



Fiscal Year 2010 Office of Inspector General Medicaid Integrity Report

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OIG

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Fiscal Year 2010 Medicaid Integrity Report

Funding for Program Integrity

IN FISCAL YEAR (FY) 2010, the Office of Inspector General (OIG) of the Department of Health & Human Services (HHS) received funding to oversee the integrity of Medicaid activities from four sources: the Health Care Fraud and Abuse (HCFAC) program, created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Medicaid Integrity Program (MIP), created by the Deficit Reduction Act of 2005 (DRA); the Supplemental Appropriations Act of 2008 (P.L. No. 110-252); and the American Recovery and Reinvestment Act of 2009 (Recovery Act).

Health Care Fraud and Abuse Control Program

The HCFAC program was established by HIPAA to be under the joint direction of the Attorney General and the Secretary of HHS, acting through the Inspector General. Funds are appropriated in amounts that the Secretary 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.”¹

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://www.oig.hhs.gov/publications/hcfac.asp> and <http://www.usdoj.gov/dag/pubdoc.html>.

Since FY 1997, the HCFAC program has been the primary source of funding for Medicare and Medicaid fraud investigations and prosecutions by OIG and the Department of Justice (DOJ). Beginning in FY 2009, we began receiving discretionary funding in support of HCFAC activities to provide additional resources for program integrity work.

¹ The Social Security Act, § 1817(k)(3)(A).

Medicaid Integrity Program

Section 6034 of the DRA established the MIP, through which we received enhanced funding for fraud and abuse control activities “with respect to the Medicaid program” (section 6034(c)). This funding was to be provided annually from FY 2006 through FY 2010 in addition to our HCFAC resources and is available until expended. Specific DRA requirements that pertain to our office are described in Appendix E.

Other Medicaid Oversight Funding

We receive funding to oversee the integrity of Medicaid activities from two other sources: the Supplemental Appropriations Act of 2008 and the Recovery Act. The Supplemental Appropriations Act of 2008 provided additional funding to our office to reduce fraud and abuse in the Medicaid program under Title XIX of the Social Security Act (Medicaid). This funding, which was provided for FY 2009 in addition to other amounts appropriated for Medicaid oversight, is available until expended. It is referred to in this report as Medicaid fraud and abuse (MFA) funding.

The Recovery Act provided funding to ensure proper expenditure of Federal funds under title XIX of the Social Security Act (Medicaid). This funding, which was provided in FY 2009, is available until September 30, 2011.

Overlap Among Oversight Activities

Because there is an overlap among the oversight activities funded by HCFAC, MIP, and other sources, our work relating to Medicaid may draw on funding from more than one source. For investigations and prosecutions, it is particularly difficult (sometimes impossible) to accurately segregate enforcement activities by funding stream. For example, even if we conduct an investigation exclusively with MIP funds, the prosecution of that case could draw upon DOJ’s 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 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 among funding sources; our Medicaid successes are typically the result of combined funding from available resources.

Our audit, evaluation, and investigation work often requires more than a year to yield results. As a consequence, many of the reviews and investigations summarized in this document reflect the results of our work over several years that culminated in FY 2010.

Allocation of Statutory Funding Streams

The table that follows estimates our allocation of statutory funding streams for Medicaid integrity oversight for FY 2005 through FY 2010.

Allocation of Statutory Funding Streams for
 Medicaid Integrity Oversight, FY 2005 – FY 2010
 (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
	HIPAA/ HCFAC	MIP & Other	HIPAA/ HCFAC	MIP & Other		
2005	160	–	36.8	–	36.8	23 %
2006	160	25	44.8	–	44.8	28 %
2007 ²	165.9	25	24.6	24.8	49.4	26 %
2008	169.7	25	32.5	28.3	60.8	31 %
2009 ^{3, 4}	196.2	81 ⁵	33.9	30.9	64.8	29 %
2010	208.5	25	42.1	34.1	76.2	32%

Note: Numbers are approximate because of rounding.

The table illustrates that a sizable portion of our HCFAC funds has been used for Medicaid oversight in recent years.

² 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.

³ Figures have been revised from the FY 2009 publication to reflect revisions in the analysis of FY 2009 data.

⁴ In FY 2009, OIG received a 42-percent increase in funding available for Medicare and Medicaid program integrity activities. Because of this significant increase, and consistent with the purpose of the funding, OIG manages oversight work over multiple years.

⁵ In FY 2009, OIG was appropriated \$25 million for Medicaid oversight through the Supplemental Appropriations Act of 2008 and \$31.25 million for Medicaid oversight through the Recovery Act.

Use and Effectiveness of Program Integrity Funds

To demonstrate the use and effectiveness of our funding, we are attaching appendixes that draw from our core publications that present Medicaid-related accomplishments, work in progress, and open recommendations. Our core publications are:

- *Office of Inspector General Semiannual Report to Congress*
- *Office of Inspector General Work Plan*
- *Office of Inspector General Compendium of Unimplemented Recommendations*

Appendix A

We present in Appendix A the results of Medicaid-related reviews and investigative outcomes completed in FY 2010 that were included in our *Semiannual Report(s) to Congress* (Semiannual Report) for FY 2010.

The Inspector General Act of 1978 (P.L. No. 95-452), as amended, requires that the Inspector General report semiannually to the Congress and the Secretary of HHS on activities and results during the 6-month periods ending March 31 and September 30. Our Semiannual Report describes waste, fraud, abuse, and other management issues arising from our completed work on HHS programs and operations during each period. The report also describes our recommendations and activities to curb the vulnerabilities we find. Semiannual Reports are reliable sources for delineating our accomplishments and priorities in historical increments.

Because our program oversight generally takes the form of a continuous stream of projects that require more than a year to yield results, our use of funding in a year often bears fruit in future years. Therefore, accomplishments highlighted in Appendix A reflect projects that began in prior funding periods but were completed in FY 2010. The funding we used in FY 2010 no doubt supported outcomes that will be realized in FY 2011 or beyond.

Appendix B

We present in Appendix B a list of Medicaid projects in progress at the end of FY 2010 that are described in the *Office of Inspector General Work Plan* (Work Plan) for FY 2011. The list captures the long-term nature of many of our major initiatives, some of which result in multiple reviews and reports. The list also includes Medicaid-related work expected to start in FY 2011.

Appendix C

In Appendix C, we list Medicaid recommendations that are included in the FY 2011 *Office of Inspector General Compendium of Unimplemented Recommendations* (Compendium). The Compendium describes recommendations developed from work completed in prior periods, including in FY 2010 and other years in which DRA funding was received and used. The Compendium summarizes the background, findings, management response, and status of recommendations that, when implemented, will save taxpayer dollars, put funds to better use, and/or improve HHS programs and operations and quality of care.

Appendix D

Appendix D, which is a complete list of our Medicaid-related reports issued during FY 2010, differs from Appendix A in that Appendix A provides short summaries of items that were included in our Semiannual Reports for FY 2010. Not all reports are summarized in the Semiannual Reports. The full text of the publicly available reports listed in Appendix D can be accessed on our Web site by searching on the claim number that follows each title.

Appendix E

Appendix E describes the DRA provisions that apply to our office. Sections 6001, 6031, and 6034 include provisions that require the HHS OIG to conduct specified activities. Section 6001 requires us to review Federal upper payment limits for multiple source drugs and other drug payment provisions. Section 6031 requires us to review State false claims acts to determine whether States would be eligible for 10-percentage-point increases in their shares of false claims recoveries. Section 6034, which established our MIP funding, requires us to identify to Congress annually the use and effectiveness of our use of DRA funds. This document responds to that requirement for FY 2010.

Appendix F

Appendix F defines selected acronyms and abbreviations used in this report and its appendixes.

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Medicaid Results From the
FY 2010 Semiannual Reports to Congress

Appendix A:

Medicaid Results From the FY 2010 Semiannual Reports to Congress

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Appendix A:

Medicaid Results From the FY 2010 Semiannual Reports to Congress

Audits and Evaluations

Audits and evaluations by the Office of Inspector General (OIG) monitor payments, processes, program administration, and information systems. In addition to identifying misspent funds, OIG's reviews often bring about program improvements that help reduce the cost of providing necessary services to Medicaid beneficiaries. Many reviews focus largely on whether the Medicaid program is managed properly and pays a fair price in the health care marketplace. The following are highlights¹ of the findings of OIG audits and evaluations that were included in OIG's *Semiannual Report(s) to Congress* for FY 2010, which, along with the full text of the reports, are posted on OIG's Web site at <http://www.oig.hhs.gov>.

Hospitals

Medicaid Hospitals > Disproportionate Share Hospital Program

States' Uncompensated Care Reimbursements Found To Favor State-Owned Institutions

During Federal fiscal years (FY) 2003 through 2007, most of seven selected States (Kansas, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas) reimbursed State-owned institutions for mental disease (IMD) and other State-owned hospitals the highest proportion of uncompensated care costs. The Medicaid disproportionate share hospital (DSH) program requires States to make special payments, known as DSH payments, to hospitals that serve unusually large numbers of low-income and/or uninsured patients. The Federal Government reimburses States for a percentage of their DSH payments.

¹ The titles of the highlights in Appendix A differ from the titles in the Semiannual Reports, which more closely reflect the report titles. Report titles are provided at the end of each highlight. The full reports can be accessed by searching the OIG Web site using the report numbers that follow the report titles.

We classified hospitals in four categories: State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals. In comparing DSH payments between hospital categories, we found that three of the seven States reimbursed State-owned IMDs the highest proportion of uncompensated care costs; three other States reimbursed other State-owned hospitals the highest proportion of uncompensated care costs; and one State reimbursed private hospitals the highest proportion of uncompensated care costs.

In analyzing the relationship between DSH payments and uncompensated care costs for all of the hospitals classified as DSH hospitals in the seven States, we found that, in the aggregate, State-owned IMDs received DSH payments averaging 92 percent of their uncompensated care costs; other State-owned hospitals received DSH payments averaging 95 percent of their uncompensated care costs; local public hospitals received DSH payments averaging 69 percent of their uncompensated care costs; and private hospitals received DSH payments averaging 38 percent of their uncompensated care costs. *Review of Medicaid Disproportionate Share Hospital Payment Distribution* ([A-07-09-04150](#)) June 2010.

