Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Payer Focus

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 organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan 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 OIG Work Plan sets forth various projects, including OIG audits and evaluations, that are underway or planned to be addressed during the fiscal year and beyond. The Work Plan item summaries provided herein are referenced by their respective Work Plan numbers at the end of each abstract. SunHawk's report summarizes currently active Work Plan items and sorts relevant Work Plans items into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original Work Plan item summaries.

We review the OIG Work Plan items related to other Governmental programs that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused Work Plan items, 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] Audit of Medicaid Components for States in Cycle 1 of CMS's PERM Review

Expected Issue Date: 2022
Announced or Revised: November 2020

The Improper Payments Information Act of 2002 requires the heads of Federal agencies to annually review programs they administer to identify programs that may be susceptible to significant improper payments and estimate the amount of improper payments. The Medicaid program has been identified as a program at risk for significant improper payments. CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program. PERM produces an improper payment rate based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid. In 2017, CMS published a new, final rule implementing substantive changes to the PERM program that, among other things, were aimed at improving program integrity and promoting State accountability through policy and operational improvements. OIG will assess the adequacy of the PERM program by determining the accuracy of determinations for the eligibility, fee-for-service, and managed care components of the PERM error rate.

Work Plan #: W-00-20-31540
Government Program: Medicaid

[NEW] Medicaid and ACA Enrollment Processes During the COVID-19 Pandemic

Expected Issue Date: 2022
Announced or Revised: November 2020

Economic and health impacts caused by the COVID-19 pandemic have left States facing increases in new applications for health insurance through the Medicaid and ACA Marketplace programs. Responding to the pandemic, including meeting the new enrollment and oversight demands, has taxed State health care systems. This evaluation will assess efforts by the States and CMS to effectively enroll residents impacted by the COVID-19 pandemic in Medicaid and ACA Marketplace plans. By identifying effective practices or any breakdowns in enrollment and oversight systems, this review would help improve the efficiency of State health insurance enrollment processes under both emergency and more typical conditions.

Work Plan #: OEI-09-20-00590
Government Program: Medicaid

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Nationwide Review of the Administration and Oversight of Physician-Administered Drugs

Expected Issue Date: 2021
Announced or Revised: October 2020

States are required to collect rebates on covered outpatient drugs administered by physicians in order to be eligible for Federal matching funds (SSA § 1927(a)). Previous OIG work identified significant concerns with States' efforts in obtaining rebates for these physician-administered drugs. OIG will summarize the results and issues identified in these audits and examine CMS's policies and procedures to ensure States appropriately collect Medicaid rebates on physician-administered drugs.

Work Plan #: W-00-20-35860
Government Program: Medicaid

Joint Work with State Agencies

Expected Issue Date: 2021
Announced or Revised: October 2020

To strengthen program integrity and efficiently use audit resources, OIG will enhance their efforts to provide broader oversight of the Medicaid program by partnering with State auditors, State comptroller's general, and State inspectors general. Federal-State partnerships will provide effective methods that address improper payments in fee-for-service programs such as home health, hospice, and durable medical equipment, and in managed care. OIG will partner with States to: (1) address known vulnerabilities that it has identified in both Medicare and Medicaid to curb such vulnerabilities in Medicaid nationwide; and (2) identify new areas that put the integrity of the Medicaid program at risk.

Work Plan #: W-00-21-40002
Government Program: Medicaid

Risk Assessment of Puerto Rico Medicaid Program

Expected Issue Date: 2021
Announced or Revised: October 2020

The Puerto Rico Medicaid program is a 100-percent managed care program that provides health services to more than 1 million beneficiaries. In December 2019, Congress provided Puerto Rico additional funding under the Further Consolidated Appropriations Act of 2020 (P.L. 116—94). P.L. 116—94 also contains anticorruption measures including requirements for OIG to develop and submit to Congress a report identifying payments made under Puerto Rico's

Medicaid program to managed care organizations that are at high risk for waste, fraud, or abuse, and a plan for auditing such payments.

Work Plan #: W-00-20-31544
Government Program: Medicaid

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Centers for Medicare & Medicaid Services and States Implement Policy Modifications to Ensure That Medicaid Beneficiaries Continue to Receive Prescriptions

Expected Issue Date: 2021
Announced or Revised: July 2020

Medicaid is a joint Federal-State program that pays for medical assistance for individuals and families with low incomes. All States currently provide coverage for outpatient prescription drugs within their State Medicaid programs. Under section 1135 of the Act, CMS may temporarily waive or modify certain Medicaid requirements to ensure that sufficient health care items and services are available to meet the needs of beneficiaries in times of an emergency. The coronavirus disease 2019 (COVID-19) pandemic highlights the need for States to efficiently and effectively respond to protect the needs of Medicaid beneficiaries. This audit will provide insights from State officials on action taken by States and DC to ensure Medicaid beneficiaries continue to receive prescriptions during the COVID-19 pandemic. OIG will interview State officials from several States and DC to determine actions taken or planned. OIG's objective is to review actions taken or planned by States and DC to ensure Medicaid beneficiaries continue to receive prescriptions during the COVID-19 pandemic.

Work Plan #: W-00-20-31550
Government Program: Medicaid

Medicaid: Expedited Provider Enrollment During COVID-19 Emergency

Expected Issue Date: 2021
Announced or Revised: Jul 2020

As a result of the coronavirus disease 2019 (COVID-19) pandemic, Medicaid provider enrollment through State Medicaid agencies has been expedited under the SSA §1135 Authority to Waive Requirements during National Emergencies. Rapid loosening of established provider screening and background check requirements may limit a State's ability to identify providers who are not eligible to participate in Medicaid. OIG's objective is to determine whether the State agency and providers complied with Federal and State requirements for newly enrolled providers under the national emergency declaration and if the State established tracking controls for these providers as well as giving providers adequate guidance on waived enrollment requirements.

