Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Payer-Focused Audits Summary

December 2019 - December 2020

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as, give our colleagues and clients focused insights into the over 300 audits, performed by HHS OIG, over the last 12 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 12 months and sorts relevant audits into Payer and Provider categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

We review all OIG completed audits that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused completed audits, SunHawk has identified other audit items which we determined relevant to a limited number of Providers and Payers. We plan to publish a summary of these items in January 2021.

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

[1] HHS OIG's Semi-annual reports to Congress for the April 1, 2019 to March 31, 2020 periods reported 304 new Audits and Evaluations which was an increase of 111 more issued reports during the same prior year period.

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[NEW] Ohio Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

The Patient Protection and Affordable Care Act gave States the option to expand Medicaid coverage to low-income adults without dependent children. It also mandated changes to Medicaid eligibility rules and established a higher Federal reimbursement rate for services provided to these beneficiaries, which led OIG to review whether States were correctly determining eligibility for these newly eligible beneficiaries. (States operate and fund Medicaid in partnership with the Federal Government through the Centers for Medicare & Medicaid Services.) Ohio chose to expand Medicaid coverage. OIG's objective was to determine whether Ohio determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Ohio did not determine eligibility for 18 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that the remaining 66 potentially ineligible beneficiaries were newly eligible. (The total exceeds 150 because 3 beneficiaries were found to be ineligible for 1 determination period and found to be potentially ineligible for another period.) These deficiencies occurred because Ohio's eligibility determination system lacked the necessary system functionality, and eligibility caseworkers made errors. In addition, Ohio did not always maintain documentation to support eligibility determinations. Based on sample results, OIG estimated that Ohio made Medicaid payments of $77.5 million (Federal share) on behalf of 51,219 ineligible beneficiaries and $746.4 million (Federal share) on behalf of 241,998 potentially ineligible beneficiaries.

OIG recommended that Ohio: (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure that its eligibility determination system has the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; (3) educate eligibility caseworkers about relevant Federal and State eligibility requirements; and (4) ensure that documentation supporting eligibility determinations is maintained in beneficiaries' records. The "Recommendations" section in the body of the report lists OIG recommendations in more detail.

Work Plan #: A-05-18-00027 (November 2020)
Government Program: Medicaid

[NEW] Florida Received Unallowable Medicaid Reimbursement for School-Based Services

Florida school districts participating in Medicaid as providers certify quarterly that they have used non-Federal education funds for school-based services. Prior Office of Inspector General (OIG) audits identified significant overpayments to school districts for school-based services. In those audits, OIG recommended that the States refund to the Federal

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Government the unallowable reimbursement that was claimed for the Medicaid school-based services. OIG performed this audit in Florida to determine whether the unallowable reimbursements OIG identified in other States also occurred in Florida. OIG's objective was to determine whether Florida claimed Federal Medicaid reimbursement for school-based services in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Florida did not always claim Federal Medicaid reimbursement for school-based services in accordance with Federal and State requirements. Florida incorrectly claimed reimbursement for the 32 sampled services totaling $644 because they did not meet one or more Federal requirements as follows: Individual Education Plans or Plans of Care without the required signature, not enough supporting documentation to substantiate services, and provider qualification requirements such as licenses and training courses missing.

OIG recommended that Florida refund $1.4 million to the Federal Government, work with CMS to review Medicaid claims for school-based services after OIG's audit period and refund any overpayments, and improve its policies and procedures to ensure that it is adequately monitoring school-based service claims to ensure compliance with Federal and State requirements.

Work Plan #: A-04-18-07075 (November 2020)
Government Program: Medicaid

States Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs

For a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. However, a prior Office of Inspector General review found that States did not always invoice and collect all rebates due for drugs administered by physicians. OIG's objective was to determine whether States complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

SunHawk Summary of OIG Audit Findings and Recommendations

Massachusetts (A-06-18-04001)

OIG found that Massachusetts did not invoice manufacturers for rebates associated with $11.4 million (Federal share) in physician-administered drugs. Of this amount, $10.5 million was for single-source drugs, and $883,000 was for top 20 multiple-source drugs. Of the $11.4 million, $9.7 million was related to claims identified as hospital outpatient. Massachusetts did not invoice for rebates for any physician-administered drug claims identified as hospital outpatient claims. In addition, some claims identified as physician claims were not invoiced for rebates. Because Massachusetts' internal controls did not always ensure that it invoiced manufacturers to secure rebates, Massachusetts improperly claimed Federal reimbursement for these single-source drugs and top-20 multiple-source drugs.

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OIG recommended that Massachusetts refund $11.4 million and work with CMS to determine the proper resolution of the other claims in question.

Minnesota (A-05-17-00018)

OIG reported that Minnesota did not bill for and collect manufacturers' rebates that OIG calculated to be $6.1 million (Federal share). Specifically, it did not bill for and collect manufacturers' rebates that OIG calculated to be (1) $5.9 million (Federal share) for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that were eligible for rebates and (2) $173,780 (Federal share) for physician-administered drugs that may have been eligible for rebates. Minnesota did not always bill for and collect manufacturers' rebates because Minnesota and its contractor did not identify all the rebate-eligible drugs in the utilization data submitted by the MCOs.

OIG recommended that Minnesota (1) bill for and collect manufacturers' rebates for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that OIG calculated to be $5.9 million (Federal share) and refund the Federal Government and (2) work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates that OIG calculated to be $173,780 (Federal share) and, if so, upon receipt of the rebates, refund the Federal share. OIG also made a recommendation related to pharmacy and physician-administered drugs that were not billed for rebates after OIG's audit period and a procedural recommendation to ensure that all rebate-eligible drugs are properly identified and billed for rebate.

Maine (A-07-18-06079)

OIG found that Maine did not invoice for and collect from manufacturers rebates associated with $4.3 million (Federal share) in physician-administered drugs as required. Of this amount, $4.0 million was for single-source drugs and $276,000 was for top-20 multiple-source drugs. Further, Maine did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $606,000 (Federal share). Finally, Maine could have invoiced manufacturers for rebates totaling $10.8 million (Federal share) that were associated with physician-administered drugs dispensed at non-Critical Access Hospitals.

OIG recommended that Maine refund to the Federal Government $4.0 million (Federal share) for claims for single-source physician-administered drugs and $276,000 for claims for top-20 multiple-source physician-administered drugs. OIG also recommended that Maine work with CMS to determine the unallowable portion of $606,000 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determined that the drug claims are allowable. In addition, OIG recommended that Maine consider invoicing drug manufacturers for rebates totaling $10.8 million (Federal share) for claims for physician-administered drugs dispensed at non-Critical Access Hospitals, and that Maine strengthen its internal controls.

Vermont (A-07-19-06086)

OIG found that Vermont did not invoice for and collect from manufacturers rebates associated with $483,458 (Federal share) in physician-administered drugs. Of this amount, $357,706 (Federal share) was for single-source drugs and $47,389 (Federal share) was for top-20 multiple-source drugs. Further, OIG was unable to determine whether, in some cases, Vermont was required to invoice for rebates for other multiple-source physician-administered drug claims. Vermont did not invoice the manufacturers for rebates associated with claims totaling $78,363 (Federal share) for these multi-source drugs.

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OIG recommended that Vermont refund to the Federal Government $357,706 (Federal share) for claims for single-source physician-administered drugs and $47,389 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommended that Vermont work with CMS to determine the unallowable portion of $78,363 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determines that the drug claims are allowable. In addition, OIG recommended that Vermont work with CMS to determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not invoiced for rebates after December 31, 2017, and strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.

Michigan (A-05-17-00017)

OIG reported that Michigan did not fully comply with Federal Medicaid requirements for billing manufacturers for rebates for drugs dispensed to MCO enrollees. Michigan did not bill for and collect manufacturers' rebates that OIG calculated to be at least $31.5 million (federal share). Specifically, it did not bill for and collect manufacturers' rebates that OIG calculated to be at least (1) $30 million (federal share) for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that were eligible for rebates and (2) $1.5 million (federal share) for physician-administered drugs that may have been eligible for rebates that OIG set aside for CMS resolution. Michigan did not always bill for and collect manufacturers' rebates because Michigan and its contractor did not identify all the rebate-eligible drugs in the utilization data submitted by the MCOs.

