

**DEFICIT REDUCTION ACT OF 2005 REPORT TO CONGRESS  
FOR FISCAL YEAR 2006**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL

**Table of Contents**

<b>Section</b>	<b>Title</b>	<b>Page</b>
1	Introduction	1
2	Overview of OIG	1
3	Summary of DRA Provisions That Affect OIG	4
4	History of OIG Involvement in Medicaid Oversight	6
5	OIG Oversight of the Medicaid Program During FY 2006	6
6	Medicaid Oversight in FY 2007 and Beyond	19
Appendix A	List of Audits and Evaluations of Medicaid in FY 2006	
Appendix B	List of Planned Medicaid Work From the FY 2007 OIG Work Plan	

## **SECTION 1: INTRODUCTION**

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This report fulfills the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) statutory requirement to report on the use and effectiveness of funds provided through section 6034 of the Deficit Reduction Act of 2005 (Pub. L. 109-171, DRA). Specifically, this report summarizes the OIG's Medicaid related oversight activities during fiscal year (FY) 2006. In addition, this report includes an overview of Medicaid integrity work that OIG anticipates undertaking during FY 2007.

## **SECTION 2: OVERVIEW OF OIG**

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### Organization of OIG

The mission of the OIG, as mandated by Public Law 95-452 (as amended), is to protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. OIG accomplishes its statutory responsibilities through audits, evaluations, investigations, legal services, and, when appropriate, with criminal and civil enforcement actions, as well as administrative sanctions, such as the imposition of civil monetary penalties, assessments, and exclusions. OIG is organized into the following component offices to carry out these activities:

- *Office of Audit Services (OAS)* - OAS conducts and oversees financial and performance audits of departmental programs and operations to determine whether objectives are being achieved; to determine which aspects of programs need to be performed more efficiently; and to identify systemic weaknesses that give rise to fraud, waste, or abuse. OAS audits are conducted in accordance with the Government Auditing Standards. OAS also provides leadership and direction in carrying out the mandates of the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.
- *Office of Evaluation and Inspections (OEI)* - OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.
- *Office of Investigations (OI)* - OI conducts investigations of fraud and misconduct to safeguard the Department's programs and protect its beneficiaries. OI concentrates its resources on criminal investigations, but its activities are also aimed at deterring fraud and abuse by identifying systemic weaknesses and vulnerabilities that can be mitigated through corrective management actions,

regulation, or legislation and by pursuing criminal convictions and recovering damages and penalties through civil and administrative proceedings.

- *Office of Counsel to the Inspector General (OCIG)* - OCIG coordinates OIG's role in the judicial and administrative resolution of fraud and abuse cases involving HHS programs, including the litigation and imposition of administrative sanctions, such as program exclusions and civil monetary penalties and assessments; the global settlement of cases arising under the Civil False Claims Act (FCA); and the development and monitoring of corporate integrity agreements (CIAs) for certain providers that have settled their FCA liability with the Federal Government. OCIG also develops and promotes industry-specific voluntary compliance program guidance and issues special fraud alerts to the public, special advisory bulletins, and advisory opinions regarding the application of OIG's sanction authorities. OCIG is responsible for developing new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG provides general legal services to OIG components, including advice and representation on HHS programs and operations, administrative law issues, and criminal procedure.
- *Office of Management and Policy (OMP)* - OMP provides mission support services to the Inspector General and OIG components by formulating and executing the budget, issuing grants to State Medicaid Fraud Control Units (MFCU), developing administrative policies, disseminating OIG information in the form of publications, and managing information technology and human resources. OMP also executes and maintains an internal quality assurance system, which includes quality control reviews of OMP processes and products, to ensure that OIG policies and procedures are followed effectively and function as intended.

OIG accomplishes its mission through a network of offices, including a headquarters in Washington, DC, and Baltimore, MD, multiple regional offices, and approximately 90 field offices. In total, more than 80 percent of OIG resources are deployed in regional and field offices.

OIG staff at all locations work closely with the Department, its Operating and Staff Divisions, the Department of Justice (DOJ) and other agencies in the Executive Branch, Congress, and the States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds.

### OIG Budget

The funding that supports the oversight activities that OIG conducts is divided among a single discretionary budget authority and multiple mandatory authorities. OIG's discretionary funding is used for oversight of all HHS programs and offices except for Medicare and Medicaid (including the State Children's Health Insurance Program), which are funded separately under the Health Care Fraud and Abuse Control Program (HCFAC) and the Medicaid Integrity

Program (MIP). Following are summaries of the two Acts that provide OIG with funding for oversight of health care and, in particular, of the Medicaid program:

- HCFAC Program.* The Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, HIPAA) established a Health Care Fraud and Abuse Control Program under the joint direction of the Attorney General and the Secretary of HHS, acting through the HHS Inspector General. HIPAA appropriates monies from the Medicare Trust Fund in amounts that the HHS Secretary and Attorney General jointly certify as necessary to finance antifraud activities, up to ceilings fixed by the Act. Certain of these funds are, by law, set aside for OIG “activities . . . with respect to Medicare and Medicaid.” (Social Security Act, §1128C(a)(1), SSA) HIPAA also requires the Attorney General and the HHS Secretary to submit a joint annual report to Congress identifying expenditures and accomplishments under the law. (SSA, §1817(k)(5)) These reports are available on the Web sites of both agencies at <http://oig.hhs.gov/reading/publications.html> and <http://www.usdoj.gov/dag/pubdoc.html> respectively. Since FY 1997, HCFAC has been the primary source of funding for health care fraud investigations and prosecutions by both OIG and DOJ.
- MIP.* The DRA established the MIP through which OIG receives enhanced funding for fraud and abuse control “activities with respect to the Medicaid program.” (42 U.S.C. section 1396(c)) This funding is provided annually from FY 2006 though FY 2010 in addition to OIG’s HCFAC resources and is available until expended.

Table 1 presents a summary of OIG’s recent funding history and current estimates of its future funding commitment for Medicaid oversight.

**Table 1: Summary of OIG’s Financial Expenditures  
Related to Medicaid Oversight, FY 2004 – FY 2008  
(Dollars in Thousands)**

Fiscal Year	Estimated Medicaid Percentage*	Funds Availability		Estimated Funding Utilization		Estimated Total Medicaid Funding
		HCFAC	MIP	HCFAC	MIP <sup>1</sup>	
2004	19	\$160,000	--	\$30,400	--	\$30,400
2005	23	\$160,000	--	\$36,800	--	\$36,800
2006	28	\$160,000	\$25,000	\$44,800	--	\$44,800
2007	30	\$165,920	\$25,000	\$27,350	\$30,000	\$57,350
2008	32	\$169,238	\$25,000	\$29,400	\$33,500	\$62,900

\* FY 2007 and FY 2008 are estimated as percentages of the combined HIPAA/HCFAC and DRA/MIP funding streams.

<sup>1</sup> OIG did not begin spending MIP funds until FY 2007 because the funding was not available until mid-year FY 2006.

As illustrated in Table 1, a significant portion of OIG's HCFAC funds has been used for Medicaid oversight in recent years. As OIG starts spending its MIP funding in FY 2007, it can enhance the depth and scope of Medicaid integrity work it undertakes. Because there is an overlap among the activities funded by the HCFAC and MIP sources, however, OIG work activities relating to Medicaid may draw on funding from both sources, especially with respect to investigations and subsequent prosecutions, where it is difficult – sometimes impossible – to accurately segregate HCFAC- and MIP-funded Medicaid enforcement activities. For example, even if OIG conducted a given investigation exclusively with MIP funds, the subsequent prosecution of that case would draw upon DOJ's own HCFAC money, so the matter would be in both the annual HCFAC and DRA reports. The overlap is compounded when an investigation involves fraud in both Medicaid and other Federal health care programs, such as Medicare, as is often the case. For these reasons, this report does not artificially divide accomplishments between the two funding sources; OIG's successes are typically the result of the combined funding from both resources.

