Through a review of selected States, we will determine whether Medicaid has similar program integrity issues. States may provide physical, occupational, and speech therapy services to Medicaid beneficiaries pursuant to the Social Security Act, § 1905(a), and regulations at 42 CFR § 440.110. (OEI; 07-10-00370; expected issue date: FY 2012; work in progress)

Medicaid Medical Equipment

We will determine whether Medicaid payments for medical supplies and equipment were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines. Rules and guidance about necessary medical supplies and

equipment for home health services; physical therapy services; occupational therapy services; services for individuals with speech, hearing, and language disorders; and HCBS are in Federal regulations at 42 CFR pt. 440 and various provisions of CMS's *State Medicaid Manual*. (OAS; W-00-11-31390; various reviews; expected issue date: FY 2012; new start)

Medicaid Family Planning Services

We will review family planning services in several States to determine whether enhanced Federal funding was improperly claimed for such services and the resulting financial impact on Medicaid. Previous OIG work found improper claims for enhanced funds for family planning services. States may claim Medicaid reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. (Social Security Act, § 1903(a)(5).) (OAS; W-00-10-31078; W-00-11-31078; various reviews; expected issue date: FY 2012; work in progress)

Payments for Transportation Services

We will review payments to providers for transportation services to determine the appropriateness of State Medicaid agencies' payments for such services. Federal regulations require States to ensure necessary transportation for Medicaid beneficiaries to and from providers. (42 CFR § 431.53.) Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. (OAS; W-00-09-31121; W-00-10-31121; W-00-11-31121; various reviews; expected issue date: FY 2012; work in progress)

State-Operated Facilities: Reasonableness of Payment Rates (New)

We will determine whether Medicaid payment rates to State-operated facilities are reasonable and in accordance with Federal and State requirements. We will determine in selected States the extent to which payments to providers have exceeded the requirements. Payments for services must be consistent with efficiency, economy, and quality of care. (Social Security Act, §1902(a)(30)(A).) Federal regulations state that a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. (2 CFR § 225, Appendix A, § C. 2.) (OAS; W-00-11-31398; various reviews; expected issue date: FY 2012; work in progress)

Payments for Health-Care-Acquired Conditions (New)

We will determine whether selected State agencies made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions. As of July 1, 2011, Federal payments to States under the Social Security Act, § 1903, are prohibited for any amounts expended for providing medical assistance for health care-acquired conditions. (Affordable Care Act, § 2702.) Federal regulations prohibiting Medicaid payments by States for services related to health care-acquired conditions and provider-preventable conditions are at 42 CFR § 447.26. (OAS; W-00-12-31452; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

Supplemental Payments to Private Hospitals

We will review Medicaid supplemental payments by States to private hospitals to determine whether errors exist involving such payments. Federal funds are not available for Medicaid payments that exceed applicable upper payment limits (UPL). Prior OIG work involving supplemental payments to public facilities found errors. Federal regulations define the UPL for inpatient hospital services as a reasonable estimate of the maximum amount that would be paid

for Medicaid services under Medicare payment principles. (42 CFR § 447.272.) States are permitted to make payments under their approved plans to hospitals up to the applicable aggregate UPL, and many States use this flexibility to make lump-sum supplemental payments based on the difference between the ordinary rate and the UPL. Medicaid agencies pay for inpatient hospital and long-term-care services using rates determined in accordance with methods and standards specified in their approved State plans. (42 CFR § 447.253(i).) (OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2012; work in progress)

Supplemental Payments to Public Providers (New)

We will review Medicaid supplemental payments by States to public providers (State and Non-State government operated facilities) and determine whether they comply with Federal UPL requirements. Federal funds are not available for Medicaid payments that exceed the UPL. This is a followup to previous OIG work involving supplemental payments to public facilities that resulted in program revisions that saved billions in Medicaid funding. Our work will focus on the amount of Medicaid funding claimed by selected States as part of UPL programs, as well as the use of the funds. States are permitted to make payments to providers under their approved plans to hospitals up to the applicable aggregate UPL based on reasonable estimations of what Medicare would have paid for equivalent services. Federal regulations define the UPL for inpatient and outpatient hospital services at 42 CFR § 447.272 and 42 CFR § 447.321. A State agency's proposed payment rate is not to exceed the UPL. (42 CFR § 447.253(b)(2).) (OAS; W-00-12-31453; various reviews; expected issue date: FY 2013; new start)