OIG recommended that Michigan (1) bill for and collect manufacturers' rebates for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that OIG calculated to be at least $30.0 million (federal share) and refund the Federal Government and (2) work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs and other physician-administered drugs without NDCs were eligible for rebates that OIG calculated to be at least $1.5 million (federal share) and, if so, upon receipt of the rebates, refund the Federal share. OIG also made a recommendation related to pharmacy and physician-administered drugs that were not billed for rebates after OIG's audit period and a procedural recommendation to improve the processes for determining drug rebate eligibility.

Alaska (A-09-19-02001)

OIG found that Alaska did not bill for and collect from manufacturers rebates associated with about $1 million (Federal share) in claims for physician-administered drugs. Of this amount, $939,361 was for single-source drugs, and $73,892 was for top-20 multiple-source drugs. Because Alaska's internal controls did not always ensure that it billed manufacturers to secure rebates, Alaska improperly claimed Federal reimbursement for these single-source drugs and top-20 multiple-source drugs. In addition, Alaska did not submit the drug utilization data necessary to secure rebates for other physician-administered drugs that did not have valid NDCs, totaling $3,615 (Federal share). Furthermore, claims totaling $185,066 (Federal share), which contained NDCs, could have been eligible for rebates.

OIG recommended that Alaska: (1) refund to the Federal Government $939,361 (federal share) for claims for single-source physician-administered drugs; (2) refund to the Federal Government $73,892 (federal share) for claims for top-20 multiple-source drugs; (3) work with CMS to determine the unallowable portion of $188,681 (federal share) for claims for other physician-administered drugs that did not have valid NDCs or could have been eligible for rebates, and make the appropriate refunds; (4) work with CMS to determine and refund the unallowable portion of federal reimbursement for

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physician-administered drugs that were not billed for rebates after December 31, 2017; and (5) strengthen its internal controls to ensure that it bills manufacturers for rebates for all physician-administered drugs that are eligible for rebates.

Connecticut (A-07-18-06078)

OIG reported Connecticut did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. Connecticut did not invoice manufacturers for rebates associated with $1.1 million (Federal share) in physician-administered drugs. Of this amount, $1.07 million was for single-source drugs, and $46,210 was for top-20 multiple-source drugs. Further, Connecticut did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $2.8 million (Federal share).

OIG recommended Connecticut refund to the Federal Government $1.07 million (Federal share) for claims for single-source physician administered drugs, and $46,210 for claims for top-20 multiple-source physician-administered drugs, and work with CMS to determine the unallowable portion of the $2.8 million (Federal share) for other claims for outpatient physician-administered drugs that were at issue.

New York (A-02-18-01016)

OIG reported that New York did not bill for and collect from manufacturers estimated rebates of more than $10.8 million (federal share) for pharmacy and physician administered drugs that were eligible or may have been eligible for rebates during OIG's audit period. For drugs that were eligible for rebates, New York did not bill for estimated rebates of $7.8 million (federal share) for single-source and top-20 multiple-source pharmacy and physician-administered drugs. For drugs that may have been eligible for rebates, New York did not bill for estimated rebates of $3 million (federal share) for other pharmacy and physician-administered drugs. Although its policies and procedures require the collection of drug utilization data necessary to invoice for rebates on all claims, New York's internal controls did not always ensure that the data were used to invoice manufacturers to secure rebates.

OIG recommended that New York (1) bill for and collect from manufacturers rebates for single-source and top-20 multiple-source pharmacy and physician administered drugs and refund the estimated $7.8 million (federal share); (2) work with CMS to determine whether the other pharmacy and physician administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to an estimated $3 million (federal share) of rebates collected; and (3) strengthen its internal controls to ensure that all pharmacy and physician-administered drugs eligible for rebates are invoiced.

Texas (A-06-17-04001)

OIG found that Texas did not bill for and collect manufacturer rebates totaling $4.4 million ($2.6 million Federal share) for physician-administered drugs. For drugs that were eligible for rebates, Texas did not bill and collect rebates totaling $2.2 million (Federal Share) for single-source and top-20 multiple-source physician-administered drugs. For drugs that may have been eligible for rebates, Texas did not bill for rebates totaling $366,578 (Federal share) for other physician-administered drugs. In addition, Texas did not bill for rebates on 160,579 claim lines for other physician-administered drugs that may have been eligible for rebates. These errors occurred because Texas's internal controls did not always ensure that it billed manufacturers to secure rebates, and Texas did not always collect the utilization data necessary to bill the manufacturers.

OIG recommended that Texas (1) bill manufacturers for the $2.2 million (Federal share) in rebates for single-source and top-20 multiple-source physician administered drugs, and refund the Federal share of rebates collected; (2) work with

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CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates and, if so bill manufacturers for the $366,578 (Federal share) in rebates, and refund the Federal share of rebates collected; (3) work with CMS to determine whether the other physician administered drugs, associated with 160,579 claim lines, were eligible for rebates and, if so, determine the rebates due and upon receipt of the rebates refund the Federal share of the rebates collected; and (4) strengthen internal controls to ensure that all eligible physician administered drugs are billed for rebate.

New Jersey (A-02-16-01011)

OIG found that New Jersey did not fully comply with Federal Medicaid requirements for billing manufacturers for rebates for drugs dispensed to MCO enrollees. Specifically, New Jersey did not bill for and collect from manufacturers estimated rebates of $75.5 million (federal share) for pharmacy and physician-administered drugs that were eligible or may have been eligible for rebates for OIG's audit period. For drugs that were eligible for rebates, New Jersey did not bill for estimated rebates of $28.1 million (federal share) for single-source and top-20 multiple-source pharmacy and physician-administered drugs. For drugs that may have been eligible for rebates, New Jersey did not bill for estimated rebates of $47.4 million (federal share) for other pharmacy and physician-administered drugs. New Jersey did not always bill for and collect from manufacturers' rebates because it did not have a system edit to ensure that NDCs were submitted for physician-administered drugs before January 1, 2015. Even after New Jersey implemented the edit on January 1, 2015, this edit did not ensure that NDCs or valid NDCs were captured for all physician administered drugs.

OIG recommended that New Jersey (1) bill for and collect from manufacturers' rebates for single-source and top-20 multiple-source pharmacy and physician-administered drugs and refund the estimated $28.1 million (federal share); and (2) work with CMS to determine whether the other pharmacy and physician-administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to an estimated $47.4 million (federal share) for OIG's audit period and $119.6 million (federal share) for the nearly four-year period before OIG's audit period.

Work Plan #: A-06-18-04001 (October 2020); A-05-17-00018 (October 2020); A-07-18-06079 (September 2020); A-07-19-06086 (September 2020); A-05-17-00017 (August 2020); A-09-19-02001 (July 2020); A-02-18-01016 (April 2020); A-07-18-06078 (August 2019); A-06-17-04001 (August 2019); A-02-16-01011 (August 2019); A-09-16-02031 (February 2018); A-06-16-00004 (December 2017); A-09-16-02028
Government Program: Medicaid

Colorado Improperly Claimed Millions in Enhanced Federal Medicaid Reimbursement for New Adult Group Beneficiaries Because of a Data Processing Error

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA). The ACA established enhanced Federal reimbursement rates for services provided to nondisabled, low-income adults without dependent children (new adult group). The enhanced reimbursement rates established under the ACA have raised concerns about the possibility that States could improperly enroll individuals for Medicaid coverage in the new adult group and, as a consequence, the potential for improper payments. OIG's objective was to determine whether Colorado properly claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Colorado claimed reimbursement for Medicaid services provided from January 1, 2014, through September 30, 2015, to some beneficiaries who were enrolled in the new adult group but who later became ineligible for Medicaid coverage. As a result, Colorado improperly claimed and received over $1.9 million in Federal reimbursement for these beneficiaries past the termination dates of their Medicaid eligibility.

OIG recommended that Colorado (1) refund to the Federal Government the over $1.9 million in improperly claimed Medicaid reimbursement, (2) identify and refund to the Federal Government any payments made on behalf of ineligible beneficiaries for whom services after OIG audit period were claimed and reimbursed past the termination dates of their eligibility, and (3) establish adequate system controls that ensure that eligibility determinations transfer correctly from the CBMS to the MMIS to prevent payments from being made on behalf of ineligible beneficiaries.