Medicaid Hospitals > Supplemental Rate Payments

Massachusetts Supplemental Rate Payment Claims Failed to Meet Federal and State Plan Requirements

Of the \$337 million that Massachusetts claimed in Medicaid supplemental rate payments to one hospital company during FYs 2004 and 2005, \$11.5 million (\$5.75 million Federal share) was not claimed in accordance with Federal and State plan requirements. Supplemental payments are in addition to the standard reimbursement made under the State agency's acute care hospital contract. The excessive supplemental Medicaid payments occurred because the audited company did not follow procedures set forth in the State plan to calculate the payments. We identified an additional \$5.6 million (\$2.8 million Federal share) in supplemental payments to a medical school affiliated with the company on which we were unable to express an opinion. *Review of Medicaid Supplemental Rate Payments to UMass Memorial Health* ([A-01-07-00013](#)) December 2009.

Home- and Community-Based Services

Medicaid Home- and Community-Based Services > Administrative Costs

Connecticut's Community-Based Administrative Claims of \$19.8 Million May Not Have Met Federal Requirements

In our review of community-based Medicaid administrative costs that Connecticut claimed for State FYs 2005 and 2006, we found that claims totaling \$19.8 million may not have fully complied with Federal requirements. The State claimed reimbursement from the Centers for Medicare & Medicaid Services (CMS) for administrative case management activities provided by contracted organizations. Because the State made omissions and deviations

from acceptable practices when calculating its claims and was unable to provide adequate documentation, we were unable to express an opinion on whether the claims should be allowed. *Review of Connecticut's Community Based Medicaid Administrative Claims for State Fiscal Years 2005 and 2006* ([A-01-08-00003](#)) September 2009.

Other Services, Equipment, and Supplies

Medicaid Services > Children > Health Screening

Most Medicaid Children in Nine States Not Receiving All Required Preventive Screening Services

Most children in nine selected States are not fully benefitting from Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive screening services. Services provided under the EPSDT benefit are intended to screen, diagnose, and treat children eligible for EPSDT services at early, regular intervals to avoid or minimize childhood illness. EPSDT services cover four health-related areas: medical, vision, hearing, and dental. Complete medical screenings under the EPSDT benefit must include the following five age-appropriate components: a comprehensive health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations according to age and health history, appropriate laboratory tests, and health education.

This study focused on medical, vision, and hearing screenings. We found that:

- Seventy-six percent, or 2.7 million children, in 9 States did not receive all of the required medical, vision, and hearing screenings.
- Forty-one percent did not receive any required medical screenings.
- More than half of children did not receive any required vision or hearing screenings.
- Fifty-five percent of children in the nine States received a medical screening during the study period. Of these, 59 percent lacked at least one component of a complete medical screening.

Officials from all nine selected States identified strategies to improve participation in the EPSDT and the completeness of medical screenings. However, additional efforts are required. *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services* ([OEI-05-08-00520](#)) May 2010.

Medicaid Services > Children > School-Based Health Program

New Jersey School-Based Health Services Claims Not Fully Compliant

In two reviews, we found that New Jersey's claims for reimbursement of Medicaid school-based health services submitted by its billing agents did not fully comply with Federal and

State requirements. In addition to meeting other Federal and State requirements, school-based health services must be (1) referred or prescribed by a physician or another appropriate professional, (2) provided by an individual who meets Federal and State qualification requirements, (3) fully documented, (4) actually furnished, and (5) documented in the child's individualized education plan. During our audit periods, New Jersey contracted with separate billing agents to help administer its Medicaid school-based health services program under contingency-fee-based agreements. The results of our reviews follow:

Billing Agent A—Based on our sample results for July 27, 2003, through October 4, 2006, we estimated that New Jersey was improperly reimbursed \$8 million in Federal Medicaid funds. Of the 100 school-based health claims in our sample, 51 did not comply with Federal and State requirements. The 51 claims pertained to services that were not (1) provided or supported, (2) in compliance with referral or prescription requirements, (3) in compliance with Federal provider qualification requirements, or (4) documented in the child's plan. *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Maximus, Inc.* ([A-02-07-01051](#)) April 2010.

Billing Agent B—Based on our sample results for April 6, 2005, through June 27, 2007, we estimated that New Jersey was improperly reimbursed \$5.6 million in Federal Medicaid funds. Of the 100 school-based health claims in our sample, 36 did not comply with Federal and State requirements. The 36 claims pertained to services that were not (1) provided or supported, (2) in compliance with referral or prescription requirements, (3) in compliance with Federal provider qualification requirements, and (4) documented in the child's plan. *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc.* ([A-02-07-01052](#)) September 2010.

Medicaid Services > Children > School-Based Health Program

Estimated \$21.3 Million Improper Federal Funding for Arizona's School-Based Health Services

Arizona did not always claim Federal reimbursement for Medicaid school-based health services in accordance with Federal and State requirements. Of the 100 sampled student-months from January 1, 2004, to June 30, 2006, 46 had 1 or more school-based health services that were not allowable. Based on our sample results, we estimated that the State was improperly reimbursed at least \$21.3 million in Federal Medicaid funds for school-based health services. Medicaid pays for medical services provided to children under Part B of the Individuals with Disabilities Education Act of 2004 (IDEA) through a child's individualized education plan. In addition to meeting other Federal and State requirements, school-based health services must be (1) actually furnished, (2) fully documented, (3) provided by an individual who meets Federal and State qualification requirements, (4) prescribed or referred by a physician or another appropriate professional, and (5) provided to eligible recipients. *Review of Arizona's Medicaid Claims for School-Based Health Services* ([A-09-07-00051](#)) March 2010.

Medicaid Administrative Costs > School-Based Health Program

Allocation Methodology Errors Caused Unallowable Federal Reimbursement Claims by Missouri

Of the \$15.3 million (Federal share) that Missouri claimed in Medicaid administrative costs for the St. Louis Public and Springfield school districts for FYs 2004 through 2006, \$4.2 million was unallowable for Federal reimbursement. Medicaid's school-based health program permits children to receive health-related services, generally without having to leave school. States may be reimbursed for the administrative activities that directly support identifying and enrolling potentially eligible children in Medicaid.

Missouri's School District Administrative Claiming program uses a Department of Health & Human Services (HHS)-approved time and activities allocation methodology to develop, on a statewide basis, the percentages of effort that employees spend on various Medicaid administrative activities. Any errors associated with the allocation methodology and related sampling process affect all of the Missouri school districts. We estimated that the combination of errors that we identified in our review of the St. Louis Public and Springfield districts also caused other Missouri school districts to receive \$16.3 million in unallowable Medicaid payments for FYs 2004 through 2006. We set aside for CMS's adjudication an additional \$1.5 million for administrative costs claimed for the St. Louis Public and Springfield school districts and \$3.9 million for administrative costs claimed for all other Missouri school districts. *Review of Missouri Medicaid Payments for the School District Administrative Claiming Program for Federal Fiscal Years 2004 Through 2006* ([A-07-08-03107](#)) March 2010.

Medicaid Services > Family Planning

New York State Improperly Claimed \$3.8 Million Federal Share for Family Planning Services

Based on our sample results, we estimated that New York received \$3.8 million in unallowable Federal Medicaid reimbursement by improperly claiming enhanced 90-percent Federal reimbursement for Medicaid family planning services claims that were submitted by selected providers. Of the 105 claims in our sample, 50 qualified as family planning services and could be claimed at the enhanced 90-percent Federal reimbursement rate. However, the remaining 55 could not be claimed as family planning services. Of those 55 claims, 51 were for services unrelated to family planning and 4 lacked documentation. The overpayment occurred because the selected providers incorrectly claimed services as family planning and the State's Medicaid Management Information System (MMIS) edit routines did not adequately identify claims unrelated to family planning. *Review of Family Planning Claims Submitted by Selected Providers Under the New York State Medicaid Program* ([A-02-09-01015](#)) September 2009.

Prescription Drugs

Medicaid Prescription Drugs > Federal Share

Compound Drug Expenditures in California May Not Be Eligible for Reimbursement

California's claims for reimbursement of Medicaid compound drug expenditures for FYs 2004 and 2005 did not fully comply with Federal requirements. Of the \$29.5 million (Federal share) reviewed, \$383,000 represented expenditures for compound drug ingredients that were not eligible for Medicaid coverage because the drugs were dispensed after their termination dates. In addition, the State claimed \$1.3 million for compound drug ingredients that were not listed on the quarterly drug tapes and that may not have been eligible for Federal reimbursement. Medicaid generally covers outpatient drugs if manufacturers have rebate agreements with CMS and pay rebates to the States. Under the Medicaid drug rebate program, CMS provides States with a quarterly Medicaid drug tape, which lists all covered outpatient drugs, indicates each drug's termination date if applicable, and specifies whether the Food and Drug Administration (FDA) 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. *Review of Medicaid Compound Drug Expenditures in California for Fiscal Years 2004 and 2005* ([A-09-08-00034](#)) March 2010.

Medicaid Prescription Drugs > Federal Upper Limit

Some Outlier Average Manufacturer Prices in the Federal Upper Limit Program Were Inaccurate

We found that about 20 percent of average manufacturer prices (AMP) reported for the 242 outlier drugs were inaccurate. When the new AMP-based Federal upper limit (FUL) provisions are implemented, CMS will exclude the lowest AMP from the FUL calculation if it is more than 60 percent below the second-lowest AMP to ensure that at least two drug products are available at or below the FUL amount. In January 2008, the lowest AMPs for 242 FUL drugs met this criterion. This study examined the accuracy of the AMP data submitted by manufacturers that would be used in the new FUL calculation, pending the lifting of the Federal court's injunction on its implementation.

Inaccuracies in the reported data resulted in part from discrepancies in the unit of AMP submission that created the appearance of outliers. Furthermore, some outlier AMPs are not accurate and would no longer be outliers if revised data were used. Also, several outlier drug products are no longer sold by manufacturers and therefore should not be included in FUL calculations. *Outlier Average Manufacturer Prices in the Upper Limit Program* ([OEI-03-07-00740](#)) September 2009.

