

**Use of Funds Appropriated
to the Office of Inspector General
for Medicaid-Related Program Integrity Activities**

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**U.S. Department of Health and Human Services
Office of Inspector General**

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Use of Funds Appropriated to the Office of Inspector General for Medicaid-Related Oversight and Program Integrity Activities

INTRODUCTION

This document summarizes Medicaid-related oversight and program integrity activities of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) during fiscal year (FY) 2008 and includes an overview of Medicaid-related work that OIG anticipates undertaking during FY 2009 and beyond.

BACKGROUND

Office of Inspector General Mission and Organization

OIG's operational mission is to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws. OIG carries out its mission by conducting audits, evaluations, and investigations; providing guidance to industry; and, when appropriate, imposing civil monetary penalties (CMP), assessments, and administrative sanctions. OIG works closely with HHS and its Operating and Staff Divisions; the Department of Justice (DOJ); and other agencies in the executive branch, Congress, and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds.

OIG is organized into six components, which carry out OIG's mission and support functions: the Office of Audit Services, Office of Investigations, Office of Evaluation and Inspections, Office of Counsel to the Inspector General, Office of Management and Policy, and Immediate Office of the Inspector General. OIG is headquartered in Washington, DC, and has a nationwide network of approximately 90 regional and field offices with almost 80 percent of its staff working outside Washington, DC.

Office of Inspector General Resources

Funding Sources. Funding for OIG derives from multiple sources, including a single discretionary appropriation¹ and multiple statutory funding streams provided through other legislation. The discretionary appropriation represents approximately 20 percent of OIG's total annual funding, while separate statutory funding streams that are mandated for OIG's oversight of Medicare and Medicaid provide approximately 80 percent. Accordingly, OIG's annual budget is devoted largely to oversight of Medicare and Medicaid because of statutory mandates.

¹ OIG refers to its annual appropriation, made as part of the overall appropriation for HHS, as its "discretionary appropriation." This is distinguished from the permanent appropriation for the Health Care Fraud and Abuse Control Program (HCFAC) contained in section 1817(k) of the Social Security Act (our "HCFAC funds") and other funds appropriated by Congress in other legislation for specified purposes.

Statutory Funding Streams. The separate statutory funding streams generally mirror HHS's budget; for FY 2009, funds for Medicare and Medicaid are estimated to constitute about 85 percent² of HHS's total outlays. In FY 2008, OIG's statutory funding streams provided approximately \$195 million³ for overseeing the integrity of an estimated \$595 billion⁴ in Medicare and Medicaid mandatory program outlays. For FY 2008, the two statutory funding streams were the HCFAC program created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Medicaid Integrity Program (MIP) created by the Deficit Reduction Act of 2005 (DRA).

- *Health Care Fraud and Abuse Control Program.* The HCFAC program was established by the HIPAA to be under the joint direction of the Attorney General and the Secretary of HHS, acting through the HHS Inspector General. Monies are appropriated from the Medicare Trust Fund in amounts that the Secretary of HHS and Attorney General jointly certify as necessary to finance antifraud activities, up to ceilings fixed by the legislation. Certain of these funds are, by law, set aside for OIG "activities . . . with respect to Medicare and Medicaid."⁵ The HIPAA also requires the Attorney General and the Secretary of HHS to submit a joint annual report to Congress identifying expenditures and accomplishments under the law (Social Security Act, § 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>.

Since FY 1997, the HCFAC has been the primary source of funding for Medicare and Medicaid fraud investigations and prosecutions by both OIG and DOJ.

- *Medicaid Integrity Program.* The DRA established the MIP, through which OIG receives enhanced funding for fraud and abuse control activities "with respect to the Medicaid program" (section 6034(c) of the DRA). This funding is to be provided annually from FY 2006 through FY 2010 in addition to OIG's HCFAC resources and is available until expended. Specific DRA requirements that pertain to OIG are described in Appendix A.

² U.S. Department of Health and Human Services Budget in Brief FY 2009, p. 1.

³ Office of Inspector General Justification of Estimates for FY 2009, enacted amounts, p. 9.

⁴ U.S. Department of Health and Human Services Budget in Brief FY 2009, p. 13.

⁵ The Social Security Act, § 1817(k)(3)(A).

**Allocation of Statutory Funding Streams for
Medicaid Integrity Oversight, FY 2005 –FY 2008**

(Dollars in Millions)

Fiscal Year	Statutorily Mandated Funding Provided to OIG for Health Care Oversight		Estimated OIG Obligations for Medicaid Oversight		Estimated Total OIG Obligations for Medicaid Oversight	Estimated Percentage of OIG Health Care Oversight Obligations for Medicaid Integrity ⁶
	HIPAA/HCFAC	DRA/MIP	HCFAC	MIP ⁷		
2005	160	–	36.8	–	36.8	23 %
2006	160	25	44.8	–	44.8	28 %
2007	165.9	25	24.6	24.8	49.4	26 %
2008	169.7	25	32.5	28.3	60.8	31 %

Note: Numbers are approximate because of rounding.

As illustrated in the preceding table, a sizeable portion of OIG’s HCFAC funds has been used for Medicaid oversight in recent years.

Because there is an overlap among the activities funded by the HCFAC, MIP, and other sources, OIG work activities relating to Medicaid may draw on funding from more than one source. For investigations and subsequent prosecutions, it is particularly difficult (sometimes impossible) to accurately segregate enforcement activities by funding stream. For example, even if OIG conducts a given investigation exclusively with MIP funds, the subsequent prosecution of that case could draw upon DOJ’s own HCFAC money, and the matter would be reportable pursuant to the requirements of both the HCFAC and MIP programs. An overlap could also occur 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 document does not artificially divide accomplishments between the funding sources; OIG’s Medicaid successes are typically the result of the combined funding from available resources.

In addition, OIG’s audit, evaluation, and investigation work often requires more than 1 year to yield results. As a consequence, many of the accomplishments summarized in this document reflect the results of OIG work performed over several years that culminated in FY 2008.

OVERSIGHT DURING FISCAL YEAR 2008

This section highlights OIG’s Medicaid-related oversight and program integrity activities conducted during FY 2008, much of which has been described in OIG’s “Semiannual Reports to Congress.” Many of the Medicaid enforcement actions and collections cited in this document will also be included in the total figures set forth in OIG’s annual State Medicaid Fraud Control

⁶ Figures given for FYs 2008 and 2009 are estimated percentages of the combined HIPAA/HCFAC and DRA/MIP funding streams.

⁷ OIG began FY 2007 with \$25 million of unspent MIP funds that were appropriated during FY 2006. These funds are being used to fund OIG’s continued Medicaid oversight from FY 2007 through FY 2010.

Unit (MFCU) report and the joint OIG-DOJ annual HCFAC report. When published, these reports will be made available on OIG's Web site at: <http://www.oig.hhs.gov/publications.asp>.

Medicaid-Related Audits and Evaluations

As a result of audits and evaluations of the Medicaid program in FY 2008, OIG questioned \$610.6 million in costs and identified \$1.02 billion in funds that could be put to better use. Furthermore, management action on OIG's Medicaid-related recommendations resulted in audit disallowances of \$662.1 million (Federal share).

Appendix B of this document contains a list of OIG's audits and evaluations related to Medicaid that were completed in FY 2008. Any publicly available reports published as a result of these reviews can be accessed through the "Reports" section of OIG's Web site at <http://www.oig.hhs.gov/reports.asp>. Below are highlights of the findings from several of the Medicaid reviews listed in Appendix B.

Generic Drug Price Increases. Our review of the Medicaid drug rebate program found that, from 1991 through 2004, the program could have received \$966 million in additional rebates for the top 200 generic drugs ranked by Medicaid reimbursement if a rebate provision that applies to brand-name drugs had been extended to generic drugs. For covered outpatient drugs to be eligible for Federal Medicaid funding, manufacturers must enter into rebate agreements with the Centers for Medicare & Medicaid Services (CMS) and pay quarterly rebates to the States. Manufacturers are required to pay an additional rebate when the average manufacturer price (AMP) for a brand-name drug increases by more than a specified inflation factor. There is no similar inflation-based rebate provision for generic drugs. The President's budget request for FY 2001 sought extension of the rebate provision to generic drugs, but the proposal has not been adopted. In response to our recommendation to consider seeking legislative authority to extend the additional rebate provisions to generic drugs, CMS agreed to do so once it had sufficient time to assess the impact of recent changes to the Medicaid prescription drug program required by the DRA. (A-06-07-00042)

Unit of Measure Inconsistencies in the Medicaid Prescription Drug Program. In our review of the impact of unit of measure inconsistencies on Medicaid rebate claims, we identified \$11.8 million in inappropriately claimed Medicaid rebates during the first 6 months of 2006. The method for defining units determines the number of units in a package, or package size; the unit of measure and package size are used together to calculate the per unit reimbursement that Medicaid makes to retail pharmacies and per unit rebate amounts that prescription drug manufacturers pay to States. We found specifically that most inconsistencies involved the unit type "each"; on average, States converted 45 percent of their utilization data for drugs with unit of measure inconsistencies; and States could not use package size data from CMS to efficiently detect or correct for unit of measure inconsistencies. Inappropriately claimed Medicaid rebates can lead to incorrect rebate payments or disputes with manufacturers. In addition, unit of measure inconsistencies have implications for future Medicaid reimbursement based on AMPs. We recommended that CMS provide more specific guidance to manufacturers regarding the unit type "each" and improve its guidance to States regarding detecting and converting unit of measure inconsistencies. CMS disagreed, stating that unit of measure inconsistencies did not

account for significant improper Medicaid rebate payments. However, we believe that the effects of unit of measure inconsistencies may increase as AMP data are increasingly used for Medicaid reimbursement. (OEI-05-07-00050)

Medicaid Outpatient Prescription Drug Expenditures. In our reviews of the Medicaid outpatient prescription drug expenditures in two States, we found that both States had claimed Federal Medicaid reimbursement for prescription drug expenditures that did not fully comply with Federal requirements. Medicaid generally covers outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. Under the Medicaid drug rebate program, CMS provides the States with a quarterly Medicaid drug tape, which lists all covered outpatient drugs, indicates a drug's termination date if applicable, and specifies whether the Food and Drug Administration has determined the drug to be less than effective. CMS guidance instructs the States to use the tape to verify coverage of the drugs for which they claim reimbursement. Our specific findings follow.

- Illinois – For FYs 2004 and 2005, Illinois claimed \$108,000 in unallowable expenditures for prescription drugs that were no longer eligible for reimbursement. The State claimed an additional \$3.5 million for drugs that were not listed on the quarterly drug tapes. Because the State did not verify whether these drugs were eligible for the coverage, their costs may not be allowable. We recommended that the State refund \$108,000, work with CMS to resolve \$3.5 million in payments for drugs that were not listed on the quarterly drug tapes, and strengthen its internal controls. The State agreed with the first two recommendations but said that it would not change its internal controls because they were sufficient to comply with Federal requirements. (A-05-07-00019)

- Missouri – For FYs 2003 and 2004, Missouri claimed \$2.9 million in unallowable expenditures for prescription drugs that were no longer eligible for reimbursement or were inadequately documented. In addition, the State claimed \$1.9 million for drugs that were not listed on the quarterly drug tapes and therefore may not be allowable. We recommended that the State refund \$2.9 million, work with CMS to resolve \$1.9 million in payments for drugs that were not listed on the quarterly drug tapes, and strengthen its internal controls. The State disagreed with all of our findings and said that its internal controls were adequate. The State did not provide information that would cause us to revise our findings. (A-07-06-04063)

Hurricane Katrina Uncompensated Care Costs Claimed by Two Mississippi Medical Facilities. We issued reports on two Mississippi medical facilities' claims, as of December 2006, for medically necessary uncompensated care furnished to Hurricane Katrina evacuees and other affected individuals without other coverage in eligible States. In response to Hurricane Katrina, section 6201 of the DRA authorized Federal funding for such costs through Medicaid demonstration projects approved by CMS under the authority granted to the Secretary under section 1115 of the Social Security Act. The findings of these reports follow.