Medicaid Nursing Facility Incentive Payments

We will review Medicaid incentive payments by States to nursing facilities based on the facilities' quality-of-care performance measures. We will determine whether States have sufficient controls to assess nursing facilities' quality-of-care performance measures and determine whether incentive payments were in accordance with program requirements. States are authorized to establish programs to reward nursing facilities (through public recognition, incentive payments, or both) that provide the highest quality care to their Medicaid-eligible residents. (Social Security Act, § 1919(h)(2)(F).) (OAS; W-00-10-31331; W-00-11-31331; various reviews; expected issue date: FY 2012; work in progress)

Emergency Payments by State Medicaid Agencies (New)

We will determine whether emergency payments to providers made by State Medicaid agencies were adequately supported. We will review the emergency payments and assess States' overpayment reconciliation and recoupment processes to determine whether charges to Medicaid were based on actual expenditures. Emergency payments often occur during transitions between fiscal agents or when systems are upgraded. These payments have a substantial additional risk of inaccuracy because they may bypass the usual payment edits and claim-support requirements. One State Medicaid agency recently made \$792 million in emergency payments to providers, for which the State auditor identified numerous deficiencies, including that such payments were not supported by valid claims but based on estimates. Federal regulations require States to account for Medicaid funds based on expenditures, not estimates. (42 CFR § 430.30.) (OAS; W-00-12-31454; various reviews; expected issue date: FY 2012; new start)

Medicaid Integrity and Accountability

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

CHIP—CHILDREN’S HEALTH INSURANCE PROGRAM

CPE—CERTIFIED PUBLIC EXPENDITURES

DRA—DEFICIT REDUCTION ACT OF 2005

FFP—FEDERAL FINANCIAL PARTICIPATION

FFS—FEE FOR SERVICE

FORM CMS-64—QUARTERLY MEDICAID STATEMENT OF EXPENDITURES

MEDI-MEDI—MEDICARE AND MEDICAID DATA MATCHING PROJECT

MIC—MEDICAID INTEGRITY CONTRACTOR

MIP—MEDICAID INTEGRITY PROGRAM

OMB—OFFICE OF MANAGEMENT AND BUDGET

PERM—PAYMENT ERROR RATE MEASUREMENT (PROCESS)

Early Results From Medicaid Integrity Contractors

We will review the progress of CMS’s Medicaid Integrity Contractors (MIC) in completing program integrity tasks outlined in their contracts. We will also examine the results of the MICs’ work. An integral part of the Medicaid Integrity Program (MIP) is the program integrity work that will be performed by MICs. MICs are tasked with preventing and detecting Medicaid fraud, waste, and abuse through the review of the actions of individuals or entities furnishing items or services under Medicaid. CMS began awarding contracts in April 2008 and subsequently awarded contracts covering CMS’s 10 regions. The MIP was established by the Social Security Act, § 1936, as amended by the DRA, § 6034. (OEI; 05-10-00200; 05-10-00210; expected issue date: FY 2012; work in progress)

Medicare and Medicaid Data Matching Project

We will review CMS’s oversight and monitoring of the Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi task orders. We will also determine the extent to which Medi-Medi contractors identified potential fraud, waste, and abuse through the Medi-Medi project. This review matches Medicare and Medicaid data to proactively identify program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data individually. CMS began the Medi-Medi project in 2001 in partnership with California to improve coordination of Medicare and Medicaid program integrity efforts pursuant to the Social Security Act, § 1893. As of 2007, there were 10 active Medi-Medi task orders in California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois. Federal regulations provide policies and establish responsibilities for agencies to record and maintain contractor performance information. (48 CFR §§ 42.1500 to 42.1503.) (OEI; 09-08-00370; expected issue date: FY 2012; work in progress)

Addressing Vulnerabilities Identified During Medicaid State Program Integrity Reviews (New)

We will review corrective actions that State Medicaid agencies have implemented to address the findings and recommendations from State Medicaid program integrity reviews conducted by CMS. We will determine why States have not implemented all corrective actions, examine the followup CMS performed to ensure that corrective actions were taken by States, and examine the evidence CMS reviews to ensure that corrective actions were implemented. As part of the MIP, CMS conducts a triennial review of each State’s program integrity functions to assess their effectiveness and compliance with Federal requirements. CMS issues to the State a final report of findings and recommendations and requires the State to provide a corrective action plan within 30 days of the report issuance. The MIP was established by DRA, § 6034. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Claims With Inactive or Invalid Physician Identifier Numbers