Medicaid Prescription Drugs > Rebates

Rebate Loophole for Multiple-Version Brand-Name Drugs Closed by New Law

Our review found that of the top 150 brand-name drugs for calendar year (CY) 2007 ranked by Medicaid reimbursement, 114 had more than 1 version. For 65 of the 114, the prices of the earliest versions of the drugs exceeded their inflation-adjusted prices when the new versions entered the market. We calculated that, for CYs 1993–2007, States could have collected about \$2.5 billion in additional rebates for the 65 brand-name drugs if the baseline AMPs of the new versions had been adjusted (i.e., reduced) to reflect price increases in excess of inflation for the earliest versions.

For a manufacturer’s covered outpatient drug to be eligible for Federal Medicaid funding, the manufacturer must enter into a rebate agreement that is administered by CMS and pay quarterly rebates to the States. Federal law requires manufacturers to pay an additional rebate when the AMP for a brand-name drug increases more than inflation. We did not evaluate the drug manufacturers’ bases for developing the new versions of drugs identified in our review. Because the Medicaid drug rebate program calculates rebates separately for each version of a drug, manufacturers could develop new versions of brand-name drugs solely to avoid paying additional rebates when they substantially increase prices. [Based on our review, we reported that the risk of manufacturers taking advantage of this potential loophole could increase over time. That risk was effectively eliminated by enactment of section 2501(d) of the Patient Protection and Affordable Care Act of 2010, as amended by section 1206(a) of the Health Care and Education Reconciliation Act of 2010, together called the Affordable Care Act.] *Review of Additional Rebates for Brand-Name Drugs With Multiple Versions* ([A-06-09-00033](#)) March 2010.

Medicaid Administration

Medicaid Administration > Provider Enrollment

States Imposed Few of Their Own Medicaid Enrollment Requirements

Of 188 providers from 26 States who had been excluded by OIG after their enrollment, 8 had disclosed false ownership information at the time of enrollment. Another 8 of the 188 had criminal convictions before they enrolled and committed health care-related crimes after they enrolled. Of the 188 excluded providers, 88 had Federal or State tax liens before or after they enrolled in Medicaid, and 24 had a history of tax debt, criminal convictions, or false disclosures before they enrolled.

We examined the providers’ backgrounds before and after they enrolled to gather information related to potential weaknesses in States’ provider enrollment procedures. In addition, we surveyed the 26 States that enrolled the 188 providers about the procedures they used to enroll the providers and the process they now use to enroll providers.

Pursuant to Federal regulations at 42 CFR § 455.104 and 42 CFR § 455.106, States require providers to disclose information on ownership and control of an entity and criminal convictions related to Federal health care programs. However, the regulations do not require States to verify this information. We found that States impose few enrollment requirements beyond those mandated by Federal regulations. Over half of the excluded providers were subject to no State enrollment requirements beyond the Federal regulations when they enrolled in Medicaid. *Excluded Medicaid Providers: Analysis of Enrollment* ([OEI-09-08-00330](#)) May 2010.

Medicaid Administration > Payment Error Rate

Sampling, Other Issues Prevented Clear Picture of Payment Error Rate Measurement Program

We were unable to determine whether the Payment Error Rate Measurement (PERM) program produced a reasonable estimate of improper FY 2007 fee-for-service (FFS) and managed care payments for Medicaid and the Children's Health Insurance Program (CHIP) because (1) CMS's statistical contractor sampled payments from State universes that were or may have been incomplete or inaccurate, (2) the estimate of improper CHIP payments did not meet the required precision levels, and (3) CMS did not review States' repricing actions.

The Improper Payments Information Act of 2002 (IPIA) requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimates of the improper payments. CMS developed the PERM program to comply with requirements for measuring improper Medicaid program and CHIP payments. The PERM program has measured improper payments made in the FFS, managed care, and eligibility components of Medicaid and CHIP since FY 2007. *Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program* ([A-06-08-00078](#)) May 2010.

Medicaid Administration > Payment Error Rate

California Unable To Reconcile Payment Error Rate Measurement Universes

California was unable to reconcile the FY 2007 PERM universes to the quarterly Forms CMS-64 and CMS-21. CMS developed the PERM program to comply with Federal requirements for measuring improper payments made in the FFS, managed care, and eligibility components of Medicaid and State CHIP in FY 2007 and future years. The Office of Management and Budget (OMB) requires CMS to include the PERM results in its annual accountability report.

We could not determine whether California's managed care and FFS universes were complete and accurate because we were unable to reconcile these universes to Forms CMS-64 and CMS-21. CMS regional officials said they had reconciled the forms to the

accounting records that the State used to support the forms. However, those accounting records did not include detailed claim information. State officials said that they could not reconcile the forms to the managed care or FFS universes, and the California state auditor found that Form CMS-64 was not traceable to individual claims.

Without reconciling the PERM universe to Forms CMS-64 and CMS-21, CMS is unable to show that it has complied with the requirements to produce a statistically valid estimate of improper payments. *Review of California's Department of Health Care Services Fiscal Year 2007 Payment Error Rate Measurement Universes* ([A-06-08-00050](#)) March 2010.

Medicaid Administration > Payment Error Types

Main Causes of Payment, Data Errors Identified

Of 1,356 PERM program medical review errors that we analyzed for FYs 2006 and 2007, 4 types accounted for 78 percent of the errors and 95 percent of the net improper Medicaid overpayments. The four error types were insufficient documentation, no documentation, services that violated State policies, and medically unnecessary services. Of the 202 PERM program data-processing errors that we analyzed for the same period, 4 types accounted for 8 percent of the errors and 64 percent of the net improper Medicaid overpayments. The four error types were pricing errors, noncovered services, rate cell errors for managed care claims, and errors in the logic edits of claim-processing systems. The PERM program annually measures improper payments based on sampled Medicaid claims in 17 States and the District of Columbia; each jurisdiction is chosen once every 3 years. *Analysis of Improper Payments Identified During the Payment Error Rate Measurement Program Reviews in 2006 and 2007* ([A-06-09-00079](#)) April 2010.

Medicaid Administration > Federal Share

Michigan Did Not Report Medicaid Overpayments in Accordance With Regulations

In two reviews summarized below, we determined that Michigan did not report all Medicaid overpayments in accordance with Federal requirements. Federal law requires States to refund the Federal share of a Medicaid overpayment made to a provider, and Federal regulations require States to refund the Federal share at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment.

FYs 2008 and 2009: We estimated that Michigan did not report Medicaid overpayments totaling \$2.3 million (\$1.3 million Federal share) in accordance with Federal requirements. The State also did not report all Medicaid overpayments within the 60-day requirement. Because the State did not report some overpayments and was not prompt in reporting others, the Federal Government incurred a potentially higher interest expense. *Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009* ([A-05-09-00103](#)) September 2010.

First quarter of FY 2010: Our review found that for the quarter ended December 31, 2009, Michigan did not report \$3 million (\$2.2 million Federal share) in Medicaid overpayments in accordance with Federal requirements because of a clerical error. The State did not properly report the overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the Form CMS-64. *Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for the First Quarter 2010* ([A-05-10-00061](#)) September 2010.

Medicaid Administration > Recovery Act

Tennessee's Medical Assistance Program Claim Was Adequately Supported

We found that Tennessee's claim for Federal reimbursement of expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program for the quarter ended December 31, 2008, was adequately supported by actual recorded expenditures. The American Recovery and Reinvestment Act of 2009 (Recovery Act) provides fiscal relief to States to protect and maintain State Medicaid programs during a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' Federal medical assistance percentages (FMAP). For the majority of Medicaid expenditures claimed, CMS reimburses States based on the FMAP, which varies depending on a State's relative per capita income. For the quarter ended December 31, 2008, Tennessee's regular FMAP for Medicaid expenditures was 64.28 percent, and the temporarily increased FMAP was 73.25 percent. *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Tennessee* ([A-04-09-04040](#)) May 2010.

Medicaid Administration > Recovery Act

New York in Compliance With the Recovery Act's Political Subdivision Requirement

New York State complied with the political subdivision requirement for receiving the increased FMAP under the Recovery Act. The State did not require its social services districts (i.e., political subdivisions) to contribute a greater percentage of the non-Federal share of Medicaid expenditures than the percentage required under the State Medicaid plan on September 30, 2008. A State is not eligible for the increased FMAP if it requires its political subdivisions to pay a greater percentage of the non-Federal share of Medicaid expenditures than the percentage required under the State Medicaid plan on September 30, 2008. *Review of New York State's Compliance With the Political Subdivision Requirement for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-02-09-01029](#)) May 2010.

Medicaid Administration > Recovery Act

Five States in Compliance With the Recovery Act's Medicaid Eligibility Requirements

Five States that we reviewed complied with Recovery Act eligibility requirements during the first three quarters of Federal FY 2009. Pursuant to the Recovery Act, States generally are not eligible for FMAP increases for quarters during the recession adjustment period in which their Medicaid eligibility standards, methodologies, or procedures are more restrictive than those in effect on July 1, 2008.

Louisiana, Minnesota, New Hampshire, and Rhode Island—In all four States, the Medicaid eligibility standards, methodologies, and procedures during the audit period were not more restrictive than those in effect on July 1, 2008. The full reports are:

- *Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Louisiana* ([A-06-09-00100](#)) April 2010;
- *Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Minnesota* ([A-05-10-00014](#)) May 2010;
- *Review of New Hampshire's Compliance With the American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements* ([A-01-10-00002](#)) May 2010; and
- *Review of Rhode Island's Compliance With the American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements* ([A-01-09-00007](#)) May 2010.

Texas—Texas made one policy change after July 1, 2008, that resulted in more restrictive Medicaid eligibility standards, methodologies, and procedures during the audit period. However, in accordance with the Recovery Act, the State reinstated the less restrictive policy before July 1, 2009. The State also made administrative policy changes that did not affect the eligibility process. *Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Texas* ([A-06-09-00099](#)) July 2010.