- Medical Center – We found that the State appropriately claimed most of the \$17.9 million in uncompensated care reimbursement for services provided by a medical center. However, 4 of the 200 claims that we sampled, totaling \$22,400, were improper

because the individuals who received the services had health care coverage under other programs. We recommended that the State refund to CMS the unallowable reimbursement and consider reviewing the medical center's claims that were not included in the sample to ensure that no other health care coverage was available and make refunds if appropriate. The State did not fully agree with the recommendations but said that it would make the proper adjustments in cooperation with CMS. The State also provided detailed explanations for three of the seven claims we originally questioned. Based on this additional information, we allowed the three claims and amended our findings and recommendations accordingly. (A-04-07-06004)

■ Hospital – We found that the State appropriately claimed \$7.9 million in uncompensated care reimbursement for services provided by a hospital. This report had no recommendations. (A-04-07-06017)

States' Medicaid Claims for Hurricane Katrina Evacuees. We issued five audit reports on the allowability of States' claims for services provided to Hurricane Katrina evacuees from Alabama, Louisiana, and Mississippi. To ensure the continuity of health care services for victims following Hurricane Katrina, States could apply to CMS for Medicaid demonstration projects authorized by section 1115 of the Social Security Act and, with an approved demonstration, be eligible under section 6201(a)(1)(A)(i) of the DRA to receive Federal payment of the non-Federal share of medical assistance costs for evacuees. The results of our audits, which covered costs claimed as of March 31, 2007, follow.

■ Delaware – The State generally claimed reimbursement in accordance with its approved demonstration project. However, we found no evidence that three applicants met displacement requirements. As a result, the State claimed a net total of \$9,300 (of a total of \$173,000) in unallowable reimbursement. We recommended that the State refund the \$9,300 and revise its claims by our audit adjustment amounts. In its comments on our draft report, the State generally disagreed with our findings and recommendations but did not provide information that caused us to revise our findings. (A-03-07-00201)

■ District of Columbia – The District of Columbia improperly claimed reimbursement for services provided to 18 applicants after their eligibility periods had expired and to 3 applicants who did not meet eligibility requirements. As a result, the District claimed a net total of \$44,900 (of a total of \$246,000) in unallowable reimbursement. We recommended that the District refund the \$44,900 and revise its claims by our audit adjustment amounts. The District generally agreed. (A-03-07-00202)

■ Maryland – The State claimed a total of \$1.3 million for medical assistance services provided to 929 evacuees; of this amount, \$412,000 was not allowable. Under section 1115, CMS approved Maryland's request for Medicaid demonstration authority to provide benefits to eligible hurricane evacuees for a maximum of 5 months, ending June 30, 2006, and limited eligibility to individuals from specified counties or parishes. The claims that we identified as unallowable were not supported by actual recorded expenditures, were for services provided to individuals whose eligibility had expired, or were for services provided to individuals who may not have met eligibility requirements.

We recommended that the State refund \$412,000 and revise its waiver reports for Alabama, Louisiana, and Mississippi by our audit adjustment amounts. The State agreed with our recommendation. (A-03-07-00200)

■ Pennsylvania – The State claimed a total of \$1.4 million for medical assistance services provided to 747 evacuees; of this amount, \$552,000 was not allowable. Under its approved section 1115 demonstration project, Pennsylvania was allowed to provide benefits to eligible evacuees for a maximum of 5 months. Most of the claims that we identified as unallowable included costs for services provided to individuals after their eligibility periods had expired or costs that were not supported by actual recorded expenditures. We recommended that the State refund \$552,000 in unallowable reimbursement and revise its waiver reports for Alabama, Louisiana, and Mississippi by our audit adjustment amounts. The State agreed with our recommendations. (A-03-07-00210)

■ Virginia – The State claimed nearly \$523,000 for medical assistance services provided to 641 evacuees and associated administrative costs; we determined that of this amount, \$73,000 was not allowable. Under the terms of the approved section 1115 demonstration project and section 6201 of the DRA, the State could claim reimbursement for reasonable administrative costs related to providing services to evacuees. The claims that we identified as unallowable were for administrative costs that did not pertain to the demonstration project, were for medical assistance costs that were erroneously reported, or were related to services provided to ineligible individuals. We recommended that the State refund \$73,000 in unallowable reimbursement and revise its waiver reports for Alabama, Louisiana, and Mississippi by our audit adjustment amounts. The State agreed with our recommendation. (A-03-07-00211)

Medicaid Targeted Case Management Services Provided by Several States. We issued five reports on States' claims for Medicaid targeted case management (TCM) services. Such services help specific Medicaid populations gain access to medical, social, educational, and other services. CMS has specified that TCM services do not include direct medical, educational, or social services to which Medicaid eligibles have been referred. All of the reports identified inappropriate claimed costs.

■ Georgia – For FYs 2003 and 2004, we estimated that the State claimed \$4.7 million (\$2.8 million Federal share) in unallowable claims for TCM costs for individuals deemed at risk of incarceration. Claims were unallowable because they were not supported as TCM in case records, were for TCM services provided to ineligible incarcerated juveniles, or had no supporting documentation. We recommended that the State refund the estimated overpayment, examine later claims and refund any overpayment identified, and establish monitoring procedures to provide assurance that claims comply with Federal and State requirements. The State said that it would refund the overpayment once a final determination had been made and that it would implement the other recommendations. (A-04-06-00022)

■ Iowa – For FYs 2003 and 2004, we estimated that the State improperly claimed \$2.5 million (\$1.5 million Federal share) in unallowable TCM costs. The State provides TCM services to Medicaid-eligible pregnant women; recipients with diagnoses of mental retardation, developmental disability, or chronic mental illness; eligibles under the Early and Periodic Screening, Diagnostic, and Treatment services program; and children from age 3 to 21 who meet the eligibility categories under Part B and Part C of the Individuals With Disabilities Education Act. We questioned the costs because they lacked sufficient documentation or were for services that did not meet the definition of TCM services. We also found that the State claimed direct medical services as TCM costs; because these costs may be allowable under other provisions of the Medicaid program, we set aside \$303,000 (\$196,000 Federal share) for CMS adjudication. We recommended that the State refund \$1.5 million to the Federal Government for unallowable TCM claims, work with CMS to determine the allowability of the \$196,000 in direct medical services claimed as TCM services, and strengthen related internal controls. The State partly agreed with the first two recommendations and fully agreed with the third. (A-07-06-03078)

■ Kansas – For State FYs 2001 through 2003, the State did not ensure that its \$61.8 million (\$37.2 million Federal share) in TCM claims for recipients of child welfare services was equal to or less than the limit specified in the State’s Medicaid plan. Because the State could not produce the rate and cost data necessary to apply the limit, we were unable to express an opinion on the reasonableness of the claim. We recommended that the State work with CMS to determine the allowability of the \$61.8 million claimed for the audit period, as well as claims for all subsequent periods, and strengthen internal controls to ensure that State plan requirements are followed in submitting future TCM claims. The State generally agreed. (A-07-06-03074)

■ Maine – For FYs 2002 and 2003, the State overstated by a total of \$44.2 million (\$29.8 million Federal share) the cost of Medicaid TCM services provided to recipients of family services because the State did not have procedures for ensuring that Medicaid TCM costs were reasonable, allowable, and allocable and met Federal requirements. We were unable to express an opinion on the remaining \$12.4 million (\$8.3 million Federal share) claimed for TCM-type activities that we were not able to separate from services provided by State family services programs. We recommended that the State refund to the Federal Government \$29.8 million in unallowable costs, work with CMS to determine the allowability of the \$8.3 million for which we were unable to express an opinion, identify and refund any unallowable TCM costs reimbursed after the audit period, and establish procedures to ensure that claims for Medicaid TCM reimbursement include only allowable and adequately documented TCM costs. The State disagreed with our findings and recommendations but did not provide information that would cause us to revise our findings. (A-01-05-00004)

■ Minnesota – For FYs 2003 and 2004, we estimated that the State claimed \$7.3 million (\$3.8 million Federal share) for various services for which the claims did not meet Federal and State documentation requirements. We recommended that the State refund the \$3.8 million overpayment and ensure that TCM services are properly documented.

The State did not address our recommendations but requested information about the claims that lacked documentation. Based on a review of these claims, the State indicated that it may modify existing procedures or develop new ones to correct the problem. (A-05-05-00059)

Tennessee Home- and Community-Based Mental Retardation Services. Based on our review of Tennessee's claims for home- and community-based services (HCBS) provided to Medicaid beneficiaries with mental retardation and developmental disabilities during State FY 2003, we estimated that the State claimed approximately \$11 million (\$7 million Federal share) for HCBS that were not supported by provider records. We recommended that the State refund the excess Federal reimbursement, establish certain HCBS controls and procedures, and review claims after the audit period and refund any overpayments. The State did not address our recommended refund but agreed that additional oversight and controls were needed. (A-04-03-03026)

Medicaid School-Based Services in Utah. We found that Utah's claims for Medicaid reimbursement of school-based services provided in FYs 2001 through 2005 generally did not comply with Federal requirements or the State's Medicaid plan. It was not possible to determine what portion of the \$36.8 million Federal share claimed was allowable as final payments. The State had not, as required by its plan, performed a cost settlement reconciling interim payments to actual costs to determine final payments. The State concurred with our recommendations to work with CMS to determine what portion of the \$36.8 million was allowable and to perform cost settlements to ensure that final payments for school-based services are based on actual costs. (A-07-06-04069)

State Medicaid Agency Referrals to the Office of Inspector General Exclusions Program. We found that about two-thirds of providers with final actions imposed by State Medicaid agencies were not found in the OIG exclusions database. Through the legal authorities contained in sections 1128 and 1156 of the Social Security Act, OIG established a program to exclude individuals and entities from participating in Medicaid, Medicare, and other Federal health care programs. When State Medicaid agencies take final actions against providers, they are required to promptly report the providers to OIG to be considered for exclusion. Our study matched data from the OIG exclusions database with information on providers with final actions taken by State Medicaid agencies. We also surveyed State Medicaid agency officials. OIG determined that match rates varied widely across States. For 11 States, less than 25 percent of the final actions taken against providers were reflected in the OIG exclusions database. For nine States, 75 percent were reflected in the OIG exclusions database. Officials from State Medicaid agencies conveyed uncertainty about the types of information to send with referrals, the types of final actions to refer to OIG, and the outcomes of the referrals that they make. They rated recent outreach from OIG as helpful and would welcome more information about exclusions processes. Although this report did not include specific recommendations, our results showed that opportunities exist for both OIG and State Medicaid agencies to increase the number of referrals of providers with final actions. OIG has efforts underway to improve its tracking of exclusions program referrals and outreach and communications to State agencies. (OEI-01-06-00301)

External Quality Review in Medicaid Managed Care. We found that of the 37 States that had arranged for external quality reviews of Medicaid managed care organizations (MCO) in 2005, most found the results of such reviews useful, but more than half reported concerns about the external review process. The Social Security Act requires States to provide for external, independent reviews of their MCOs, which, as of 2006, enrolled 65 percent of the 45.6 million Medicaid beneficiaries. States contract with independent entities called external quality review organizations (EQRO) to conduct the reviews. Our specific findings included the following: 33 States required their MCOs to make changes based on EQRO reports and 24 States cited three primary concerns about external quality reviews, which related to staffing (turnover and training), EQRO report quality (timeliness and feasibility of recommendations), and redundancy with other monitoring efforts. Some EQRO reports did not include all of the information required by the contracts. We recommended that CMS work with States to ensure that EQROs provide complete information and provide States with additional technical assistance and written guidance. In commenting on the draft report, CMS agreed with these recommendations and cited actions that it had taken in both areas. (OEI-01-06-00510)

New Jersey Medicaid Contingency Fee Contract Payments. We found that New Jersey made improper claims of \$16 million (\$8 million Federal share) to the Medicaid program for contingency fees paid to two consultants. The State had hired the consultants to generate increased Federal reimbursement by identifying and submitting to the Federal Government unclaimed State expenses. According to the terms of the contracts, the consultants were paid fees contingent on additional Federal funds recovered. Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments," prohibits Federal reimbursement for consultant services that are contingent on recovery of costs from the Federal Government. We recommended that the State refund \$8 million to the Federal Government. The State disagreed with our interpretation of the OMB circular, but we maintained that OMB Circular A-87 prohibits Federal reimbursement for consultant services when the costs of those services are contingent on recovery of costs from the Federal Government. (A-02-06-01006)

California's Medicaid Management Information System Expenditures. In a review of costs claimed by California for operating its Medicaid Management Information System (MMIS) from July 1, 2003, to June 30, 2005, we found that most costs were allowable. However, \$2.3 million was improperly claimed, mostly because the costs were not equitably allocated to all benefiting programs, were not related to the Medicaid program, or were claimed twice. The MMIS is a system of software and hardware used to process Medicaid claims and manage information about beneficiaries and services. States may receive Federal reimbursement from CMS for the operation of an MMIS at an enhanced rate. We recommended that the State refund the improperly claimed costs, strengthen its internal controls, and review the appropriateness of costs claimed after the audit period. The State generally agreed with our recommendations. (A-09-06-00032)

Medicaid Information Technology Audit Resolution Process. In our review of CMS's resolution of 197 information technology (IT) recommendations that we made regarding the MMIS in 16 reports between 2002 and 2005, we found that CMS: resolved 17 recommendations within the required 6 months following report issuance; resolved 124 recommendations after the