We will review Medicaid claims to determine the extent to which State agencies have controls in place to identify claims associated with inactive or invalid national provider identifiers (NPI), including claims for services alleged to have been provided after the dates of the referring physicians' deaths. In a prior OIG review, we found instances in which Medicare had paid durable medical equipment (DME) claims with inactive or invalid NPIs for the referring physicians. In 2009, the Senate Permanent Subcommittee on Investigations, Committee on Homeland Security and Governmental Affairs, reported that a substantial volume of Medicare-paid DME claims contained NPIs of deceased physicians. Given the vulnerabilities identified in the Medicare program, we will review State Medicaid programs to determine whether States have controls in place to identify claims with inactive or invalid NPIs. (OAS; W-00-11-31338; various reviews; expected issue date: FY 2012; new start)

Beneficiaries With Multiple Medicaid Identification Numbers

We will review duplicate payments on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and the procedures for preventing such payments. We will determine whether States made duplicate Medicaid payments on behalf of these beneficiaries. A preliminary data match has identified a significant number of individuals who were assigned more than one Medicaid identification number and for whom multiple Medicaid payments were made for the same period. The IPIA states that a duplicate payment is an improper payment. (OAS; W-00-11-31374; various reviews; expected issue date: FY 2012; work in progress)

State Medicaid Fraud Control Units Performance Standards

We will review the overall management, operations, and performance of a State Medicaid Fraud Control Unit (MFCU). The Secretary has delegated to OIG the responsibility for administering the MFCU grants and providing oversight and guidance to the MFCUs. Part of that oversight responsibility, as required by 42 CFR § 1007.15(d), includes certifying and then annually recertifying every State MFCU. Section 1902(a)(61) of the Social Security Act required the Secretary to establish performance standards that could be used in evaluating a MFCU's performance for recertification purposes; the twelve standards were published at 59 Federal Register 49080. Periodically, OIG conducts an in depth, on-site review of each State MFCU as part of the recertification process. We will determine the extent to which a State MFCU operates in accordance with the twelve published performance standards and identify areas for improvement in the MFCU's management and operations. (OEI, 02-11-00440, expected issue date: FY 12; work in progress; multiple reviews; new start)

State Agencies' Terminations of Providers Terminated Under Medicare or by Other States (New)

We will review States' compliance with a new requirement that State Medicaid agencies terminate providers that have been terminated under Medicare or by another State. We will determine whether such providers are terminated by all States, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify obstacles States face in complying with the termination requirement. This new requirement became effective January 1, 2011. (Social Security Act, § 1902(a)(39), as amended by the Affordable Care Act, § 6501.) We will compare lists of providers terminated from Medicare and each State Medicaid program and examine the information-sharing system being implemented

to comply with the requirement. (Affordable Care Act, § 6401(b)(2).) (OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)

Federally Excluded Providers and Suppliers

We will review Medicaid payments to providers and suppliers to determine the extent to which payments were for services provided during periods of exclusion from Medicaid. Excluded providers and suppliers are not permitted to receive payments for services provided during periods of exclusion. (Social Security Act, §§ 1128, 1128A, and 1156, and 42 CFR § 1001.1901.) (OAS; W-00-10-31337; W-00-11-31337; various reviews; expected issue date: FY 2012; work in progress)

States' Contingency Fee Payment Arrangements

We will determine the extent to which State Medicaid agencies have contracted with consultants through contingency fee payment arrangements and determine how the impact the arrangements have affected the submission of questionable or improper claims to the Federal Government. Previous OIG work in one State found that improper claims had been submitted by the State as a result of a contingency fee payment arrangement. Some State Medicaid agencies use consulting firms to help identify ways to maximize Federal Medicaid reimbursement. In some cases, States pay the consulting firms a percentage of the increase in Federal Medicaid funding. The claiming of the costs of such contingency fee arrangements from the Federal Government are precluded by OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*. (OAS; W-00-07-31045; W-00-08-31045; W-00-11-31045; various reviews; expected issue date: FY 2012; work in progress)

Federal Funds Generated Through Medicaid Provider Taxes (New)

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

Impact of Certified Public Expenditures

We will determine whether States are complying with Federal regulations for claiming certified public expenditures (CPE). CPEs are normally generated by local governments as part of their contribution to the coverage of Medicaid services. States may claim CPEs to provide the State's share in claiming Federal reimbursement as long as the CPEs comply with Federal regulations and the CPEs are being used for the required purposes. (42 CFR § 433.51 and 45 CFR § 95.13.) (OAS; W-00-12-31110; various reviews; expected issue date: FY 2012; new start)

Overpayments: Medicaid Credit Balances

We will review patient accounts of providers to determine whether there are Medicaid overpayments in the accounts with credit balances. Previous OIG work found Medicaid overpayments in patients' accounts with credit balances. Medicaid is the payer of last resort and providers are to identify and refund overpayments received. (Social Security Act, § 1902(a)(25); 42 CFR pt. 433, subpart D; various State laws; and CMS's *State Medicaid Manual*, Pub. No. 45, pt. 3,