Medicaid Administration > Recovery Act

Two States in Compliance With Recovery Act's Prompt-Pay Requirements

With one exception that was resolved, we found New York and Pennsylvania to be in sufficient compliance with prompt-pay requirements for receiving an increased FMAP under the Recovery Act. Federal regulations require States to pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt. A clean claim is one that can be processed without obtaining additional information from the provider or a third party.

New York—For January 1 through June 30, 2009, New York State complied with the prompt-pay requirement for receiving an increased FMAP. The State paid 100 percent of the 125,618,625 clean claims that it received from applicable providers within 30 days of the

date of receipt. *Review of New York State's Compliance With the Prompt Pay Requirements for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-02-09-01037](#)) August 2010.

Pennsylvania—Pennsylvania complied with the prompt-pay requirement for receiving an increased FMAP for claims received on all days from February 16, 2009, through September 30, 2009. In addition, all practitioner, nursing facility, and hospital claims received after May 31, 2009, met the requirements for an increased Federal share. The State did not meet the 30-day prompt-pay requirement for claims received on any day from January 20, 2009, through February 15, 2009, and for claims received on November 29, 2008, and December 13, 2008. However, during our review, the State requested a waiver of the prompt-pay requirement for claims submitted by practitioners that were received by the State before February 18, 2009. CMS granted the waiver. *Review of Pennsylvania's Compliance With the Prompt Payment Requirements of the American Recovery and Reinvestment Act of 2009*. ([A-03-09-00204](#)) September 2010.

Medicaid Administration > Recovery Act

Results Mixed in Two States' Compliance With the Recovery Act's Medicaid Expenditure Base Requirements

Reviews in two States of the Recovery Act's Medicaid expenditure base requirements had mixed results. Pursuant to the Recovery Act, States must have policies and procedures in place to segregate Medicaid expenditures that qualify for the temporarily increased FMAP during the recession adjustment period and to ensure that Medicaid expenditures that do not qualify are not claimed for reimbursement at the temporarily increased FMAP. We reviewed two States' compliance with this requirement from October 1, 2008, through March 31, 2009.

Colorado—Colorado's \$142 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State's accounting records. Colorado had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that Medicaid expenditures that did not qualify were not claimed for reimbursement at the temporarily increased FMAP. However, the State had not documented all of its policies and procedures. *Review of Colorado's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-07-09-02767](#)) March 2010.

Delaware—Delaware's \$60 million in claims associated with the temporarily increased FMAP was computed using the Medicaid expenditure base specified in the Recovery Act, and the expenditures were supported by the State's accounting records. The State had policies and procedures in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that Medicaid expenditures that did not qualify were not claimed for reimbursement at the temporarily increased FMAP. The State had

correctly documented and disseminated these policies and procedures. *Review of Delaware's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-03-09-00202](#)) March 2010.

Medicaid Administration > Recovery Act

New Jersey Complied With the Recovery Act's Reserve Fund Requirement

Our review found that New Jersey complied with the Recovery Act reserve fund requirement for receiving the increased FMAP. The State did not use additional Medicaid funding to supplement any reserve account. Under the Recovery Act, a State is not eligible for the increased FMAP if any amounts attributable (directly or indirectly) to such an increase are deposited in or credited to any reserve, or "rainy day," fund.

Review of New Jersey's Compliance With the Reserve or Rainy Day Fund Requirement for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act ([A-02-09-01030](#)) September 2010.

Medicaid Administration > Recovery Act

State Medicaid Claims Correctly Computed Under the Recovery Act

We conducted audits of four States' Medicaid claims associated with the increased FMAP under the Recovery Act. The Act provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs during a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Act provides an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income.

Our audits found that the four States' claims associated with the temporarily increased FMAP were computed using the Medicaid expenditure base specified in the Recovery Act. These claims totaled \$174 million in Alabama, \$817 million in Florida, \$276 million in Maryland, and \$273 million in Missouri. In all four States, expenditures were supported by accounting records, and policies and procedures were in place to segregate Medicaid expenditures that qualified for the temporarily increased FMAP and to ensure that Medicaid expenditures that did not qualify were not claimed for reimbursement at the temporarily increased FMAP. Missouri said it would update its written policies and procedures for claiming the temporary increase in the FMAP. The reports are:

- *Review of Alabama's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-04-09-06111](#)) March 2010;

- *Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-04-09-06110](#)) January, 2010;
- *Review of Maryland's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-03-09-00203](#)) January 2010; and
- *Review of Missouri's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009* ([A-07-09-02762](#)) February 2010.

Other Medicaid-Related Issues

Other Issues > Gulf Coast Hurricanes

Discrepancies Found in Hurricane Katrina Health-Care-Related Professional Workforce Supply Grants

We were not able to express an opinion on \$26 million that Louisiana awarded to health care professionals from March 1 through December 31, 2007, because we discovered after our fieldwork was complete that practitioner contracts may have been improperly signed. In addition, of the \$5.3 million that the State awarded to 100 sampled recipients during the period, \$1.4 million was not awarded to 20 recipients in accordance with grant terms. Based on our sample results, we estimated that the State did not award \$5.8 million of grant funds to 85 awardees in accordance with grant terms. The \$50 million Federal grant, which covered March 1, 2007, through September 30, 2012, funded payments to licensed health care professionals for their retention and recruitment in communities affected by Hurricane Katrina. *Review of the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area* ([A-06-08-00026](#)) March 2010.

Other Issues > Gulf Coast Hurricanes

\$3.4 Million in Hurricane-Related Uncompensated Care Claims in Louisiana Unallowable

Louisiana did not always claim reimbursement for services provided by one hospital in accordance with Federal and State laws and regulations or with the approved provisions of the uncompensated care pool (UCCP) plan. In response to Hurricane Katrina, the Deficit Reduction Act of 2005 (DRA) authorized Federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals without other coverage in eligible States. CMS approved Louisiana's UCCP plan to reimburse providers for medically necessary services provided to Hurricane Katrina evacuees and affected individuals and to Hurricane Rita evacuees who did not have other coverage.

Of the \$3.7 million in costs claimed for services provided to 86 patients, \$3.4 million was unallowable. Louisiana claimed the unallowable costs because it (1) did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan; (2) relied on the hospital to verify that the costs claimed were based on actual inpatient days; (3) did not offset its uncompensated care claims by payments received from other sources on behalf of the patients; and (4) did not have procedures to verify that patients whose costs were claimed under the Hurricane Rita UCCP were, in fact, evacuees. *Review of Central Louisiana State Hospital's Hurricane-Related Uncompensated Care Claims* ([A-06-09-00084](#)) May 2010.

Other Issues > CHIP > Federal Share

Florida Claimed \$5.3 Million for Concurrent Program Enrollees

Based on our sample results, we estimated that from April 1, 2007, through March 31, 2008, Florida claimed \$5.3 million in Federal financial participation (FFP), or matching funds, for CHIP enrollees who were concurrently enrolled in CHIP and Medicaid for a total 65,121 enrollment-months. If an individual is eligible for Medicaid, he or she is ineligible for CHIP. The Federal Government uses enhanced FMAPs to determine the amount of FFP for State expenditures in CHIP. The concurrent enrollments occurred primarily because (1) Medicaid enrollment can be retroactive for up to 3 months, during which time the individual may also have been enrolled in CHIP, and (2) the State agency's partners did not have adequate internal controls to prevent or correct concurrent enrollments promptly. *Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007, Through March 31, 2008* ([A-04-09-03046](#)) September 2010.

Legal and Investigative Activities

OIG provides industry guidance in concert with our enforcement activities. For example, pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (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 us to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and our other health care fraud and abuse sanctions. OIG advisory opinions are available at: <http://www.oig.hhs.gov/fraud/advisoryopinions.asp>.

Our industry outreach and enforcement efforts affect all Federal health care programs, including Medicaid. OIG investigates allegations of criminal and civil wrongdoing in Medicaid and, in conjunction with the Department of Justice (DOJ) and others, conducts administrative enforcement and litigation and provides technical support for such efforts. Our enforcement work and industry guidance are often designed to have broad impact on Federal health care programs.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. 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 false claims often involves the combined investigative efforts and resources of OIG, the Federal Bureau of Investigation (FBI), Medicaid Fraud Control Units (MFCU), and other law enforcement agencies. OIG is responsible for assisting DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases before litigation. As part of their settlements, providers often agree to enter into Corporate Integrity Agreements (CIA) with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance their compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct.

During FY 2010, the Government's enforcement efforts resulted in 552 criminal actions and 371 civil actions against individuals or entities that engaged in health-care-related offenses. These efforts resulted in \$3.2 billion in HHS and \$570.2 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs. Some of the notable enforcement actions, and other related activities, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Pharmaceutical Companies

New Hampshire—Mylan Pharmaceuticals, Inc. (Mylan), and UDL Laboratories, Inc., agreed to pay \$118 million plus interest to resolve allegations that the companies submitted false claims to the Medicaid program by underpaying rebates due to the States under the Medicaid Drug Rebate Program. The amounts of the rebates are determined in part by whether a drug is considered an "innovator" drug or a "noninnovator" drug. The rebate that must be paid for innovator drugs is higher than the rebate for noninnovator drugs. Mylan and UDL were alleged to have sold innovator drugs that were manufactured by other companies and classified the drugs as noninnovator drugs for Medicaid rebate purposes. As a result of the improper classification of the drugs, the companies underpaid their rebate obligations under the Medicaid Rebate Program.

Massachusetts—Omnicare, Inc., a provider of pharmacy services to long-term-care (LTC) facilities, agreed to pay \$98 million plus interest to resolve its FCA liability for allegedly engaging with several parties in kickback schemes that resulted in false or fraudulent claims being submitted to Medicare Part D and Medicaid. One of the kickback schemes involved generic drug manufacturer IVAX Pharmaceuticals, Inc., and IVAX Corporation

(collectively, “IVAX”). IVAX also entered into a settlement agreement with the Government, under which it agreed to pay \$14 million plus interest to resolve its FCA liability for a kickback violation involving an \$8 million payment to induce Omnicare to purchase \$50 million in drugs from IVAX. As a result of the kickback, Omnicare submitted false or fraudulent claims to Medicaid from January 2000 through June 2004. Omnicare’s settlement also resolved liability related to kickback schemes it had with skilled nursing facilities (SNF) Mariner Health Care, Inc., and SavaSeniorCare Administrative Services, LLC, and with pharmaceutical manufacturer Johnson & Johnson. The settlement with Omnicare resolves allegations made in five separate *qui tam* complaints. Omnicare also entered into a 5-year Amended and Restated CIA, which consolidates the terms set out in Omnicare’s pre-existing CIA and First Amendment to the CIA effective in November 2006 and October 2007, respectively. IVAX also entered into a 5-year CIA.