6 months had elapsed; and had not resolved 56 recommendations as of June 30, 2007. CMS is responsible for resolving Federal and non-Federal audit report recommendations related to its activities, grantees, and contractors within 6 months after formal issuance of reports. We recommended that CMS establish procedures to ensure that all IT audit recommendations are resolved within 6 months of receiving an audit report. In commenting on our draft report, CMS concurred with our recommendation and described steps that it had taken to improve the audit resolution process. (A-04-06-05039)

Indiana Medicaid Disproportionate Share Hospital Eligibility. In our review of Indiana's compliance with Medicaid disproportionate share hospital (DSH) payment requirements, we found that from July 2000 through June 2003, the State paid \$142.3 million (\$88.2 million Federal share) to three State-owned psychiatric hospitals that were not eligible to receive DSH payments. States are required to make additional Medicaid payments to hospitals that serve disproportionate numbers of low-income patients. For psychiatric hospitals to qualify for such DSH payments, they are required to meet special Medicare conditions of participation related to staffing and medical records. Although the State believed that the three hospitals met the special requirements by virtue of being accredited by the Joint Commission on Accreditation of Healthcare Organizations, we found that the hospitals had not complied with the more stringent requirements for psychiatric hospitals. We recommended that the State refund \$88.2 million and ensure that Medicaid DSH payments are made only to eligible hospitals. The State disagreed with our finding and recommendations but did not provide additional information to demonstrate compliance with the special requirements for psychiatric hospitals. (A-05-06-00045)

Texas Medicaid Upper Payment Limit for Hospitals. In our review of Texas's June 2005 upper payment limit (UPL) payments to State owned and operated hospitals for inpatient services, we were unable to determine whether the State had calculated UPL payments totaling \$112.3 million in accordance with Federal regulations and the State plan because the State did not retain the required supporting documentation. The Medicaid program provides payments to certain hospitals for inpatient services insofar as the aggregate payments do not exceed the UPL, which is a reasonable estimate of the amount that would be paid for Medicaid services under Medicare payment principles. We recommended that the State work with CMS to recalculate the UPL, refund the Federal share of any overpayments identified, and implement procedures to retain supporting documentation for UPL payments. In commenting on our draft report, the State said that it had recalculated the UPL and planned to provide the revised calculation and documentation to CMS. The State also said that it had implemented the recommended procedures. (A-06-07-00025)

Substance Abuse Treatment Facilities. In our reviews of two States' claims for Federal Medicaid reimbursement for services provided in inpatient substance abuse treatment facilities, we found that both States had made improper claims. Federal Medicaid funding generally does not cover substance abuse treatment when it is provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 and 64. The specific findings follow.

- New Jersey – From January 2002 through December 2006, the State improperly claimed \$1.7 million in Federal Medicaid reimbursement for substance abuse services

provided to beneficiaries between the ages of 22 to 64 residing in facilities that were IMDs or to beneficiaries residing in nonparticipating institutional Medicaid facilities or nonaccredited psychiatric facilities. This overpayment occurred because the State had not established controls to designate the claims in question as federally nonparticipating. The State informed us that following the period of our review, it had modified its controls to designate these facilities as federally nonparticipating. We recommended that the State refund \$1.7 million, ensure that its new controls are working properly, determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period, and refund the overpayments. The State concurred with our findings and recommendations. (A-02-07-01005)

■ New York – From April 2001 through March 2006, New York improperly claimed \$21.5 million in Federal Medicaid reimbursement for services provided to beneficiaries between the ages of 22 and 64 who resided in IMDs. The State had improperly designated certain detoxification claims as eligible for Federal Medicaid reimbursement; one provider had billed Medicaid for inpatient rehabilitation services using an outpatient category-of-service code; and the State had continued to claim Federal Medicaid reimbursement after another provider increased its number of beds and, as a result, met the Medicaid definition of an IMD. After our audit period, the State refunded a portion of the overpayment. We recommended that the State refund the \$6.6 million balance of the overpayment, ensure that its controls to designate certain detoxification claims as federally nonparticipating are working properly, designate two providers as federally nonparticipating for beneficiaries under age 65, determine the amount of improper Federal Medicaid reimbursement claimed subsequent to our audit period, and refund the overpayments. The State concurred with the recommendations. (A-02-06-01021)

Kansas's Medicaid Claims for the Child Welfare Services and Family Preservation Programs.

In our reviews of Kansas's Medicaid claims for child welfare services during State FYs 2001 through 2003, we found that the State's documentation did not provide assurance that its \$61 million (\$36.9 million Federal share) claim for the Child Welfare Services program or its \$3.4 million (\$2 million Federal share) claim for the Family Preservation Program were, respectively, equal to or less than the limit specified in the State's Medicaid plan. Without auditable documentation, we were unable to express an opinion on the reasonableness of the State's claims for these programs on its quarterly Medicaid reports to CMS. CMS requested these reviews subsequent to its 2004 review of Kansas's Child Welfare Services program, which found that the State had submitted claims for Federal reimbursement that did not reflect actual payments to providers. CMS deferred reimbursement of expenditures that did not meet Federal and State requirements and requested these reviews. For both programs, we recommended that the State work with CMS to determine the allowability of claims for the audit period and all subsequent periods and ensure that State plan requirements are followed in submitting future claims. In response to both reports, the State concurred with our first recommendation but did not directly address our second recommendation. (A-07-06-03079, A-07-06-03076)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility

in Two States. In our review of States' payments in August 2003 on behalf of individuals who should not have been Medicaid eligible because of their eligibility in another State, we estimated

that States paid approximately \$2 million in that month on behalf of individuals who were already eligible in another State. In each of these States, Medicaid eligibility depends in part on residency, and the general definition of residency provides that an individual can be a resident in only one State at a time. Thus, when an individual establishes residency in one State, he or she should lose resident status (and Medicaid eligibility) in other States. We recommended that CMS share the results of our review with all States to emphasize the need to identify beneficiary eligibility changes and encourage States to identify opportunities to use existing eligibility data to minimize concurrent Medicaid eligibility periods. CMS concurred with the recommendations. (A-05-06-00057)

Medicaid Buy-In Payments in North Carolina. In our review of North Carolina's claims of Medicare Part B premiums that it paid on behalf of Medicaid beneficiaries for the quarters ended June 2004 through March 2007, we determined that the State had not met Federal requirements in claiming the Federal share of Medicare Part B premiums that it paid on behalf of some Medicaid beneficiaries. Of the \$722 million that the State claimed, approximately \$24 million (\$16 million Federal share) was for beneficiaries in "buy-in" eligibility categories that were ineligible for the Federal share. Under the buy-in program, States that have agreements with CMS may enroll individuals who are eligible for benefits under both Medicare and Medicaid (dual eligibles) in Medicare Part B and pay the monthly premium on behalf of these recipients. Participating States are eligible to receive the Federal Medicaid share of the Part B premiums for certain groups of dual eligibles. We recommended that the State refund the \$16 million, review claims submitted following our audit period, refund any unallowable Federal reimbursement, and develop adequate internal controls. The State concurred with our finding and recommendations. (A-04-07-03011)

Rhode Island Medicaid Transportation Claims. In our review of Rhode Island's claimed nonemergency transportation costs for the period March 2004 through May 2005, we found that the State had not claimed the costs in accordance with Federal and State requirements. States must ensure that Medicaid beneficiaries have transportation to and from medical providers and that the transportation is cost effective. Rhode Island provided nonemergency transportation by distributing monthly bus passes. We determined that the State could have saved at least \$9.8 million (\$4.9 million Federal share) by purchasing 10-ride bus passes instead of monthly passes. We also found that the State had claimed \$386,000 (\$193,000 Federal share) in unallowable costs for beneficiaries of two non-Medicaid State programs. We recommended that the State either refund \$4.9 million or provide documentation to show that monthly bus passes were the most cost-effective means of providing nonemergency transportation, refund \$193,000 in unallowable costs, recalculate claims for bus passes reimbursed after our audit period and refund the excess reimbursement, and establish policies and procedures to comply with Federal requirements and the State plan. The State agreed to refund the \$193,000 related to our second recommendation but disagreed with the other recommendations. After considering the State's comments, we maintain that our findings and recommendations are valid. (A-01-06-00007)

Separate State Children's Health Insurance Program Enrollees' Eligibility for Medicaid in 2006. In this review, the third in a series of congressionally mandated reviews of State Children's Health Insurance Program (SCHIP) enrollment, we found that 4 percent of the children enrolled in separate SCHIPs (16 sample cases and about 105,000 children projected nationwide) were

eligible for their States' Medicaid programs. Federal regulations require States to screen SCHIP applicants for Medicaid eligibility in part to prevent inappropriate enrollment of Medicaid-eligible children in SCHIP, whose expenditures have a higher Federal match than Medicaid expenditures. Details of this review included the following:

- The 4-percent enrollment error rate found in this review was somewhat higher than error rates found in our earlier reviews (i.e., 1.8 percent in 2000 and 1 percent in 2003).
- The 16 cases were erroneously enrolled in SCHIP because of miscalculations of the families' net incomes, clerical mistakes, and other unclassified errors.
- An additional 4.5 percent of SCHIP enrollees (18 sample cases) lacked sufficient documentation to determine Medicaid eligibility, raising the possibility that the actual number of children enrolled in separate SCHIPs who were eligible for Medicaid in 2006 could have been higher than our projection.

We recommended that CMS take further action to ensure that children are appropriately enrolled in their States' Medicaid programs. In responding to our draft report, CMS indicated that it supported "the spirit of the OIG recommendations" and requested additional information on the cases that we had identified as enrollment errors. (OEI-06-07-00310)

Fee-for-Service Payments for Services Covered by Capitated Medicaid Managed Care.

We reviewed the extent to which Medicaid programs in five States paid noninstitutional fee-for-service claims for services provided to beneficiaries enrolled in capitated Medicaid managed care plans during the first quarter of FY 2005. We identified approximately \$1.8 million (State expenditures and Federal financial participation) in total Medicaid claims paid, or potentially paid, in error. In capitated managed care arrangements—through which 65 percent of the Nation's Medicaid beneficiaries received all or some of their health or mental health services in 2006—State Medicaid programs pay managed care plans a fixed rate per Medicaid beneficiary in exchange for services included in the plan. Except in limited circumstances specified by the State, Medicaid programs should not pay claims for services that are included in capitated Medicaid managed care plans on a fee-for-service basis. Otherwise, Medicaid programs pay twice for the same service: once through the fee-for-service claim and once as a portion of the capitated payment. Our specific findings included the following:

- Four of the States reimbursed fee-for-service claims totaling nearly \$864,000 (\$462,000 Federal share) in error. Manual overrides of Medicaid automated payment system edits and faulty system logic contributed to these errors.
- Two States potentially paid an additional \$974,000 in error, but Medicaid staff in these States were unable to confirm whether these fee-for-service claims were paid in error without conducting a detailed, resource-intensive claims-level review.

We recommended that CMS work with States to prevent erroneous fee-for-service payments by issuing guidance to States addressing Medicaid payment systems' vulnerabilities, identifying erroneous payments, and developing payment systems to prevent payment errors. We also recommended that CMS take appropriate action to collect overpayments associated with Medicaid claims paid in error. In responding to our draft report, CMS agreed with our recommendation and listed actions it planned to take to eliminate erroneous payments.

The agency also indicated that it would work with the four States to voluntarily collect the overpayments associated with erroneous fee-for-service payments. (OEI-07-05-00320)

Investigations and Legal Services

In addition to conducting audits and evaluations of Medicaid, OIG investigates allegations of criminal and civil wrongdoing in Medicaid and, in conjunction with DOJ and others, conducts administrative enforcement and litigation and provides technical support to such efforts. 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 as well as Medicaid. The following table presents a summary of OIG’s investigative, enforcement, and industry outreach activities during FY 2008 related to Medicaid.

OIG’s Medicaid-Related Investigations and Legal Services in FY 2008

OIG Activity Area ⁸	Number
Enforcement	
Medicaid Cases Worked	1,341
Joint Investigations Conducted With State Medicaid Fraud Control Units	879
Total Medicaid Cases Opened	497
Criminal Convictions	149
Civil Actions ⁹	88
Program Exclusions – Imposed	3,129
Program Exclusions – Appeal Proceedings	90
Civil Monetary Penalty Actions	47
Emergency Medical Treatment and Labor Act Actions (aka “Patient Dumping”)	32
Corporate Integrity Agreements – New	73
Corporate Integrity Agreements – Monitored	452
Outreach	
Advisory Opinions	26

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicaid and other Federal health care programs involves filing false claims for reimbursement. The filing of false claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the civil False Claims Act (FCA).