Work Plan #: W-00-20-31547
Government Program: Medicaid

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Penetration Tests of State Medicaid Management Information Systems and Eligibility & Enrollment Systems

Expected Issue Date: 2021
Announced or Revised: Jun 2020

State Medicaid agencies use the Medicaid Management Information System (MMIS) for administrating the Medicaid program, processing beneficiary and provider inquiries and services, operating claims control and computer capabilities and managing reporting for planning and control. State Medicaid Eligibility & Enrollment (E&E) systems support processes related to a determination of Medicaid coverage and required procedures necessary for registration. State agencies are responsible for the security of MMIS and E&E systems. HHS OIG will perform a series of penetration tests in select State MMIS or Medicaid E&E environments to identify cybersecurity vulnerabilities on high-risk information systems and networks.

Work Plan #: W-00-20-42028
Government Program: Medicaid

Utilization and Pricing Trends for Naloxone in Medicaid

Expected Issue Date: 2021
Announced or Revised: Completed Work Plan

Opioid abuse and overdose deaths are at epidemic levels in the United States. In response, both the U.S. Surgeon General and CMS have stated that increasing access to naloxone, especially among members of the public who are at risk or who know someone at risk, is a top priority. Naloxone is a medication designed to rapidly reverse opioid overdose. However, many stakeholders have expressed concerns that the high cost of naloxone may impede increased access. Medicaid could play a significant role in addressing the issue of naloxone access because the program covers nearly 40 percent of nonelderly adults with opioid addiction. The proposed data brief would (1) trend utilization of and expenditures for naloxone in Medicaid over a 5-year period; (2) determine how the cost-per-dose for naloxone under Medicaid compares to other available prices; and (3) determine the proportion of all naloxone distributed in the U.S. that was paid under Medicaid between 2014 and 2018. This information can help stakeholders determine how to cost-effectively increase naloxone access to affected Medicaid-eligible beneficiaries.

Work Plan #: OEI-BL-18-00360
Government Program: Medicaid

Blood Lead Screening Tests, Followup Services, and Treatment for Medicaid-Enrolled Children

Expected Issue Date: 2021
Announced or Revised: May 2020

There is no safe level of lead exposure for children. In the absence of timely screening, follow-up services, and treatment, children remain vulnerable to cognitive deficiencies associated with lead exposure. Medicaid-enrolled children are

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required to receive blood lead screenings. Under the Early and Periodic Screening, Diagnostic, and Treatment program, children are also entitled to receive follow up services and treatment for conditions identified through screenings (e.g., elevated blood lead levels (EBLLs). Although previous OIG reports identified low rates of lead screenings, an evaluation of follow up services for Medicaid-enrolled children with EBLLs has not been done. OIG will identify the percentage of children under 26 months of age who (1) received required blood lead screenings, (2) had EBLLs, and (3) received needed follow up services and treatment. Additionally, OIG will determine why children with EBLLs did not receive screening, follow up services, and treatment and the extent to which the Centers for Medicare & Medicaid Services provided guidance and technical assistance to States.

Work Plan #: OEI-07-18-00370
Government Program: Medicaid

Blood Lead Screening Tests for Medicaid-Enrolled Children

Expected Issue Date: 2021
Announced or Revised: May 2020

Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid-enrolled children are required to receive blood lead screenings, follow up services, and treatment for conditions identified through screenings. This work expands on previous OIG work in EPSDT screenings and will incorporate State health department data to supplement screening rates for Medicaid-enrolled children who may receive lead screenings in other settings. Additionally, this work will identify barriers to and opportunities for improving required lead screenings and boosting education and outreach for practitioners, parents, and caregivers.

Work Plan #: OEI-07-18-00371
Government Program: Medicaid

States' Oversight of Medicaid Managed Care Medical Loss Ratios

Expected Issue Date: 2021
Announced or Revised: April 2020

Medical loss ratio (MLR) requirements in Medicaid managed care are a method to address State and Federal concerns about the growth in Medicaid spending. Federal MLR requirements are intended to ensure that Medicaid managed care plans spend the majority of the Medicaid capitation payments that they receive from the State on beneficiaries' medical care rather than on administration and profit. Pursuant to the May 2016 Medicaid managed care final rule, States must include requirements in managed care plan contracts for plans to collect MLR data, calculate an MLR percentage, and report that percentage and related, underlying data to the State. States' collection of complete and accurate MLR data from their managed care plans is a critical first step for determining Medicaid managed care MLR performance nation-wide. Complete and accurate MLR data will also enable States to set appropriate managed care payment rates to control Medicaid costs. This work will provide timely, nation-wide data on MLR performance in Medicaid managed care and identify the actions that States have taken to ensure the completeness and accuracy of their managed care plans' MLR data.

Work Plan #: OEI-03-20-00230
Government Program: Medicaid

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Medicaid MCO PBM Pricing

Expected Issue Date: 2022
Announced or Revised: February 2020

The State Medicaid agency and the Federal Government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services including prescription drugs. MCOs may contract with pharmacy benefit managers (PBMs) to manage or administer the prescription drug benefits on their behalf. Spread pricing is a practice where a PBM charges an MCO more for a drug than the amount a PBM pays a pharmacy. OIG's audit will determine whether States provide adequate oversight of Medicaid MCOs to ensure accountability over amounts paid for prescription drug benefits to its PBMs.

Work Plan #: W-00-20-31542
Government Program: Medicaid

Community First Choice State Plan Option Under the Affordable Care Act

Expected Issue Date: 2020
Announced or Revised: Completed Work Plan

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.