In addition, much of OIG's audit, evaluation, and investigation work requires more than 1 year to yield results. As a consequence, many of the accomplishments summarized in this report reflect the results of work performed over several years that culminated in OIG results in FY 2006.

### **SECTION 3: SUMMARY OF DRA PROVISIONS THAT AFFECT OIG**

Sections 6001, 6031, and 6034 of the DRA include provisions that require OIG to conduct mandatory activities including specified audits and evaluations as well as annual reporting on overall Medicaid activities. These sections are summarized below:

- *Section 6001: Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions.* This section required OIG to, by no later than June 1, 2006, (1) review the requirements for, and manner in which, average manufacturer prices (AMP) are determined under section 1927 of the SSA and (2) submit to the Secretary of HHS and Congress recommendations for changes in such requirements or manner as the Inspector General determines to be appropriate.

On May 30, 2006, OIG issued an audit report entitled "Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005" (A-06-06-00063), which fulfilled the statutory requirement of this section. The AMP is used in the calculation of Medicaid rebates paid by drug manufacturers, and pursuant to the DRA, the AMP became the basis of Medicaid reimbursement limits for drugs subject to the Federal upper payment limits. In this report, OIG found that some AMP requirements were unclear and that manufacturers' methods of calculating AMPs were inconsistent. Consistent with OIG's findings, industry groups also emphasized the need to clarify certain AMP requirements and raised additional issues related to the implementation of DRA provisions. OIG recommended that the Secretary direct the Centers for Medicare

and Medicaid Services (CMS), in promulgating the AMP regulation, to clarify requirements in regard to the definition of retail class of trade and the treatment of pharmacy benefit manager rebates and Medicaid sales, and to consider addressing issues raised by industry groups. OIG also recommended that the Secretary direct CMS to issue guidance that specifically addresses the implementation of the AMP-related reimbursement provisions of the DRA and to encourage States to analyze the relationship between AMP and pharmacy acquisition cost before using AMP for their reimbursement methodology.

- *Section 6031: Encouraging the Enactment of State False Claims Acts.* This section provides a financial incentive for States to enact FCAs that establish liability to the State for the submission of false or fraudulent claims to the State's Medicaid program. If a State's FCA is determined to meet certain enumerated requirements, the Federal share of Medicaid recoveries under the State FCA will be reduced by 10 percentage points, or in other words, the State will be allowed to keep an extra 10 percent of such recoveries.

Specifically, for a State to be eligible for the 10 percentage point increase in its share of false claims recoveries, the State law relating to false and fraudulent claims must be determined by OIG, in consultation with the Attorney General, to meet the following criteria: (1) establish liability to the State for false or fraudulent claims described in the FCA with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA, (3) contain a requirement for filing an action under seal for 60 days with review by the State Attorney General, and (4) contain a civil penalty that is not less than the amount authorized by the FCA. The provision was effective beginning January 1, 2007.

On August 21, 2006, OIG published in the Federal Register its guidelines for evaluating State FCAs under the requirements of section 6031 of the DRA. This notice was developed in consultation with DOJ's Civil Division. In the notice, OIG invited the States to request review of their FCAs. Since the publication of the Federal Register notice, OIG has received requests to review both existing and proposed State laws.

As of March, 2007, OIG has provided written responses to 12 States and approved 5 of the State laws – those passed by Massachusetts, Illinois, Tennessee, Virginia, and Hawaii – for the DRA incentive. OIG made these determinations in consultation with DOJ's Civil Division. The response letters are published on the OIG's Web site, <http://www.oig.hhs.gov>.

- *Section 6034: Medicaid Integrity Program.* This section establishes MIP and requires the Secretary to enhance the capacity of CMS to conduct oversight of Medicaid expenditures. The section further establishes that, from FY 2006 through FY 2010, \$25 million shall be appropriated to OIG for the Medicaid

activities of OIG in addition to any other amounts appropriated or made available for Medicaid oversight. Such funds shall remain available until expended.

This section also requires OIG to submit to Congress a report that identifies the use and effectiveness of the use of such funds no later than 180 days after the end of each fiscal year.

#### **SECTION 4: HISTORY OF OIG INVOLVEMENT IN MEDICAID OVERSIGHT**

In the 10-year period from FY 1997 through FY 2006, the total Federal Medicaid expenditures increased 59 percent from \$100 billion to \$156 billion.<sup>2</sup> As funding increased, so too did the programmatic and operational complexities involved in administering the program. In response to the rapid growth in the Medicaid program, OIG has committed to effective oversight of the program through the wide range of audit, evaluation, investigative, and legal services activities it undertakes each year.

Additional information on the content and results of OIG's prior work activities related to Medicaid oversight is contained in past OIG Semiannual and HCFAC reports to Congress and the joint OIG-DOJ MFCU report. These documents are available on the OIG Web site at <http://www.oig.hhs.gov/publications.html>.

#### **SECTION 5: OIG OVERSIGHT OF THE MEDICAID PROGRAM DURING FY 2006**

This section includes information on the Medicaid oversight activities conducted by OIG during FY 2006. Many of the Medicaid enforcement actions and collections cited in this report will also be included in the total figures set forth in the OIG Semiannual and the annual HCFAC reports.

##### Audit and Evaluation Reports

During FY 2006, OIG issued 364 audit and 59 evaluation reports. Of these, 70 audits and 9 evaluations were related specifically to Medicaid. Table 2 on the following page provides a summary of the health care sectors that these audits and evaluations addressed.

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<sup>2</sup> "Table 8.6—Outlays for Mandatory and Related Programs in Constant (FY 2000) Dollars: 1962-2012." Historical Tables: Budget of the U.S. Government Fiscal Year 2008. Washington: GPO, 2007.

**Table 2: OIG’s Medicaid Audit, and Evaluation  
Reports Issued in FY 2006**

<b>Healthcare Sectors</b>	<b>Reports Issued</b>
Medicaid Services	31
Medicaid Hospitals	17
Medicaid Long Term and Community Care	9
Medicaid Information Systems Controls	8
Medicaid Drug Reimbursement	4
Medicaid/State Children’s Health Insurance Program	4
Medicaid Mental Health Services	2
Medicaid Administration	3
Medicaid Hurricane Response	1
<b>Total</b>	<b>79</b>

As a result of OIG’s FY 2006 audits and evaluations of the Medicaid program, \$503 million in costs were questioned and \$137 million in potential savings of funds put to better use were identified. Furthermore, management action on OIG recommendations, some of which were outstanding at the beginning of the FY 2006, resulted in audit disallowances of \$279 million.

A complete list of the audit and evaluation reports is contained in Appendix A of this document. The complete text of all reports, excluding the Medicaid Information Systems Controls reports, which are considered sensitive, can be accessed through the Reports section of the OIG Web site at <http://www.oig.hhs.gov/reports>. Below are highlights of the findings contained in several of these Medicaid reports.

- *Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003* – Medicaid pays for targeted case management services to assess Medicaid beneficiaries’ service needs, refer beneficiaries to needed services, and monitor the services. It does not pay for direct social services to which beneficiaries have been referred. In this review, OIG found that Massachusetts included the costs for direct social services in the rates used to claim reimbursement for targeted case management services. OIG recommended that the State refund the resulting \$87 million Federal overpayment and work with CMS to determine the allowability of the remaining \$13.5 million Federal share claimed. The \$13.5 million claimed may have already been reimbursed under other Federal programs. (A-01-04-00006)
  
- *Medicaid Upper Payment Limit Calculations in Three States* – The Federal upper payment limit is an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. As part of a series of reviews, OIG found that three States had made large Medicaid overpayments to hospitals and/or nursing facilities because the States had not calculated the upper payment limits in compliance with Federal regulations and State Medicaid plans. OIG

recommended that Alabama and New York refund a total of approximately \$69.1 million to the Federal Government and that Mississippi work with CMS to resolve approximately \$171 million in potential Federal overpayments. (A-04-03-02027; A-04-03-02025; A-02-03-01021)

- *Medicaid Hospital Outlier Payments in Four States* – Some States make outlier payments to hospitals when the cost of treating a Medicaid inpatient is extraordinarily high compared with the average cost of treating comparable conditions. As part of a series of reviews, OIG found that New York, North Carolina, Ohio, and Pennsylvania did not use accurate hospital cost-to-charge ratios to convert allowable billed charges to outlier payments. As a result, the outlier payments exceeded estimated costs. If the States had used more accurate cost-to-charge ratios, the States could have saved \$147 million in Medicaid expenditures. (A-02-04-01022; A-07-04-04038; A-05-04-00064; A-03-04-00211)
- *Medicaid Disproportionate Share Hospital Payments* – Section 1923 of the SSA requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital’s uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific DSH limit.