The successful resolution of such civil FCA matters often involves the combined investigative efforts and resources of OIG, State MFCUs, and a variety of other law enforcement agencies. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter into integrity agreements with OIG to avoid exclusions and to be permitted to continue participating in Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require providers to enhance existing

⁸ Matters listed here are not necessarily Medicaid specific. Many also involve fraud against other health care programs.

⁹ The category “Civil Actions” does not include civil monetary penalty actions.

compliance programs or establish new ones. Providers that settle these cases generally do not admit that they were liable or that they committed the alleged conduct.

In FY 2008, OIG opened 497 Medicaid-related cases for investigation of criminal or civil wrongdoing and participated in 149 successful criminal convictions and 135 civil actions. In addition, the Government's enforcement efforts, including FCA cases, resulted in over \$2 billion in investigative receivables related to Medicaid and other Federal health care programs. Some successful enforcement actions are described below.

Pharmaceutical Manufacturers and Distributors.

■ Illinois – CVS Caremark Corporation (CVS) agreed to pay \$36.7 million and enter into a 5-year corporate integrity agreement (CIA) with OIG to resolve its FCA liability based on allegations that it fraudulently overcharged Medicaid programs in 23 States by improperly switching drugs it dispensed. Specifically, the Government and relator alleged that CVS dispensed ranitidine (generic Zantac) capsules rather than tablets in order to increase its reimbursement from Medicaid. As a result of dispensing and billing Medicaid for capsules, CVS was reimbursed, on average, four times what it would have been reimbursed had it dispensed tablets. The CIA requires CVS's Board of Directors Audit Committee to oversee and evaluate CVS's compliance program and requires annual reviews by an independent review organization to determine whether similar conduct is occurring on an ongoing basis to avoid Federal upper limits (FUL) and maximum allowable costs (MAC). No patient harm was alleged.

■ Massachusetts – The Bristol-Myers Squibb Company (BMS) and its wholly owned subsidiary, Apothecan, Inc., agreed to pay \$499 million plus interest as part of the resolution of an FCA case associated with a variety of drug marketing and pricing practices. The settlement and a 5-year CIA between BMS and OIG resolved, in whole or in part, allegations made in seven *qui tam* actions. The investigation revealed that BMS and Apothecan devised and implemented fraudulent marketing and pricing schemes aimed at inducing providers to purchase and prescribe their drugs. First, BMS and Apothecan allegedly reported fraudulent and inflated prices for a wide assortment of oncology and generic drug products with the knowledge that Federal health care programs established reimbursement rates based on those prices. This type of pricing scheme benefits providers by creating a “spread” between the reimbursement rates for Federal health care providers and the actual prices for the drugs charged to BMS customers. Second, BMS allegedly paid illegal remuneration to physicians and other health care professionals in the form of consulting fees and expenses associated with certain consulting programs. Third, the Government alleged that Apothecan knowingly and willfully paid illegal remuneration to retail pharmacy and wholesaler customers to induce them to purchase its products. Fourth, allegations were made that BMS used fraudulent marketing tactics to promote the sale of the drug Abilify, an antipsychotic drug, for pediatric uses and for treating dementia-related psychosis—both off-label uses. Finally, BMS allegedly violated the requirements of the Federal Medicaid drug rebate statute by failing to accurately report the “best price” at which it sold its antidepressant

drug Serzone. The Government alleged that as a result, BMS underpaid rebates owed to the States under the Medicaid rebate program.

■ Michigan – Four institutional pharmacies owned by Omnicare, Inc., agreed to pay \$3,498,570 and enter into an amendment to a preexisting CIA to settle allegations of improper Medicaid billing. The TCPI Acquisition Corp.; Specialized Pharmacy Services, Inc.; Specialized Pharmacy Services North, Inc.; and excellRx, Inc. (collectively, Specialized) allegedly double-billed Medicaid for drugs provided to hospice patients. Specifically, in Michigan, Medicaid pays hospice providers a flat fee that includes all medications related to a hospice patient’s terminal diagnosis. Therefore, the pharmacy is required to bill the hospice provider directly for all drugs related to the patient’s terminal diagnosis. Drugs not related to the terminal diagnosis are not included in this flat fee, and the pharmacy must bill Medicaid directly for these other drugs. The *qui tam* relator in the case alleged that Specialized knowingly billed Medicaid for all drugs that it dispensed to hospice patients, including those unrelated to the patients’ terminal diagnoses. Therefore, Specialized allegedly caused Medicaid to pay twice for the same drugs—one payment to the hospice provider and another payment to the pharmacy.

■ Pennsylvania and Louisiana – Merck and Company (Merck), Inc., agreed to pay \$399 million plus interest to resolve its FCA liability in connection with certain discounting, pricing, and marketing practices associated with some of its drug products. The United States alleged that Merck failed to properly include the discounts in the “best prices” that are required to be reported to CMS under the Medicaid drug rebate program and, as a result, underpaid rebates owed to the States. Specifically, the United States alleged that Merck had established certain tiered discount programs, in effect between 1998 and March 2006, under which it offered hospitals deep discounts on Vioxx (no longer marketed), Zocor, and Mevacor. Under these so-called nominal price programs, hospitals that met certain market share requirements could purchase the Merck products at discounts of up to 92 percent off the AMPs for the drugs. The United States further contended that through this conduct, Merck overcharged covered entities that purchased Merck products under the 340B Drug Pricing Program, which limits the costs of certain outpatient prescription drugs to Federal entities and Federally Qualified Health Centers, such as community health centers and acquired immunodeficiency syndrome (AIDS) drug assistance programs that serve vulnerable populations. Finally, the United States alleged that between January 1997 and December 2001, Merck sales representatives used approximately 15 different programs to induce physicians to use its drug products. These programs consisted primarily of excess physician payments disguised as fees paid to them for “training,” “consultation,” or “market research.” The Government alleged that these fees were, in fact, illegal kickbacks intended to induce the purchase of Merck drug products. Merck agreed to pay \$399 million to settle this matter at the same time that it settled a separate FCA lawsuit filed in the Eastern District of Louisiana for \$250 million plus interest. The Louisiana matter involved similar discounted pricing programs offered to hospitals for another Merck drug, Pepcid. Merck allegedly offered incentives to hospitals to obtain the benefit of spillover business when patients continued to purchase Pepcid following their hospital stays. Through both settlements, Merck agreed to pay a

total of \$649 million plus interest. Merck further agreed to enter into a 5-year CIA with OIG that includes corrective measures to address its conduct in both cases.

■ Illinois – Walgreens Co. (Walgreens) agreed to pay the United States, 42 States, and Puerto Rico \$35,214,026 to settle Medicaid prescription drug fraud claims. The *qui tam* complaint alleged that Walgreens substituted different forms of generic prescription drugs for others (such as tablets for capsules) solely to increase its reimbursement rate rather than for any legitimate medical reason. The drugs at issue were ranitidine (generic Zantac), fluoxetine (generic Prozac), and selegiline (generic Eldepryl). The Government alleged that Walgreens' systematic substitution of more expensive forms of these drugs for less expensive, prescribed forms was motivated by its intent to avoid CMS's FUL on prices for the drugs and States' MACs for the drugs. In addition, Walgreens entered into a 5-year CIA that requires an independent review organization to review its Medicaid reimbursement for generic drugs for which Government reimbursement is limited by FUL and MAC lists.

Hospitals. New York – Staten Island University Hospital (SIUH) agreed to pay \$88,916,448 in a global settlement resolving allegations that it defrauded Medicare, Medicaid, and TRICARE (the military's health insurance program). The global settlement resolves two separate lawsuits filed in the U.S. District Court for the Eastern District of New York and two Government investigations. As part of the global settlement, SIUH also entered into a 5-year CIA with OIG. In the first lawsuit, the Government's investigation led to allegations that SIUH fraudulently billed Medicaid and Medicare for inpatient alcohol and substance abuse detoxification treatment and that during the period July 1, 1994, through June 30, 2000, SIUH submitted claims for payment for treatment provided to patients in beds for which SIUH had received no certificate of operation from the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and concealed the existence of those beds from OASAS. SIUH has agreed to pay \$11,824,056 to the United States and \$14,883,883 to the State of New York. The global settlement also addresses SIUH's billings to Medicare and Medicaid for treatment of psychiatric patients in unlicensed beds during the period July 2003 through September 2005. The hospital has agreed to pay the United States \$1,478,989 to settle this claim.

Practitioners.

■ Texas – Dr. Raul Marquez, an orthopedic surgeon, agreed to pay \$3,128,466 and enter into a CIA to resolve allegations of Medicare and Medicaid fraud brought against him and hospitals with which he was affiliated and in which he had an ownership interest. The Government's investigation, initiated with information presented in a *qui tam* suit, led to allegations that Marquez and the Orthopedic Surgery Center and Sports Medicine billed Medicare and Medicaid programs for services not rendered as represented. Also, the Government alleged that Marquez and Cornerstone Regional Hospital obtained inflated payments from the Medicare program by billing postsurgical patients as though they had been discharged to home, when, in fact, they had been discharged to Cornerstone Rehabilitation Hospital for continuing treatment.

■ Maryland – Podiatrist LaVergne Andre-Hayes agreed to pay the Government \$534,884 plus interest and entered into a 5-year integrity agreement with OIG to resolve allegations of false Medicare and Medicaid billing. Dr. Andre-Hayes allegedly billed Medicare and Maryland Medicaid for separate evaluation and management services even though she performed no significant, separately identifiable evaluation and management service at the same time that she performed a procedure. Dr. Andre-Hayes also allegedly submitted claims to Medicare and Maryland Medicaid for services not rendered and for noncovered services. The Maryland State Board of Podiatric Medical Examiners had also previously investigated Dr. Andre-Hayes and on February 8, 2007, suspended her medical license in Maryland for 2 years (with 1 year stayed).

■ Illinois – Dr. Ajit Trikha, a psychiatrist, was sentenced to 30 months' imprisonment and was ordered to pay restitution in the amount of \$1,755,754 following his guilty plea to health care fraud. TRX Health Systems PC (TRX), Dr. Trikha's business practice, was also ordered to pay a \$400 special assessment for mail fraud. Dr. Trikha and TRX billed Medicare and Medicaid for individual psychotherapy, group psychotherapy, and pharmacologic management services that he did not render. In some cases, Dr. Trikha was traveling outside the United States on the claimed dates of service.

Clinics. Mississippi – Frank Wiley and Michael Yant owned and operated Canton Rehabilitation Services, Inc., which billed Medicare and Medicaid for fraudulently rendered physical therapy services. The scheme involved the submission of claims purporting that the physical therapy services were rendered by a physician or a licensed physical therapist under the direct supervision of a physician, as required by Medicare. The services were in fact rendered by unlicensed, untrained, and unsupervised individuals. Wiley and Yant also owned and operated Mississippi Central Rehabilitation, Inc., which was operated in the same manner. Wiley and Yant were sentenced to 37 and 48 months in prison, respectively, and ordered to pay restitution in the amount of \$4,568,560.

Transportation Providers. District of Columbia – Leonard Young, owner of nonemergency transportation company Young Star Tours (YST), was sentenced to 1 year and 1 day in prison and 6 months' home detention and ordered to pay \$173,491 and forfeit \$37,950 previously seized from his bank accounts. YST billed DC Medicaid for 6,660 transportation services that he never provided.

Individuals. Ohio – Joe Winston Langley, who pleaded guilty to aggravated identity theft, was sentenced to 2 years' imprisonment and ordered to pay \$155,485 in restitution, of which \$93,915 is owed to the Medicaid program. Langley stole the identity of a Texas resident approximately 20 years ago and, beginning in 1998, falsely represented his identity to the State of Ohio to receive Medicaid and public assistance benefits. When the identity theft victim became eligible for Medicare in 2004, Langley began using the stolen identity to incur charges that were paid by the Medicare program.