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

MCO Payments for Services After Beneficiaries' Deaths

Expected Issue Date: 2021

Previous OIG reports found that Medicare paid for services that purportedly started or continued after beneficiaries' dates of death. OIG identified Medicaid managed care payments made on behalf of deceased beneficiaries. OIG also identified trends in Medicaid claims with service dates after beneficiaries' dates of death.

Work Plan #: A-05-19-00007 (January 2020); A-04-15-06190 (December 2017); A-06-16-05004 (November 2017); A-04-19-06223 (July 2020), W-00-19-31497
Government Program: Medicaid

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Audit of Medicaid Components for for States in Cycle 1 of CMS's PERM Review

Expected Issue Date: 2022
Announced or Revised: January 2020

The Improper Payments Information Act of 2002 requires the heads of Federal agencies to annually review programs they administer to identify programs that may be susceptible to significant improper payments and estimate the amount of improper payments. The Medicaid program has been identified as a program at risk for significant improper payments. CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program. In 2017, CMS published a new final rule implementing changes to PERM and Medicaid Eligibility Quality Control (MEQC) programs. These changes aimed to reduce State burden, improve program integrity, and promote State accountability through policy and operational improvements to the PERM and MEQC programs. PERM produces an improper payment rate based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid. OIG will assess the adequacy of the PERM program by determining whether the Federal contractor conducted eligibility reviews in accordance with Federal PERM requirements.

Work Plan #: W-00-20-31540
Government Program: Medicaid

Medicaid Concurrent Eligibility

Expected Issue Date: 2021
Announced or Revised: November 2019

State Medicaid agencies contract with managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries. The contractual arrangement shifts financial risk for the cost of care to the MCO. State Medicaid agencies pay MCOs on a per-beneficiary per-month basis, and MCOs are at financial risk if the costs of care exceed those payments. If a beneficiary who resides in one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end and the MCO should not receive payments for that beneficiary. OIG's review will determine whether States made capitation payments on behalf of beneficiaries who established residency in another State.

Work Plan #: W-00-19-31539
Government Program: Medicaid

State Cost Allocations That Deviate from Acceptable Practices

Expected Issue Date: 2021

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.

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

Specialty Drug Coverage and Reimbursement in Medicaid

Expected Issue Date: 2021
Announced or Revised: September 2019

Medicaid spending on specialty drugs has rapidly increased. There is no standard definition for specialty drugs. They may be expensive; be difficult to handle, monitor or administer; or treat rare, complex or chronic conditions. OIG will describe States' definitions of, and payment methodologies for, Medicaid specialty drugs and determine how much States paid for specialty drugs. OIG will also review strategies that States use to manage specialty drug costs, such as formularies, cost sharing, step therapy, and prior authorization.

Work Plan #: OEI-03-17-00430
Government Program: Medicaid

Medicaid Eligibility Determinations in Selected States

Expected Issue Date: 2021

The ACA required significant changes affecting state processes for Medicaid enrollment, modified criteria for Medicaid eligibility, and authorized the use of an enhanced FMAP of 100 percent for newly eligible individuals. OIG determined the extent to which selected states made inaccurate Medicaid eligibility determinations. OIG examined eligibility inaccuracy for Medicaid beneficiaries in selected states that expanded their Medicaid programs pursuant to the Patient Protection and Affordable Care Act and in states that did not. OIG also assessed whether and how the selected states addressed issues that contributed to inaccurate determinations. For some states, OIG calculated a Medicaid eligibility error rate and determined the amount of payments associated with beneficiaries who received incorrect eligibility determinations.

Work Plan #: A-07-16-04228 (August 2019); A-02-16-01005 (July 2019); A-09-16-02023 (February 2018); A-04-16-08047 (August 2017); W-00-16-31140
Government Program: Medicaid

Opioids in Medicaid: Review of Extreme Use and Overprescribing in the Appalachian Region

Expected Issue Date: 2021
Announced or Revised: August 2019

Opioid abuse and overdose deaths remain at crisis levels in the United States and the Appalachian region. In 2017, opioids were involved in nearly 48,000 overdose deaths nation-wide, and the opioid overdose death rate was 72 percent

higher in Appalachian counties than non-Appalachian counties. These issues are of particular concern for Medicaid beneficiaries, who are more likely to have chronic conditions and comorbidities that require pain relief, especially those beneficiaries who qualify through a disability. Consistent with previous OIG work in Medicaid and Medicare Part D, OIG will identify beneficiaries who received extreme amounts of opioids through Medicaid, beneficiaries who appear to be doctor or pharmacy shopping, and prescribers associated with these beneficiaries.

Work Plan #: OEI-05-19-00410
Government Program: Medicaid

States' Collection of Rebates for Drugs Dispensed to Medicaid MCO Enrollees

Expected Issue Date: 2021

Medicaid MCOs are required to report enrollees' drug utilization to the state for the purpose of collecting rebates from manufacturers. Section 2501(c) of the Patient Protection and Affordable Care Act expanded the rebate requirement to include drugs dispensed to MCO enrollees. OIG determined whether states are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid MCOs.

Work Plan #: A-02-16-01011 (August 2019); A-09-16-02031 (February 2018); A-06-16-00004 (December 2017); A-09-16-02028 (September 2017); A-09-16-02029 (September 2017); A-09-16-02027 (September 2017); A-07-16-06065 (May 2017); W-00-16-31483
Government Program: Medicaid

Oversight and Effectiveness of Medicaid Waivers

Expected Issue Date: 2021

More states are using waivers to alter their Medicaid program in significant ways. Oversight of state waiver programs present challenges to ensure that payments made under the waivers are consistent with regards to efficiency, economy, and quality of care and do not inflate federal costs. OIG determined the extent to which selected states made use of Medicaid waivers and if costs associated with the waivers are efficient, economic, and do not inflate federal costs.