DSH payments to a hospital in New Jersey exceeded the hospital-specific limits by \$171.4 million (\$85.7 million Federal share). The State’s consultant erroneously included \$169.2 million in appropriations to a medical school in its calculations of the hospital’s DSH limits. This amount was not DSH-eligible and should not have been included in the DSH limit calculations. In addition, the State claimed \$2.2 million of duplicate DSH expenditures.

OIG recommended that the State refund \$85.7 million to the Federal Government, adhere to Federal law and State plan requirements when submitting future DSH claims for Federal reimbursement, and review consultants’ work to ensure the veracity of future Medicaid claims. The State partly agreed. (A-02-04-01004)

- *Medicaid School-Based Health Claims and Service Payment Rates*

*Health Claims in New Jersey* – Under Federal and State law and the Medicaid State plan, New Jersey school children who are eligible for the State’s Medicaid school-based health program must receive a health professional’s prescription or referral to receive speech, physical, or occupational therapy and nursing services. Individuals who provide such services must meet Federal qualification standards. Of New Jersey’s 150 school-based claims sampled, 109 did not comply with these requirements. Deficiencies occurred because the State did not provide guidance regarding Federal Medicaid requirements and school health providers failed to

comply with other State guidance they had received. In addition, the State did not adequately monitor school-based health claims for compliance. OIG estimated that approximately \$51 million in Federal Medicaid funding to New Jersey was unallowable.

OIG recommended that New Jersey refund the \$51 million and emphasize to school districts the need to comply with Federal and State requirements. New Jersey did not concur with OIG's financial adjustment but agreed to work with CMS concerning approximately \$1 million in set-aside claims arising from the State's lack of guidance and/or compliance. (A-02-03-01003)

*Payment Rates in Kansas* – Kansas did not develop its payment rates for Medicaid school-based health services pursuant to Federal requirements and the State plan. Kansas used incorrect indirect cost rates and service utilization data to develop the payment rates. As a result, the payments to school districts for FY 1998 through FY 2003 were incorrect and Kansas received \$18.5 million of overpayments.

OIG recommended that Kansas refund \$18.5 million to the Federal Government, calculate and refund all overpayments that occurred subsequent to the audit period, and develop and implement adequate internal controls to ensure that future Federal claims for school-based services are consistent with Federal requirements and the State plan. Kansas concurred with two of the recommendations but did not address the recommendation to calculate and refund overpayments subsequent to the audit period. (A-07-05-01018)

- *Nursing Home Emergency Preparedness and Response During Hurricanes* – Federal regulations require Medicare- and Medicaid-certified facilities to maintain written plans and procedures to meet all potential emergencies and to train employees in emergency procedures. An OIG review found that, nationwide, 94 percent of nursing homes met Federal standards for emergency plans and 80 percent for sufficient emergency training in 2004-2005. Among selected nursing homes in Gulf States affected by four recent hurricanes, however, all experienced problems whether evacuating or sheltering in place.

OIG recommended that CMS consider strengthening Federal certification standards for nursing home emergency plans by including requirements for specific elements of emergency planning, and that CMS encourage communication and collaboration between State and local emergency entities and nursing homes. CMS concurred with these recommendations and is exploring ways to strengthen Federal certification standards for emergency preparedness and to promote better coordination among Federal, State, and local emergency management entities. (OEI-06-06-00020)

- *Generic Drug Utilization in State Medicaid Programs* – Prescription drug costs are one of the largest and fastest growing Medicaid expenditures. Congress and

CMS have expressed support for using generic drugs to contain prescription drug costs. An OIG evaluation found that, in 2004, Medicaid demonstrated high utilization of generic drugs. The level of generic drug utilization was affected by how often generics were dispensed when generic substitutes were available (“generic substitution”) as well as by physicians’ prescribing habits. On average, generics were dispensed 89 percent of the time when generic substitutes were available. This compares favorably with a 90-percent private sector benchmark. However, 41 percent of prescriptions were for drugs that have no generic substitutes, limiting opportunities to dispense generics.

OIG concluded that many States may have already achieved much of the possible gains in generic utilization through increasing generic substitution. States may realize greater gains by encouraging the prescribing of drugs that have generic equivalents, rather than single-source drugs with no generic alternatives. Such efforts should be undertaken with caution to ensure that beneficiaries retain access to appropriate treatment. OIG suggested that CMS consider providing information and technical assistance to States that wish to further increase generic drug utilization. (OEI-05-05-00360)

- *Nursing Home Complaint Investigations* – The nursing home complaint process is the front-line response system for addressing problems raised by residents, their families, and nursing home staff. An OIG evaluation found that State agencies did not investigate some of the most serious nursing home complaints within the required timeframe, including 7 percent of complaints alleging immediate jeopardy and 27 percent of complaints alleging actual harm. OIG also found that CMS oversight of nursing home complaint investigations is limited. CMS conducts few Federal Oversight and Support Surveys (FOSS), which allow CMS’s regional offices an opportunity to observe a State agency’s complaint investigation process. However, CMS guidance states that State agencies should provide CMS with at least 2 weeks advance notice of scheduled surveys, thus limiting the use of the FOSS for the most serious nursing home complaints.

OIG recommended that CMS require State agencies to meet the 10-day timeframe for investigating complaints involving actual harm, increase oversight of the State agencies, and offer additional training on the ASPEN Complaints/Incidents Tracking System to its regional offices as well as to State agencies. OIG also recommended that CMS remove the 2-week advance notice period for FOSS. (OEI-01-04-00340)

### Investigations and Legal Services

In addition to conducting audits and evaluations, OIG investigates allegations of criminal and civil wrongdoing through its OI in conjunction with DOJ and conducts administrative enforcement and litigation and provides technical support through its OCIG. As a result of these activities, OIG reported over \$3 billion in monetary receivables to both Federal and non-Federal

entities in FY 2006. Of that amount, \$621 million was specifically identified as restitutions or recoveries to be returned to Federal and State Medicaid programs.

The OIG’s enforcement work and industry guidance are often designed to have broad impact on Federal health care programs. In large part, OIG’s industry outreach and enforcement efforts affect other health care programs, not just Medicaid. Table 3 presents a summary of the investigative, enforcement, and industry outreach related to Medicaid that OIG conducted during FY 2006.

**Table 3: OIG’s Medicaid-Related Investigations and Legal Services in Which There Was a Medicaid Component in FY 2006**

OIG Activity Area*	Number
Enforcement	
Medicaid Cases Worked	905
Total Medicaid Cases Opened	346
Joint Investigations Worked With State MFCUs	543
Criminal Convictions	127
Civil Actions	91
Program Exclusions – Imposed	3,425
Program Exclusions – Appeal Proceedings	96
Civil Monetary Penalty Cases	25
Emergency Medical Treatment and Labor Act – “Patient Dumping”	21
CIAs – New	97
CIAs – Monitored <sup>3</sup>	419
Outreach	
Advisory Opinions	15

\* Matters listed here are not necessarily Medicaid-specific. Many also involve fraud against other health care programs.