Joint Investigations With State Medicaid Fraud Control Units. In FY 2008, OIG participated in 879 joint investigations with MFCUs and opened 497 investigations into potential fraud involving the Medicaid program. MFCUs are key partners in the fight against fraud, waste,

and abuse in State Medicaid programs. State MFCUs operate in 49 States and the District of Columbia pursuant to the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 with the objective of strengthening the Government's capability to detect, prosecute, and punish fraud against Medicaid programs. MFCUs investigate and prosecute, or refer for prosecution, providers alleged to have defrauded the Medicaid program or to have abused or neglected beneficiaries in Medicaid-sponsored facilities. OIG partners with MFCUs in conducting joint investigations and outreach work. Examples of joint investigations include the following:

- Georgia – Chiropractors Rafael Razuri and Eric Baty were sentenced to 5 years' imprisonment and 42 months' imprisonment, respectively, and ordered to pay \$1.8 million in restitution because of their convictions for conspiracy to commit health care fraud. While owners and operators of Southside Medical & Rehabilitation Center, Razuri and Baty conspired to bill over \$5 million in fraudulent physical therapy claims to Medicare and Georgia Medicaid. The investigation involved OIG, the Federal Bureau of Investigation (FBI), and the Georgia MFCU.
- Texas – Psychologist Joe Lerma was sentenced to 4 years in Federal prison and ordered to pay \$530,000 in restitution for fraudulently billing Medicare and Medicaid. A jury found Lerma guilty of billing Medicare and Medicaid for psychological interviews and testing as if he performed the services when, in fact, the services were performed by unlicensed technicians and associates. The investigation involved OIG and the Texas MFCU.
- Wisconsin – Nicole Stewart was sentenced to 5 years' imprisonment and ordered to pay \$320,603 in restitution for defrauding the Wisconsin Medicaid program. Stewart owned and operated Compassionate Mothers, a company she founded to provide prenatal and child care coordination services. An investigation revealed that she billed the Medicaid program for services never rendered and for services not covered. In addition, Stewart attempted to cover up the fraudulent billings by paying employees to fabricate records to support the claims submitted. Four codefendants had been previously sentenced for their roles in fabricating documents. The investigation involved OIG and the Wisconsin MFCU.
- Indiana – Varnador K. Sutton, the sole owner and operator of Regenerations, Inc. (Regenerations), purportedly a mental health counseling agency employing high- and mid-level psychologists and counselors, was sentenced to 120 months' imprisonment and ordered to pay \$3,288,347 in restitution for health care fraud. An investigation revealed that Sutton and Regenerations billed for 84,000 psychotherapy services that were never rendered and used 2,500 separate Medicaid recipients' identities and benefits to defraud the Medicaid program. The investigation involved OIG, the FBI, and the Indiana MFCU.
- Indiana – Jennifer Williams was sentenced to 30 months' imprisonment and ordered to pay \$79,000 in restitution following her guilty plea to charges of health care fraud and being a felon in possession of a firearm. Williams, the owner of A New Way Transportation, knowingly submitted approximately 5,000 claims to Medicaid as nonambulatory transports when, in fact, the majority of the beneficiaries transported

were ambulatory. During the investigation, large amounts of marijuana and prescription narcotics were found. Additionally, a semiautomatic handgun was recovered. This investigation involved OIG; the Bureau of Alcohol, Tobacco, Firearms and Explosives; and the Indiana MFCU.

■ Illinois – Heartland Dental Care, Inc., a provider of management services to dental practitioners located throughout the United States, and Richard E. Workman (collectively, Heartland) agreed to pay the United States and the State of Illinois a total of \$1.65 million to resolve allegations that Heartland violated the Federal FCA and the Illinois FCA. Specifically, Heartland allegedly allowed dentists to call in prescriptions for Medicaid beneficiaries under other dentists’ Drug Enforcement Administration registration numbers, in violation of the Controlled Substances Act; billed Medicaid for nonsurgical tooth extractions as surgical tooth extractions; and billed Medicaid for crown buildups, which are noncovered services, as four-surface restorations or amalgams, which are covered services. In addition, Heartland entered into a 5-year CIA with OIG. The investigation involved OIG and the Illinois MFCU.

■ Oregon – Susan Ilene Pearson was sentenced to 39 months’ imprisonment and ordered to pay \$108,225 in restitution and fines after being convicted of making false claims and theft. A 3-day jury trial revealed that Pearson, an in-home caregiver paid with Medicaid funds, and her codefendant, Carolyn Elliott, a Medicaid recipient, engaged in a 7-year fraud scheme whereby Elliott would pretend to be disabled and Pearson would claim to be providing caregiver services to Elliott. Each month for 7 years, Elliott and Pearson would bill the State Medicaid program for phantom services Pearson claimed to provide and then split the Medicaid payments. Elliott died 1 month before trial; charges against her were dismissed. The investigation involved OIG, the Social Security Administration, and the Oregon MFCU.

Oversight of Federal Grants to Medicaid Fraud Control Units

In addition to conducting audits, evaluations, and investigations and providing legal services, OIG is responsible for administering the Medicaid fraud control grant program and providing oversight and guidance to State MFCUs. In FY 2008, OIG oversaw the distribution and administration of \$185 million to MFCUs in 49 States and the District of Columbia. The Social Security Act, § 1902(a)(61), as amended by the Omnibus Budget Reconciliation Act of 1993, § 13625, required MFCUs to operate in accordance with applicable standards. The standards were developed in consultation with the MFCU community and made effective on September 26, 1994 (59 Fed. Reg. 49080). They are used 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 laws.

During FY 2008, we conducted onsite reviews of 11 selected MFCUs to determine their compliance with the following:

- 42 CFR pt. 1007, entitled “State Medicaid Fraud Control Units,” containing regulations for MFCUs;

- 45 CFR pt. 92, entitled “Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments,” establishing uniform administrative rules for Federal grants; and
- the 12 MFCU performance standards developed by OIG in consultation with the National Association of Medicaid Fraud Control Units.

As part of the onsite review process, we made recommendations and suggestions to improve the operation of the MFCUs reviewed.

Administrative Sanctions

OIG has the authority to impose administrative sanctions for instances of fraud or abuse or other activities that pose a risk to Federal health care programs and their beneficiaries. These sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of CMPs for submitting false or fraudulent claims to a Federal health care program or violating the anti-kickback statute, physician self-referral statute, or the “patient dumping” provision of the Social Security Act.

Program Exclusions

Through the legal authorities contained in sections 1128 and 1156 of the Social Security Act, 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, available on OIG’s Web site at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp. 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 2008, OIG excluded 3,129 individuals and entities from participating in Medicaid, Medicare, and other health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid. The following are examples of Medicaid-related program exclusions in FY 2008.

- New York – Neil E. Norwood, a pharmacist, was excluded for a minimum of 25 years based on his conviction for his scheme to defraud Medicaid and a private insurer. As part of the scheme, Norwood provided patients with less medication than prescribed but billed Medicaid and the private insurer as if the full prescription had been dispensed. Norwood was sentenced to 2 to 6 years’ imprisonment and ordered to pay \$3 million.
- Virginia – Kenneth D. Beverly, the owner of a rehabilitation facility, was excluded for a minimum of 25 years based on his scheme to bill Medicaid for psychosocial rehabilitation services for Medicaid beneficiaries who were not eligible to receive such services. In addition, Beverly was convicted of various other charges, including charges related to income tax evasion. Beverly was ordered to pay \$2,604,500 in restitution and was sentenced to 151 months’ imprisonment.

■ Ohio – Wilma Kpohanu, a home health agency owner, was excluded for a minimum of 30 years as a result of her conviction for health care fraud and health care false statements. Through her agency, Kpohanu submitted claims to Medicaid for skilled nursing and home health aide services that were not rendered or performed from September 1999 to March 2006. Kpohanu was ordered to pay restitution of approximately \$2,712,148 and was sentenced to 97 months of incarceration.

■ Kansas – Johnnie Franklin-El and Peggy Franklin-El, counseling center owners/operators, were each excluded for a minimum of 25 years based on their convictions on multiple counts of health care fraud. From June 2003 to January 2006, they submitted, or caused to be submitted, false claims to Medicaid for community-based drug and alcohol abuse services that were not provided. Both subjects were sentenced to 92 months' imprisonment and ordered to pay approximately \$1,243,244 in joint and several restitution. They were also convicted of obstruction of justice.

Civil Monetary Penalties

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits or causes to be submitted, claims to a Federal health care program, including Medicaid, that the person knows or should know are false or fraudulent. The following are examples of CMP actions that were resolved during FY 2008 and which involved the improper billing of Medicaid services.

■ New York – The State Office of the Medicaid Inspector General entered into a CMPL Settlement Agreement with St. Barnabas Hospital (SBH). The settlement resolved the liability of SBH and Cardiology Physicians, P.C. arising from the hiring of several excluded persons. Under the terms of the settlement, SBH agreed to pay the United States \$132,000. In addition, SBH was required to certify that it had policies and procedures in place to prevent the future hiring of excluded persons.

■ Michigan – OIG entered into a CMPL settlement with Courtyard Manor of Farmington Hills, Inc. (Courtyard Manor). The settlement resolves Courtyard Manor's liability arising from its receipt of Federal health care program funds while the entity was excluded. Under the terms of the settlement, Courtyard Manor agreed to pay the United States \$1,700,000 and to be excluded from all Federal health care programs, including Medicaid, for 2 years in addition to the 10-year period of exclusion effective August 20, 2002. The State of Michigan will receive \$742,954 of the settlement amount.

■ Massachusetts – Caritas Christi, the parent entity of a health care system comprising hospitals, physicians groups, laboratories, and home care agencies in southern New England, agreed to pay \$250,060 to resolve its liability under the CMPL. In May 2007, Caritas Christi disclosed to OIG that it employed or contracted with five individuals who were excluded from participating in Federal health care programs (including Medicaid). Caritas Christi discovered this problem during an annual review of the Federal sanctions lists in late 2006. After disclosing this matter, Caritas Christi cooperated with OIG in

determining the damages related to the employment of four of these individuals and a one-time contract with the fifth person. In addition, as part of the settlement agreement, Caritas Christi provided a certification of its policy and procedures to prevent hiring or contracting with ineligible providers.

Of the CMPs imposed in FY 2008, some were pursued under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), codified at 42 U.S.C. § 1395dd, with regulations at 42 CFR § 489.24. EMTALA, or the “patient dumping” law, is designed to ensure patient access to appropriate emergency medical services. The requirements of EMTALA apply to all Medicare-participating hospitals, irrespective of the presenting individual’s coverage or ability to pay. As such, OIG’s imposition of CMPs for EMTALA violations help ensure that Medicaid patients, among others, obtain needed emergency care.

Outreach and External Activities

As part of OIG’s ongoing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we have continued to issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid waste, fraud, and abuse.

Advisory Opinions to Outside Parties

Pursuant to section 205 of the 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, safe harbor provisions,¹⁰ and other OIG health care fraud and abuse authorities. The following are examples of advisory opinions issued in FY 2008 that relate to the Medicaid environment:

- Advisory Opinion 07-18 – OIG considered an existing and a proposed arrangement whereby a nonprofit, tax-exempt charitable organization would subsidize cost-sharing and premium obligations associated with outpatient drug treatment owed by financially needy Medicare and Medicaid patients with certain chronic diseases. The organization was funded mostly by manufacturers of drugs used to treat the covered diseases, and all donations were in either cash or cash equivalents. OIG determined that although the arrangements could implicate the anti-kickback statute, OIG would not impose sanctions. In addition, OIG determined that the arrangements would not constitute grounds for the imposition of CMPs under section 1128A(a)(5) of the Social Security Act, which prohibits inducements to beneficiaries. OIG made these determinations following an analysis of two remunerative aspects of the arrangements: the donor contributions to the organization and the organization’s grants to beneficiaries. With respect to the former, OIG determined that it appeared unlikely that the donor contributions would influence any beneficiary’s selection of a provider, practitioner, supplier, or product or the selection of any particular insurance plan and that there appeared to be a minimal risk that the

¹⁰ The safe harbor regulations specify various payment and business practices that, although potentially capable of inducing referrals of business reimbursable under the Federal health care programs, would not be treated as criminal offenses under the anti-kickback statute.

donor contributions would improperly influence referrals by the organization. With respect to the latter, OIG determined that the organization's subsidy for certain eligible, financially needy Medicare and Medicaid beneficiaries would not be likely to improperly influence any beneficiary's selection of a particular provider, practitioner, supplier, or product. OIG reached these conclusions based on a combination of many factors more fully described in the opinion.

■ Advisory Opinion 08-04 – OIG considered a proposed arrangement whereby a manufacturer of health care products and pharmaceuticals would provide one complimentary trial supply of a hemophilia medication to hemophilia A patients, including Medicare and Medicaid beneficiaries. An eligible patient would receive the medication free of charge after a participating physician prescribed it, and the patient submitted enrollment and authorization forms to an administrator of the proposed arrangement. No third-party payors, including Federal health care programs, would be billed for the medication dispensed under the proposed arrangement. OIG determined that although the proposed arrangement could implicate the anti-kickback statute, OIG would not impose sanctions for a combination of reasons. First, with respect to whether the proposed arrangement would entail an offer of remuneration from the manufacturer to the participating physicians, OIG concluded that there would be no direct or indirect monetary or economic remuneration to the physicians, and OIG did not discern any other benefit to the physicians of the type that would be subject to sanctions. Second, with respect to whether patients would be receiving remuneration in the form of the free one-time trial supply of the medication as an inducement to self-refer to the medication in the future, OIG concluded that the risk would be low based on a number of considerations, for example, that the proposed arrangement entailed no cost to Federal health care programs; the risk of steering associated with starting patients on a particular course of treatment was reduced in the proposed arrangement, the proposed arrangement would not likely result in overutilization of the medication, and the proposed arrangement included a number of additional safeguards that limit the risk of fraud.