§ 3900.1.) (OAS; W-00-10-31311; W-00-11-31311; various reviews; expected issue date: FY 2012; work in progress)

States' Efforts To Improve Third-Party Liability Payment Collections in Medicaid

We will review States' procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries to determine the extent to which States' efforts have improved since our last review. We will also examine changes to State laws and Medicaid procedures and determine whether such changes have improved States' identification of third-party liabilities. Many Medicaid beneficiaries may have additional health insurance through third-party sources, such as employer-sponsored health insurance. OIG work in 2006 described problems that State Medicaid agencies had in identifying and collecting third-party payments. States are to take all reasonable measures to ascertain the legal liabilities of third parties with respect to health care items and services. (Social Security Act, § 1902(a)(25).) The DRA, § 6035, clarified the provision for entities defined as third-party payers. (OEI; 05-11-00130; expected issue date: FY 2012; work in progress)

Proper Allocation of Medicaid Administrative Costs

We will review administrative costs claimed by several States to determine whether they were properly allocated and claimed or directly charged to Medicaid. Prior reviews in one State noted problems with the State's administrative costs. The Federal share of Medicaid administrative costs is typically 50 percent, with enhanced rates for specific types of costs. Federal cost sharing for the proper and efficient administration of Medicaid State plans is provided by the Social Security Act, § 1903(a)(7). Administrative costs are claimed in accordance with OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, and State requirements. (OAS; W-00-10-31123; W-00-11-31123; various reviews; expected issue date: FY 2012; work in progress)

Form CMS-64: Oversight of State Data Reporting

We will examine CMS's oversight of State quarterly expenditure reporting on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). We will also identify opportunities to improve the accuracy of such reporting. Previous OIG and GAO studies have shown significant inaccuracies in the reporting of State expenditures, thus affecting the Federal reimbursement match. The Form CMS-64 is a detailed accounting of expenditures that the Federal Government uses to reimburse States under Title XIX of the Social Security Act. Federal regulations require each State to submit the Form CMS-64 as a report of actual quarterly expenditures. (42 CFR § 430.30(c).) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Form CMS-64: Pharmacy Prescription Drug Claims

We will review Medicaid pharmacy prescription drug claims for selected State Medicaid agencies to determine whether States accurately reported Medicaid expenditures for prescription drugs and whether the claims related to the expenditures were adequately supported by pharmacy records. CMS requires States to report actual expenditures on Form CMS-64 and maintain supporting documentation. (CMS's *State Medicaid Manual*, Pub. 45, pt. 2, §§ 2497 and 2500.) (OAS; W-00-09-31318; W-00-11-31318; various reviews; expected issue date: FY 2012; work in progress)

Form CMS-64: Medicaid Monetary Drawdowns (New)

We will review the Medicaid monetary drawdowns that States received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the States on the Form CMS-64. States draw monetary advances against a continuing letter of credit certified to

the Secretary of the Treasury in favor of the State payee throughout a quarter. (42 CFR § 430.30(d)(4).) After the end of each quarter, States must submit the Form CMS-64, which shows the disposition of Medicaid funds used to pay for actual medical and administrative expenditures for the reporting period. (42 CFR § 430.30(c).) The amounts reported on the Form CMS-64 should reconcile the monetary advances for a quarter. (OAS; W-00-12-31456; various reviews; expected issue date: FY 2012; new start)

Form CMS-64: Medicaid Overpayment Reporting and Collections (New)

We will determine whether States are reporting overpayments identified by Federal audits on the Form CMS-64, as Federal regulations require. For cases in which CMS concurred with our prior recommendations, we will determine whether the overpayments have been recouped. Prior OIG reviews identified Medicaid overpayments in various States, and we recommended collection of those overpayments. If a Federal review indicates that a State has failed to identify an overpayment, CMS is to consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery. (42 CFR § 433.316(e).) Federal regulations require States' use of the Form CMS-64. (42 CFR part 433, subpart F). (OAS; W-00-11-31399; various reviews; expected issue date: FY 2012; work in progress)

Form CMS-64: Accuracy of Medicaid Collections and Federal Share (New)

We will determine whether States accurately captured Medicaid collections on their Form CMS-64, as well as returned the correct Federal share related to those collections. Previous OIG work revealed multiple errors in compiling collections amounts on the Form CMS-64, particularly errors related to the calculation of the Federal share returned. The States should report collections on lines 9a-9e of the Form CMS-64. These collections decrease the total expenditures reported for the period. (42 CFR §§ 433.154 and 433.320.) Instructions for line 9 indicate that States should compute the Federal share of collections at the rate at which CMS matched the original expenditure. (CMS's *State Medicaid Manual*, § 2500.1(B).) (OAS; W-00-12-31457; various reviews; expected issue date: FY 2012; new start)