### **Criminal and Civil Enforcement**

In FY 2006, OIG opened 346 Medicaid-related cases for investigation of criminal or civil wrongdoing and participated in 127 successful criminal convictions and 91 civil actions.

One of the most common types of fraud perpetrated against Medicaid and other Federal health care programs involves filing false claims for reimbursement. DOJ has authority to pursue false claims through the civil FCA, but the successful resolution of such matters often involves the combined investigative efforts and resources of OIG, State MFCUs, and a variety of other law enforcement agencies.

<sup>3</sup> This number includes 17 quality-of-care CIAs representing more than 1,250 facilities funded primarily by Medicaid.

Providers that enter settlements resolving potential liability under the FCA often agree to enter CIAs with OIG to avoid program exclusions and to be permitted to continue participating in Medicaid and other Federal health care programs. Such agreements are monitored by OIG and require the providers to either create or enhance existing compliance programs. As such, the agreements may prevent or reduce fraudulent behavior in Medicaid and in other Federal health care programs in which the provider may participate.

In FY 2006, the Government's enforcement of FCA cases resulted in over \$2.7 billion in investigative receivables, representing civil and administrative settlements or civil judgments related to Medicaid and other Federal health care programs. Some successful actions as well as notable criminal enforcement actions are described below:

### Criminal Enforcement

- An oncologist in Tennessee was found guilty by a Federal jury, and was sentenced to 15 years and 8 months in jail and ordered to pay \$432,000 in restitution for her scheme to provide partial doses of medications to chemotherapy patients and for lying to a Federal agent about the scheme. An investigation and comprehensive analysis of records revealed that the oncologist billed for substantially more chemotherapy and related medications than she actually purchased from manufacturers. The oncologist instructed her staff to give patients partial doses of Procrit but to indicate on patients' charts that full doses were provided. Diluted doses of chemotherapy drugs Taxol and Camptosar were also administered to patients. This investigation involved OIG and the Tennessee MFCU.
- A physician in Texas was sentenced to 11 years and 3 months in prison and ordered to pay \$14.4 million in joint and several restitution for his role in defrauding the Medicare and Medicaid programs. Beginning in August 1999, the physician caused the submission of false claims to Medicare for physical therapy evaluations and services. As part of the scheme, the physician received payments for signing patient charts so that clinic owners could fraudulently bill Medicare and Medicaid. In 2001, the physician became involved in another scheme related to the submission of claims for services he provided to beneficiaries who were unlawfully referred to him for motorized wheelchairs. The beneficiaries were transported to his clinic for the purpose of having motorized wheelchairs authorized. The physician performed medical services, many of which were unnecessary, then prepared and signed certificates of medical necessity authorizing the motorized wheelchairs. Some beneficiaries never saw the physician or qualified for wheelchairs.

A durable medical equipment company owner involved in the above-referenced wheelchair scheme was sentenced to 5 years' and 3 months' incarceration, ordered to pay \$478,000 in restitution to the Medicaid program, and held jointly responsible for paying \$4.2 million of the joint and several restitution ruling. In addition, two individuals paid to recruit Medicare and Medicaid beneficiaries

were sentenced for their roles in the scheme. One was sentenced to 12 months and 1 day in prison, and the other was sentenced to 6 month home detention.

### Civil Enforcement

False claims submitted in violation of the FCA or Civil Monetary Penalties Law give rise to OIG's permissive exclusion authority under 42 U.S.C. §1320a-7(b)(7). As part of the resolution of these cases, OIG often negotiates compliance obligations, including CIAs, with health care providers and other entities. A provider or entity consents to these obligations in exchange for OIG's agreement not to seek an exclusion of that health care provider or entity from participation in Medicaid and other Federal health care programs. Providers who settle these cases generally deny that they were liable or that they committed the alleged conduct.

The typical term of a CIA is 5 years. Although many CIAs have common elements, each agreement addresses the specific facts of the conduct at issue and is tailored to comport with the capabilities of the provider. The agreements often attempt to accommodate and recognize many of the elements of preexisting voluntary compliance programs established by the providers. Examples of CIAs issued in FY 2006 include the following:

- Tenet Healthcare Corporation, operator of the nation's second largest hospital chain, entered into a global civil settlement to resolve a number of investigations for alleged unlawful billing practices, improper outlier payments, kickbacks, and other conduct. Tenet agreed to pay the Government \$900 million plus interest and enter into a 5-year CIA to resolve its liability under the FCA and related authorities. Over \$788 million of the settlement is attributable to claims related to outlier payments that were based on inflated charges Tenet billed for inpatient and outpatient care. More than \$47 million will resolve Tenet's liability for allegedly paying a kickback to physicians for patient referrals and for billing Medicare for services that were ordered or referred by a physician with whom Tenet had a financial relationship. Another \$46 million is attributed to allegations that in order to increase its reimbursements, Tenet submitted claims that assigned diagnosis related group (DRG) codes that were improper or were not supported by patient records, a practice known as "upcoding." Over \$10 million of the settlement amount was returned to both Federal and State Medicaid programs.

As part of the resolution of its civil and administrative liability, Tenet agreed to a 5-year CIA in September 2006. Under the CIA, Tenet will implement a comprehensive compliance program and engage independent review organizations to review its DRG claims, outlier payments, physician relationships, and clinical quality management. The CIA also includes unprecedented provisions requiring the Quality, Compliance and Ethics Committee of Tenet's Board of Directors to review the effectiveness of Tenet's compliance program.

- Serono, S.A., along with its U.S. subsidiaries, Serono, Inc., Serono Holdings, Inc., and Serono Laboratories, Inc. (collectively known as Serono), agreed to enter a

global criminal, civil, and administrative settlement that included the payment of \$704 million plus interest and a 5-year CIA. Over \$390 million of the settlement amount was returned to both Federal and State Medicaid programs. The global settlement resolved allegations that Serono engaged in the illegal promotion of its AIDS-related drug Serostim and offered and paid illegal remunerations to physicians and pharmacies to induce them to prescribe and/or purchase Serostim. The company also used an unapproved medical device as a marketing tool to diagnose AIDS-wasting syndrome, the condition that Serostim was approved to treat.

- American Healthcare Management, Inc. (AHM), its individual owners, and three affiliated nursing homes agreed to pay the Government \$1.25 million to settle allegations of submitting false and fraudulent nursing home billings to Medicare and Medicaid for poor quality of care. From January 1998 through June 2001, the Government alleged that because of staffing limitations, numerous residents of the nursing homes suffered from dehydration and malnutrition, went for extended periods of time without being cleaned or bathed, and developed preventable pressure sores. In addition, the Government alleged that instances of elopements of residents from the facilities occurred, a resident was found covered with ants, and a resident was physically abused by a staff member. As part of the settlement, AHM and the three nursing homes agreed to permanent exclusions, and the principal owner agreed to a 20-year exclusion from participation in Federal health care programs. The other owner agreed to certify annually that he had no involvement in Medicare or Medicaid, and that if he did opt to bill those programs, he would enter a CIA at that time.
- SmithKline Beecham Corporation, doing business as GlaxoSmithKline, agreed to pay the Government \$149 million plus interest to resolve its liability associated with certain pricing and marketing practices for Zofran and Kytril, two antiemetic drugs used primarily in conjunction with oncology and radiation treatment to prevent nausea. Over \$16 million of the settlement amount is expected to be returned to both Federal and State Medicaid programs. The Government alleged that during different times between 1994 and 2002, GlaxoSmithKline engaged in a scheme to set and maintain fraudulent and inflated prices for the drugs knowing that Federal health care programs, including Medicaid, established reimbursement rates based on those prices. The inflated prices were substantially higher than the prices paid by the majority of GlaxoSmithKline's customers, and the company is alleged to have used the spread between the inflated prices and actual acquisition costs in marketing and selling the drugs to customers, causing the customers to submit false and fraudulent claims. The Government also alleged that, with regard to Kytril, GlaxoSmithKline engaged in a scheme to encourage customers to pool leftover product from multiple vials of Kytril to create an extra dose of the drug. The extra doses were then allegedly administered to patients and rebilled to Federal health care programs. As part of the settlement, GlaxoSmithKline agreed to enter into a 5-year addendum to its existing CIA with OIG.