Provider Self-Disclosure Protocol

Since 1998, OIG has made available comprehensive guidelines describing the process for providers to voluntarily submit self-disclosures of fraud, waste, or abuse. The guidelines, entitled "Provider Self-Disclosure Protocol," enable providers to minimize the potential costs and disruptions that a full-scale OIG audit or investigation may entail if fraud is uncovered. The self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from doing business with Federal health care programs. After making an initial disclosure, the provider or supplier undertakes a thorough internal investigation of the nature and cause of the matters uncovered and makes a reliable assessment of their economic impact, e.g., estimated losses to Federal health care programs. OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. On April 15, 2008, OIG published an "Open Letter to Health Care Providers" describing refinements to the Self-Disclosure Protocol, such as actions to streamline OIG's internal procedures.

During FY 2008, self-disclosure cases resulted in \$56.4 million in HHS receivables. Many disclosure situations involve Medicaid as well as Medicare. For example, Inglis House, a specialty nursing care facility for adults with physical disabilities, agreed to pay \$5,547,940 to resolve its liability under the CMPL and Pennsylvania State law. Inglis used OIG's Provider Self-Disclosure Protocol to report that it submitted eight types of false claims to Medicare and Medicaid. Violations included overly frequent comprehensive resident assessments, which improperly inflated Inglis's Medicaid case mix index; billing Medicaid for services covered by Medicare Part A; billing Medicare part B and Medicaid for services that should have been included in the Medicare Part A payment; and wrongfully billing Medicare and Medicaid for Certified Registered Nurse Practitioner services. In addition to entering into the monetary settlement, Inglis entered into a 5-year CIA with OIG.

Medicaid Integrity Program Conferences

In FY 2008, OIG hosted the remaining 7 of 13 Medicaid Integrity Program (MIP) training conferences involved in a national Medicaid fraud and abuse outreach effort initiated in 2007. The seven conferences provided 900 attendees training in Medicaid oversight and enforcement activities and set in motion working relationships and future collaboration among OIG, Federal and State investigators, auditors, attorneys, and analysts from 24 States.

Medicaid Integrity Program Conferences

	Region	Location	Dates	Attendance
FY 2007	New York	Cape May, NJ	March 5–7, 2007	90
	Boston	Boston, MA	May 9–10, 2007	90
	Dallas	Dallas, TX	June 5–7, 2007	100
	Chicago	Indianapolis, IN	July 10–11, 2007	120
	Atlanta	Atlanta, GA	August 21–22, 2007	110
	Dallas	Baton Rouge, LA	September 11–13, 2007	140
FY 2008	Philadelphia	State College, PA	October 16–18, 2007	125
	Atlanta	Orlando, FL	November 5–7, 2007	130
	Los Angeles San Francisco	Monterey, CA	November 27–29, 2007	225
	San Francisco	Spokane, WA	April 8–10, 2008	135
	Kansas City	Des Moines, IA	May 7– 8, 2008	120
	Kansas City	Denver, CO	June 11–12, 2008	100
	Los Angeles	Phoenix, AZ	July 15–16, 2008	95

Organizing and holding the MIP conferences has enabled OIG to involve each of the following agencies in a strategic planning process to collaboratively address Medicaid fraud and abuse: CMS, the CMS Medicaid Integrity Group (CMS/MIG); District Attorneys' Offices; the FBI; independent/nonprofit health insurance associations (e.g., the National Insurance Crime Bureau); MFCUs; CMS Program Safeguard Contractors; State agencies (e.g., State Health and Human Services Departments, Divisions of Medical Assistance and Human Services, Offices of the State Comptroller); State Attorney General Offices; State Medicaid Inspector General Offices; and United States Attorneys' Offices.

Holding multiple conferences across the country enabled OIG to address program integrity issues and vulnerabilities that differ substantially across State lines and within various regions. Each agenda was tailored to address specific needs unique to the States within the hosting OIG region. Breakout sessions helped further achieve these goals by focusing on specific areas with the highest risk for fraud.

Collaboration With Medicaid Integrity Group

OIG collaborates with CMS/MIG to coordinate and maximize our respective activities to protect the integrity of Medicaid. OIG has provided feedback and technical assistance to CMS/MIG on a number of products, including the statement of work, task orders, and audit protocols for its Medicaid integrity contractors and letters to State Medicaid Directors. OIG has also offered input into the curriculum for CMS/MIG's training programs for its newly hired staff and for State Medicaid program integrity staff. In addition, OIG and CMS/MIG jointly developed procedures for CMS/MIG's Medicaid integrity contractors to refer cases of potential fraud to OIG. Finally, in followup to OIG's report on suspected fraud referrals from State Medicaid programs to MFCUs, OIG provided technical assistance to CMS/MIG on the development of suspected fraud referral performance standards for State Medicaid agencies. On September 30, 2008, CMS/MIG implemented its Performance Standard for Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit.

Government-Industry Roundtable

On December 6, 2007, OIG and the Health Care Compliance Association (HCCA) cosponsored a Government-industry roundtable, Driving for Quality in Long-Term Care: A Board of Directors Dashboard. The roundtable discussions enabled representatives from the long-term care industry to share experiences and inform OIG and HCCA of issues related to boards of directors' oversight of quality of care. On January 31, 2008, OIG and HCCA published a report summarizing the roundtable discussions. The report is available on the OIG Web site at: <http://www.oig.hhs.gov/fraud/docs/complianceguidance/Roundtable013007.pdf>.

Collaboration With Department of Justice on Litigation

DOJ and OIG launched a program in which OIG attorneys serve as Special Assistant United States Attorneys (SAUSA). Some are detailed full-time to DOJ's Criminal Division, Fraud Section, for 6-month assignments; others prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the departments in fighting fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to durable medical equipment as well as other Medicare and Medicaid fraud. Given the SAUSA program's success, OIG and DOJ plan to expand the it to augment prosecutorial resources in districts across the country.

OVERSIGHT IN FISCAL YEAR 2009 AND BEYOND

At the beginning of each FY, OIG publishes its Work Plan to highlight the areas in which it expects to conduct oversight and program integrity activities during the coming year. In addition to being a planning document, the Work Plan serves as a means for focusing public attention on the areas deemed important and identified as particularly vulnerable to fraud, waste, and abuse.

Throughout each FY, OIG work undertaken may change for a number of reasons. Some activities announced in the Work Plan may shift from higher to lower priority or may be postponed until future years as a result of the changing focus of Congress, the Secretary, or OIG; because of an intervening emergency; or in response to trends identified in 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 C of this document identifies the Medicaid work in progress and new work that OIG anticipates undertaking during FY 2009. Although most Work Plan items will be initiated in FY 2009, many will not be completed within the FY. Some of these reviews increase the scope and depth of prior OIG work by conducting follow-up activities and others expand into new and emerging areas of interest. OIG will also continue its investigative and enforcement activities, as well as its outreach and guidance to the health care industry. Detailed summaries of OIG's anticipated work activities for FY 2009 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.asp>.

In addition, we are planning other activities to enhance Medicaid enforcement and fraud prevention. For example, we expect to continue working with CMS, State MFCUs, and the National Association for Medicaid Program Integrity to improve coordination and collaboration on joint investigations, projects, and issues. OIG will continue to closely analyze the Medicaid program for vulnerabilities and to develop new methods and initiatives to identify and combat evolving fraud, waste, and abuse activities.

CONCLUSION

The varied and far-reaching activities described in this document and its appendixes help position OIG and its partners to effectively monitor the integrity of funds appropriated to HHS to operate and oversee Medicaid and related programs.

APPENDIX A: DEFICIT REDUCTION ACT REQUIREMENTS

Sections 6001, 6031, and 6034 of the Deficit Reduction Act of 2005 (DRA) include provisions that require the Department of Health and Human Services (HHS), Office of Inspector General (OIG), to conduct specified activities, as well as to report annually on overall Medicaid activities. These sections are summarized below.

Section 6001: Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions

Effective January 1, 2007, section 6001 required the Centers for Medicare & Medicaid Services (CMS) to change its Federal upper limit (FUL) calculations (i.e., the method of setting limits on what the Federal Government would reimburse Medicaid State agencies for prescription drug payments) to base the limits on average manufacturer price (AMP) and to provide AMP data to States on a monthly basis beginning July 1, 2006. This section also required OIG to, by no later than June 1, 2006, (1) review the requirements for, and manner in which, AMPs are determined under section 1927 of the Social Security Act 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 a report entitled “Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005” (A-06-06-00063), which fulfilled this statutory requirement. In this report, OIG found that existing requirements for determining aspects of AMP were unclear and that manufacturers’ methods of calculating AMPs were inconsistent. OIG recommended that the Secretary direct CMS 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.

In July, 2007, CMS issued a final regulation at 72 Fed. Reg. 39142, which implemented the requirements of the DRA by establishing a new method of calculating FULs, based on AMPs and aimed at reining in inflated drug product payments. The rule was to take effect on January 1, 2008. However, in December 2007, a Federal district court issued a preliminary injunction prohibiting CMS from implementing the new FULs. Additionally, in July 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 delaying the implementation of the new FULs and prohibiting public disclosure of AMPs until October 2009. While this prohibition is in effect, CMS continues to calculate FUL amounts based on the previous formula (i.e., 150 percent of the lowest published price).

During FY 2007, OIG continued to address topics related to the FUL for multiple source drugs and other drug payment provisions by issuing an evaluation report in June 2007 entitled

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

Section 6031: Encouraging the Enactment of State False Claims Acts

Effective January 1, 2007, this section provides a financial incentive for States to enact false claims acts (FCA) that establish liability to the States for the submission of false or fraudulent claims to the States’ Medicaid programs. 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 percent, increasing the State’s share by 10 percent.

Specifically, for a State to be eligible for the 10-percent 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: it establishes liability to the State for false or fraudulent claims described in the FCA with respect to Medicaid expenditures; it contains provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA; it contains a requirement for filing an action under seal for 60 days with review by the State Attorney General; and it contains a civil penalty that is not less than the amount authorized by the FCA.

On August 21, 2006, OIG published in the Federal Register (71 Fed. Reg. 48552) its guidelines for evaluating State FCAs under the requirements of section 6031 of the DRA. This notice was developed in consultation with the Department of Justice’s (DOJ) Civil Division. In the notice, OIG invited the States to request review of their FCAs.

During FY 2008, OIG provided written responses to 10 States and approved 4 of the State laws—those passed by California, Georgia, Indiana, and Rhode Island—for the DRA incentive. OIG made these determinations in consultation with DOJ’s Civil Division. The response letters are published on OIG’s Web site at <http://www.oig.hhs.gov>.

Section 6034: Medicaid Integrity Program

This section establishes the Medicaid Integrity Program and requires the Secretary to enter into contracts to enhance the capacity of CMS to conduct oversight of Medicaid expenditures. The program’s activities include: review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made; audit of claims for payment for items or services furnished or for administrative services rendered; and education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care. The section further establishes that from fiscal year (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 of the DRA also requires OIG to identify to Congress the use and effectiveness of OIG’s use of such funds no later than 180 days after the end of each FY. This document responds to that requirement for FY 2008.

**APPENDIX B:
AUDIT AND EVALUATION REVIEWS COMPLETED IN FISCAL YEAR 2008**

This appendix contains report titles and reference numbers for the Office of Inspector General’s (OIG) Medicaid-related audits and evaluations that were completed during fiscal year 2008. Any publicly available reports published as a result of these reviews are available on OIG’s Web site at <http://www.oig.hhs.gov>.