Massachusetts—As part of a global criminal, civil, and administrative settlement, Biovail Corporation agreed to pay \$24,775,172 to resolve its liability related to the marketing and promotion of the drug Cardizem, L.A., an extended-release version of a heart medication to control high blood pressure. From 2003 to 2004, Biovail Pharmaceuticals, Inc. (BPI), a U.S. subsidiary of Canada-based Biovail, allegedly paid physicians and other medical prescribers up to \$1,000 each to induce them to recommend and/or write prescriptions for Cardizem, L.A., thereby causing false and/or fraudulent claims for payment to be submitted to Medicaid. Under the civil resolution, Biovail agreed to pay \$2,528,782 plus interest to settle its potential FCA liability. Under the criminal resolution, BPI pleaded guilty to conspiracy and kickback charges and was ordered to pay an assessment of \$2,800 and a criminal fine of \$22,243,590 (total \$22,246,390). In addition to the monetary settlement, Biovail agreed to enter a 5-year CIA with OIG.

Hospitals

Texas—South Texas Health System (STHS) agreed to pay \$27.5 million and enter into a 5-year CIA to resolve its liability for violations of the Stark Law, anti-kickback statute, and the FCA. STHS allegedly engaged in improper financial relationships, including medical directorships and leases, with seven doctors during various periods from January 1, 1999, to December 31, 2006. STHS submitted claims to Medicare and Medicaid for services rendered to patients referred by these doctors to its hospitals.

Home Health

Michigan—Visiting-physicians practices VPA, PC, and VPA of Texas, PLLC (collectively, VPA), agreed to pay \$9.5 million and enter into a 5-year CIA to resolve allegations under the FCA for submitting claims for unnecessary services to Medicare, TRICARE, and the Michigan Medicaid program. VPA was alleged to have improperly billed for unnecessary home visits and care plan oversight services, unnecessary tests and procedures, and more complex evaluation and management (E&M) services than were actually provided.

Practitioners

West Virginia—Dr. John Sharp was sentenced to 36 months' incarceration and ordered to pay \$542,275 in restitution for health care fraud. From May 1998 to January 2006, Dr. Sharp defrauded the Medicare, Medicaid, and West Virginia Workers' Compensation programs by billing for services that were not rendered and causing the programs to pay higher rates of reimbursement than were warranted. The investigation found that Dr. Sharp was given notice on several occasions that his billing practices were improper, yet he continued the fraudulent billings.

Maryland—Podiatrist Leon Booker agreed to pay \$100,629 to resolve his liability under the FCA. An OIG investigation determined that from January 1, 2005, to March 30, 2008, Booker falsely submitted claims for payment to Medicare and Medicaid by billing for E&M services even though no significant, separately identifiable E&M service was performed. Booker also billed for multiple procedures on the same day even though he performed no distinct and separate procedure on that day.

Transportation Companies

Maine—Ambulance Service, Inc. (ASI) and Northern Maine Medical Center (NMMC) agreed to pay a total settlement amount of \$1,032,000 to resolve their liability under the FCA. ASI also entered into a 5-year CIA with OIG. The settlement resolves ASI's and NMMC's liability for allegedly submitting improper Advanced Life Support transport claims to Medicare and Medicaid between January 1, 2003, and December 31, 2005. Investigators found that an ASI employee was improperly billing and coding for ASI's services in 2003 and 2004. In 2005, NMMC took over the billing and coding functions for ASI, and in doing so, hired the same ASI biller who had been improperly billing and coding. OIG concluded that ASI and NMMC failed to adequately supervise the employee or ensure that she was properly trained. As a result of the investigation, NMMC terminated the employee.

Medicaid Employee Fraud

Minnesota—Kim Austen was sentenced to 42 months' incarceration and ordered to pay \$903,896 in restitution to the Minnesota Department of Human Services after her guilty plea to health care fraud. An investigation revealed that Austen, a unit supervisor at the department, embezzled State and Federal Medicaid funds between August 5, 2003, and September 10, 2008. Austen created a fictitious vendor number in the State's electronic accounting system under the name of her boyfriend. Using this vendor number, Austen caused 23 paper checks and/or warrants to be manually drafted with her boyfriend as the payee. The payments were taken from an expense account set aside to make advance payments to Medicaid providers. Austen was authorized to approve these types of payments as part of her responsibilities at the department. Austen picked up the checks drafted to her boyfriend directly from the Minnesota Department of Finance and deposited

them into two personal bank accounts, a joint savings account in her and her boyfriend's names and a checking account in her name only.

Identity Theft

Iowa—Dr. Douglas Dvorak was sentenced to 85 months' incarceration and ordered to pay \$71,375 in restitution for mail fraud, aggravated identity theft, and money laundering. Dr. Dvorak obtained names and dates of birth of Medicaid beneficiaries (primarily children) through family members and friends and used this information to bill the maximum number of chiropractic manipulation services allowed by Medicaid for each beneficiary per year. In one example in 2006, he billed the annual maximum chiropractic services (24) on nearly consecutive days for premature twin newborns who were patients in a neonatal intensive care unit at the time of the purported services. According to his friends and family members who provided the names and dates of birth to Dr. Dvorak, this information was provided as potential referrals and not as part of a criminal scheme. The beneficiaries had never heard of Dr. Dvorak or received chiropractic services from him or any other chiropractor.

Medicaid Fraud

Idaho—Vanessa Cattanea was sentenced to 20 months' incarceration and ordered to pay \$1,054,259 in restitution after she was found guilty of aiding and abetting health care fraud. Cattanea was treatment director for Teton Family Services, a company, owned by Ronald Hamilton, that provided mental health services to children. Between August 2002 and March 2006, Hamilton and Cattanea knowingly and fraudulently billed Medicaid for services performed by unlicensed staff members and for trips to Yellowstone National Park, Bear Lake, and Salt Lake City, which were not reimbursable Medicaid services. Hamilton, who was also found guilty of health care fraud, died in March 2010.

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCU) are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2010, HHS awarded \$193.6 million in Federal grant funds to 50 State MFCUs (including Washington, DC), which employed 1,827 individuals.

Collectively, in FY 2010, MFCUs reported 13,210 investigations, of which 9,710 were related to Medicaid fraud and 3,500 were related to patient abuse and neglect, including patient funds cases. The cases resulted in 1,603 individuals being indicted or criminally charged, including 1,048 for fraud and 555 for patient abuse and neglect, including patient funds cases. In total, 1,324 convictions were reported in FY 2010, of which 836 were related to Medicaid fraud and 488 were related to patient abuse and neglect, including patient funds cases.

Joint Investigations

Pennsylvania—Pediatrician Dr. Saroj Parida was sentenced to 8 years' incarceration and ordered to pay \$7,116,423 in restitution after pleading guilty to charges of health care fraud, mail fraud, and forfeiture. From 2003 through 2009, Dr. Parida submitted fraudulent claims to Medicaid, TRICARE, and private insurance companies for services not rendered. The investigation involved OIG, the U.S. Postal Inspection Service, the Defense Criminal Investigative Service, the Pennsylvania Attorney General's MFCU and Insurance Fraud Section, the South Carolina Attorney General's MFCU and Insurance Fraud Division, and the Cumberland County, Pennsylvania, District Attorney's Office.

South Dakota—Reed Hittle, physical therapist and owner of Precision Physical Therapy, Inc., was sentenced to 10 months' home confinement and ordered to pay \$119,260 in restitution for his guilty plea to charges of false statements relating to health care matters. Between January 2005 and July 2008, Hittle billed Medicare and Medicaid for physical therapy treatments on patients, documenting that he performed the treatments himself. However, many of the billed treatments were administered by an unlicensed and untrained assistant. The investigation involved OIG, the FBI, and the South Dakota MFCU.

Tennessee—FORBA Holdings, LLC, agreed to pay \$24 million plus interest and enter into a 5-year quality-of-care CIA to resolve its liability for violations of the FCA. FORBA manages a chain of 68 pediatric dental clinics in 22 States and the District of Columbia commonly known as "Small Smiles Centers." The settlement resolves allegations that FORBA caused false claims to be submitted to Medicaid programs for dental services performed on low-income children insured by Medicaid. The investigation revealed that, among other things, FORBA was alleged to have caused the submission of claims for reimbursement for dental services that were not medically necessary or did not meet professionally recognized standards of care. The services billed to the Medicaid programs included performing pulpotomies (baby root canals), placing crowns, administering anesthesia, performing extractions, and providing fillings and/or sealants. The investigation involved the OIG, the FBI, and the National Association of Medicaid Fraud Control Units (NAMFCU).

Florida—Sachin Amin, owner and managing pharmacist of The Rx Shop, was sentenced to 18 months' incarceration and ordered to pay \$738,000 in restitution after pleading guilty to submitting false claims to Medicare and Medicaid. From 2005 through 2007, Amin submitted false claims for prescription medications that were never dispensed. The investigation involved OIG, the FBI, the Defense Criminal Investigative Service, the Office of Personnel Management (OPM), the Drug Enforcement Agency, the Florida Department of Law Enforcement, and the Florida MFCU.

South Carolina—Lalendra DeSilva and Carolina Pennington, co-owners of the durable medical equipment (DME) company Helex, Inc., were sentenced for conspiracy to commit income tax fraud. DeSilva was sentenced to 30 months' incarceration and ordered to pay \$201,984 in restitution, of which \$112,000 is owed to the Medicaid program. Pennington

was sentenced to 1 year and 1 day of incarceration and ordered to pay \$86,123 in restitution. The investigation revealed that Helex billed Medicaid for volume ventilators that beneficiaries never received. DeSilva and Pennington bought a \$415,000 home in cash without filing tax returns during Helex's first 2 years in operation. The investigation involved OIG, the Internal Revenue Service (IRS), and the South Carolina MFCU.