## Administrative Sanctions

### Program Exclusions

Through the legal authorities contained in sections 1128 and 1156 of the SSA, OIG established a program to exclude individuals and entities from participation in Medicaid, Medicare, and other Federal health care programs. OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities from Federal health care programs. The bases for exclusion include convictions for program-related fraud, patient abuse, State licensing board actions, default on Health Education Assistance Loans, and violation of existing CIAs. Many of these are acts committed against the Medicaid program or its beneficiaries.

During FY 2006, OIG excluded 3,425 individuals and entities from participating in Medicaid, Medicare, and other health care programs. These exclusions can have the effect of reducing potential fraud that may be committed by the excluded entities against similar Federal health care programs.

Examples of program exclusions in FY 2006 include:

- *Maryland* – A psychiatrist was excluded for a minimum of 25 years for his conviction related to a health care fraud scheme and was sentenced to 18 months’ home detention and ordered to pay \$305,000 in restitution. The psychiatrist caused an estimated loss of \$1.7 million to the Medicaid program.
- *New York* – A clinic owner/operator was excluded for a minimum of 15 years as a result of his conviction for filing false claims with the Medicaid program. The owner/operator was sentenced to 1 year in jail and ordered to pay \$245,000 in restitution.
- *Florida* – OIG excluded South Beach Community Hospital (formerly South Shore Hospital and Medical Center) from participation in Medicare, Medicaid, and other Federal health care programs. The exclusion resulted from the hospital’s material breach of the terms of a CIA that the hospital negotiated with OIG in 2002 as part of the resolution of a FCA case against the hospital. OIG determined that South Beach was in material breach for its repeated failure to submit timely, complete, and accurate required reports and its failure to implement fully the Independent Review Organization requirements of the CIA. South Beach also neglected to notify OIG, as required under the CIA, of its sale to new owners, who are also subject to the terms of the CIA. OIG determined that South Beach’s repeated and egregious failure in this case to abide by the terms of its CIA necessitated that the OIG, for the first time, seek exclusion for such a violation.

### Emergency Medical Treatment and Labor Act (42 U.S.C. §1395dd)

The Emergency Medical Treatment and Labor Act (EMTALA) requires of all hospitals that receive Federal funding through Medicaid and other Federal health care programs that “if any

individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility.” This statute is designed to ensure patient access to appropriate emergency medical services regardless of the patient’s health insurance coverage status.

In FY 2006, OIG collected \$680,000 in civil monetary penalties, representing collections from 19 hospitals and one physician under EMTALA. The following are examples of settlements involving alleged violations of that statute:

- Citizens Memorial Hospital (CMH), Missouri, agreed to pay \$75,000 to resolve its liability for civil monetary penalties under EMTALA. OIG alleged that CMH failed to provide appropriate medical screening examinations to three patients who went to CMH’s emergency department with various medical conditions, including a baby with life-threatening acute bronchitis and exacerbated asthma; a woman whose intestines were protruding from a loose C-section incision; and a teenage boy who complained that he could not move, stand, walk, or feel his limbs.
- Poudre Valley Health System, Poudre Valley Hospital (PVH), Colorado, agreed to pay \$55,000 to resolve its liability for civil monetary penalties under the patient dumping statute. OIG alleged that PVH failed to transport to its emergency department and failed to provide an appropriate medical screening examination to a deaf, nonverbal, and developmentally disabled male. Two days after being turned away, the man died at home of hypovolemic shock caused by gastritis with erosion, ulcers, and gastric hemorrhage.

### **Medicaid Fraud Control Units**

In addition to conducting its audits, evaluations, investigations and providing legal services, OIG is also responsible for oversight of Federal grants to State MFCUs. In FY 2006, OIG oversaw the distribution of \$159 million to MFCUs in 48 States and the District of Columbia. During this same time period, OIG participated in 536 joint investigations with MFCUs and opened 345 investigations into potential fraud involving the Medicaid program.

OIG has an additional responsibility to oversee MFCUs. Section 1902(a)(61) of the SSA, as amended by section 13625 of the Omnibus Budget Reconciliation Act of 1993, required OIG to develop performance standards for assessing MFCUs. The standards are to assess the effectiveness and efficiency of MFCUs and enable OIG to determine whether the MFCUs are carrying out their duties and responsibilities in an effective manner and in accordance with applicable law. These standards were created in consultation with the MFCU community and made effective on September 26, 1994. In FY 2006, OIG conducted 12 onsite reviews of MFCUs.

## **Outreach**

### Joint Audits of Medicaid – Federal and State Partnership

OIG works closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster joint reviews and provide broader coverage of the Medicaid program. Since its inception, the partnership approach has ensured more effective use of scarce audit resources by both the Federal and the State audit sectors in 25 States.

Reports issued to date have resulted in identification of more than \$263 million in Federal and State savings and have led to joint recommendations for savings and improvements in internal controls and computer systems operations at the Federal and State levels.

### Advisory Opinions

In accordance with section 205 of HIPAA, OIG, in consultation with DOJ, issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. This authority allows OIG to provide case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse authorities.

In Advisory Opinion 06-15, OIG considered an agreement between a corporation (Requestor) and a State Medicaid agency (the Agency), under which Requestor would develop and implement a disease management program that included “pay-for-performance” payments to physicians. For Requestor to comply with State law, the Agency required that Requestor disburse the incentives to Medicaid providers participating in the program in the form of checks drawn on a bank account owned by Requestor. Despite the appearance that Requestor was making payments to physicians by issuing pay-for-performance program checks drawn on Requestor’s bank account, OIG found that Requestor’s duties as a payment administrator for the Agency’s pay-for-performance program did not implicate the anti-kickback statute because the payments were not made with Requestor’s money and Requestor did not have control or discretion over the payments. Moreover, because the payments did not reflect the use of Requestor’s products or services, Requestor was not using another party’s funds to disguise payments for referrals.

In Advisory Opinion 06-06, OIG evaluated a city’s request for proposal (RFP) concerning emergency ambulance services in the city. The city required each bidder to propose a per response payment to the city for each call in which the city provided first responder services. Under the RFP, the successful bidder agreed to charge uninsured city residents for only basic life support and transportation services and also agreed to replenish without charge certain supplies used by the city in providing first responder services. OIG determined that although the proposed arrangement could implicate the anti-kickback statute, OIG would not impose sanctions because the arrangement was only one part of a comprehensive regulatory scheme to manage emergency medical services; it was established pursuant to an open and competitive bidding process; it would only partially reimburse the city for its costs; and the compensation would inure to the public benefit. In addition, OIG noted that the proposed arrangement did not

pose an increased risk of overutilization or increased costs to Federal health care programs because ambulance services are paid by Medicare and Medicaid based on fee schedules, and the successful bidder remained obligated to bill for such services in accordance with applicable payment and coverage rules.

#### Other OIG Activities Enhancing Medicaid Integrity

OIG has undertaken a diverse array of other activities to enhance its capacity to fight fraud, waste, and abuse in Medicaid and develop the capacity of its Federal and State partners in conducting their Medicaid oversight responsibilities. Specifically, during FY 2006, OIG:

- Cosponsored a conference with DOJ’s Office of Legal Education on Medicaid fraud enforcement entitled “HHS Seminar on Strengthening OIG Response to Medicaid Fraud – Developing Successful Investigations.” The conference was designed for Federal agents and attorneys with backgrounds in health care fraud and included 130 attendees and speakers from OIG, the Government Accountability Office (GAO), MFCUs, State Attorneys General, U.S. Attorney’s Offices, and DOJ.