Payment Error Rate Measurement: Fiscal Year 2008 Error Rate

We will evaluate certain aspects of CMS's Medicaid Payment Error Rate Measurement (PERM) process for determining the FY 2008 Medicaid fee for service (FFS) payment error rate. We will also determine whether the independent medical review organization met its contractual obligations to CMS and will analyze the organization's review. We will also evaluate the methodology and medical review determinations underlying the error rate testing conducted by the PERM contractor. Federal agencies are to annually develop a statistically valid estimate of improper payments under programs with a significant risk of erroneous payments. (Improper Payments Information Act of 2002 (IPIA) and the OMB implementation of IPIA in Memorandum M-06-23.) CMS contracted with an independent medical review organization to perform a random independent review of its PERM contractor's payment determinations for 250 Medicaid FFS claims. (OAS; W-00-10-40045; W-00-11-40045; expected issue date: FY 2012; work in progress)

Payment Error Rate Measurement Program: Error Rate Accuracy and Health Information Security

We will review CMS's implementation of the PERM process to determine whether it has produced valid and reliable error rate estimates for Medicaid and Children's Health Insurance Program (CHIP) FFS, managed care, and eligibility. We will also review the physical and data security of health

information transmitted by various States for use in the PERM. We will also verify CMS's actions to implement recommendations from a March 2010 OIG review. Annually, Federal agencies must develop statistically valid estimates of improper payments under programs with a significant risk of erroneous payments, including Medicaid and CHIP. (Improper Payments Elimination and Recovery Act (IPERA) and OMB's implementation of IPERA.) CMS developed the PERM process to comply with the IPERA. The process includes conducting FFS, managed care, and eligibility reviews. (42 CFR, pt. 431, subpart Q.) OMB's instructions on protecting sensitive information and reporting incidents involving potential and confirmed breaches of personally identifiable information are provided by OMB Memorandums M-06-16 and M-07-16. OIG has oversight and monitoring responsibilities related to CMS's error rate process pursuant to the Chief Financial Officers Act of 1990. (OAS; W-00-11-40046; various reviews; expected issue date: FY 2012; new start)

Payment Error Rate Measurement Program: Eligibility Determinations in One State

We will review compliance in one State with PERM requirements for reviewing eligibility in its Medicaid and CHIP programs. As part of the PERM program, CMS requires States to have an independent review performed of Medicaid and CHIP eligibility determinations to assess whether they are in compliance with the States' eligibility requirements and have properly documented their eligibility determinations. The PERM process includes conducting required FFS, managed care, and eligibility reviews. (42 CFR pt. 431, subpart Q.) CMS developed the PERM program to comply with IPERA and OMB's implementation of IPERA. (OAS; W-00-12-40038; expected issue date: FY 2012; new start)

Program Administration, Information Systems, and Data Integrity

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

CHIP—CHILDREN'S HEALTH INSURANCE PROGRAM

CMS—CENTERS FOR MEDICARE & MEDICAID SERVICES

FFP—FEDERAL FINANCIAL PARTICIPATION

MDS—MINIMUM DATA SET

MMIS—MEDICAID MANAGEMENT INFORMATION SYSTEM

NCCI—NATIONAL CORRECT CODING INITIATIVE

OMB—OFFICE OF MANAGEMENT AND BUDGET

PARIS—PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM

VFC—VACCINES FOR CHILDREN (PROGRAM)

State Buy-In of Medicare Coverage

We will review States' Medicaid buy-in programs for Medicare Part B to determine whether States have adequate controls to ensure that Medicare premiums are paid only for individuals eligible for State buy-in coverage of Medicare services. States may enroll dual-eligible beneficiaries in the Medicare Part B program. States that operate buy-in programs pay the Medicare Part B premium for each dual-eligible individual that they enroll in Medicare Part B. (Social Security Act, § 1843, and 42 CFR §§ 407.40 through 407.42.) (OAS; W-00-10-31220; W-00-11-31220; various reviews; expected issue date: FY 2012; work in progress)

Provider Enrollment: Collection and Verification of Provider Ownership Information by State Medicaid Agencies