Work Plan #: A-07-17-02807 (October 2020)
Government Program: Medicaid

Indiana Did Not Ensure That Medicaid Payments Were Made Properly for Some Claims Identified as Having Third-Party Coverage

Prior Office of Inspector General and other reports indicated substantial improvements in States' third-party liability (TPL) identification and recovery efforts. However, the reports also indicated longstanding challenges States had in their TPL efforts. OIG conducted an audit of Indiana's efforts to determine whether Medicaid is paying too much for claims in which members were identified as having TPL. OIG's objective was to determine whether Indiana ensured that Medicaid payments were made properly for claims identified as having third-party coverage.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Indiana ensured that, for 9 of the 120 claims, Indiana should not have paid some or all of the Medicaid payments totaling $5,082. For the remaining 57 claims, as well as 6 of the 9 overpayments, OIG found that Indiana; its contractor, DXC Technology (DXC); or DXC's subcontractor, HMS, did not (1) maintain accurate or complete information, or both, to avoid or recover Medicaid payments when there was TPL; (2) verify that members had other Medicaid expenditures to which excess payments received from third-party carriers could be applied; or (3) did not bill the third-party carrier in a timely manner or did not pursue recovery when there was TPL.

OIG recommended that Indiana refund $36,573 to the Federal Government.

Work Plan #: A-05-18-00046 (September 2020)
Government Program: Medicaid

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CMS Should Pursue Strategies to Increase the Number of At-Risk Beneficiaries Acquiring Naloxone Through Medicaid

On average, 130 people in the United States die every day from an opioid overdose. The drug naloxone plays a critical role in saving the lives of those who abuse or misuse opioids. One review of emergency data found that, when given naloxone, 94 percent of people survived their overdose. In April 2018, the U.S. Surgeon General issued an advisory stating that increasing the availability and targeted distribution of naloxone is a critical component of efforts to reduce deaths from opioid related overdoses. Similarly, Federal and State agencies have undertaken numerous efforts to increase access to naloxone for those in need. However, it is widely acknowledged that more needs to be done. Medicaid covers almost 40 percent of nonelderly adults with opioid use disorder, underscoring the key role that the program can play in providing access to naloxone.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that access to naloxone for Medicaid beneficiaries has expanded significantly, with the program paying for 21 times more doses in 2018 than in 2014. Despite this growth, Medicaid paid for only 5 percent of all naloxone distributed in the United States in 2018. This figure is especially concerning given that (1) Medicaid covers almost 40 percent of nonelderly adults with opioid use disorder (OUD) and (2) some States with extremely high overdose mortality rates paid for relatively little naloxone under Medicaid.

Because of statutory rebates paid by manufacturers to Medicaid, the program has been able to recoup a large percentage of its spending on naloxone. For example, in 2018, Medicaid's net cost for Narcan in 2018 was less than the substantially discounted price that Narcan's manufacturer offered to public health organizations for this "community use" version of naloxone.

OIG recommended that CMS pursue strategies to increase the number of at-risk beneficiaries acquiring community-use versions of naloxone through Medicaid.

Work Plan #: OEI-BL-18-00360 (September 2020)
Government Program: Medicaid

Oregon's Oversight Did Not Ensure That Four Coordinated-Care Organizations Complied with Selected Medicaid Requirements Related to Access to Care and Quality of Care

In 2012, Oregon was one of the first States to adopt a type of Medicaid accountable care organization when it established coordinated care organizations (CCOs). A CCO is a network of different types of participating providers that have agreed to work together in their local communities to provide coordinated care to Medicaid beneficiaries. Two goals of the CCO model are to improve access to care and the quality of care. OIG's objective was to determine whether Oregon's oversight ensured that four CCOs complied with selected Federal and State Medicaid requirements related to access to care and quality of care.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the CCOs did not comply with requirements related to provider credentialing and beneficiary grievances and appeals. Specifically, CCOs: (1) did not ensure that services were provided within the scope of license of a provider with a restricted license or report providers with licensing board actions against them, (2) did not credential all provider types (e.g., mental health providers), and (3) did not perform or document all minimum required credentialing checks. In addition, CCOs did not resolve or review beneficiary grievances appropriately and did not adjudicate appeals in compliance with their contracts with Oregon. Also, CCOs submitted inaccurate or incomplete data on grievances and appeals, which Oregon used for oversight.

OIG reported that these issues occurred because: (1) Oregon provided insufficient oversight of, and guidance to, the CCOs and (2) the CCOs provided insufficient oversight of, and guidance to, their subcontractors. Because not all providers were appropriately credentialed, there was an increased risk of poor quality of care. In addition, the mishandling of grievances and appeals may have reduced beneficiaries' access to care and the quality of care.

Work Plan #: A-09-18-03035 (September 2020)
Government Program: Medicaid

Indiana Properly Reported Adjustments Related to the Drug Rebate Program

On the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) for the quarter ended September 30, 2014, the Indiana Family and Social Services Administration's Office of Medicaid Policy and Planning (State agency) claimed increasing adjustments on Line 10A, Adjustments Decreasing Claims For Prior Quarters: Federal Audit (Line 10A). OIG audited Indiana's methodology for claiming the increasing adjustment.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Indiana followed its Centers for Medicare and Medicaid Services (CMS)-approved methodology and properly reported $8.3 million ($5.6 million federal share) in increasing adjustments to the drug rebate program on Line 10A of the September 30, 2014, Form CMS-64. The State agency made the adjustments to correct clerical errors made on the Form CMS-64s for the quarters ending September 30, 2011, and June 30, 2013.

This report contains no recommendations.

Work Plan #: A-05-19-00028 (August 2020)
Government Program: Medicaid

Nebraska Claimed Unallowable School-Based Administrative Costs Because of Improper Coding of Random Moment Time study Responses

Prior Office of Inspector General audits of State Medicaid agencies that used random moment time studies (RMTSs) to allocate costs for school-based administrative (SBA) costs determined that states did not always correctly claim Federal

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Medicaid reimbursement for SBA services. Nebraska, whose SBA costs OIG has not previously audited, uses RMTSs to allocate those costs. OIG's objective was to determine whether SBA costs that Nebraska claimed for Medicaid reimbursement for the school-year quarters from September 1, 2014, through August 31, 2017 (audit period), were reasonable and adequately supported in accordance with the terms of the State Medicaid plan and applicable federal and state requirements.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that Nebraska did not correctly calculate and claim SBA costs for Medicaid reimbursement because the contractors incorrectly coded some RMTS responses. Additionally, one contractor incorrectly assigned some participants to the RMTSs. Nebraska claimed and received Federal reimbursement totaling $25.3 million; however, OIG determined that the allowable SBA costs were $12.1 million. Therefore, Nebraska claimed and received $13.2 million in unallowable SBA costs. Nebraska claimed these unallowable costs because it did not exercise proper oversight to ensure that contractors followed state requirements when coding RMTS responses and when assigning participants to the RMTSs.

OIG recommended that Nebraska refund the $13.2 million to the Federal Government, review SBA costs claimed after OIG's audit period and refund unallowable amounts, and strengthen oversight of its contractors to ensure that they follow state requirements when coding RMTS responses and when assigning participants to the RMTSs.

Work Plan #: A-07-19-03234 (August 2020)
Government Program: Medicaid

States Did Not Fully Comply with Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities

OIG has performed audits in several states in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. Federal waivers permit states to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. CMS requires states to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

OIG's objective was to determine whether states complied with federal waiver and state requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January through December 2016.

SunHawk Summary of OIG Audit Findings and Recommendations

Texas (A-06-17-04003)

OIG reported that Texas did not ensure that all beneficiary deaths were reported and reviewed; that all complaints not closed within 10 days were tracked; and that all allegations of abuse, neglect, and exploitation were entered into the Human Services Enterprise Administration Reporting and Tracking (HEART) system. Texas had a procedure to detect unreported deaths but was not following it, did not have a system in place to track complaints not closed within 10 days, and did not have procedures to ensure that allegations were entered into the HEART system.