Seminar topics included:

- Medicaid Vulnerabilities – The GAO Perspective,
  - Federal and State False Claims Acts,
  - Investigative Tools,
  - Drug Diversion,
  - Kickbacks,
  - Case Resolution,
  - Challenges to Collaboration: A Panel Discussion,
  - Nursing Home Fraud: Financial Fraud and Failure of Care,
  - Trying a Fraud Case: Lessons Learned; Home Health Care Fraud,
  - Medical Transportation Fraud,
  - Hospital Medicaid Fraud, and
  - Pharmaceutical Cases.
- Established an OIG MIP workgroup to plan OIG’s Medicaid oversight work and coordinate with CMS on matters of mutual interest. The group meets with the CMS Medicaid Integrity Group at least once each month to strengthen existing relationships, improve coordination and collaboration efforts between OIG and CMS, and offer technical assistance to the CMS Medicaid Integrity Group.

## **SECTION 6: MEDICAID OVERSIGHT IN FY 2007 AND BEYOND**

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At the beginning of each fiscal year, OIG publishes its Work Plan to highlight the areas in which the office expects to conduct oversight work during the coming year. In addition to being a planning document, the work plan also serves as a method for focusing public attention on the areas deemed important and identified as particularly vulnerable to fraud, waste, and abuse.

Throughout the course of each fiscal year, the OIG work actually undertaken changes as a result of a number of factors. Some activities announced in the Work Plan may shift from high to low priority or may be postponed until future years as a result of the changing focus of Congress, the Secretary, OIG, or an intervening emergency or in response to trends identified in other related work. As such, OIG's work planning is an evolving process that enables OIG to remain adaptable to the changing priorities of its stakeholders.

Appendix B of this report identifies more than 80 new Medicaid audits and evaluations that OIG anticipates undertaking during FY 2007 in addition to those activities that were undertaken but not completed in prior fiscal years. Although most Work Plan items will be initiated in FY 2007, many will not be completed within the fiscal year. Some of these reviews increase the scope and depth of prior OIG work by conducting follow-up activities; others expand into new and emerging areas of interest. Detailed summaries of OIG's anticipated work activities for FY 2007 can be found in the OIG Work Plan, which is located in the Publications section of the OIG Web site at <http://www.oig.hhs.gov/publications>.

In addition to conducting the activities contained in the FY 2007 Work Plan, OIG will continue to undertake investigations of allegations of criminal and civil wrongdoing committed against the Medicaid program along with other activities focused on enhancing Medicaid enforcement and fraud prevention. These activities include the following:

- A nationwide MFCU outreach, coordination, and training initiative. The initiative is an ambitious plan to bring together senior leadership and investigators from OIG, CMS, and State MFCUs to build on existing relationships and optimize the joint investigative potential and utilization of review in the Medicaid program. OIG is planning meetings in New York, Boston, Dallas, Philadelphia, and Atlanta during FY 2007.

The meetings will span 2 to 3 days and involve a number of presentations from OIG, State MFCU directors, and CMS representatives involved with the Medicaid Integrity Group, Medicare-Medicaid data match program (Medi-Medi), and Medicare Part D. The meetings will be organized so that Federal and State investigators can share best practices from casework examples to increase their awareness of successful investigative techniques and identify areas where partnership and collaboration can enhance the quality and efficiency of investigations.

In FY 2008, OIG plans to expand this outreach effort to additional State partners nationwide.

- OIG plans to begin working with CMS, State MFCUs, and the National Association for Medicaid Program Integrity to improve the capacity of the three organizations to make proper referrals based on a shared understanding of the elements of successful investigations.
- OIG will conduct its biannual training conferences to help the MFCUs meet their training needs. The purpose of these training conferences is to provide guidance on issues and concerns that relate directly to the oversight responsibilities of OIG. Topics such as OIG's Federal oversight role, Federal reporting requirements, and budget administration will be addressed during the conferences. The FY 2007 training will take place in Chicago, Illinois, from July 30 through August 2, 2007.

Together, the varied and far-reaching activities that OIG undertakes each year position the Federal Government to better monitor the integrity of funds appropriated to HHS for the operation of Medicaid and more than 300 other departmental programs. In so doing, OIG serves Congress, the Department, and the American public by improving the solvency of all Government-sponsored health and human services programs.

## **Appendix A: List of Audits and Evaluations of Medicaid in FY 2006**

The following section contains report titles and reference numbers for OIG's Medicaid-related audit and evaluation reports issued during FY 2006. The full reports are available on the OIG website at <http://www.oig.hhs.gov>.

### **Medicaid Hospitals**

Review of Medicaid Support for Graduate Medical Education in Minnesota During Fiscal Year 2000 (A-05-04-00071)

Medicaid Graduate Medical Education in Texas (A-06-06-00027)

Review of Medicaid Support for Graduate Medical Education in Iowa (A-07-04-03055)

Review of Medicaid Support for Graduate Medical Education in Ohio During Fiscal Year 2000 (A-05-05-00032)

Review of Medicaid Support for Graduate Medical Education in the State of Michigan (A-05-05-00018)

Review of Medicaid Disproportionate Share Hospital Payments to University Hospital, University of Medicine and Dentistry of New Jersey: July 1, 1995, Through June 30, 2001 (A-02-04-01004)

Medicaid Hospital Outlier Payments in New York for State Fiscal Years 1998 Through 2002 (A-02-04-01022)

Medicaid Outlier Payments at Inpatient Hospitals in Texas (A-06-04-00051)

Review of Georgia's Medicaid Cost Outlier Payments (A-04-04-00009)

Review of Ohio's Medicaid Hospital Outlier Payments for State Fiscal Years 2000 Through 2003 (A-05-04-00064)

Medicaid Hospital Outlier Payments in North Carolina for State Fiscal Years 1998 Through 2002 (A-07-04-04038)

Audit of New York State's Medicaid Upper Payment Limits for Non-State Government Inpatient Hospitals and Nursing Homes (A-02-03-01021)

Review of Alabama's Medicaid Upper Payment Limit Calculations for Hospitals and Nursing Facilities (A-04-03-02027)

Review of Mississippi's Medicaid Upper Payment Limit Calculations for Hospitals and Nursing Facilities (A-04-03-02025)

Review of the Methodology for Calculating the Upper-Payment-Limit for Inpatient Hospitals by the Massachusetts Office of Medicaid for State Fiscal Year 2003 (A-01-03-00009)

Medicaid Hospital Outlier Payments in Pennsylvania for State Fiscal Years 1998-1999 Through 2002-2003 (A-03-04-00211)

Audit of Selected States' Medicaid Disproportionate Share Hospital Programs (A-06-03-00031)

### **Medicaid Long Term and Community Care**

Review of Durable Medical Equipment Providers' Medicaid Claims for Residents of Assisted Living Programs (A-02-05-01017)

Medicaid Payments for Beneficiaries With Concurrent Eligibility in Michigan and Ohio - Michigan Department of Community Health (A-05-06-00020)

Medicaid Payments for Beneficiaries with Concurrent Eligibility in Ohio and Michigan, Ohio Department of Job and Family Services (A-05-06-00021)

Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003 (A-01-04-00006)

Review of Medicaid Claims for Assisted Living Program Beneficiaries Who Are Hospitalized (A-02-05-01003)

Audit of Hawaii's Medicaid Expenditures for Nursing Facility Services for the Period July 1, 2003, Through June 30, 2004 (A-09-05-00058)

Nursing Home Enforcement: Application of Mandatory Remedies (OEI-06-03-00410)

Nursing Home Enforcement: State Compliance With Referral Requirements (OEI-06-03-00400)

Nursing Home Enforcement: Complaint Investigations (OEI-01-04-00340)

### **Medicaid Mental Health Services**

Review of Medicaid Community Mental Health Provider Services in Illinois (A-05-05-00055)

Review of Kansas's Mental Health Center Medicaid Administrative Cost for the Quarters Ended December 31, 2002, and March 31, 2003 (A-07-05-03063)