Work Plan #: A-04-17-04058 (August 2019); A-02-17-01005 (July 2019); A-03-17-00200 (June 2018); W-00-17-31513
Government Program: Medicaid

States' Medicaid Agency Claims for Indian Health Service Expenditures

Expected Issue Date: 2021
Announced or Revised: August 2019

The Federal government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage (FMAP), which varies depending on the State's relative per capita income. States' regular FMAPs range from a low of 50 percent to a high of 83 percent; however, States receive a 100-percent FMAP for expenditures related to services received through Indian Health Service (IHS) facilities. In Federal fiscal years 2016 through 2018, States claimed

$6.6 billion in expenditures at the IHS services FMAP, all of which was federally funded. OIG will analyse selected States' methodologies for identifying expenditures claimed at the IHS services FMAP and determine whether the States claimed these expenditures in accordance with Federal requirements.

Work Plan #: W-00-19-31538
Government Program: Medicaid

Recovery of Federal Funds Through Judgments/Settlements

Expected Issue Date: 2021

Any State action taken because of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. On October 28, 2008, CMS issued a letter (SHO #08-004) to State health officials that clarified language from Section 1903(d) of the Social Security Act, stating that the Federal Government is entitled to the Federal Medical Assistance Percentages (FMAP) proportionate share of a States entire settlement or final judgment amount. OIG will determine whether selected States reported and returned the applicable FMAP share of the settlement and judgment amounts to the Federal Government.

Work Plan #: A-03-17-00203 (June 2019); A-05-17-00041 (December 2018); W-00-17-31522; A-05-17-00000
Government Program: Medicaid

Quality of Medicaid Encounter Data

Expected Issue Date: 2021
Announced or Revised: June 2019

Effective oversight of Medicaid requires a national Medicaid dataset. Although all States submit Transformed Medicaid Statistical Information System (T-MSIS) data, OIG has consistently identified deficiencies in the of managed care encounter data, including inaccurate and missing information, which can render the data of limited use. OIG will determine whether the encounter data for selected States contain the required elements and include the quality data needed to oversee the Medicaid program more effectively. OIG will also determine what steps these States have taken to ensure that all required data elements are submitted to T-MSIS and identify any factors that contributed to data quality issues. This study will be based on a review of three to five States.

Work Plan #: OEI-02-19-00180
Government Program: Medicaid

Overturned Denials in Medicaid Managed Care

Expected Issue Date: 2021
Announced or Revised: June 2019

Managed care organizations (MCOs) contract with State Medicaid agencies to provide beneficiaries with Medicaid services. MCOs must cover services in at least the same amount, duration, and scope that would be covered under

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Medicaid fee-for-service. However, capitated payment models in managed care may create an incentive for MCOs to inappropriately limit or deny access to covered services to increase profits. OIG will review the extent to which selected MCOs' denied services and payments were overturned upon appeal. OIG will also review any concerns about the selected MCOs' performance related to denials and appeals that were identified through State oversight and monitoring efforts.

Work Plan #: OEI: 09-19-00350
Government Program: Medicaid

States' Collection of Rebates on Physician-Administered Drugs

Expected Issue Date: 2021

States are required to collect rebates on covered outpatient drugs administered by physicians in order to be eligible for Federal matching funds (SSA § 1927(a)). Previous OIG work identified concerns with States' collection and submission of data to Centers for Medicare & Medicaid Services, including national drug codes that identify drug manufacturers, thus allowing States to invoice the manufacturers responsible for paying rebates (Deficit Reduction Act of 2005). OIG will determine whether States have established adequate accountability and internal controls for collecting Medicaid rebates on physician-administered drugs. OIG will assess States' processes for collecting national drug code information on claims for physician-administered drugs and subsequent processes for billing and collecting rebates.

Work Plan #: A-02-16-01012 (May 2019); A-06-16-00018 (February 2018); A-05-16-00013 (November 2017); A-05-16-00014 (March 2019); W-00-16-31400
Government Program: Medicaid

Review of State Uncompensated Care Pools

Expected Issue Date: 2021
Announced or Revised: April 2019

Some State Medicaid agencies operate uncompensated care pools (UCPs) under waivers approved by CMS. Section 1115 of Title XIX of the Social Security Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to help promote the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations. To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State. The purpose of the UCPs is to pay providers for uncompensated cost incurred in caring for low-income (Medicaid and uninsured) patients. Through UCPs, States pay out hundreds of millions of dollars to providers and receive Federal financial participation. However, in some States there has previously been little oversight of the payments. OIG will determine whether selected States' Medicaid agencies made payments to hospitals under the UCPs that were in accordance with the STCs of the waiver and with applicable Federal regulations.

Work Plan #: W-00-19-31537
Government Program: Medicaid

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Medicaid Managed Care Organization Denials

Expected Issue Date: 2022
Announced or Revised: April 2019

The State Medicaid agency and the Federal Government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO, which can create an incentive to deny beneficiaries' access to covered services. OIG review will determine whether Medicaid MCOs complied with Federal requirements when denying access to requested medical and dental services and drug prescriptions that required prior authorization.

Work Plan #: W-00-19-31535
Government Program: Medicaid

Delivery System Reform Incentive Payments

Expected Issue Date: 2021

Delivery System Reform Incentive Payments are incentive payments made under Section 1115 waivers to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and increase the health of patients and families served. States must be able to demonstrate outcomes and ensure accountability for allocated funding. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. For example, one State made incentive payments totaling more than $6 billion in a 5-year period. OIG will ensure that select States adhered to applicable Federal and State requirements when they made incentive payments to providers.