We will review State practices for collection and verification of Medicaid provider ownership information, assess the accuracy of the information on file, and assess the effectiveness of the

practices. Payments to providers that have not disclosed the required information are not eligible for FFP. State Medicaid agencies cannot approve a provider participation agreement or contract with any entity that has not disclosed the required information. Federal regulations require Medicaid providers to disclose the name and address of each person with an ownership or control interest in the provider. (42 CFR § 455.104.) (OEI; 04-11-00590; expected issue date: FY 2012; work in progress)

Beneficiary Eligibility: State Agencies' Redeterminations of Medicaid Eligibility (New)

We will review State agencies' procedures for redetermining the eligibility status of Medicaid beneficiaries and determine the amount of unallowable payments associated with beneficiaries who did not receive the required Medicaid eligibility redeterminations. During recent audits of Medicaid payments for services provided to beneficiaries with concurrent eligibility in two States, we found that eligibility status reviews were not always performed in a timely manner. Federal regulations require that State agencies redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. (42 CFR § 435.916.) (OAS; W-00-11-31140; various reviews; expected issue date: FY 2012; work in progress)

State Medicaid Plans' Vaccines for Children Program: Storage and Management of Vaccines

We will determine the extent to which providers in the Vaccines for Children program (which is a required part of each State's Medicaid plan) are properly storing and managing vaccines. We will also determine the extent to which they perform additional vaccine storage and management activities recommended by the Centers for Disease Control and Prevention (CDC). Vaccines for Children is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The program was created as a new entitlement to be a required part of each state's Medicaid plan. (Omnibus Budget Reconciliation Act of 1993.) Funding for the program is approved by OMB and allocated through CMS to CDC. (OEI; 04-10-00430; expected issue date: FY 2012; work in progress)

Children's Health Insurance Program: Dually Enrolled Beneficiaries in a State

We will assess the appropriateness of a State's claims for FFP under the State's CHIP program for individuals who were enrolled in the State's Medicaid program. A previous OIG review of CHIP eligibility in one State for the first 6 months of 2005 indicated that the State had made some CHIP payments on behalf of individuals who were also enrolled in Medicaid. No payment shall be made to a State for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly under any other federally operated or financial health care insurance program. (Social Security Act, § 2105(c)(6)(B).) (OAS; W-00-10-31314; W-00-11-31314; various reviews; expected issue date: FY 2012; work in progress)

Children's Health Insurance Program: State Compliance With Eligibility and Enrollment Notification and Review Requirements

We will review State compliance with the CHIP eligibility and enrollment notification and review requirements. We will also determine whether beneficiaries remain enrolled during reviews of suspension or termination in enrollment. Federal regulations contain requirements relating to applicant and enrollee protections. (42 CFR pt. 457, subpart K.) Requirements include, among other things, that eligibility determinations be timely and be in writing and that the State ensure that an applicant or enrollee has an opportunity for an impartial review of eligibility denials and that the

results of such reviews be timely and be in writing. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Children's Health Insurance Program Administrative Costs

We will determine whether States are complying with CHIP's 10-percent cap on administrative costs. Administrative expenditures include those related to administration, outreach, and other child health assistance and initiatives. There is a limit on administrative funds that are eligible for Federal matching equal to 10 percent of the amounts expended to provide child health assistance. (Social Security Act, § 2105(c)(2)(A).) (OAS; W-00-10-31226; W-00-11-31226; various reviews; expected issue date: FY 2012; work in progress)

Medicaid Management Information System Costs

We will review Medicaid Management Information System (MMIS) costs in selected States to determine whether costs allocated to Medicaid are allowable. FFP in State expenditures is provided for the design, development, or installation of mechanized claims-processing and information retrieval systems and for the operation of certain systems. Social Security Act, § 1903(a)(3), as implemented by regulations at 42 CFR pt. 433, subpart C. (OAS; W-00-10-31312; W-00-11-31312; various reviews; expected issue date: FY 2012; work in progress)

States' Use of the Public Assistance Reporting Information System To Reduce Medicaid Benefits Received From More Than One State

We will review eligibility data from the Public Assistance Reporting Information System (PARIS) to determine the extent to which States use PARIS to identify Medicaid recipients who are simultaneously receiving Medicaid benefits in more than one State. We will also determine the extent to which States investigate instances in which recipients are receiving Medicaid benefits in more than one State simultaneously and recover Medicaid payments for recipients determined to be ineligible. PARIS is a computer matching and information exchange system operated by the Administration for Children and Families. Using States' eligibility data, PARIS identifies those who concurrently receive benefits from Medicaid and other means-tested programs, such as food stamps, in more than one State. Federal law requires States' Medicaid eligibility determination systems to provide data matching through PARIS. (Social Security Act, § 1903, as amended by the Qualifying Individual Program Supplemental Funding Act of 2008 (QI).) (OEI; 09-11-00780; expected issue date: FY 2012; work in progress)