Georgia—Dr. Randy Lentz and physical therapist Scott Bowlin were sentenced after their guilty pleas to conspiracy to commit health care fraud. Lentz was sentenced to 34 months' incarceration and ordered to pay \$248,755 in restitution, and Bowlin was sentenced to 19 months' incarceration and ordered to pay \$19,839 in restitution. Dr. Lentz owned and operated a Jesup gym that was in financial difficulty. To keep the gym in operation, Dr. Lentz and Bowlin devised a scheme to bill Medicare and Medicaid for physical therapy services that were not provided; their alleged patients were simply working out in the gym. The investigation involved OIG, the FBI, and the Georgia MFCU.

Rhode Island—Drs. Frank Lafazia and James Gallo entered into a settlement and release agreement with the Rhode Island MFCU. Drs. Lafazia and Gallo agreed to pay \$40,300 and \$34,700, respectively, to settle allegations that they charged patients between \$100 and \$175 in cash for office visits to obtain prescriptions for Suboxone, despite the fact that the patients were enrolled in Medicare and/or Medicaid. The investigation determined that the physicians told beneficiaries that if they did not pay cash for each office visit, which typically lasted only a few minutes, they would not receive a prescription for Suboxone, which is used to help treat Opioid drug addiction. Drs. Lafazia and Gallo also required Suboxone patients to sign agreements that stated the physicians would not bill any Suboxone-related visits to Medicare or Medicaid, despite the fact that both physicians billed Medicare and Medicaid for services such as laboratory tests related to Suboxone treatment and office visits unrelated to Suboxone treatment. There was no technical loss to the Medicare or Medicaid programs, and both physicians agreed to give full refunds to the beneficiaries who paid out of pocket for the Suboxone prescriptions. The settlement amount also included expenses incurred in the joint OIG-Rhode Island MCFU investigation.

Provider Self-Disclosure Protocol

OIG makes available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. OIG's "Provider Self-Disclosure Protocol" gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation may entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a reasonable monetary settlement and potentially avoid being excluded from participation in Federal health care programs. The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature

and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG Web site at: <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>.

The following are Medicaid-related examples:

Massachusetts—Elder Service Plan of the North Shore (ESPNS) and East Boston Neighborhood Health Center (EBNHC) agreed to pay \$308,709 and \$200,962, respectively, to resolve their Civil Monetary Penalties Law (CMPL) liability for contracting with an excluded dentist, Dr. Steven Ramos, for dental services that he provided to Medicare and Medicaid beneficiaries. Both parties had contracted with Dr. Ramos from May 2006 through February 2009. EBNHC self-disclosed to OIG that it had contracted with Dr. Ramos while he was excluded. During the course of investigating EBNHC's self-disclosure, OIG discovered that ESPNS had also contracted with Dr. Ramos.

North Carolina—The Neurological Institute, P.A., formerly known as Neurology Consultants of the Carolinas, P.A. (Institute), agreed to pay \$181,851 to resolve its CMPL liability. The Institute disclosed to OIG that from October 1, 2003, through June 30, 2006, it improperly submitted claims to Medicare and Medicaid for (1) a physician's services (or an item or service incident to a physician's service) when the individual who furnished the service was not a physician, (2) services provided by Dr. T. Hemanth Rao when the services were not actually provided by Dr. Rao, and (3) services provided based on codes that the Institute knew or should have known would result in greater payments than were appropriate.

Program Exclusions

During FY 2010, OIG excluded 3,340 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. See <http://exclusions.oig.hhs.gov/>.

For example:

Kansas—Shelley Harding, a certified alcohol and drug abuse counselor, owner, and operator of a counseling center in Kansas, was excluded for a minimum of 30 years based on her health care fraud conviction. Between June 2001 and February 2006, Harding, doing business as A New Beginning, submitted materially false and fraudulent claims and caused others to submit materially false and fraudulent claims to Medicaid for community-based drug and alcohol abuse services for 81 children. Harding was sentenced to 24 months' incarceration and ordered to pay \$3,758,951 in restitution.

Ohio—Chiropractor Gregory Dew was excluded for a minimum of 60 years based on his conviction for rape, corruption of a minor, and gross sexual imposition. The Ohio State Chiropractic Board permanently revoked his license, and the State Medical Board of Ohio permanently revoked his license to practice as a physician assistant. The Ohio Department of Job and Family Services also terminated his Medicaid Provider Agreement. Dew was sentenced to 43 years' incarceration.

Appendix B:
Medicaid Projects
From the FY 2011 Work Plan

Appendix B:

Medicaid Projects From the FY 2011 Work Plan

Medicaid Hospitals

Hospital Outlier Payments

(OAS; W-00-10-31069; W-00-11-31069; various reviews; expected issue date: FY 2011; work in progress)

Provider Eligibility for Medicaid Reimbursement

(OAS; W-00-10-31301; W-00-11-31301; various reviews; expected issue date: FY 2011; work in progress)

Supplemental Payments to Private Hospitals

(OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2011; work in progress)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services

(OAS; W-00-09-31127; W-00-10-31127; W-00-11-31127; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Home, Community, and Nursing Home Care

Community Residence Rehabilitation Services

(OAS; W-00-08-31087; W-00-09-31087; W-00-10-31087; W-00-11-31087; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments to Continuing Day Treatment Providers

(OAS; W-00-09-31128; W-00-11-31128; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Home Health Agency Claims

(OAS; W-00-09-31304; W-00-10-31304; W-00-11-31304; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments for Personal Care Services

(OAS; W-00-09-31035; W-00-10-31035; W-00-11-31035; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Hospice Services

(OAS; W-00-11-31385; various reviews; expected issue date: FY 2011; new start.
OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Adult Day Care Services for Elderly Individuals Who Have Chronic Functional Disabilities

(OAS; W-00-11-31386; various reviews; expected issue date: FY 2011; new start)

Medicaid Adult Day Health Service

(OEI; 09-07-00500; expected issue date: FY 2011; work in progress)

Appropriateness of Level of Care Determinations for Home- and Community-Based Services Waiver Recipients

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

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

(OEI; 02-08-00170; expected issue date: FY 2011; work in progress)

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

(OEI; 09-08-00360; expected issue date: FY 2011; work in progress)

CMS Oversight of Accuracy of Nursing Home Minimum Data

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Transparency Within Nursing Facility Ownership

(OAS; W-00-11-31130; various reviews; expected issue date: FY 2011; new start)

States' Administration and Use of Civil Monetary Penalty Funds in Medicaid Nursing Homes

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Incentive Payments for Nursing Facility Quality-of-Care Performance Measures

(OAS; W-00-10-31331; W-00-11-31331; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Waiver Administrative Costs

(OAS; W-00-10-31332; W-00-11-31332; various reviews; expected issue date: FY 2011; work in progress)

Health Screenings of Medicaid Home Health Care Workers

(OAS; W-00-11-31387; various reviews; expected issue date: FY 2011; new start)

Medicaid Prescription Drugs

Calculation of Average Manufacturer Prices

(OAS; W-00-11-31202; various reviews; expected issue date: FY 2011; new start)

Recalculation of Base Date Average Manufacturer Prices

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Medicaid Drug Claims

(OAS; W-00-10-31203; various reviews; expected issue date: FY 2011; work in progress)

Federal Upper Payment Limit Drugs

(OAS; W-00-11-31333; various reviews; expected issue date: FY 2011; new start)

Pharmacy Prescription Drug Claims

(OAS; W-00-09-31318; W-00-10-31318; W-00-11-31318; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Pharmacy Reimbursement

(OAS; W-00-11-31388; various reviews; expected issue date: FY 2011; new start)

Medicaid Payments for Drugs Not Approved for Use by Children

(OAS; W-00-11-31131; various reviews; expected issue date: FY 2011; new start)

Medicaid Third-Party Liability for Prescription Drug Payments

(OAS; W-00-10-31134; W-00-11-31134; various reviews; expected issue date: FY 2011; work in progress)

Compound Drugs

(OAS; W-00-10-31317; various reviews; expected issue date: FY 2011; work in progress)

The Deficit Reduction Act of 2005: Impact on Medicaid Rebates for Authorized Generic Drugs

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Collection of Medicaid Rebates for Physician-Administered Drugs

(OEI; 03-09-00410; expected issue date: FY 2011; work in progress)

Medicaid Claims for Drugs Purchased Under Retail Discount Generic Programs

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Review of Medicaid Policies and Oversight Activities Related to 340B Entities

(OEI; 05-09-00321; expected issue date: FY 2011; work in progress)

High-Cost HIV/AIDS Drugs

(OAS; W-00-10-31334; W-00-11-31334; various reviews; expected issue date: FY 2011; work in progress)

Reporting Lowest Accepted Reimbursement Rates

(OAS; W-00-11-31336; various reviews; expected issue date: FY 2011; new start)

Zero-Dollar Unit Rebate Amounts for Drugs in Medicaid's Drug Rebate Program

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Drug Pricing in State Maximum Allowable Cost Programs

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Efforts and Experiences With Resolving Medicaid Rebate Disputes

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Changes in Prices for Medicaid Brand-Name Drugs

(OEI; 03-10-00260; expected issue date: FY 2011; work in progress)

Other Medicaid Services

Medicaid Dental Services

(OAS; W-00-10-31135; W-00-11-31135; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Payments for Physical, Occupational, and Speech Therapy Services

(OEI; 07-10-00370; expected issue date: FY 2011; work in progress)

Rehabilitative Services

(OAS; W-00-11-31389; various reviews; expected issue date: FY 2011; new start)

Medicaid Medical Equipment

(OAS; W-00-11-31390; various reviews; expected issue date: FY 2011; new start)

Family Planning Services

(OAS; W-00-09-31078; W-00-10-31078; W-00-11-31078; various reviews; expected issue date: FY 2011; work in progress)