Work Plan #: A-02-17-01007 (March 2019); W-00-17-31516
Government Program: Medicaid

Medical Loss Ratio - Recoveries of MCO Remittances from Profit-Limiting Arrangements

Expected Issue Date: 2022

When a State recovers a prior expenditure, it must refund the Federal share by reporting the recovery to Centers for Medicare & Medicaid Services at the FMAP used to calculate the amount it had originally received (SSA § 1903(d)(2); Centers for Medicare & Medicaid Services State Medicaid Manual, § 2500.6(B)). In its final rule (81 Fed. Reg. 27498 (May 6, 2016)), Centers for Medicare & Medicaid Services encouraged States to adopt provisions in contracts with managed care plans that would require remittances from the MCOs if a minimum medical loss ratio is not met. A medical loss ratio is a tool that can help ensure that the majority of capitated payments are used to deliver services to beneficiaries. Prior OIG reviews found that some States have adopted such remittance provisions. OIG will review States and managed care plans with contract provisions that require remittances from managed care plans if a minimum percentage of total costs to be expended for medical services (medical loss ratio) is not met. OIG will determine whether the Federal share of

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recoveries of MCO payments that States received through profit-limiting methodologies is returned to the Federal Government. Centers for Medicare & Medicaid Services reimburses each State at the FMAP for the quarter in which the expenditure was made (SSA § 1903(a)(1)).

Work Plan #: A-06-18-09001 (February 2019); W-00-18-31508
Government Program: Medicaid

Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid

Expected Issue Date: 2020
Announced or Revised: January 2019

Medicare Home Health Agency (HHA) coverage requirements state that an HHA is responsible for providing all services either directly or under arrangement while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare pays a single HHA overseeing that plan. "Dual eligible beneficiaries" generally describes beneficiaries eligible for both Medicare and Medicaid. Medicare pays covered medical services first for dual eligible beneficiaries because Medicaid is generally the payer of last resort. OIG will determine whether States made Medicaid payments for home health services for dual eligible beneficiaries who are also covered under Medicare.

Work Plan #: W-00-19-31141
Government Program: Medicaid

State Use of Provider Taxes to Generate Federal Funding

Expected Issue Date: 2020
Announced or Revised: Completed Work Plan

Many States finance a portion of their Medicaid spending by imposing taxes on health care providers. Federal regulations define and set forth the standard for permissible health-care-related taxes (42 CFR §§ 433.55 and 433.68). Previous OIG work raised concerns about States' use of health-care-related taxes. OIG will review State health-care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable Federal requirements. OIG work will focus on the mechanism States use to raise revenue through provider taxes and determine the amount of Federal funding generated.

Work Plan #: A-03-16-00202 (November 2018); W-00-17-31455
Government Program: Medicaid

Medicaid Capitation Payments Made on Behalf of Incarcerated Individuals

Expected Issue Date: 2022
Announced or Revised: October 2018

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States contract with Medicaid managed care organizations to provide specific services to enrolled Medicaid beneficiaries, usually in return for a predetermined periodic payment, known as a capitation payment. Section 1905 of Title XIX of the Social Security Act, 42 CFR § 435, and guidance from the Centers for Medicare & Medicaid Services state that Federal financial participation is not available for services provided to inmates of public institutions, except when the inmate is not in a prison setting and becomes an inpatient in a medical institution. OIG will determine whether select States made unallowable capitation payments to Medicaid managed care organizations on behalf of individuals who were incarcerated.

Work Plan #: W-00-18-31534
Government Program: Medicaid

Potential Abuse and Neglect of Children Receiving Medicaid Benefits

Expected Issue Date: 2022
Announced or Revised: August 2018

Medicaid beneficiaries, including children, are treated at inpatient and outpatient medical facilities for conditions that may be the result of abuse or neglect. Although all States have laws mandating reporting of suspected child abuse, these laws vary considerably in their definitions, scope, and procedures. Prior OIG reviews have highlighted problems with the quality of care and the reporting and investigation of potential abuse or neglect of vulnerable beneficiary populations at group homes, nursing homes, and skilled nursing facilities. Based on diagnoses from medical facilities treating conditions potentially related to abuse or neglect, OIG will determine the prevalence of Medicaid claims indicating potential abuse or neglect of children receiving Medicaid benefits.

Work Plan #: W-00-18-31533
Government Program: Medicaid

ACF Child Care Development Fund: Program Integrity

Expected Issue Date: 2020
Announced or Revised: August 2018

The Child Care and Development Fund (CCDF) program provides subsidized childcare to low-income families, families receiving temporary public assistance, and families transitioning from public assistance so family members can work or attend training or education. Each State must develop, and submit to the Administration for Children and Families (ACF) for approval, a plan that identifies the purposes for which CCDF funds will be spent for a 3-year grant period and designates a lead agency responsible for administering childcare programs. States receive block grants and other Federal funds (approximately $5.77 billion annually) to operate their childcare programs. Prior OIG work identified vulnerabilities in States' internal controls for the CCDF program and a national CCDF payment error rate of 5.74 percent. OIG will determine whether State agencies complied with Federal and State requirements when making payments to licensed providers under these childcare programs for Federal fiscal years 2016 through 2018.

Work Plan #: W-00-18-20019
Government Program: Medicaid

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Enhanced Federal Medical Assistance Percentage

Expected Issue Date: 2021

The ACA, § 2001, authorized the use of an FMAP of 100 percent for individuals who are newly eligible because of Medicaid expansion. In addition, the ACA, § 1202, required that Medicaid payments to primary care providers be at least those of the Medicare rates in effect for CYs 2013 and 2014. States can claim 100 percent FMAP for the difference between the Medicare rate and the States' Medicaid rate. OIG will review States' Medicaid claims to determine whether the States correctly applied enhanced FMAP payment provisions of the ACA.