Medicaid National Correct Coding Initiative Effectiveness (New)

We will review selected States' implementation of National Correct Coding Initiative (NCCI) edits for Medicaid claims. Federal law requires States to incorporate compatible methodologies of the NCCI for Medicaid claims filed on or after October 1, 2010. (Social Security Act, § 1903(r), as amended by the Affordable Care Act, § 6507.) States were permitted to deactivate some or all NCCI edits because of conflicts with State laws, regulations, administrative rules, payment policies, and/or the States' levels of operational readiness. (State Medicaid Director Letter #10-017.) As of April 1, 2011, lack of operational readiness was no longer a permissible basis for deactivation of the edits. (State Medicaid Director Letter #11-003.) After April 1, 2011, the only basis for deactivation is conflicts with State laws, regulations, administrative rules and/or payment policies. (OAS; W-00-12-31459; various reviews; expected issue date: FY 2013; new start; OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)

Medicaid Management Information Systems Business Associate Agreements

We will review CMS's oversight activities related to data security requirements of State MMIS, which process and pay claims for Medicaid benefits. We will determine whether business associate agreements have been properly executed to protect beneficiary information, including safeguards implemented pursuant to Federal standards. Business associates of States' MMISs typically include support organizations, such as data processing services and medical review services. State Medicaid agencies are among the covered entities that must comply with established minimum requirements for contracts with business associates to protect the security of electronic-protected health information. (Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rules at 45 CFR pt. 164, subpart C.) (OAS; W-00-11-41015; various reviews; expected issue date: FY 2012; work in progress)

CMS Oversight and Accuracy of Nursing Home Minimum Data Set Data

We will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. We will also review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. Nursing homes must conduct accurate comprehensive assessments for residents using an instrument that includes the MDS. (Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act.) Federal regulations specify the requirements of the assessment instrument. (42 CFR § 483.20.) CMS implemented a skilled nursing facility prospective payment system based on MDS data in July 1998 and began posting MDS-based quality performance information on its Nursing Home Compare Web site in 2002. About half of the States base their Medicaid payment systems on MDS data. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Security Controls Over State Web-Based Applications

We will review States' security controls over Web-based applications that allow Medicaid providers to electronically submit claims to determine whether they contain any vulnerabilities that could affect the confidentiality, integrity, and availability of the Medicaid claims' protected health information. Electronic claims transactions may contain protected health information as defined under regulations that also define "health plan" to include Medicaid. (45 CFR § 160.103.) Medicaid programs must comply with the security standards set forth at 45 CFR pt. 164, subpart C, which is known as the HIPAA Security Rule. We will use an application security assessment tool in conducting this review. (OAS; W-00-12-41016; various reviews; expected issue date: FY 2012; new start)

Medicaid Security Controls at the Mainframe Data Centers That Process States' Claims Data

We will review security controls at States' mainframe data centers that process Medicaid claims data. We will focus on security controls, such as access controls over the mainframe operating system and security software. We will also review some limited general controls, such as disaster recovery plans and physical security. OMB requires that agencies implement and maintain programs to ensure that adequate security is provided for all agency information that is collected, processed, transmitted, stored, or disseminated in general support systems and major applications. OMB also established a minimum set of controls to be included in Federal automated information security programs. (OMB Circular A-130, *Management of Federal Information Resources*, Appendix III.) (OAS; W-00-10-40019; W-00-11-40019; expected issue date: FY 2012; work in progress, new start)

Medicaid Managed Care

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

MCE—MANAGED CARE ENTITIES

MCO—MANAGED CARE ORGANIZATIONS

MSIS—MEDICAID STATISTICAL INFORMATION SYSTEM

OMB—OFFICE OF MANAGEMENT AND BUDGET

Completeness and Accuracy of Managed Care Encounter Data (New)

We will review the extent to which Medicaid managed care encounter data included in Medicaid Statistical Information System (MSIS) submissions to CMS accurately represent all services provided to beneficiaries. We will also determine the extent to which CMS acted to enforce Federal requirements that Medicaid managed care encounter data be included in MSIS. A prior OIG review of 2007 data found that although all 40 States with Medicaid managed care were collecting encounter data and most of those States used the data, only 25 States included it in their MSIS submissions to CMS. Of the 25 States that included encounter data in their MSIS submissions, the MSIS files containing encounter data varied by service (e.g., inpatient, pharmacy, long-term care) and eligibility, as did the data elements reported in each file. Federal law requires States and managed care entities to submit data elements deemed necessary by the Secretary for use in program integrity, program oversight, and administration. (Affordable Care Act, § 6504.) Federal Medicaid matching funds for the operation of an MSIS are authorized pursuant to the Social Security Act, § 1903(a)(3)(B).) Such matching funds can be withheld from States that fail to submit required Medicaid data, including encounter data. (Social Security Act, §§ 1903(m)(2)(A) and 1903(r)(1).) (OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)