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OIG recommended that Texas (1) ensure that procedures are followed to detect unreported deaths; (2) implement a system to ensure that it can track complaints not closed within 10 days; and (3) implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system.

Iowa (A-07-18-06081)

OIG found that Iowa failed to ensure that community based providers reported all major incidents to the state; ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish the probability of future occurrences; review Critical Incident Reports to determine trends, problems, and issues in service delivery; ensure that community-based providers reported all member deaths to the state; and report all known major incidents to CMS.

OIG made procedural recommendations to Iowa, including that it works with community-based providers on how to identify and report all major incidents and to ensure that they appropriately document resolution of major incidents. OIG also recommended that Iowa perform trend analysis that identifies patterns and trends to assess the health and safety of members and determine whether changes need to be made for service implementation or whether staff training is needed to prevent recurrences of major incidents and to reduce the number or severity of incidents; ensure that community-based providers report to the State all member deaths; include all major incidents reported by Medicaid Managed Care Organizations in Iowa's reports to CMS; and develop and implement internal controls adequate to ensure full compliance with Federal and State requirements.

Work Plan #: A-06-17-04003 (July 2020); A-07-18-06081 (March 2020)
Government Program: Medicaid

Medicaid Data Can Be Used to Identify Instances of Potential Child Abuse or Neglect

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of OIG Nation's most vulnerable populations, including children, the elderly, and individuals with developmental disabilities.

OIG's objectives were to determine: (1) whether Medicaid claims data can be used to identify incidents of potential child abuse or neglect and, if they can, the number of incidents of potential abuse or neglect of children receiving Medicaid benefits that OIG identified using hospital emergency rooms (ERs) claims data; (2) whether the incidents were reported to child protective services (CPS) agencies and other appropriate agencies; and (3) who may have committed those incidents and where they occurred.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG determined that Medicaid claims data can be used to identify incidents of potential child abuse or neglect and, using that data, estimated that 29,260 of the 29,534 Medicaid beneficiaries in OIG's sampling frame were involved with incidents of potential child abuse or neglect that were supported by Medicaid claims data and evidence contained in the medical records. OIG further estimated that, of the beneficiaries in OIG's population associated with incidents of potential child abuse or neglect, 3,928 were involved with incidents that were not reported to CPS. OIG also determined that most

incidents of potential child abuse or neglect identified in OIG's sample occurred in familiar settings by perpetrators known to the victims.

OIG recommended that CMS: (1) issue guidance, such as an Informational Bulletin, to inform states that performing a data analysis to identify Medicaid claims containing one or more diagnosis codes indicating potential child abuse or neglect could help identify incidents of potential child abuse or neglect and help ensure compliance with their mandatory reporting laws and (2) assess the sufficiency of existing federal requirements to report suspected child abuse and neglect of Medicaid beneficiaries to determine whether CMS should strengthen those requirements or seek additional authorities to provide oversight over the reporting of suspected child abuse and neglect of Medicaid beneficiaries.

Work Plan #: A-01-19-00001 (July 2020)
Government Program: Medicaid

State Medicaid Agencies Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths

State Agencies pay managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payments). Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly made capitation payments on behalf of deceased beneficiaries. OIG's objective was to determine whether State Programs made capitation payments on behalf of deceased beneficiaries.

SunHawk Summary of OIG Audit Findings and Recommendations

New York (A-04-19-06223)

The New York Medicaid Assistance Program (New York Medicaid) is the second largest Medicaid program in the Nation. New York Medicaid provides health coverage to almost 6.2 million of New York's residents. Approximately 80 percent of the New York Medicaid population is enrolled in managed care.

OIG found that, for 84 payments, New York made unallowable payments totaling $269,473 ($143,643 federal share). The unallowable payments occurred because New York did not: (1) have system edits to identify errors in the automated process that terminates beneficiaries' eligibility after dates of death were identified; (2) update the eligibility and payment systems with correct dates of death; (3) identify as deceased and disenroll beneficiaries that had a date of death in one of its death data sources; or (4) use additional sources of death information and alternative procedures similar to those that OIG used in OIG's audit to identify, verify, or determine dates of death.

Based on OIG's sample results, OIG estimated that New York made payments to MCOs on behalf of deceased beneficiaries totaling at least $23.3 million ($13.7 million Federal share) during OIG's audit period.

OIG recommended that New York: (1) refund the $13.7 million to the Federal Government and (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries.

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Michigan (A-05-17-00048)

OIG estimated that Michigan made unallowable capitation payments totaling at least $39.9 million ($27.5 million Federal share) to managed care entities on behalf of deceased beneficiaries during OIG's audit period. Of the 100 capitation payments in OIG's stratified random sample, Michigan made 99 unallowable payments totaling $117,746 ($79,348 Federal share).

OIG recommended Michigan (1) refund $27.5 million to the Federal Government; (2) identify and recover unallowable payments made to managed care entities during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $39.9 million; and (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period and repay the federal share of amounts recovered.

Indiana (A-05-19-00007)

OIG found that Indiana made capitation payments on behalf of deceased beneficiaries and confirmed that 70 beneficiaries associated with the 100 capitation payments in OIG's stratified random sample were deceased. Of the 100 capitation payments, Indiana made 95 unallowable payments totaling $79,403 ($58,773 federal share). Based on OIG's sample results, OIG estimated that Indiana made payments totaling at least $1.1 million ($862,097 federal share) to MCOs on behalf of deceased beneficiaries during OIG's audit period.

OIG recommended that Indiana (1) refund $862,097 to the Federal Government; (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the Federal Government a share of amounts recovered; and (4) ensure that dates of death are added to the MMIS and that capitation payments made after the beneficiaries' deaths are recovered.

Illinois (A-05-18-00026)

OIG estimated that Illinois did not recover unallowable MCO payments made on behalf of deceased beneficiaries during OIG's audit period, totaling at least $4.6 million ($3.2 million Federal share). OIG confirmed that 80 of the 94 beneficiaries associated with the 100 capitation payments in OIG's stratified random sample were deceased. Illinois did not recover any of the 84 sampled capitation payments made on behalf of the 80 deceased beneficiaries, totaling $74,319 ($45,032 Federal share). Illinois did not always process Medicaid beneficiaries' death information in the MMIS. Additionally, although Illinois' eligibility systems interfaced with Federal data exchanges that identify dates of death, Illinois did not enter the dates of death in the MMIS for many OIG's sampled beneficiaries.

OIG recommended Illinois (1) refund $3.2 million to the Federal Government; (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $4.6 million; (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the Federal share of amounts recovered; and (4) ensure that dates of death are added to the MMIS for deceased beneficiaries that were previously marked as "inactive."

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Minnesota (A-05-17-00049)

OIG estimated that Minnesota made unallowable capitation payments totaling at least $3.7 million ($3.2 million federal share) to MCOs on behalf of deceased beneficiaries during OIG's audit period. Of the 100 capitation payments in OIG's random sample, Minnesota made 95 unallowable payments totaling $62,665 ($55,932 federal share).

OIG recommended Minnesota (1) refund $3.2 million to the Federal Government; (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $3.7 million; (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the federal share of amounts recovered; (4) ensure Minnesota Medicaid staff are properly trained to process dates of death and eligibility termination in accordance with Minnesota's internal policies; and (5) utilize additional sources to identify dates of death to help reduce unallowable payments.

Georgia (A-04-15-06183)

OIG found that only 2 capitation payments were for beneficiaries who were still alive. For 118 payments, Georgia made payments totaling $109,252 ($82,362 federal share) after a beneficiary's death.

OIG recommended that Georgia (1) use additional sources of date of death to help reduce the risk of making payments after a beneficiary's death; (2) implement additional controls to more effectively detect payments involving deceased beneficiaries to reduce the risk of payments after a beneficiary's death; and (3) continue to identify payments made after a beneficiary's death to prevent additional payments similar to the $2.2 million identified in this report.