Work Plan #: A-06-17-09003 (May 2018); W-00-17-31480
Government Program: Medicaid

Medicaid Nursing Home Supplemental Payments

Expected Issue Date: 2021
Announced or Revised: April 2018

CMS approved a nursing home supplemental payment program in certain States that pays the difference between Medicare and Medicaid rates for nursing home services. In some of these programs, local governments fund the States' share of the supplemental payments through intergovernmental transfers. Prior OIG and Government Accountability Office audits have found that Federal supplemental payments often benefit the State and local governments more than the nursing homes. OIG will review the nursing home supplemental payment program's flow of funding and determine how the funds are being used.

Work Plan #: W-00-18-31530
Government Program: Medicaid

Medicaid School-Based Costs Claimed Based on Contingency Fee Contractor Coding

Expected Issue Date: 2021
Announced or Revised: March 2018

Several State Medicaid agencies retain consultants to assist with preparing Medicaid claims for school-based activities. Consultants often are paid a contingency fee based on the percentage of Federal funds reimbursed to the State. During a prior review, OIG found that one consultant developed unsupported timestudies that it used to develop payment rates for school-based health services. Based on those rates, the State claimed unallowable Federal funds. Consultants developed time studies using a similar methodology in many other States. OIG will initiate a multiple State review with a roll-up report to CMS to determine whether consultants developed school-based Medicaid rates based on unsupported time studies and unallowable costs in these States.

Work Plan #: W-00-18-31529
Government Program: Medicaid

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Duplicate Payments for Beneficiaries with Multiple Medicaid Identification Numbers

Expected Issue Date: 2021

During a preliminary data match, OIG 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. OIG will review duplicate payments made by States on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and identify States' procedures or other controls for preventing such payments.

Work Plan #: A-04-16-07061 (December 2017); W-00-16-31374
Government Program: Medicaid

Use of Funds by Medicaid Managed Care Organizations

Expected Issue Date: 2022
Announced or Revised: November 2017

Managed care is a health care delivery system organized to manage cost, utilization, and quality. In 2015, Federal Medicaid managed care payments were approximately $161.8 billion, which was more than 40 percent of the $349.8 billion in total Federal expenditures for Medicaid. States continue to expand their use of managed care. To deliver services to Medicaid managed care enrollees, States contract with managed care organizations (MCOs) and make monthly payments, called a capitation payment, to those plans to provide enrollees with Medicaid-covered services. Appropriately set capitation rates help to ensure that adequate payments are made to provide services to beneficiaries. OIG will examine how Medicaid funds received by MCOs are used to provide services to enrollees.

Work Plan #: W-00-18-31526
Government Program: Medicaid

States' Accuracy of Reporting TANF Spending Information

Expected Issue Date: 2021
Announced or Revised: October 2017

The Temporary Assistance for Needy Families (TANF) program is designed to help needy families achieve self-sufficiency. States receive block grants ($16.5 billion annually) to design and operate programs that accomplish one of the four purposes of the TANF program. States must report expenditures to ACF on a quarterly basis. Effective FY 2015, States will report actual transfers, expenditures, and unliquidated obligations (henceforth referred to as expenditures) made with each open grant year award during a fiscal year on form ACF-196R. Each quarterly report will reflect expenditures cumulative through that quarter for the fiscal year, resulting in a fourth quarter report that reflects actual expenditures made with the grant year award funds for the fiscal year. States will no longer report expenditures cumulative through the current reporting period. OIG will determine the accuracy of States' reporting of TANF spending information using the new form ACF-196R.

Work Plan #: W-00-17-25100
Government Program: Medicaid

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicaid Managed Care Reimbursement

Expected Issue Date: 2022
Announced or Revised: November 2016

States contract with MCOs to provide coverage for specific services to enrolled Medicaid beneficiaries. In return for covering those services, MCOs are paid a set monthly capitation payment. Previous work by GAO found that Centers for Medicare & Medicaid Services's oversight of States' rate-setting required improvement and that States may not audit or independently verify the MCO-reported data used to set rates (GAO-10-810). OIG will review States' managed care plan reimbursements to determine whether MCOs are appropriately and correctly reimbursed for services provided. OIG will ensure that the data used to set rates are reliable and include only costs for services covered under the State plan or costs of services authorized by Centers for Medicare & Medicaid Services (42 CFR § 438.6(e)). OIG will also verify that payments made under a risk-sharing mechanism and incentive payments made to MCOs are within the limits set forth in Federal regulations.

Work Plan #: W-00-17-31471
Government Program: Medicaid

Third-Party Liability Payment Collections in Medicaid

Expected Issue Date: 2021
Announced or Revised: November 2016

Medicaid beneficiaries may have additional health insurance through third-party sources. Previous OIG work 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 (SSA § 1902(a)(25)). Medicaid is the payer of last resort and providers are to identify and refund overpayments received. OIG will determine if States have taken action to ensure that Medicaid is the payer of last resort by identifying whether a third-party payer exists and if the State correctly reports the third-party liability to Centers for Medicare & Medicaid Services.

Work Plan #: W-00-17-31517; A-05-17-00000
Government Program: Medicaid

Accountable Care in Medicaid

Expected Issue Date: 2020
Announced or Revised: November 2016

The Medicaid program is experiencing a shift toward new models that promote accountability for the cost and quality of care delivered to patients and focus on better, more efficient coordination of care. Several delivery system reform initiatives in Medicaid, including, for example, medical homes and accountable care organizations, focus on accountable care and include elements such as implementing value-based payment structures, measuring quality improvement, and

collecting and analysing data. OIG will review selected accountable care models in Medicaid for compliance with relevant State and Federal requirements.