**Medicaid Audits and Evaluations
Completed in Fiscal Year 2008**

Health Care Sectors	Reviews Completed
Medicaid Hospitals	6
Medicaid Home, Community, and Nursing Home Care	9
Medicaid Prescription Drugs	48
Other Medicaid Services	13
Medicaid Administration	33
Medicaid Information Systems and Data Security	10
Medicaid and State Children’s Health Insurance Program	2
Total	121

Medicaid Hospitals

Review of Medicaid Services Provided on the Day of Admission to an Inpatient Hospital or During an Inpatient Hospital Stay in New York State (A-02-04-01006)

Review of Disproportionate Share Hospital Payments Made by Pennsylvania to Temple University Hospital for State Fiscal Year 2005-2006 (A-03-07-00207)

Review of Disproportionate Share Hospital Payments Made by Penn State Milton S. Hershey Medical Center for State Fiscal Year 2005-2006 (A-03-07-00208)

Review of Disproportionate Share Hospital Payments Made by Pennsylvania to University of Pittsburgh Medical Center—Presbyterian/Shadyside for State Fiscal Year 2005-06 (A-03-07-00209)

Review of Indiana Medicaid Disproportionate Share Hospital Eligibility for July 1, 2000, Through June 30, 2003 (A-05-06-00045)

Review of Missouri’s Determination of Medicaid Disproportionate Share Hospital Eligibility for State-Owned Institutions for Mental Diseases (A-07-06-03086)

Medicaid Home, Community, and Nursing Home Care

Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003 (A-01-05-00004)

Review of Personal Care Services Claimed by The Center for Living and Working, Inc.
(A-01-06-00011)

Review of Selected Alabama Medicaid Rehabilitation Services Costs for State Fiscal Year 2002
(A-04-04-04005)

Review of Medicaid Targeted Case Management Services Rendered by the Georgia Department
of Juvenile Justice During Federal Fiscal Years 2003 and 2004 (A-04-06-00022)

Review of Minnesota Medicaid Reimbursement for Targeted Case Management Services for
Fiscal Years 2003 and 2004 (A-05-05-00059)

Review of Kansas's Medicaid Payments for Targeted Case Management for the Period July 1,
2000, Through June 30, 2003 (A-07-06-03074)

Iowa Medicaid Payments for Targeted Case Management for Fiscal Years 2003 Through 2004
(A-07-06-03078)

Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic
Services (OEI-07-06-00640)

Payments Made in Error for Personal Care Services During Institutional Stays
(OEI-07-06-00620)

Medicaid Prescription Drugs

Follow-Up Audit of the Medicaid Drug Rebate Program in Connecticut (A-01-08-00002)

Follow-Up Audit of the Medicaid Drug Rebate Program in Vermont (A-01-08-00004)

Follow-Up Audit of the Medicaid Drug Rebate Program in New York (A-02-07-01055)

Follow-Up Audit of the Medicaid Drug Rebate Program in New Jersey (A-02-07-01056)

Follow-Up Audit of the Medicaid Drug Rebate Program in the District of Columbia
(A-03-07-00216)

Follow-Up Audit of the Medicaid Drug Rebate Program in Delaware (A-03-07-00217)

Follow-Up Audit of the Medicaid Drug Rebate Program in Virginia (A-03-07-00218)

Review of Medicaid Outpatient Drug Expenditures in West Virginia for the Period October 1,
2003, Through September 30, 2005 (A-03-07-00220)

Follow-Up Audit of Medicaid Drug Rebate Program in Pennsylvania (A-03-08-00201)

Follow-Up Review of the Medicaid Drug Rebate Program in Florida (A-04-07-07022)

Follow-Up Review of the Medicaid Drug Rebate Program in Alabama (A-04-07-07024)

Follow-Up Audit of the Medicaid Drug Rebate Program in Tennessee (A-04-07-07026)

Follow-Up Review of Medicaid Drug Rebate Program in North Carolina (A-04-07-07028)

Review of Medicaid Outpatient Drug Expenditures in Illinois for the Period October 1, 2003, Through September 30, 2005 (A-05-07-00019)

Review of the Medicaid Drug Rebate Program in Minnesota (A-05-08-00010)

Review of Medicaid Drug Rebate Program in Illinois (A-05-08-00011)

Follow-Up Review of the Medicaid Drug Rebate Program in Wisconsin (A-05-08-00012)

Follow-Up Review of the Medicaid Drug Rebate Program in Michigan (A-05-08-00014)

Follow-Up Review of the Medicaid Drug Rebate Program in Kentucky (A-05-08-00015)

Review of Minnesota's Drug Rebate Accounts Receivable Balance Report on the Form CMS-64 (A-05-08-00058)

Follow-Up Audit of the Medicaid Drug Rebate Program in Arkansas (A-06-07-00015)

Review of Average Manufacturer Price Calculations – Manufacturer A (A-06-07-00041)

Review of Average Manufacturer Price Calculations – Manufacturer B (A-06-07-00040)

Review of Average Manufacturer Price Calculations – Manufacturer C (A-06-07-00039)

Review of Generic Drug Price Increases (A-06-07-00042)

Follow-Up Audit of the Drug Rebate Program in Louisiana (A-06-07-00067)

Follow-Up Audit of the Medicaid Drug Rebate Program in Oklahoma (A-06-07-00069)

Follow-Up Audit of the Medicaid Drug Rebate Program in New Mexico (A-06-07-00071)

Follow-Up Audit of the Medicaid Drug Rebate Program in Texas (A-06-08-00028)

Review of Medicaid Outpatient Drug Expenditures in Missouri for the Period October 1, 2002, Through September 30, 2004 (A-07-06-04063)

Follow-Up Audit of Medicaid Drug Rebate Program in Iowa (A-07-07-03094)

Follow-Up Audit of the Medicaid Drug Rebate Program in Missouri (A-07-07-03096)

Follow-Up Audit of the Medicaid Drug Rebate Program in Nebraska (A-07-07-03097)

Follow-Up Audit of the Medicaid Drug Rebate Program in Utah (A-07-07-03098)

Follow-Up Audit of the Medicaid Drug Rebate Program in Montana (A-07-07-03101)

Review of Medicaid Outpatient Drug Expenditures in Montana for the Period October 1, 2001, Through September 30, 2004 (A-07-07-04103)

Review of Medicaid Outpatient Drug Expenditures in Colorado for the Period October 1, 2002, Through September 30, 2004 (A-07-07-04113)

Follow-Up Audit of the Medicaid Drug Rebate Program in Kansas (A-07-08-03102)

Follow-Up Audit of the Medicaid Drug Rebate Program in North Dakota (A-07-08-03105)

Follow-Up Audit of the Medicaid Drug Rebate Program in Wyoming (A-07-08-03106)

Follow-Up Audit of the Medicaid Drug Rebate Program in Colorado (A-07-08-03108)

Follow-Up Audit of the Medicaid Drug Rebate Program in South Dakota (A-07-08-03110)

Follow-Up Audit of the Medicaid Drug Rebate Program in Oregon (A-09-07-00052)

Follow-Up Audit of the Medicaid Drug Rebate Program in Washington State (A-09-07-00062)

Follow-Up Audit of the Medicaid Drug Rebate Program in Idaho (A-09-07-00064)

Follow-Up Audit of the Medicaid Drug Rebate Program in Hawaii (A-09-07-00081)

Follow-Up Audit of the Medicaid Drug Rebate Program in California (A-09-07-00084)

Unit of Measure Inconsistencies in the Medicaid Prescription Drug Program (OEI-05-07-00050)

Other Medicaid Services

Review of New Jersey's Medicaid School-Based Rates (A-02-04-01017)

Review of New Jersey Family Planning Claims for the Period July 1, 1997, Through March 31, 2002 (A-02-05-01016)

Review of Outpatient Medicaid Claims Billed as Family Planning by New Jersey
(A-02-06-01010)

Review of Inpatient Hospital Claims Billed as Family Planning Under New Jersey Medicaid
Program (A-02-06-01020)

Review of Medicaid Claims Made by Freestanding Residential Treatment Facilities in New York
State (A-02-06-01021)

Review of Federal Medicaid Claims for Beneficiaries in the Family Planning Benefit Program in
New York State (A-02-07-01001)

Review of Federal Medicaid Claims Made by Inpatient Substance Abuse Treatment Facilities in
New Jersey (A-02-07-01005)

Review of Non-Emergency Transportation Services Provided by Epps Transportation Services,
Inc. from January 1, 2004, Through December 31, 2006 (A-03-07-00204)

Review of Wisconsin's Non-Emergency Medical Transportation Costs for Services Provided by
American United Taxicab, Inc. for January 1 Through December 31, 2005 (A-05-08-00040)

Review of Kansas's Medicaid Payments for the Family Preservation Program for the Period
July 1, 2000, Through June 30, 2003 (A-07-06-03076)

Review of Kansas's Medicaid Payments for the Child Welfare Services Program for the Period
July 1, 2000, Through June 30, 2003 (A-07-06-03079)

Medicaid School-Based Services in Utah – Review of Payment Rates (A-07-06-04069)

External Quality Reviews in Medicaid Managed Care (OEI-01-06-00510)

Medicaid Administration

Review of Rhode Island's Medicaid Nonemergency Transportation Costs for March 1, 2004,
Through May 31, 2005 (A-01-06-00007)

Review of Medicaid Credit Balance at Boston Medical Center for the Period Ending March 31,
2007 (A-01-07-00008)

Review of Medicaid Overpayments at First Atlantic Nursing Facilities in Maine for Calendar
Years 2004 Through 2006 (A-01-07-00009)

Review of Medicaid Overpayments at North Country Associates, Inc. in Maine for Calendar
Years 2004 Through 2006 (A-01-07-00012)

Review of New Jersey Medicaid Contingency Fee Contract Payments for the Period April 1, 1996, Through June 30, 2001 (A-02-06-01006)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in New Jersey and New York for July 1, 2005, Through June 30, 2006 (A-02-07-01029)

Medicaid Payments Services Provided to Beneficiaries With Concurrent Eligibility in New York and New Jersey for July 1, 2005, Through June 30, 2006 (A-02-07-01030)

Medical Assistance Provided by Maryland to Hurricane Katrina Evacuees (A-03-07-00200)

Medical Assistance Provided by Delaware to Hurricane Katrina Evacuees (A-03-07-00201)

Medical Assistance Provided by the District of Columbia to Hurricane Katrina Evacuees (A-03-07-00202)

Medical Assistance Provided by Pennsylvania to Hurricane Katrina Evacuees (A-03-07-00210)

Medical Assistance Provided by Virginia to Hurricane Katrina Evacuees (A-03-07-00211)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in the District of Columbia and Maryland for July 1, 2005, Through June 30, 2006 (A-03-07-00214)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Maryland and the District of Columbia for July 1, 2005, Through June 30, 2006 (A-03-07-00215)

South Carolina Medicaid Durable Medical Equipment Provider Enrollment Practices From March 21, 1995, Through June 30, 2005 (A-04-05-04010)

Audit of North Carolina's Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries From April 2004 Through March 2007 (A-04-07-03011)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Georgia and Florida for July 1, 2005, Through June 30, 2006 (A-04-07-03033)

Review of Hurricane Katrina Uncompensated Care Costs Claimed by Mississippi for the University of Mississippi Medical Center (A-04-07-06004)

Review of Hurricane Katrina Uncompensated Care Costs Claimed by Mississippi for Forrest General Hospital (A-04-07-06017)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Florida and Georgia for July 1, 2005, Through June 30, 2006 (A-04-08-03034)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Two States During August 2003 (A-05-06-00057)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Illinois and Indiana for July 1, 2005, Through June 30, 2006 (A-05-06-00069)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Indiana and Illinois for July 1, 2005, Through June 30, 2006 (A-05-06-00070)

Review of Section 1915(c) Mental Retardation or Related Condition Waiver Services at Dunganvin, Minnesota, From July 1, 2004, Through June 30, 2005 (A-05-07-00023)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Arizona and California for July 1, 2005, Through June 30, 2006 (A-05-07-00057)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in California and Arizona for July 1, 2005, Through June 30, 2006 (A-05-07-00058)

Review of Social Security Act Section 1915(c) Waiver Payments for Home and Community-Based Services at Chicago ARC, July 1, 2004, Through June 30, 2005 (A-05-07-00080)

Review of Social Security Act Section 1915(c) Waiver Payments for Home and Community-Based Services at Seguin Services, Inc., July 1, 2004, Through June 30, 2005 (A-05-08-00018)

Upper Payment Limit Payments to Texas State Hospitals for Inpatient Services (A-06-07-00025)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Missouri and Kansas for July 1, 2005, Through June 30, 2006 – Missouri Department of Social Services (A-07-07-04078)

Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Kansas and Missouri for July 1, 2005, Through June 30, 2006 – Kansas State Agency (A-07-07-04079)

Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003, Through June 30, 2005 (A-09-06-00032)

State Medicaid Agency Referrals to the Office of Inspector General Exclusions Program (OEI-01-06-00301)

Medicaid Information Systems and Data Security

Review of Centers for Medicare & Medicaid Services' Medicaid Information Technology Audit Resolution Process (A-04-06-05039)

Medicaid Information Technology Controls at the State of Indiana – Follow-Up (A-05-07-00071)

Review of Information System Controls Over New Mexico's Medicaid Claims Processing (A-06-06-00084)

Review of Information System General Controls Over New Mexico's Eligibility System for Entitlement Programs (A-06-07-00076)

Audit of General Controls for Montana Medicaid Claims Processing (A-07-07-00255)

Audit of General Controls for Medicaid Eligibility Determination at the Montana Department of Public Health and Human Services (A-07-07-00256)

Review of Technical Support Component of South Dakota Bureau of Information and Telecommunications (A-07-08-00261)

Review of Information System General Controls Over Arizona's Medicaid Claims Processing (A-09-07-00022)

Review of Data Security Controls Over Medicaid Claims Processing at Arizona's Department of Administration Data Center (A-09-07-00057)

Fee-for-Service Payments for Services Covered by Capitated Medicaid Managed Care (OEI-05-07-00320)

Medicaid and State Children's Health Insurance Program

Review of State Children's Health Insurance Program Payments in Puerto Rico (A-02-04-01019)

Separate State Children's Health Insurance Program Enrollees' Eligibility for Medicaid in 2006 (OEI-06-07-00310)

APPENDIX C: WORK IN PROGRESS AND NEW STARTS

This appendix lists Medicaid-related audit and evaluation work included in the Office of Inspector General's (OIG) fiscal year (FY) 2009 Work Plan designated as work in progress (as of October 1, 2008) or as new starts to begin during FY 2009 or FY 2010. The work will be conducted by OIG's Office of Audit Services (OAS) and Office of Evaluation and Inspections (OEI). Summaries of the objectives and context of each project are provided in the Work Plan, which is available in the "Publications" section of the OIG Web site at: <http://www.oig.hhs.gov/publications.asp>.