## **Medicaid/State Children's Health Insurance Program**

Review of Medicaid Claims Made by Lake Grove Schools in New York (A-02-06-01001)

Resolution of Audit Findings on States' Beneficiary Eligibility Determinations for Medicaid and the State Children's Health Insurance Program (A-07-06-03073)

Review of the Adequacy of New Jersey Controls for Preventing Duplicate Medicaid and State Children's Health Insurance Program Payments (A-02-04-01011)

Determining If Children Classified as SCHIP Medicaid Expansion Meet Eligibility Criteria (OEI-07-03-00221)

## **Medicaid Drug Reimbursement**

Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005 (A-06-06-00063)

Follow-up Audit of the Medicaid Drug Rebate Program in Colorado (A-07-05-04048)

Dual Eligibles' Transition: Drug Access Under Prescription Drug Plans' Formularies (OEI-05-06-00090)

Generic Drug Utilization in State Medicaid Programs (OEI-05-05-00360)

## **Medicaid Services**

Review of Medicaid School-Based Services in Kansas - Bundled Rate Development (A-07-05-01018)

Medicaid School-Based Services in Kansas - Adjustment of the Bundled Rates (A-07-06-01030)

Review of Medicaid Claims for School-Based Health Services in New Jersey (A-02-03-01003)

Review of School-Based Health Services in Kansas (A-07-03-00155)

Review of Medicaid School-Based Services in Kansas – Application of Bundled Rates (A-07-04-01003)

Review of Family Planning Service Costs Claimed by Pennsylvania's Medicaid Managed Care Program (A-03-03-00214)

Review of Family Planning Service Costs Claimed by Delaware's Medicaid Managed Care Program (A-03-03-00220)

Audit of Vermont's Medicaid Payments for Family Planning Services Reimbursed at Enhanced Rates for the Period October 1, 2003 Through September 30, 2004 (A-01-05-00002)

Audit of Medicaid School-Based Services in Texas (A-06-02-00047)

Review of Vermont's Accounts Receivable System for Medicaid Provider Overpayments (A-01-06-00002)

Review of Administrative Costs for Community Mental Health Centers in Indiana (A-05-04-00081)

Review of Medicaid School-Based Administrative Costs in Minnesota From July 1, 2003, Through June 30, 2004 (A-05-05-00040)

Review of Arkansas's Reporting of Medicaid Overpayments Collected by Contractors (A-06-06-00023)

Review of The Maine Claims Management System (A-01-05-00007)

Missouri Medicaid Payments for Skilled Professional Medical Personnel (A-07-05-03066)

Audit of the Kentucky Medicaid Agency's Buy-In of Medicare Parts A and B (A-04-05-03003)

Review of Louisiana's Accounts Receivable System for Medicaid Provider Overpayments (A-06-06-00036)

Audit of Illinois' Medicaid Payments for Skilled Professional Medical Personnel for the Period October 1, 2003 Through September 30, 2004 (A-05-05-00051)

Nebraska Medicaid Payments for Skilled Professional Medical Personnel (A-07-05-03067)

Review of Texas's Accounts Receivable System for Medicaid Provider Overpayments (A-06-05-00041)

Iowa Medicaid Payments for Skilled Professional Medical Personnel (A-07-05-03062)

Review of University of Massachusetts Administrative Cost Claims Under the Medicaid Program for the Period From July 1, 2002 Through June 30, 2004 (A-01-04-00012)

Review of Montana's Accounts Receivable System for Medicaid Provider Overpayments for the Period October 1, 2002, Through September 30, 2004 (A-07-05-03064)

Review of Medicaid Administrative Costs Claimed Through Maryland's Statewide Cost Allocation Plan (A-03-05-00202)

Review of Arkansas's Accounts Receivable System for Medicaid Provider Overpayments (A-06-05-00039)

Review of New Jersey's System for Medicaid Provider Overpayments (A-02-04-01009)

Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services (A-06-02-00051)

Review of Florida's Accounts Receivable System for Medicaid Provider Overpayments (A-04-03-06003)

Review of Hawaii's Medicaid Management Information System Expenditures for the Period July 1, 2002, Through December 31, 2004 (A-09-05-00052)

Audit of Ohio's Medicaid Payments for Skilled Professional Medical Personnel for the Period October 1, 2002 Through September 30, 2003 (A-05-04-00078)

Review of Medicaid Provider Overpayments in North Dakota (A-07-05-03065)

### **Medicaid Administration**

Audit of Selected States' Medicaid Payments for Services Claimed To Have Been Provided to Deceased Beneficiaries (A-05-05-00030)

Factors Impacting Referral of Suspected Medicaid Fraud Cases: State Medicaid Agency and Medicaid Fraud Control Unit Experiences (OEI-07-04-00180)

Review of the Centers for Medicare and Medicaid Services' Medicaid Financial Management Oversight (OEI-06-04-00480)

### **Medicaid Information Systems Controls**

Information System Controls Over Medicaid Claims Processing - Florida (A-04-04-05010)

Information System Controls Over Medicaid Claims Processing - Louisiana (A-06-05-00030)

Information System Controls Over Medicaid Eligibility - Louisiana (A-06-05-00031)

Information System Controls Over Medicaid Claims Processing - Oklahoma (A-06-06-00024)

General Controls for Medicaid Claims Processing - Colorado (A-07-05-02706)

General Controls for Medicaid Eligibility - Colorado (A-07-05-02707)

General Controls for Medicaid Claims Processing - California (A-09-04-00045)

General Controls for Medicaid Claims Processing - Oregon (A-09-05-00078)

**Medicaid Hurricane Response**

Nursing Home Emergency Preparedness and Response During Recent Hurricanes  
(OEI-06-06-00020)

## **Appendix B: List of Planned Medicaid Work From the FY 2007 OIG Work Plan**

The following section contains Medicaid-related audit and evaluation work that OIG plans to conduct during FY 2007. For access to the summaries of the objectives of each report please visit the Publications section of the OIG website at <http://www.oig.hhs.gov>.

### **Medicaid Hospitals**

Hospital Outlier Payments (OAS; W-00-04-31069; W-00-05-31069)

Disproportionate Share Hospital Payments  
(OAS; W-00-04-31001; W-00-05-31001; W-00-05-39023)

Hospital Eligibility for Disproportionate Share Hospital Payments (OAS; W-00-05-31084)

### **Medicaid Long Term and Community Care**

Billing for Medicaid Nursing Home Patients Transferred to Hospitals (OAS; W-00-07-31201)

Community Residence Claims (OAS; W-00-07-31087)

Assisted Living Facilities (OAS; W-00-04-31076; W-00-05-31076)

Targeted Case Management (OAS; W-00-05-31082; W-00-06-31082)

Home and Community Based Services Administrative Costs (OAS; W-00-03-39003; W-00-04-39003; A-04-03-03025; A-04-03-03026; A-04-04-04006)

Home and Community Based Services: Erroneous Medicaid Payments After a Beneficiary's Death (OEI; 00-00-00000)

Home and Community Based Services: Erroneous Medicaid Payments During a Beneficiary's Institutionalization (OEI; 00-00-00000)

Medicaid Payments for Medicare-Covered Home Health Services (OEI; 07-06-00641)

### **Medicaid Mental Health Services**

Community Mental Health Centers (OAS; W-00-04-39020; W-00-05-39035; W-00-05-31099)

Medicaid Supplemental Mental Health Payments to Prepaid Inpatient Health Plans  
(OAS; W-00-06-31098; A-07-06-04067)

Medicaid Outpatient Mental Health Services: Appropriateness of Payments  
(OEI; 00-000-00000)

Restraint and Seclusion in Children's Psychiatric Residential Treatment Facilities  
(OEI; 00-00-00000)

Early and Periodic Screening, Diagnostic and Treatment of Mental Health in Medicaid Managed Care Plans (OEI; 00-00-00000)