Work Plan #: A-04-19-06223 (July 2020); A-05-17-00048 (February 2020); A-05-19-00007 (January 2020); A-05-17-00049 (October 2019); A-04-15-06183 (August 2019); A-05-18-00026 (August 2019); A-04-15-06190 (December 2017); A-06-16-05004 (November 2017); W-00-19-31497
Government Program: Medicaid

New Jersey Did Not Ensure That Its Managed Care Organizations Adequately Assessed and Covered Medicaid Beneficiaries' Needs for Long-Term Services and Supports

New Jersey pays managed care organizations (MCOs) to make managed long-term services and supports (MLTSS) available to Medicaid beneficiaries in home and community-based settings. Recent OIG audits of Medicaid home and community-based and managed long-term-care services identified significant vulnerabilities. Therefore, OIG decided to audit payments in New Jersey for the provision of similar Medicaid services.

OIG's Objective was to determine whether New Jersey ensured that its MCOs complied with federal and state requirements for beneficiaries enrolled in its Medicaid MLTSS program.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that, for 68 capitation payments in OIG's random sample, MCOs did not comply with the requirements to adequately assess and cover the associated beneficiaries' needs for long-term services and supports. Specifically, MCOs did not comply with requirements for (1) providing adequate service planning and care management to the beneficiaries and (2) conducting and documenting assessments; and developing, reviewing, and updating beneficiaries' care plans. These deficiencies occurred because New Jersey did not adequately monitor MCOs for compliance with certain federal and state requirements.

OIG recommended that New Jersey improve its monitoring and follow-up activities to ensure that its MCOs comply with federal and state requirements detailed in its contracts with the MCOs; and take actions, including imposing corrective action plans, fines, or other financial disincentives on MCOs, to address the MCOs' noncompliance affecting $721 million ($386 million federal share) in capitation payments in CY 2016 and ensure future compliance with contract requirements.

Work Plan #: A-02-17-01018 (June 2020)
Government Program: Medicaid

North Carolina Received $30 Million in Excess Federal Funds Related to Improperly Claimed Health Home Expenditures.

As of March 2019, North Carolina was among 23 states to receive approval to implement Medicaid health home programs. This audit is one in a series of audits to determine whether states complied with federal and state requirements when claiming Federal Medicaid reimbursement for payments made to health home providers.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that North Carolina improperly claimed $124.6 million in Primary Care Case Management (PCCM) expenditures, which should have been reimbursed at the regular Federal medical assistance percentage (FMAP) ($81.5 million federal share), as health home expenditures, which were reimbursed at the enhanced FMAP ($112.2 million federal share). North Carolina did not claim any health home expenditures before or after the enhanced FMAP period for Federal fiscal years 2012 and 2013. Of the 2,999 payments associated with 100 beneficiaries in OIG stratified random sample, none met all the requirements for payment identified in North Carolina's approved state plan amendment for health home services. North Carolina claimed PCCM expenditures as health home expenditures because it did not take certain steps to ensure implementation of the health home option and did not implement internal controls needed to ensure compliance. As a result, North Carolina received $30.7 million in excess Federal funds.

OIG recommended that North Carolina reclassify $124.6 million ($112.2 million federal share) from health home expenditures to PCCM expenditures and refund $30.7 million in excess Federal funds to the Federal Government.

Work Plan #: A-04-18-00120 (April 2020)
Government Program: Medicaid

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Recommendation Follow-up: Michigan Did Not Report and Refund the Full Federal Share of Medicaid Overpayments

In a previous audit, OIG determined that Michigan did not properly report $1.3 million (Federal share) in Medicaid overpayments for Federal fiscal years (FYs) 2008 and 2009. OIG performed this audit as a follow up to the previous audit. Specifically, OIG wanted to determine whether the Michigan Department of Health and Human Services (State agency) had reported the overpayments that OIG identified in the previous audit, as well as Medicaid overpayments identified in FYs 2011 through 2015.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reports that, of the 124 overpayments in OIG's sample, Michigan did not report an overpayment of $1.9 million ($1.2 million Federal share) and reported 70 overpayments at the incorrect Federal Medical Assistance Percentage (FMAP), which netted an underreported amount of $46,370 (Federal share).

OIG recommended Michigan refund to the Federal Government $1.2 million in overpayments not reported and $46,370 for overpayments returned at the incorrect FMAP from the current audit and $648,194 in overpayments not reported from the previous audit

Work Plan #: A-05-18-00022 (April 2020)
Government Program: Medicaid

States' Oversight of Medicaid Managed Care Organizations Did Not Ensure Providers Complied with Health and Safety Requirements at Adult Day Care Facilities Reviewed

OIG's audits of adult day care facilities in six states identified multiple health and safety issues that put vulnerable adults at risk. OIG's objective was to determine whether states' oversight of Medicaid MCOs ensured compliance with federal and state health and safety requirements for adult day care facilities.

SunHawk Summary of OIG Audit Findings and Recommendations

New York (A-02-18-01027)

In New York, adult day care facilities provide functionally impaired adults with socialization, supervision and monitoring, and nutrition services in a protective setting. Beneficiaries enrolled in New York's Medicaid managed long-term-care program receive adult day care services from providers contracted with Medicaid managed care organizations (MCOs). New York's health and safety requirements for adult day care facilities are detailed in its MCO contract approved by the Centers for Medicare & Medicaid Services (CMS).

In New York, OIG found 476 instances of noncompliance with requirements for staff training, physical environment and safety, emergency preparedness, and staff health status.

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OIG recommended that New York (1) ensure that the MCOs work with their contracted adult day care services providers to correct the 476 instances of noncompliance with health and safety requirements that OIG identified, (2) require MCOs to improve their site visit procedures to ensure compliance with health and safety requirements detailed in New York's CMS-approved MCO contract and New York's regulations on adult day care programs, and (3) obtain and review the results of MCO site visits at adult day care facilities as part of its beneficiary health and safety monitoring activities.

Kentucky (A-04-18-00123)

The Kentucky Home and Community-Based Services Waiver program funds home and community-based services for people aged 65 and older and individuals with disabilities aged 21 to 64 who are eligible for medical assistance and require the level of care provided in a nursing home but choose to live in the community. Kentucky operates the program under a Federal waiver to its Medicaid State plan. The program funds adult day health care services for Medicaid beneficiaries who reside at home and attend adult day health care facilities. OIG has conducted health and safety reviews at various types of facilities nation-wide and wanted to determine whether vulnerable adults participating in this program were at risk.

In Kentucky, OIG found that 12 providers did not comply with one or more health and safety requirements, and ten did not comply with one or more administrative requirements. OIG found 63 instances of provider noncompliance, including 26 instances of noncompliance with health and safety requirements. The remaining 37 instances related to administrative requirements, some of which could significantly affect beneficiary health and safety.

OIG recommended Kentucky ensure that providers correct the 63 instances of provider noncompliance identified in this report; improve its oversight and monitoring of providers by considering unannounced site visits and by enhancing its certification tool as it pertains to reviewing participant records; and work with providers to improve their facilities, staffing, and training.

Work Plan #: A-02-18-01027 (March 2020); A-04-18-00123 (July 2019)
Government Program: Medicaid

Most of the Non-Newly Eligible Beneficiaries for Whom Colorado Made Medicaid Payments Met Federal and State Requirements, but Documentation Supporting That All Eligibility Requirements Were Verified Properly Was Not Always in Place

Historically, only certain groups of individuals who had incomes and assets below certain thresholds were eligible for Medicaid (traditional coverage groups). After the passage of the Patient Protection and Affordable Care Act (ACA), some beneficiaries remained eligible under these traditional coverage groups. OIG refers to these beneficiaries as "non-newly eligible beneficiaries." This audit is part of an ongoing series of Office of Inspector General (OIG) audits of states' Medicaid eligibility determinations. OIG conducted these audits to address the concern that States might have difficulty accurately determining eligibility for Medicaid beneficiaries.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that most of the Medicaid payments issued by Colorado during OIG's audit period were on behalf of non-newly eligible beneficiaries who met federal and state eligibility requirements. However, Colorado made Medicaid payments on behalf of some non-newly eligible beneficiaries who may not have met federal and state eligibility requirements. OIG found that for five beneficiaries, Colorado had no documentation (specifically, that it had performed annual verifications of resources) to support that all eligibility requirements were verified properly during redeterminations as required by federal and state regulations and by Colorado's State Medicaid plan. Although Colorado had policies and procedures in place, it did not always follow them to ensure that redeterminations were properly documented.