Medicaid Hospitals

Hospital Outlier Payments

(OAS; W-00-08-31069; various reviews; expected issue date: FY 2009; work in progress)

States' Disproportionate Share Hospital Payments for Care for Individuals in Institutions for Mental Diseases

(OAS; W-00-08-31300; various reviews; expected issue date: FY 2009; work in progress)

Provider Eligibility for Medicaid Reimbursement

(OAS; W-00-07-31301; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Disproportionate Share Hospital Payment Distribution

(OAS; W-00-08-31302; various reviews; expected issue date: FY 2009; work in progress)

Supplemental Payments to Private Hospitals

(OAS; W-00-09-31126; various reviews; expected issue date: FY 2010; new start)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services

(OAS; W-00-09-31127; various reviews; expected issue date: FY 2009; new start)

Medicaid Home, Community, and Nursing Home Care

Community Residence Rehabilitation Services

(OAS; W-00-08-31087; various reviews; expected issue date: FY 2009; work in progress)

Targeted Case Management

(OAS; W-00-05-31082; W-00-06-31082; W-00-08-31082; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments to Continuing Day Treatment Providers

(OAS; W-00-09-31128; various reviews; expected issue date: FY 2010; new start)

Medicaid Payments to Nursing Homes While Dual-Eligible Beneficiaries Received Covered Medicare Part A Services

(OAS; W-00-09-31129; various reviews; expected issue date: FY 2009; new start)

Transparency Within Nursing Facility Ownership

(OAS; W-00-09-31130; various reviews; expected issue date: FY 2010; new start)

Medicaid Home Health Agency Claims

(OAS; W-00-08-31304; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Personal Care Services

(OAS; W-00-07-31035; W-00-08-31035; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Medicare-Covered Home Health Services

(OAS; W-00-08-31305; various reviews; expected issue date: FY 2009; work in progress)

Compliance With States' Requirements for Medicaid-Funded Personal Care Service Attendants

(OEI-07-08-00430; expected issue date: FY 2009; work in progress)

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

(OEI; 09-08-00360; expected issue date: FY 2009; work in progress)

State and Federal Oversight of Home- and Community-Based Services

(OEI; 02-08-00170; expected issue date: FY 2009; work in progress)

Medicaid Adult Day Health Service Payments for Ineligible and Absent Beneficiaries

(OEI; 09-07-00500; expected issue date: FY 2009; work in progress)

Community Transition Services Provided to Medicaid Home- and Community-Based Services Waiver Beneficiaries

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Plans of Care: Addressing Minimum Data Set and Resident Assessment Protocols Through Provided Services

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Use of Civil Monetary Penalty Funds

(OAS; W-00-08-31303; various reviews; expected issue date: FY 2010; work in progress; OEI; 00-00-00000; expected issue date: FY 2010; new start)

Payments for "Bed Holds"

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid Prescription Drugs

Timely Submission of Average Manufacturer Price Data
(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Manufacturer Submissions of Outlier Average Manufacturer Prices
(OEI; 03-07-00740; expected issue date: FY 2009; work in progress)

Calculation of Average Manufacturer Prices
(OAS; W-00-09-31202; various reviews; expected issue date: FY 2010; new start)

States' Medicaid Drug Claims
(OAS; W-00-07-31203, W-00-08-31203; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Drugs Not Approved for Use by Children
(OAS; W-00-09-31131; various reviews; expected issue date: FY 2009; new start)

Family Planning Access and Care and Treatment Adjustments
(OAS; W-00-09-31132; various reviews; expected issue date: FY 2010; new start)

Alien Emergency Drug Claims
(OAS; W-00-09-31133; various reviews; expected issue date: FY 2010; new start)

Medicaid Third-Party Liability for Prescription Drug Payments
(OAS; W-00-09-31134; various reviews; expected issue date: FY 2009; new start)

Compound Drugs
(OAS; W-00-08-31317; A-09-08-00034; expected issue date: FY 2009; work in progress)

Medicaid Reimbursement for Unapproved Drugs
(OEI; 03-08-00500; expected issue date: FY 2009; work in progress)

Zero Dollar Unit Rebate Amounts
(OAS; W-00-08-31106; various reviews; expected issue date: FY 2009; work in progress)

States' Accountability Over Medicaid Drug Rebate Programs
(OAS; W-00-07-31205; W-00-08-31205; various reviews; expected issue date: FY 2009; work in progress)

Additional Rebates of Brand-Name Drugs
(OAS; W-00-09-31306; various reviews; expected issue date: FY 2009; new start)

Assessing the Accuracy of Drug Type Classification in the Medicaid Drug Rebate Initiative File
(OEI; 03-08-00300; expected issue date: FY 2009; work in progress)

Comparison of Medicaid Federal Upper Limit Amounts to Wholesale, Retail, and Medicare Pricing
(OEI; 03-08-00490; expected issue date: FY 2009; work in progress)

Other Medicaid Services

Medicaid Dental Services
(OAS; W-00-09-31135; various reviews; expected issue date: FY 2009; new start)

Family Planning Services
(OAS; W-00-06-31078; W-00-07-31078; W-00-08-31078; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Transportation Services
(OAS; W-00-07-31121; W-00-08-31121; various reviews; expected issue date: FY 2009; work in progress)

State Policies To Safeguard Medicaid Nonemergency Transportation Services
(OEI; 06-07-00320; expected issue date: FY 2009; work in progress)

Medical Equipment
(OAS; W-00-08-31307; various reviews; expected issue date: FY 2009; work in progress)

Early and Periodic Screening, Diagnostic, and Treatment Services
(OEI; 05-08-00520; expected issue date: FY 2009; work in progress)

Providers Billing More Time Than Is Feasible in a Day
(OAS; W-00-09-31137; various reviews; expected issue date: FY 2009; new start)

Rehabilitative Services
(OAS; W-00-08-31028; various reviews; expected issue date: FY 2009; work in progress)

Enhanced Reimbursement to States for Indian Health Service Claims
(OAS; W-00-09-31138; various reviews; expected issue date: FY 2009; new start)

Reimbursement Rates for Services Provided by Indian Health Service Facilities
(OAS; W-00-07-31221; various reviews; expected issue date: FY 2009; work in progress)

Medical Services for Undocumented Aliens
(OAS; W-00-07-31108; W-00-08-31108; various reviews, expected issue date: FY 2009; work in progress)

Medicaid Payments for Laboratory Services for Dual-Eligible Beneficiaries
(OEI; 04-07-00340; expected issue date: FY 2009; work in progress)

Medicaid Administration

Contingency Fee Payment Arrangements

(OAS; W-00-06-31045; W-00-07-31045; W-00-08-31045; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Services Provided Under Section 1115 Demonstration Projects

(OAS; W-00-08-31208; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Waiver Safety Net Care Pools

(OAS; W-00-09-31308; various reviews; expected issue date: FY 2009; new start)

Medicaid Payments for Services Provided Under Section 1915(b) Managed Care/Freedom of Choice Waivers

(OAS; W-00-08-31125; W-00-08-31316; various reviews; expected issue date: FY 2009; work in progress)

Sections 1915(b) and (c) Concurrent Waivers

(OAS; W-00-08-31309; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Payments for Services Provided Under Section 1915(c) Home- and Community-Based Service Waivers

(OAS; W-00-07-39045; W-00-07-31124; W-00-08-31124; various reviews; expected issue date: FY 2009; work in progress)

Enrollment of Excluded Medicaid Providers

(OEI; 09-08-00330; expected issue date: FY 2009; work in progress)

Medicaid Transformation Grants

(OAS; W-00-09-31139; various reviews; expected issue date: FY 2010; new start)

Medicaid Provider Tax Issues

(OAS; W-00-08-31094; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Eligibility in Multiple States

(OAS; W-00-08-31114; various reviews; expected issue date: FY 2009; work in progress)

Duplicate Medicaid Payments to Providers on Behalf of Hurricane Evacuees

(OAS; W-00-08-31117; various reviews; expected issue date: FY 2009; work in progress)

State Agencies' Redeterminations of Medicaid Eligibility

(OAS; W-00-09-31140; various reviews; expected issue date: FY 2010; new start)

Use of Public Assistance Reporting To Reduce Improper Medicaid Payments by Multiple States

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid Administrative Costs

(OAS; W-00-07-39044; W-00-06-31123; W-00-08-31123; various reviews; expected issue date: FY 2009; work in progress)

Medicare/Medicaid Credit Balances

(OAS; W-00-08-31311; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Management Information System Costs

(OAS; W-00-08-31312; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Statistical Information System Data Reporting

(OEI; 04-07-00240; expected issue date: FY 2009; work in progress)

Medicaid Managed Care Encounter Data: Reporting and Utilization

(OEI; 07-06-00540; expected issue date: FY 2009; work in progress)

State Buy-In of Medicare Coverage

(OAS; W-00-08-31220; various reviews; expected issue date: FY 2009; work in progress)

Medicaid Services to Incarcerated Juveniles

(OAS; W-00-07-31222; various reviews; expected issue date: FY 2009; work in progress)

Early Implementation of the Medicaid Transfer of Asset Rules

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicaid's All-Inclusive Rate for Reimbursement to the Indian Health Service

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

States' Subsidies of Employer-Sponsored Insurance Premium Assistance Programs

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Medicare and Medicaid Information Systems and Data Security

Medicare and Medicaid: Security of Portable Devices Containing Personal Health Information at Contractors and Hospitals

(OAS; W-00-09-41047; various reviews; expected issue date: FY 2009; new start)

Medicare and Medicaid Health Information Data Security and Privacy

(OAS; W-00-08-41021; W-09-00-41050; various reviews; expected issue date: FY 2009; work in progress and new start; OEI; 00-00-00000; various reviews; expected issue date: FY 2009; new start)

Medicaid Management Information Systems—Business Associate Agreements

(OAS; W-00-09-41045; various reviews; expected issue date: FY 2009; new start)

Medicaid: Security Controls Over State Web-Based Applications
(OAS; W-00-09-41046; various reviews; expected issue date: FY 2009; new start)

Medicaid: Security Controls at the Mainframe Data Center That Processes States' Claims Data
(OAS; W-00-07-40019; expected issue date: FY 2009; work in progress)

Medicaid and State Children's Health Insurance Program

Medicaid and State Children's Health Insurance Program Citizenship Requirements
(OAS; W-00-09-31224; various reviews; expected issue date: FY 2010; new start)

Dually Enrolled Beneficiaries in a State
(OAS; W-00-08-31314; A-04-08-03036; expected issue date: FY 2009; work in progress)

Medicaid and State Children's Health Insurance Program Payment Error Rate Measurement
(OAS; W-00-09-31141; various reviews; expected issue date: FY 2009; new start)

Medicaid and State Children's Health Insurance Program Payment Error Rate for One State's
Managed Care Program
(OAS; W-00-09-40037; expected issue date: FY 2009; new start)

APPENDIX D: ACRONYMS AND ABBREVIATIONS

The following is a list of selected acronyms and abbreviations used in this publication.

AMP	average manufacturer price
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CMS/MIG	CMS, Medicaid Integrity Group
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	disproportionate share hospital
EMTALA	Emergency Medical Treatment and Labor Act
EQRO	external quality review organization
FCA	False Claims Act
FUL	Federal upper limit
FY	fiscal year
HCBS	home- and community-based services
HCCA	Health Care Compliance Association
HCFAC	Health Care Fraud and Abuse Control Program
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IMD	institution for mental diseases
IT	information technology
MAC	maximum allowable cost
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
OAS	Office of Audit Services
OEI	Office of Evaluation and Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
SAUSA	Special Assistant United States Attorney
SCHIP	State Children's Health Insurance Program
TCM	targeted case management
UPL	upper payment limit