Work Plan #: W-00-17-31518
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part C – Advantage

Ineligible Providers in Medicare Part C and Part D

Expected Issue Date: 2021
Announced or Revised: October 2020

CMS contracts with Medicare Advantage plans and private prescription drug plans (collectively known as "sponsors") to offer Part C and Part D managed care benefits to eligible beneficiaries. Federal law prohibits Medicare payments for services provided or prescriptions written by individuals or entities who are excluded from Federal health care programs (excluded providers) when the sponsor knows or has reason to know of the exclusion. Federal regulations also prohibit Medicare payments to ineligible providers whose billing privileges have been deactivated, denied, or revoked. OIG will conduct a nationwide audit of Medicare Part C and Part D managed care data for calendar years 2018 and 2019 to identify ineligible providers that had been excluded, precluded, or deactivated as Medicare providers but provided services through Part C and D sponsors. OIG's audit will determine whether Part C and Part D sponsors complied with Federal requirements on preventing ineligible providers from rendering services to Medicare beneficiaries.

Work Plan #: W-00-20-35859
Government Program: Medicare Part C – Advantage

Medicare Advantage Organizations' Use of Ordering Provider Identifiers for Program Integrity Oversight

Expected Issue Date: 2021
Announced or Revised: September 2020

National Provider Identifiers (NPIs) for ordering providers are essential for safeguarding the program integrity of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), clinical laboratory services, imaging services, and home health services in Medicare. However, CMS does not require Medicare Advantage organizations (MAOs) to collect NPIs for ordering providers. In past work, the Office of Inspector General (OIG) found that—although nearly two-thirds of Medicare Advantage encounter data records that MAOs submitted to CMS for DMEPOS, clinical laboratory, imaging, and home health services reviewed did not include the NPI for the ordering provider—almost all MAOs have the ability to collect ordering provider NPIs, and that many MAOs do collect these data. OIG recommended that CMS require MAOs to submit ordering provider identifiers. This issue brief will determine the extent to which MAOs conduct oversight of DMEPOS, clinical laboratory services, imaging services, and home health services using ordering provider identifiers.

Work Plan #: OEI-03-19-00432
Government Program: Medicare Part C – Advantage

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Rates of Estimated Payments from Chart Reviews and Health Risk Assessments Across Medicare Advantage Organizations

Expected Issue Date: 2021
Announced or Revised: August 2020

The Medicare Advantage (MA) program provided coverage to 23 million beneficiaries in 2019 at a cost of $264 billion. CMS risk-adjusts these payments by using beneficiaries' diagnoses to pay higher capitated payments to MA organizations (MAOs) for beneficiaries expected to have greater health care needs. This payment policy may create financial incentives for MAOs to misrepresent beneficiaries' health status and make them appear to have additional illnesses and other conditions that would command higher payment. A previous OIG evaluation identified $6.7 billion in estimated 2017 risk-adjusted payments resulting from diagnoses that MAOs reported only on chart reviews, and not on any records of services provided to beneficiaries in 2016. Findings from this evaluation raise concerns about the completeness of payment data that MAOs submit to CMS, the validity of diagnoses on chart reviews, and the quality of care provided to beneficiaries. A current OIG evaluation examines the extent to which diagnoses solely generated by health risk assessments (HRAs) were associated with higher risk scores and higher MA payments. OIG will combine data from these evaluations to perform new analyses that will determine whether certain MAOs and parent organizations had higher or lower amounts of risk-adjusted payments from both chart reviews and HRAs relative to their peers.

Work Plan #: OEI-03-17-00474
Government Program: Medicare Part C – Advantage

The Impact of Health Risk Assessments on Risk-Adjusted Payments in Medicare Advantage

Expected Issue Date: 2020
Announced or Revised: Completed Work Plan

Under Medicare Part C, the 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, when calculating risk scores and risk-adjusted payments. This is allowed regardless 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 were associated with higher risk scores and higher MA payments.

Work Plan #: OEI: 03-17-00471
Government Program: Medicare Part C – Advantage

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Advantage Risk-Adjustment Data - Targeted Review of Documentation Supporting Specific Diagnosis Codes

Expected Issue Date: 2021
Announced or Revised: November 2019

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, MA organizations receive higher payments for sicker patients. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. OIG will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

Work Plan #: W-00-20-35079
Government Program: Medicare Part C – Advantage

Inappropriate Denial of Services and Payment in Medicare Advantage

Expected Issue Date: 2021
Announced or Revised: June 2019

Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services to increase profits for managed care plans. OIG will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, OIG will determine the reasons for any inappropriate denials and the types of services involved.

Work Plan #: OEI: 09-18-00260
Government Program: Medicare Part C – Advantage

Review of CMS Systems Used to Pay Medicare Advantage Organizations

Expected Issue Date: 2021
Announced or Revised: December 2017

Medicare Advantage (MA) organizations submit to CMS diagnoses on their beneficiaries; in turn, CMS categorizes certain diagnoses into groups of clinically related diseases called hierarchical condition categories (HCC). For instances in which a diagnosis maps to a HCC, CMS increases the risk-adjusted payment. CMS has designed its Medicare Part C systems to capture the necessary data in order to make these increased payments to MA organizations. As CMS transitions to a

new data system to make these payments, OIG will conduct analysis to inform both use of current systems and the transition to a new system. OIG will review the continuity of data maintained on current Medicare Part C systems. Specifically, OIG will review instances in which CMS made an increased payment to an MA organization for an HCC and determine whether CMS's systems properly contained a requisite diagnosis code that mapped to that HCC.