OIG recommended Colorado redetermine, as appropriate, the current Medicaid eligibility of the potentially ineligible sampled beneficiaries and ensure that (1) all eligibility requirements, including those pertaining to resources, are properly verified during annual redeterminations for all non-newly eligible beneficiaries and (2) information is maintained to support that eligibility determinations were performed in accordance with federal and state requirements.

Work Plan #: A-07-18-02812 (March 2020)
Government Program: Medicaid

States' Compliance with FFS and MCO Provider Enrollment Requirements

Provider enrollment is a key program integrity tool to protect Medicaid from fraudulent and abusive providers. The 21st Century Cures Act (the Cures Act) requires States to enroll all Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs). This study, mandated by the Cures Act, will survey State Medicaid agencies about their enrollment of FFS and managed care providers and implementation of required provider enrollment screening activities.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 23 States had not enrolled all providers serving Medicaid beneficiaries in their respective Medicaid programs, exposing them to potentially harmful providers that had not been screened for sanctions or potential fraud, waste, and abuse.

OIG recommended that CMS should (1) take steps to disallow Federal reimbursements to states for expenditures associated with unenrolled MCO network providers, including seeking necessary legislative authority; (2) work with states to ensure that unenrolled MCO network providers do not participate in Medicaid managed care and assist States in establishing ways to do so; (3) work with states to ensure that they have the controls required to prevent unenrolled ORPs from participating in Medicaid FFS; and (4) work with states to ensure that they are complying with requirements to collect identifying and ownership information on Medicaid provider enrollment forms.

Work Plan #: OEI: 05-19-00060 (March 2020)
Government Program: Medicaid

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

States' Compliance with New Requirements to Prevent Medicaid Payments to Terminated Providers

To prevent terminated providers from treating Medicaid enrollees or receiving Medicaid payments, the 21st Century Cures Act (Cures Act) requires CMS to provide information to all States on Medicaid providers that have been terminated for cause. This study, mandated by the Cures Act, will examine the extent to which terminated providers included in CMS's terminations database have been terminated from all State Medicaid programs and the amount of Medicaid payments for items/services associated with terminated providers. Additionally, this study will examine the extent to which State contracts with managed care entities include a provision that terminated providers are excluded from all managed care networks.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Nearly 1,000 terminated providers were inappropriately enrolled in State Medicaid programs or were associated with $50.3 million in Medicaid payments after being terminated. These providers had been terminated for reasons such as criminal convictions, licensure issues, and provider misconduct and thus potentially posed a risk to beneficiary safety and quality of care.

OIG recommended CMS should (1) recover from States the federal share of inappropriate fee-for-service Medicaid payments associated with terminated providers, (2) implement a method to recover from states the federal share of inappropriate managed care capitation payments associated with terminated providers, (3) follow up with states to remove terminated providers that OIG identified as inappropriately enrolled in Medicaid, (4) confirm that states do not continue to have terminated providers enrolled in their Medicaid programs, (5) safeguard Medicaid from inappropriate payments associated with terminated providers, and (6) review states' contracts with MCOs to ensure that they clearly and specifically include the required provision that prohibits terminated providers from participating in Medicaid managed care networks.

Work Plan #: OEI: 03-19-00070 (March 2020)
Government Program: Medicaid

States made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers

Previous Office of Inspector General audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries. OIG's objective was to determine whether the states made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

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SunHawk Summary of OIG Audit Findings and Recommendations

Florida (A-04-18-07080)

OIG reported Florida made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. Florida incorrectly made capitation payments that totaled $383,487 ($232,520 federal share).

OIG recommended Florida: (1) refund to the Federal Government approximately $3.9 million (federal share) in unallowable payments, (2) review capitation payments that fell outside of OIG's audit period and refund any unallowable payments, and (3) modify its current methodology to identify beneficiaries with multiple Medicaid ID numbers.

New York (A-02-18-01020)

OIG reported New York improperly claimed Federal Medicaid reimbursement for Medicaid beneficiaries who were assigned more than one Medicaid ID number. Specifically, for 102 of the 103 beneficiary-matches in OIG's sample, New York made managed care payments to different MCOs for the same beneficiary for the same month under different Medicaid ID numbers.

OIG recommended New York (1) refund $11.3 million to the Federal Government; (2) identify and recover improper managed care payments made to different MCOs on behalf of beneficiaries with multiple Medicaid ID numbers prior to and after OIG's audit period, and repay the Federal share of the amounts recovered; and (3) strengthen its procedures for determining whether an individual applying for Medicaid already has a Medicaid ID number.

Tennessee (A-04-18-07079)

OIG reported that Tennessee incorrectly claimed capitation payments that totaled $75,738 ($49,260 Federal share) on behalf of the remaining 13 beneficiaries with multiple Medicaid ID numbers. The improper payments made on behalf of these beneficiaries occurred because Tennessee needed a significantly more complex matching algorithm than the one that it already had in place to identify beneficiary matches that existed in its system. Furthermore, Tennessee stated that, during the period of OIG's review, the process to recoup duplicate capitation payments after linking duplicate recipient records was limited to 9 months and did not include the recoupment of payments beyond that 9-month period.

OIG recommended that Tennessee: (1) refund to the Federal Government $378,137 (federal share) in overpayments, (2) review capitation payments that fell outside of OIG's audit period and refund any overpayments, and (3) enhance or establish new controls to ensure that no beneficiary is issued multiple Medicaid ID numbers.

Work Plan #: A-04-18-07080 (March 2020); A-02-18-01020 (February 2020); A-04-18-07079 (October 2019)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

New York Improperly Claimed Medicaid Reimbursement for Some Bridges to Health Waiver Program Services That Were Not in Accordance with an Approved Plan of Care and Did Not Meet Documentation Requirements

During prior reviews, OIG determined that New York claimed Medicaid reimbursement for home and community-based services (HCBS) under Medicaid waiver programs that did not comply with Federal requirements. New York's Bridges to Health (B2H) was an HCBS waiver program.

As of April 1, 2019, New York discontinued the B2H waiver program and transitioned these services into a comprehensive child-focused waiver known as The Children's Waivers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that during 8 of 100 sampled beneficiary-months, New York claimed Medicaid reimbursement for some B2H waiver program services that did not comply with Federal and State requirements. Specifically, services were not provided in accordance with the beneficiary's plan of care (four beneficiary-months), provider documentation did not support services billed (three beneficiary-months), and services were not provided in accordance with an approved level-of-care assessment (one beneficiary-month). In addition, for 32 beneficiary-months, New York claimed Medicaid reimbursement for B2H waiver program services more than the monthly allotment of services authorized in the associated beneficiaries' plans of care.

OIG recommended that New York (1) refund $614,530 to the Federal Government; (2) work with CMS to develop guidance through The Children's Waiver on claiming Federal Medicaid reimbursement for HCBS according to the monthly allotment authorized in beneficiaries' plans of care, which could have reduced or eliminated an estimated $3.3 million in payments made during OIG's audit period; and (3) ensure providers claim Federal Medicaid reimbursement only for services in accordance with beneficiaries' plans of care and maintain the required documentation to support claims for services provided and level-of-care assessment approvals, according to the provisions in The Children's Waiver.

Work Plan #: A-02-18-01003 (January 2020)
Government Program: Medicaid

State Cost Allocations That Deviate from Acceptable Practices

Previous OIG reviews of school and community-based administrative claims found significant unallowable payments that were based on random moment sampling systems. Such systems must be documented to support the propriety of the costs assigned to federal awards. A state must claim federal financial participation for costs associated with a program only in accordance with its approved cost allocation plan. OIG reviewed public assistance cost allocation plans and processes for selected states to determine whether the states claimed Medicaid costs that were supported and allocated based on random moment sampling systems that deviated from acceptable statistical sampling practices.

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that the random moment sampling methodology used by New Jersey to claim Medicaid school-based administrative costs did not meet federal requirements and did not comply with statistical sampling requirements and was not adequately supported. Also, the methodology did not comply with New Jersey's approved cost allocation plan. In addition, New Jersey's coding of what school employees were doing during random moments was mostly incorrect or unsupported.