Medicaid School-Based Services

(OAS; W-00-11-31391; various reviews; expected issue date: FY 2011; new start)

Medicaid Payments for Transportation Services

(OAS; W-00-09-31121; W-00-10-31121; W-00-11-31121; various reviews; expected issue date: FY 2011; work in progress)

Payments to Terminated and/or Excluded Medicaid Providers and Suppliers

(OAS; W-00-10-31337; W-00-11-31337; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Claims With Inactive or Invalid Physician Identifier Numbers

(OAS; W-00-11-31338; various reviews; expected issue date: FY 2011; new start)

Medicaid Administration

Contingency Fee Payment Arrangements

(OAS; W-00-07-31045; W-00-08-31045; W-00-09-31045; W-00-11-31045; various reviews; expected issue date: FY 2011; work in progress)

Early Results From Medicaid Integrity Contractors

(OEI; 05-10-00200, 05-10-00210; expected issue date: FY 2011; work in progress)

State Oversight of Provider Credentialing by Medicaid Managed Care Plans

(OEI; 09-10-00270; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Entities' Marketing Practices

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Excluded Providers in Medicaid Managed Care Entities

(OEI; 07-09-00630; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Fraud and Abuse Safeguards

(OEI; 01-09-00550; expected issue date: FY 2011; work in progress)

Use of Prepayment Review To Detect and Deter Fraud and Abuse in Medicaid Managed Care

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Administrative Costs

(OAS; W-00-10-31123; W-00-11-31123; various reviews; expected issue date: FY 2011; work in progress)

Impact on the Medicaid Program of Certified Public Expenditures

(OAS; W-00-11-31110; various reviews; expected issue date: FY 2011; new start)

Medicaid Management Information System Costs

(OAS; W-00-10-31312; W-00-11-31312; various reviews; expected issue date: FY 2011; work in progress)

State Buy-In of Medicare Coverage

(OAS; W-00-10-31220; W-00-11-31220; various reviews; expected issue date: FY 2011; work in progress)

State Agency Oversight of Medical Loss Ratio Experience Adjustment

(OAS; W-00-11-31372; various reviews; expected issue date: FY 2011; new start)

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

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States Reporting of Program Income From Third-Party Reimbursements

(OAS; W-00-10-31376; W-00-11-31376; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Credit Balances

(OAS; W-00-10-31311; W-00-11-31311; various reviews; expected issue date: FY 2011; work in progress)

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

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Duplicate Medicaid Payments for Beneficiaries With Multiple Medicaid Identification Numbers

(OAS; W-00-10-31374; W-00-11-31374; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Managed Care Payments for Deceased Beneficiaries

(OAS; W-00-11-31392; various reviews; expected issue date: FY 2011; new start)

States' Compliance With Estate Recovery Provisions of the Social Security Act

(OAS; W-00-09-31113; W-00-10-31113; W-00-11-31113; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Services to Incarcerated Juveniles

(OAS; W-00-07-31222; W-00-11-31222; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Citizenship Documentation Requirements

(OAS; W-00-10-31224; W-00-11-31224; various reviews; expected issue date: FY 2011; work in progress)

Payment Error Rate Measurement: Fiscal Year 2008 Error Rate

(OAS; W-00-10-40045; W-00-11-40045; expected issue date: FY 2011; work in progress)

Medicaid and Children's Health Insurance Program Payment Error Rate Measurement

(OAS; W-00-11-40046; various reviews; expected issue date: FY 2011; new start)

Compliance With Payment Error Rate Measurement Program: Medicaid and Children's Health Insurance Program Eligibility Determinations

(OAS; W-00-10-40038; expected issue date: FY 2011; work in progress)

Children's Health Insurance Program Administrative Costs

(OAS; W-00-09-31226; W-00-10-31226; various reviews; expected issue date: FY 2011; work in progress)

Dually Enrolled Beneficiaries in a State

(OAS; W-00-10-31314; various reviews; expected issue date: FY 2011; work in progress)

State Compliance With CHIP Eligibility and Enrollment Notification and Review Requirements

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Program Integrity Best Practices

(OAS; W-00-11-31396; various reviews; expected issue date: FY 2011; new start)

Medicare and Medicaid Data Matching Project

(OEI; 09-08-00370; expected issue date: FY 2011; work in progress)

Collection and Verification of Provider Ownership Information by State Medicaid Agencies

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Oversight of State Data Reporting

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

States' Readiness to Comply With ACA Eligibility and Enrollment Requirements

(OEI; 07-10-00530; expected issue date: FY 2012; work in progress)

Medicaid Information Systems and Data Security

Medicaid Management Information Systems Business Associate Agreements

(OAS; W-00-11-41015; various reviews; expected issue date: FY 2011; new start)

Medicaid Security Controls Over State Web-Based Applications

(OAS; W-00-11-41016; various reviews; expected issue date: FY 2011; new start)

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

(OAS; W-00-10-40019; W-00-11-40019; expected issue date: FY 2011; work in progress, new start)

Appendix C:
Medicaid Items From
the March 2011 Compendium
of Unimplemented Recommendations

Appendix C:

Medicaid Items From the March 2011 Compendium of Unimplemented Recommendations

This appendix lists Medicaid-related recommendations included in the March 2011 *Compendium of Unimplemented Office of Inspector General Recommendations* (Compendium). These recommendations, when implemented, will result in cost savings and program improvements. The recommendations are based on work conducted by the Office of Inspector General's (OIG) Office of Audit Services (OAS) and Office of Evaluation and Inspections (OEI). The Compendium contains explanations of the recommendations listed below and is available on OIG's Web site at: <http://www.oig.hhs.gov/publications.asp>.

OIG relies on the Department of Health & Human Services' (HHS) management and other Government policymakers to implement our recommendations. Many of our recommendations are directly implemented by organizations within HHS, and some are acted on by States that collaborate with HHS to administer, operate, and/or oversee designated programs, such as Medicaid. HHS and the States sometimes do not immediately implement OIG's recommendations for various reasons, including administrative complexities, the current policy environment, or a lack of statutory authority. In such cases, Congress may step in to incorporate OIG's recommendations into legislative actions, many of which result in substantial funds being made available for better use or in program improvements.

Federal and State Partnership

Limit Enhanced Payments to Cost and Require That Medicaid Payments Returned by Public Providers Be Used To Offset the Federal Share

Improper Payments

Ensure Compliance With Requirements for Medicaid School-Based Health Services

Prevent Duplicate Medicaid and Medicare Home Health Payments

Enforce Federal Medicaid Payment Policies for Personal Care Services

Prescription Drugs

Ensure That Medicaid Reimbursement for Brand-Name Drugs Accurately Reflects Pharmacy Acquisition Costs

Encourage States To Align Medicaid Generic Drug Pharmacy Reimbursements With Pharmacies' Acquisition Costs

Establish a Connection Between the Calculations of Medicaid Drug Rebates and Drug Reimbursements

Clarify and Improve Program Guidance to Drug Manufacturers on Average Manufacture Price Issues

Implement an Indexed Best-Price Calculation in the Medicaid Drug Rebate Program

Extend Additional Rebate Payment Provisions to Generic Drugs

Identify Drugs That Are Ineligible for Federal Payments Under Medicaid

Medicaid Administration

Enforce Federal Requirements for Submission of Medicaid Managed Care Encounter Data

Establish a National Medicaid Credit Balance Reporting Mechanism

Advise States of Their Authority To Collect From Noncustodial Parents With the Ability To Contribute Toward Their Children's Medicaid or Children's Health Insurance Program Costs

Improve Medicaid Children's Access to Required Preventive Screening Services (New)

Appendix D:
Audit and Evaluation
Final Reports Issued in FY 2010

Appendix D:

Audit and Evaluation Final Reports Issued in Fiscal Year 2010

Appendix D, which is a complete list of our Medicaid-related reports issued during FY 2010, differs from Appendix A in that Appendix A provides short summaries of the audits, evaluations, and investigative outcomes that were included in OIG's *Semiannual Report(s) to Congress* for FY 2010. Not all of our reports are included in the Semiannual Reports. The full text of the publicly available reports in the list below can be accessed on our Web site by searching on the claim number that follows each title. The Web site is at: <http://www.oig.hhs.gov>.

Medicaid Hospitals

Review of Medicaid Supplemental Rate Payments to UMass Memorial Health Care, Inc., for Fiscal Years 2004 and 2005 (A-01-07-00013)

Review of Medicaid Disproportionate Share Hospital Payments Made by Maine to the Riverview Psychiatric Center (A-01-09-00011)

Review of Medicaid Disproportionate Share Hospital Payments Made By Connecticut to Hartford Hospital for Federal Fiscal Years 2007 and 2008 (A-01-09-00012)

Review of Medicaid Settlement of the Medical University of South Carolina Medical Center for Fiscal Year Ended June 30, 2008 (A-04-10-06125)

Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007—Hospitals With Fewer Than Five High-Dollar Payments (A-05-09-00048)

Review of Medicaid Disproportionate Share Hospital Payment Distribution (A-07-09-04150)

Review of Medicaid Credit Balances at Rideout Memorial Hospital as of July 31, 2009 (A-09-09-00106)

Medicaid Home, Community, and Nursing Home Care

Review of Medicaid Payments at Age Institute of Massachusetts, Inc. for State Fiscal Years 2007 Through 2009 (A-01-10-00006)

Review of Medicaid Payments at Cummings Healthcare LTC Group for State Fiscal Years 2007 Through 2009 (A-01-10-00010)

Audit of Gentiva Medicaid Home Health Agency Claims in Kentucky (A-04-09-06012)

Review of Houston Companies Medicaid Cost Reports for Calendar Years 2003, 2004, and 2005 (A-05-08-00053)

Review of Medicaid Personal Care Service Claims Submitted by Independence First, Inc., and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 (A-05-09-00093)

Review of Medicaid Personal Care Service Claims Submitted by Dane County Department of Human Services and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 (A-05-10-00018)

Review of Iowa Medicaid Payments for Home Health Agency Claims Paid to Iowa Home Care, LLC (A-07-09-01070)

Review of Iowa Medicaid Payments for Home Health Agency Claims Paid to Ultimate Nursing Services of Iowa, Inc. (A-07-09-01078)