Managed Care Entities' Marketing Practices

We will review State Medicaid agencies' oversight policies, procedures, and activities to determine the extent to which States monitor Medicaid managed care entities' (MCE) marketing practices and compliance with Federal and State contractual marketing requirements. We will also determine the extent to which CMS ensures States' compliance with Federal requirements involving Medicaid MCE marketing practices. No marketing materials may be distributed by Medicaid MCEs without first obtaining States' approval. (Social Security Act, § 1932(d)(2).) States are permitted to impose additional requirements in contracts with MCEs about marketing activities. (42 CFR § 438.104.) (OEI; 00-00-00000; expected issue date: FY 2012; new start)

State Oversight of Provider Credentialing by Managed Care Entities

We will determine how States ensure that Medicaid MCEs (specifically MCOs), prepaid inpatient health plans, and prepaid ambulatory health plans comply with credentialing and recredentialing requirements. We will also determine how CMS ensures that States comply with provider credentialing requirements. Each entity must document its process for credentialing and recredentialing providers and not discriminate against providers that serve high-risk populations or specialize in high-cost treatment. Federal regulations require States to ensure that entities serving the Medicaid population implement written policies and procedures for selection and retention of providers. (42 CFR 438.214.) (OEI; 09-10-00270; expected issue date: FY 2012; work in progress)

Excluded Individuals Employed by in Managed Care Networks

We will determine the extent to which OIG-excluded individuals were employed by entities that provide services through MCE provider networks in 2009. We will also determine the extent to

which safeguards are in place to prevent excluded individuals and entities from participating in Medicaid managed care provider networks. HHS and OIG have authority to exclude individuals and entities from all Federal health care programs pursuant to the Social Security Act, §§ 1128, 1156, and 1892. Medicaid and any other Federal health care programs are precluded from paying for any items or services furnished, ordered, or prescribed by an excluded individual or entity, except under specific limited circumstances. (Social Security Act, § 1862(e)(1), and 42 CFR § 1001.1901(b).) The payment prohibition applies to the excluded individual or entity, anyone who employs or contracts with the excluded individual or entity, and any hospital or other provider through which the excluded individual or entity provides services. Recent State Medicaid program integrity reviews by CMS's Medicaid Integrity Group have identified provider enrollment, including the employment of excluded providers, as one of the most common vulnerabilities. (OEI; 07-09-00632; expected issue date: FY 2012; work in progress)

Managed Care Fraud and Abuse Safeguards

We will review Medicaid MCO fraud and abuse safeguards and State Medicaid agencies' oversight plans and procedures and determine the extent to which States monitor such safeguards for compliance with Federal requirements. We will also review CMS's plans and procedures for overseeing States' compliance with these requirements. Federal regulations require Medicaid MCOs to have administrative and management arrangements or procedures, including mandatory compliance plans, that are designed to guard against fraud and abuse. (42 CFR § 438.608.) (OEI; 01-09-00550; expected issue date: FY 2012; work in progress)

Managed Care Organizations' Use of Prepayment Review To Detect and Deter Fraud and Abuse

We will determine the extent to which Medicaid MCOs use prepayment reviews to detect and deter fraud and abuse. We will also examine the results of MCO prepayment reviews, the challenges addressed in developing and implementing the prepayment programs, and lessons MCOs learned about them. Federal regulations require Medicaid MCOs to have administrative and management arrangements or procedures that are designed to guard against fraud and abuse and that include mandatory compliance plans and provisions for internal monitoring and auditing. (42 CFR § 438.608.) Prepayment reviews can serve as effective fraud and abuse safeguards because they occur during the claims-processing phase prior to claim payment. (OEI; 00-00-00000; expected issue date: FY 2013; new start)

Medicaid Managed Care Plans' Medical Loss Ratio

We will review managed care plans with contact provisions that require a minimum percentage of total costs to be expended for medical expenditures (medical loss ratio) to determine whether a refund was made to the State agency when the minimum medical loss ratio threshold was not met. Prior OIG work found that, although the minimum medical loss ratios were not met, the managed care plans did not make the required refund to the State agency. State Agencies must properly report expenditures and to apply any applicable credits. (OMB Circular A-87.) (OAS; W-00-11-31372; various reviews; expected issue date: FY 2012; work in progress)

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