OIG recommended that New Jersey refund $63.8 million in Federal Medicaid payments and revise its random moment sampling methodology to comply with federal requirements, its implementation plan, CMS guidance, and assurances it made to CMS.

Work Plan #: A-02-17-01006 (November 2019); A-07-18-04107 (December 2018); W-00-17-31467
Government Program: Medicaid

Community First Choice State Plan Option Under the Affordable Care Act

Section 2401 of the Patient Protection and Affordable Care Act added section 1915(k) to the SSA, a new Medicaid state plan option that allows states to provide state-wide home and community-based attendant services and support to individuals who would otherwise require an institutional level of care. States taking up the option will receive a six-percent increase in their FMAP for Community First Choice (CFC) services. To be eligible for CFC services, beneficiaries must otherwise require an institutional level of care and meet financial eligibility criteria. OIG reviewed CFC payments to determine whether the payments are proper and allowable.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York followed its CMS-approved methodology for claiming enhanced FMAP on Medicaid fee-for-service and managed care payments made for CFCO services provided to beneficiaries that New York determined eligible in CY 2016.

Work Plan #: A-02-17-01015 (February 2020); A-06-17-08002 (December 2019); W-00-17-31495
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part C – Advantage

Incorrect Acute Stroke Diagnosis Codes Submitted by Traditional Medicare Providers Resulted in Millions of Dollars in Increased Payments to Medicare Advantage Organizations

This audit involved individuals eligible for Medicare who were covered under traditional Medicare in one year but chose to enroll in Medicare Advantage (MA) the following year (transferred enrollees). The Centers for Medicare & Medicaid Services (CMS) maps certain diagnosis codes into Hierarchical Condition Categories (HCCs). For transferred enrollees who, while covered under traditional Medicare, receive a diagnosis that maps to an HCC, CMS makes higher payments to MA organizations for the following year. Through data mining and discussions with medical professionals, OIG has identified several diagnosis codes that were at high risk of being miscoded and resulting in inaccurate payments. For this audit, OIG focused only on selected acute stroke diagnosis codes (which map to the Ischemic or Unspecified Stroke HCC) that were reported on one physician's claim without being reported on a corresponding inpatient claim. OIG's objective was to determine whether selected acute stroke diagnosis codes submitted by physicians under traditional Medicare that CMS later used to make payments to MA organizations on behalf of transferred enrollees complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that almost all of the selected acute stroke diagnosis codes that physicians submitted to CMS under traditional Medicare and that CMS later used to make payments to MA organizations for 2015 or 2016 on behalf of the 582 transferred enrollees did not comply with Federal requirements. For 580 of the transferred enrollees, the medical records did not support the acute stroke diagnosis codes. Thus, the Ischemic or Unspecified Stroke HCCs were not validated.

These errors originated from physicians submitting incorrect acute stroke diagnosis codes on claims billed under traditional Medicare. However, these errors were unnoticed and caused inaccurate payments in MA because CMS did not have policies and procedures to (1) identify beneficiaries who transferred from traditional Medicare to MA, and (2) evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare on their behalf complied with Federal requirements. As a result, OIG estimated that CMS made inaccurate payments of just over $14.4 million to MA organizations.

OIG recommended that CMS (1) educate physicians on how to correctly submit acute stroke diagnosis codes and how these diagnosis codes may impact the MA program, and (2) develop and implement policies and procedures to identify beneficiaries transferring from traditional Medicare to MA and evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare comply with Federal requirements.

Work Plan #: A-07-17-01176 (September 2020)
Government Program: Medicare Part C

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns

OIG undertook this study because of concerns that Medicare Advantage organizations (MAOs) may use health risk assessments (HRAs) to increase risk adjusted payments inappropriately. The Medicare Advantage (MA) program provided coverage to 23 million beneficiaries in 2019 at a cost of $264 billion. Unsupported risk adjusted payments have been a major driver of improper payments in the MA program. CMS risk-adjusts payments by using beneficiaries' diagnoses to pay higher capitated payments to MAOs for sicker beneficiaries, which may create financial incentives for MAOs to make beneficiaries appear as sick as possible. For CMS to risk adjust payments, MAOs report beneficiaries' diagnoses, based on services provided to beneficiaries, to CMS's MA encounter data system and the Risk Adjustment Processing System. HRAs are an allowable source of diagnoses for risk adjustment. An HRA occurs when a physician or other health care professional collects information from beneficiaries about their health to diagnose and identify gaps in care. However, CMS and the Medicare Payment Advisory Commission have raised concerns that MAOs may use HRAs mainly as a tool to collect diagnoses and increase payments to MAOs rather than to improve the health of beneficiaries.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG's findings highlight concerns about the extent to which MAOs are using HRAs to improve care, as intended, and about the sufficiency of CMS's oversight. From OIG's analysis of 2016 MA encounter data, OIG found that diagnoses that MAOs reported only on HRAs-and on no other service records-resulted in an estimated $2.6 billion in risk-adjusted payments for 2017. In addition, in-home HRAs generated 80 percent of these estimated payments. Most in home HRAs were conducted by companies that partner with or are hired by MAOs to conduct these assessments-and therefore are not likely conducted by the beneficiary's own primary care provider. Twenty MAOs generated millions in payments from in-home HRAs for beneficiaries for whom there was not a single record of any other service being provided in all of 2016. OIG's findings raise concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on HRAs, and the quality of care coordination for beneficiaries. Despite potential issues regarding HRAs, CMS has not yet reviewed the impact of HRAs on risk adjusted payments or quality of care.

OIG recommended that CMS: (1) require MAOs to implement best practices to ensure care coordination for HRAs; (2) provide targeted oversight of the 10 parent organizations that drove most of the risk-adjusted payments resulting from in-home HRAs; (3) provide targeted oversight of the 20 MAOs that drove risk-adjusted payments resulting from in-home HRAs for beneficiaries who had no other service records in the 2016 encounter data; (4) reassess the risks and benefits of allowing in-home HRAs to be used as sources of diagnoses for risk adjustment, and reconsider excluding such diagnoses from risk-adjustment; and (5) require MAOs to flag any MAO initiated HRAs in their MA encounter data. C

Work Plan #: OEI-03-17-00471 (September 2020)
Government Program: Medicare Part C

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CMS's Encounter Data Lack Essential Information That Medicare Advantage Organizations Have the Ability to Collect

Prior OIG work found that ordering provider NPIs were absent from 63 percent of Medicare Advantage (MA) encounter records for DMEPOS and for laboratory, imaging, and home health services, and recommended that CMS establish and enforce requirements for MA Organizations (MAOs) to submit ordering provider NPIs for these types of items and services. Findings from an OIG survey of MAOs may be useful as CMS weighs the program integrity benefits of requiring NPIs for ordering providers against the potential burden that MAOs would experience from establishing and enforcing these requirements. To determine the extent to which MAOs submitted ordering provider NPIs on encounter records for DMEPOS and for laboratory, imaging, and home health services, OIG extracted and analyzed 2018 MA encounter data from CMS's Integrated Data Repository in February 2020. OIG also sent an online survey to a stratified random sample of 200 MAOs and received responses from 179 MAOs.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that CMS's MA encounter data continued to lack ordering provider NPIs on records for DMEPOS and for laboratory, imaging, and home health services. However, OIG found that almost all MAOs have data systems that can receive and store these NPIs when providers submit them to MAOs on claims or encounter records. In addition, a substantial portion of MAOs reported that providers are already submitting the ordering provider NPIs on claims or encounter records for DMEPOS, laboratory services, and imaging services. Further, a majority of MAOs require NPIs to be submitted for their other lines of business (such as commercial and private health insurance, Medicaid, and the Children's Health Insurance Program). Finally, almost half of MAOs believe that NPIs for ordering providers are critical for combating fraud.

OIG recommended that CMS require MAOs to submit the ordering provider NPI on encounter records for DMEPOS and for laboratory, imaging, and home health services; and establish and implement "reject edits" that (1) reject encounter records in which the ordering provider NPI is not present when required and (2) reject encounter records that contain an ordering provider NPI that is not a valid and active NPI in the NPPES registry.