Work Plan #: W-00-18-35804
Government Program: Medicare Part C – Advantage

Risk Adjustment Data - Sufficiency of Documentation Supporting Diagnoses

Expected Issue Date: 2021
Announced or Revised: October 2017

Payments to Medicare Advantage organizations are risk adjusted based on the health status of each beneficiary. Medicare Advantage organizations are required to submit risk adjustment data to Centers for Medicare & Medicaid Services in accordance with Centers for Medicare & Medicaid Services instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause Centers for Medicare & Medicaid Services to pay Medicare Advantage organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, Medicare Advantage organizations receive higher payments for sicker patients. Centers for Medicare & Medicaid Services estimates that 9.5 percent of payments to Medicare Advantage organizations are improper, mainly due to unsupported diagnoses submitted by Medicare Advantage organizations. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to Centers for Medicare & Medicaid Services by Medicare Advantage organizations. OIG will review the medical record documentation to ensure that it supports the diagnoses that Medicare Advantage organizations submitted to Centers for Medicare & Medicaid Services for use in Centers for Medicare & Medicaid Services' risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

Work Plan #: W-00-16-35078; various reviews
Government Program: Medicare Part C – Advantage

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part D - Prescription Drug Program

[NEW] Medicare Part D Compounded Drugs

Expected Issue Date: 2022
Announced or Revised: November 2020

In 2016, OIG called attention to significant growth in spending for compounded drugs. Specifically, OIG found that Medicare Part D spending for compounded topical drugs grew by 625 percent during 2006—2015. OIG has been involved in an increasing number of fraud investigations related to compounded drugs. OIG will conduct a risk assessment of CMS's oversight of pharmacies compounding drugs for beneficiaries to determine whether systemic vulnerabilities affecting the integrity of Medicare Part D. specifically, OIG will assess the risk that pharmacies did not meet Federal and State requirements.

Work Plan #: W-00-21-35415
Government Program: Medicare Part D - Prescription Drug Program

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Opioid Use in Medicare Part D in 2020

Expected Issue Date: 2021
Announced or Revised: June 2020

The opioid crisis remains a public health emergency. In 2018, there were nearly 47,000 opioid-related overdose deaths in the United States. Identifying patients who are at risk of overdose or abuse is key to addressing this crisis. The coronavirus disease 2019 (COVID-19) pandemic has made this need even more pressing. The National Institutes of Health recently issued a warning that individuals with opioid use disorder could be particularly hard hit by COVID-19, as it is a respiratory virus that attacks the lungs. Respiratory disease is known to increase the mortality risk among people taking opioids. This data brief will provide information on opioid utilization among beneficiaries enrolled in Medicare Part D in 2020. It will build on OIG's series of annual reports, including the July 2019 data brief Opioid Use Decreased in Medicare Part D, While Medication-Assisted Treatment Increased, OEI-02-19-00390. It will provide 2020 data on Part D spending for opioids and the number of beneficiaries who received extreme amounts of opioids through Part D and those who appeared to be doctor-shopping. It will also identify prescribers who ordered opioids for large numbers of these beneficiaries.

Work Plan #: W-00-20-35846
Government Program: Medicare Part D - Prescription Drug Program

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part D Payments for Transmucosal Immediate-Release Fentanyl Drugs

Expected Issue Date: 2021
Announced or Revised: May 2020

Transmucosal Immediate-Release Fentanyl (TIRF) drugs are a Schedule II controlled substance. Medicare Part D covers TIRF drugs only for managing breakthrough pain in adult cancer patients who are already receiving and are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. OIG will determine whether TIRF drugs were appropriately dispensed in Medicare Part D in accordance with Medicare requirements.

Work Plan #: W-00-20-35846
Government Program: Medicare Part D - Prescription Drug Program

Medicare Part D Eligibility Verification Transactions

Expected Issue Date: 2020
Announced or Revised: Completed Work Plan

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 (Centers for Medicare & Medicaid Services, Medicare Prescription Drug Benefit Manual, Pub. No. 100-18, Ch. 14, § 30.4). OIG will review Centers for Medicare & Medicaid Service's oversight of E1 transactions processed by contractors and whether the E1 transactions were created and used for intended purposes. OIG will also review E1 transactions to assess the validity of the data.

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

Nationwide Audit of Medicare Part D Eligibility Verification Transactions

Expected Issue Date: 2022
Announced or Revised: February 2020

An E1 transaction is a Medicare Part D eligibility verification transaction that the pharmacy submits to the Part D transaction facilitator to bill for a prescription or determine drug coverage billing order. 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 costs (CMS, Medicare Prescription Drug Benefit Manual, Pub. No. 100-18, chapter 14, Â§ 30.4). OIG

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will review CMS's oversight of E1 transactions processed by contractors and determine whether the E1 transactions were created and used for intended purposes.

Work Plan #: W-00-20-35751
Government Program: Medicare Part D - Prescription Drug Program

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Part D Sponsors Reporting of Direct and Indirect Remunerations

Expected Issue Date: 2021

Medicare calculates certain payments to sponsors based on amounts actually paid by the Part D sponsors, net of direct and indirect remuneration (DIR). (42 CFR pt. 423, subpart G.) DIR includes all rebates, subsidies, and other price concessions from sources (including, but not limited to, manufacturers and pharmacies) that decrease the costs incurred by Part D sponsors for Part D drugs. CMS requires that Part D sponsors submit DIR reports for use in the payment reconciliation process. OIG will determine whether Part D sponsors complied with Medicare requirements for reporting DIR.
Work Plan #: A-03-18-00006 (October 2019); W-00-18-35514; A-03-18-xxxxx
Government Program: Medicare Part D - Prescription Drug Program

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Documentation of Pharmacies' Prescription Drug Event Data

Expected Issue Date: 2020

Drug plan sponsors must submit prescription drug event records, which is a summary record of individual drug claim transactions at the pharmacy, for the HHS Secretary to determine payments to the plans (SSA § 1860D-15(f)(1)). OIG will determine whether Medicare Part D prescription drug event records submitted by the selected pharmacies were adequately supported and complied with applicable Federal requirements. OIG will also conduct additional reviews of selected retail pharmacies identified in a prior OIG report as having questionable Part D billing.

Work Plan #: A-07-16-06068 (November 2018); W-00-17-35411
Government Program: Medicare Part D - Prescription Drug Program