Medicaid Outpatient Mental Health Services That Exceed State Utilization Criteria  
(OEI; 07-06-00390)

### **Medicaid/State Children's Health Insurance Program**

Detecting and Investigating Fraud and Abuse in State Children's Health Insurance Programs  
(OEI; 06-04-00380)

Accuracy of State Children's Health Insurance Program Enrollment Data (OEI; 00-00-00000)

### **Medicaid Prescription Drugs**

Review of the Average Manufacturer Price (OAS; W-00-07-31202)

Review of CMS's Oversight of the Medicaid Drug Rebate Program (OAS; W-00-07-31203)

Pharmacies' Ability To Purchase Drugs at Average Manufacturer Price (OAS; W-00-07-31204)

Drug Rebate Reviews in States (OAS; W-00-07-31205)

Medicaid Drug Rebates—Computation of Average Manufacturer Price and Best Price  
(OAS; W-00-03-31042)

Indexing the Generic Drug Rebate (OAS; W-00-04-31073)

Examining Fluctuations in Average Manufacturer Prices (OEI; 03-06-00350)

States Use of New Drug Pricing Data in the Medicaid Program (OEI; 03-06-00490)

Overprescribing of OxyContin and Other Prescription Drugs (OAS; W-00-06-31075)

Zero Dollar Unit Rebate Amounts (OAS; W-00-07-31106)

Dispute Resolution in the Medicaid Prescription Drug Rebate Program (OEI; 00-00-00000)

Medicaid Prescription Drug Program: Impact of Unit of Measure Inconsistencies  
(OEI; 05-07-00050)

Potential Medicaid Savings From Timely FDA Approval of Generic Drugs (OEI; 04-06-00600)

Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program  
(OEI; 03-06-00400)

### **Medicaid Services**

Family Planning Services (OAS; W-00-04-31078; W-00-05-31078; W-00-06-31078)

Medicaid Payments for Transportation Services (OAS; W-00-06-31121; OEI-00-00-00000)

Improper Pediatric Dental Medicaid Payments (OEI; 04-04-00210)

Medicaid Laboratory Tests (OAS; W-00-07-31206)

School-Based Health Services (OAS; W-00-03-31050; W-00-03-31061; W-00-04-31051;  
W-00-04-31062; W-00-05-31017; W-00-06-39002; W-00-06-31017; W-00-05-39024; W-00-05-  
39041)

Adult Rehabilitative Services (OAS; W-00-03-31028)

Medicaid Adult Day Health Service Payments for Ineligible and Absent Beneficiaries  
(OEI; 00-00-00000)

Outpatient Alcoholism and Substance Abuse Services (OAS; W-00-07-31079)

Freestanding Inpatient Alcoholism Providers (OAS; W-00-06-31107)

Medical Services for Undocumented Aliens (OAS; W-00-06-31108)

Inappropriate Medicaid Payments for Personal Care Services  
(OEI; 07-06-00620; OAS; W-00-05-31035)

Medicaid Payments for Therapy Services (OEI-00-00-00000)

States' Provider Safeguards for Medicaid Personal Care Services (OEI-07-05-0250)

### **Medicaid Administration**

Contingency Fee Payment Arrangements (OAS; W-00-04-31045; W-00-05-31045;  
W-00-06-31045)

Usefulness of Medicaid Statistical Information (MSIS) Data for Combatting Medicaid Fraud, Waste, and Abuse (OEI-00-00-0000)

Upper Payment Limits – Flow of Funds (OAS; W-00-07-31207)

Medicaid Payments for Services Provided Under Section 1115 Demonstration Projects (OAS; W-00-07-31208)

Medicaid Payments for Services Provided Under Section 1915(b) Managed Care/Freedom of Choice Waivers (OAS; W-00-07-31125; OEI; 00-00-00000)

Medicaid Payments for Services Provided Under Section 1915(c) Home and Community Based Service Waivers (OAS; W-00-06-39045; W-00-06-31124; OEI; 00-00-00000)

Identification of Potential Abusive Claims Volumes (OAS; W-00-07-31209)

Medicaid Payments Made for Ineligible Managed Care Members (OAS; W-00-07-31212)

Medicaid Third-Party Liability (OAS; W-00-07-31213; A-06-07-00000)

Additional Medicaid Payments to High-Volume Providers (OAS; W-00-07-31214; A-06-07-00000)

Medicaid Administrative Charges by Other State Agencies (OAS; W-00-07-31215)

Medicaid Provider Tax Issues (OAS; W-00-04-39019; W-00-06-39019; W-00-06-31094)

State-Employed Physicians and Other Practitioners (OAS; W-00-04-31081; W-00-06-31081; W-00-06-39030)

Skilled Professional Medical Personnel (OAS; W-00-05-31077; W-00-06-31077)

Physician Assistant Reimbursement (OAS; W-00-07-31089)

Medicaid and State Children’s Health Insurance Program Payment Error Rate Measurement (OAS; W-00-07-31216)

Medicaid Accounts Receivable (OAS; W-00-04-31047; W-00-05-31047; W-00-06-31047)

Impact on the Medicaid Program of Certified Public Expenditures (OAS; W-00-06-31110)

Edits on Medicaid Payment (OAS; W-00-07-31111)

Medicaid Asset Transfers and Estate Recovery Provision for Nursing Home Care (OAS; W-00-06-31113)

Medicaid Payments for County Administrative Services (OAS; W-00-05-39025; W-00-05-39026; W-00-05-39037)

Medicaid Buy-In (OAS; W-00-05-39027; W-00-07-00000)

Medicaid Eligibility in Multiple States (OAS; W-00-06-31114)

Medicaid Administrative Costs (OAS; W-00-06-39044; W-00-06-31123)

Potential Medicaid Savings for Medical Equipment (OEI; 04-05-00290)

Payments to Medicaid Durable Medical Equipment Providers (OEI; 04-06-00480)

Medicaid Fee-for-Service Payments for Beneficiaries Enrolled in Managed Care (OEI; 07-05-00320)

OIG Exclusions Program – State Referrals to the Office of Investigations (OEI; 01-06-00300)

Medicaid and SCHIP Eligibility Determinations (OAS; W-00-05-31100; W-00-06-31100)

Medicaid Encounter Data: Completeness and Accuracy of Medicaid Managed Care Encounter Data (OEI; 07-06-00540)

Ensuring External Quality Review Organizations Meet Federal Requirements (OEI; 01-06-00510)

Medicaid Provider Enrollment Safeguards: Medicaid Equipment Providers (OEI-04-05-00180)

Suspected Medicaid Fraud Referrals (OEI-07-04-00181)

### **Medicaid Information Systems Controls**

Review of CMS Compliance With FISMA for FY 2007 (OAS; W-00-07-41020)

Health Information Technology in Medicare and Medicaid – Privacy and Security Issues (OAS; W-00-04-41021)

State-Based Controls Over Medicaid Payments and Program Eligibility (OAS; W-00-04-40019; W-00-07-00000)

Oversight of System Conversions, Redesigns, and Transitions of State Medicaid Management Information Systems (OAS; W-00-07-41027)

Medicaid Management Information System – Business Associate Agreements (OAS; W-00-04-41028)

Security Planning for CMS Systems Under Development (OAS; W-00-06-41001)

Duplicate Payments for Medicaid Services (OAS; W-00-06-31109)

**Medicaid Hurricane Response**

Medicaid Services and Payments Under Hurricane Katrina Waivers (OEI; 05-06-00140)

Hurricane Katrina – Duplicate Medicaid Payments to Providers (OAS; W-00-06-31117)

Hurricane Katrina – Medicaid Payments for Evacuees (OAS; W-00-07-31216)

Hurricane Katrina – Uncompensated Care Costs (OAS; W-00-07-31219)

Hurricane Katrina – Duplicate Medicaid Payments to Managed Care Organizations  
(OAS; W-00-07-31217)