Work Plan #: OEI-03-19-00430 (August 2020)
Government Program: Medicare Part C

Financial Impact of Health Risk Assessments and Chart Reviews of Risk Scores in Medicare Advantage

Under Medicare Part C, the Centers for Medicare & Medicaid Services (CMS) makes advanced monthly payments to Medicare Advantage (MA) organizations for each beneficiary enrolled. CMS risk adjusts these payments based on beneficiaries' demographic information and clinical diagnoses from the prior year to pay MA organizations more for beneficiaries with higher expected costs. MA organizations submit to CMS encounter data, which are records of services provided to beneficiaries, including all diagnoses. Currently, CMS includes diagnoses from health risk assessments, which are visits to evaluate a beneficiary's health risks, and chart reviews, which are records based on MA organizations' review of beneficiaries' medical records, when calculating risk scores and risk-adjustment payments. This is allowed regardless

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of whether these diagnoses are supported by another service rendered to the beneficiary during that year. This study will determine the extent to which diagnoses solely generated by health risk assessments and chart reviews were associated with higher risk scores and higher MA payments. In addition, this study will determine the extent to which diagnoses removed by chart reviews were associated with lower risk scores and lower MA payments.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG Found that:

1. MA organizations almost always used chart reviews as a tool to add, rather than to delete, diagnoses and discovered over 99 percent of chart reviews in OIG's review added diagnoses.

2. Diagnoses that MA organizations reported only on chart reviews—and not on any service records—resulted in an estimated $6.7 billion in risk-adjusted payments for 2017

3. CMS based an estimated $2.7 billion in risk-adjusted payments on chart review diagnoses that MA organizations did not link to a specific service provided to the beneficiary—much less a face-to-face visit.

4. Although limited to a small number of beneficiaries, almost half of MA organizations reviewed had payments from unlinked chart reviews where there was not a single record of a service being provided to the beneficiary in all of 2016.

OIG recommended that CMS (1) provide targeted oversight of MAOs that had risk-adjusted payments resulting from unlinked chart reviews for beneficiaries who had no service records in the 2016 encounter data, (2) conduct audits that validate diagnoses reported on chart reviews in the MA encounter data, and (3) reassess the risks and benefits of allowing chart reviews that are not linked to service records to be used as sources of diagnoses for risk adjustment.

Work Plan #: OEI: 03-17-00470 (December 2019)
Government Program: Medicare Part C – Advantage

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Medicare Part D - Prescription Drug Program

Audit of Medicare Part D Pharmacy Fees: Horizon Blue Cross Blue Shield, Inc.

Medicare Part D is an optional program to help Medicare beneficiaries pay for prescription drugs. For drugs dispensed to Part D beneficiaries, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that decrease the costs that a sponsor incurs for a Part D drug. Part D sponsors or their pharmacy benefit managers (PBMs) may negotiate with pharmacies to charge various fees, and these fees are included as DIR. Part D sponsors are required to report their DIR to the Centers for Medicare & Medicaid Services each year. OIG's objective was to determine whether Horizon Blue Cross Blue Shield, Inc., complied with Federal requirements for reporting pharmacy fees in its Summary DIR Reports.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for CYs 2013 through 2016, Horizon complied with Federal requirements for reporting pharmacy fees in its DIR reports. For CY 2013, 2015, and 2016, Horizon appropriately reported pharmacy fees that its PBMs charged to pharmacies. During CY 2014, Horizon's PBM did not charge pharmacy fees for Horizon claims because Horizon was not part of its preferred network.

OIG found that Horizon reported pharmacy fees appropriately. Accordingly, this report contains no recommendations.

Work Plan #: A-03-18-00007 (September 2020)
Government Program: Medicare Part D – Prescription Drug Program

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Opioid Use in Medicare Part D Continued To Decline in 2019, but Vigilance Is Needed as COVID-19 Raises New Concerns

The United States has been grappling with the opioid crisis for several years. In 2018, nearly 47,000 opioid-related overdose deaths occurred in the United States. OIG has been tracking opioid use in Medicare Part D since 2016. OIG has identified beneficiaries at serious risk of opioid misuse or overdose and prescribers with questionable opioid prescribing for these beneficiaries. This data brief provides important information on opioid use in Medicare Part D in 2019, before the coronavirus disease 2019 (COVID-19) pandemic. data brief will also provide comparison points for a forthcoming OIG data brief, which will examine changes in opioid use that occurred during the pandemic in 2020.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that about one in four Medicare Part D beneficiaries received opioids in 2019, a decrease from the prior three years. At the same time, the number of beneficiaries receiving drugs for medication-assisted treatment (MAT drugs) for opioid use disorder has steadily increased in recent years, reaching 209,000 in 2019. The number of beneficiaries receiving prescriptions through Part D for naloxone-a drug that can reverse the effects of an opioid overdose-has also continued to grow. Nearly 267,000 beneficiaries received high amounts of opioids in 2019, with almost 34,000 of them at

serious risk of opioid misuse or overdose. About 140 prescribers had questionable opioid prescribing for beneficiaries at serious risk.

Work Plan #: OEI-02-20-00320 (August 2020)
Government Program: Medicare Part D

Medicare Part D Eligibility Verification Transactions

An E1 transaction is a Medicare Eligibility Verification transaction that the pharmacy submits to the Part D transaction facilitator to determine a beneficiary's eligibility to the Part D program and other drug coverage information. The Part D transaction facilitator returns information to the pharmacy that is needed to submit the prescription drug event. E1 transactions are part of the real-time process of the coordination of benefits and calculating the true out-of-pocket balance. OIG reviewed Centers for Medicare & Medicaid Services' oversight of E1 transactions processed by contractors and whether the E1 transactions were created and used for intended purposes. OIG also reviewed E1 transactions to assess the validity of the data.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that most providers used E1 transactions for some purpose other than to bill for a prescription or determine drug coverage billing order. On average, 98 percent of these 25 providers' E1 transactions were not associated with a prescription. Fifteen providers submitted or hired other entities to submit E1 transactions for inappropriate purposes, which involved using a beneficiary's PHI. After OIG's audit period, CMS took additional steps to monitor the use of the eligibility verification system and take appropriate enforcement action when abuse is identified.

OIG recommended that CMS (1) continue to monitor providers submitting a high number of E1 transactions relative to prescriptions processed, (2) issue guidance that clearly states that E1 transactions should not be used for marketing purposes, (3) ensure that only pharmacies and other authorized entities submit E1 transactions, and (4) take appropriate enforcement action when abuse is identified.

Work Plan #: A-05-17-00020 (February 2020); W-00-17-35751
Government Program: Medicare Part D - Prescription Drug Program

Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts

HHS is required to establish a Medicare coverage-gap discount program to provide relief to beneficiaries who are responsible for paying all drug costs during their coverage gaps. Sponsors track beneficiary payment information and the drug cost data necessary to calculate eligibility for the program. OIG reviewed data submitted by Part D sponsors for use in calculating the coverage gap discount to assess the accuracy of the data and determine whether beneficiary payments are correct, and amounts paid to sponsors are supported.

SunHawk Summary of OIG Audit Findings and Recommendations

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For CYs 2013 and 2014, OIG identified $1.1 million in Coverage Gap discounts that should have been invoiced to manufacturers but were not because the discounts were not reflected in the Prescription Drug Event (PDE) records submitted by sponsors. This amount reflects (1) PDE records associated with drugs that, as Part D sponsors validated, should have had—but did not have—Coverage Gap discounts totaling $658,396 and (2) PDE records with an estimated $406,755 in missed Coverage Gap discounts that were still being reviewed by sponsors.

OIG recommended that CMS (1) verify that Part D sponsors adjusted PDE records for $658,396 in validated Coverage Gap discounts and, of this amount, instruct the sponsors to remit $363,287 to the beneficiaries; and (2) research the remaining records for which OIG estimated missed Coverage Gap discounts totaling $406,755 and instruct Part D sponsors to validate and adjust PDE records accordingly and remit applicable amounts to the beneficiaries.

Work Plan #: A-07-16-06067 (January 2020); W-00-16-35611; W-00-17-35611
Government Program: Medicare Part D - Prescription Drug Program