Review of Iowa Medicaid Payments for Home Health Agency Claims (A-07-10-01081)

Review of Nebraska Medicaid Payments for Home Health Agency Claims Paid to First Care Home Health of Eastern Nebraska, Inc. (A-07-10-01086)

Review of Colorado Medicaid Payments for Home Health Agency Claims Paid to Professional Pediatric Home Care, Inc. (A-07-10-01088)

Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services (OEI-05-08-00520)

Medicaid Prescription Drugs

Follow-Up Audit of the Medicaid Drug Rebate Program in Maine (A-01-09-00001)

Review of Vermont's Compliance With the "Reimbursement of State Costs for Provision of Part D Drugs" Medicare Demonstration Project Requirements (A-01-10-00600)

Follow-up Review of the Medicaid Drug Rebate Program in Indiana (A-04-08-07006)

Review of Additional Rebates for Brand-Name Drugs With Multiple Versions (A-06-09-00033)

Review of Medicaid Compound Drug Expenditures in California for Fiscal Years 2004 and 2005 (A-09-08-00034)

Review of California's Invoicing of Rebates for Medicaid Compound Drug Expenditures—Manual Claims (A-09-09-00055)

Drug Manufacturers' Noncompliance With Average Manufacturer Price Reporting (OEI-03-09-00060)

Other Medicaid Services

Review of New Jersey's Medicaid Emergency Payment Program for Nonqualified Aliens (A-02-07-01038)

Review of New Jersey's Medicaid School-Based Health Claims Submitted by Maximus, Inc. (A-02-07-01051)

Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc. (A-02-07-01052)

Review of Early Intervention Services Costs Claimed by New Jersey to the Medicaid Program (A-02-08-01019)

Review of Medicaid Funding for Emergency Services Provided to Nonqualified Aliens (A-04-07-07032)

Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007, Through March 31, 2008 (A-04-09-03046)

Review of Nonemergency Medical Transportation Costs in the State of Texas (Transportation Provided by Capital Area Rural Transit System) (A-06-08-00096)

Review of Missouri Medicaid Payments for the School District Administrative Claiming Program for Federal Fiscal Years 2004 Through 2006 (A-07-08-03107)

Review of Selected Claims Included in the Kansas Medicaid Family Planning Program (A-07-09-04146)

Review of Family Planning Pharmacy Claims Submitted by Selected Providers Under the State of Kansas Medicaid Program (A-07-10-04157)

Review of Arizona's Medicaid Claims for School-Based Health Services (A-09-07-00051)

Medicaid Administration

Review of Medicaid Administrative Costs Claimed for the Massachusetts Department of Transitional Assistance (A-01-08-00014)

Review of Rhode Island's Compliance With the American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements (A-01-09-00007)

Review of New Hampshire's Compliance With ARRA Medicaid Eligibility Requirements (A-01-10-00002)

Review of Early Intervention Services Costs Claimed by New Jersey to the Medicaid Program (A-02-07-01053)

Review of New Jersey's Medicaid Management Information System Expenditures for the Period January 1, 2006, Through December 31, 2007 (A-02-08-01015)

Review of New York State's Compliance With the Political Subdivision Requirement for the Increased Federal Medicaid Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-02-09-01029)

Review of New Jersey's Compliance With the Reserve or Rainy Day Fund Requirement for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act (A-02-09-01030)

Review of New York State's Compliance With the Prompt Pay Requirements for the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-02-09-01037)

Review of Medicaid Management Information System Prepayment Edit in the District of Columbia (A-03-08-00208)

Review of Delaware's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-03-09-00202)

Review of Maryland's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-03-09-00203)

Review of Pennsylvania's Compliance With the Prompt Payment Requirements of the American Recovery and Reinvestment Act of 2009 (A-03-09-00204)

Review of Florida's Developmental Disabilities Medicaid Administrative Claiming Costs for the Period October 1, 2003, Through September 30, 2006 (A-04-07-00028)

Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Tennessee (A-04-09-04040)

Review of Florida's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-04-09-06110)

Review of Alabama's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-04-09-06111)

Review of the State of Wisconsin's Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Fiscal Years 2006 and 2007 (A-05-08-00067)

Review of Eligibility Redeterminations for Medicaid Beneficiaries in Cook County, Illinois, for the Period July 1, 2006, Through June 30, 2007 (A-05-08-00091)

Review of Minnesota's Reporting Fund Recoveries for Federal and State Programs on the CMS-64 for the Period October 1, 2005, Through December 31, 2008 (A-05-09-00022)

Review of the State of Wisconsin's Medicaid Management Information System Expenditures for the Period October 1, 2006, Through September 30, 2008 (A-05-09-00073)

Review of Ohio's Reporting Fund Recoveries for Federal and State Programs on the CMS-64 for Fiscal Years 2008 Through 2009 (A-05-09-00102)

Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009 (A-05-09-00103)

Review of Medicaid Overpayments Identified by the Illinois Division of Rehabilitation Services for Services Provided From December 1, 1999, Through December 31, 2008 (A-05-10-00013)

Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Minnesota (A-05-10-00014)

Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for the First Quarter 2010 (A-05-10-00061)

Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Oklahoma City Area Office (A-06-07-00080)

Review of California's Department of Health Care Services Fiscal Year 2007 Payment Error Rate Measurement Universes (A-06-08-00050)

Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program (A-06-08-00078)

Review of Medicaid Payments for Services Claimed To Have Been Rendered to Deceased Recipients in Texas (A-06-09-00065)

Analysis of Improper Payments Identified During the Payment Error Rate Measurement Program Reviews in 2006 and 2007 (A-06-09-00079)

Review of Central Louisiana State Hospital's Hurricane-Related Uncompensated Care Claims (A-06-09-00084)

Review of Medicaid Payments for Services Claimed To Have Been Rendered to Deceased Recipients in Louisiana (A-06-09-00089)

Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Texas (A-06-09-00099)

Review of American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements in Louisiana (A-06-09-00100)

Review of Medicaid Credit Balances at Arkansas Health Center as of June 30, 2009 (A-06-09-00102)

Review of Medicaid Credit Balances at Northridge Healthcare and Rehabilitation as of June 30, 2009 (A-06-09-00105)

Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Navajo Area Office (A-07-08-02721)

Review of the Reconciliation and Reporting of Medicaid Non-Risk Contract Payments by the Utah Department of Health (A-07-09-02754)

Review of Missouri's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act (A-07-09-02762)

Review of Colorado's Claims Associated With the Increased Federal Medical Assistance Percentage Under the American Recovery and Reinvestment Act of 2009 (A-07-09-02767)

Audit of Indian Health Service Fiscal Year 2005 Cost Statement for the Phoenix Area Office (A-09-07-00086)

Review of Medicaid Credit Balances at Tri-City Medical Center as of February 28, 2009 (A-09-09-00078)

Review of California Medicaid Credit Balances for Kapi'olani Medical Center at Pali Momi as of December 31, 2008 (A-09-09-00090)

Review of Medicaid Credit Balances at Mercy San Juan Medical Center as of July 31, 2009 (A-09-09-00107)

Review of Medicaid Payments for Services Claimed for Deceased Beneficiaries in California (A-09-09-00110)

Excluded Medicaid Providers: Analysis of Enrollment (OEI-09-08-00330)

Appendix E:
Deficit Reduction Act Requirements

Appendix E:

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 & Human Services (HHS), Office of Inspector General (OIG) to conduct specified activities, as well as to report annually on overall Medicaid activities. The sections are summarized below.

Section 6001: Federal Upper Payment Limits 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.

OIG's Related Actions. 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.

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). Although not required by the DRA, OIG completed an additional evaluation report that compared FUL payment amounts to other prices in August 2009 entitled *A Comparison of Medicaid Federal Upper Limit Amounts to Acquisition Costs, Medicare Payment Amounts, and Retail Prices*, (OEI-03-08-00490). OIG found, as in previous work, that the FUL payment amounts calculated under the current method continue to be substantially higher than other payment methods that are also causing Medicaid to overpay for certain drugs.

Other Related Actions. In July, 2007, CMS issued a final regulation at 72 Fed. Reg. 39142 that 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. While this prohibition was in effect, CMS continued to calculate FUL amounts based on the previous formula (i.e., 150 percent of the lowest published price). Effective October 1, 2010, section 2503(a)(1) of the Affordable Care Act modified the previous statutory provisions for FULs under the DRA by revising the Social Security Act, § 1927(e)(5), to establish FULs as no less than 175 percent of the weighted average of the most recently reported monthly AMPs. CMS published a final rule at 75 Fed. Reg. 69591 (November 15, 2010) to withdraw those parts of the 2007 final rule that established upper limits for multiple-source drugs and revised the definition of AMP.

Section 6031: Review 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 percentage points, increasing the State's share by 10 percentage points.

Specifically, for a State to be eligible for the 10-percentage-point increase in its share of false claims recoveries, the State law relating to false and fraudulent claims must be determined by OIG, in consultation with the Attorney General, to meet the following criteria: 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. Following are OIG's related actions:

- 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.
- During FY 2009, OIG provided written responses to three States and approved two of the State laws—those passed by Wisconsin and Michigan—for the DRA incentive. OIG made these determinations in consultation with DOJ’s Civil Division.
- In 2009 and 2010, the FCA was amended. As a result of these amendments, OIG reviewed the 14 State laws that had previously been approved by OIG and determined that none still satisfy the requirements of section 6031 of the DRA. OIG provided the States with a 2-year grace period during which their laws will continue to be deemed compliant pending amendment and resubmission to OIG. In March 2011, OIG sent letters to the 14 States. OIG also provided written responses to 10 States that had submitted their laws for review. OIG did not approve any of the 10 submitted laws. The letters to the 14 states and the response letters are published on OIG’s Web site at <http://www.oig.hhs.gov>.
- OIG has invited States to submit draft legislation for informal review and discussion prior to passage of the draft legislation.

Section 6034: Medicaid Integrity Program

This section establishes the Medicaid Integrity Program (MIP) and requires the Secretary of HHS to enter into contracts to enhance the capacity of CMS to conduct oversight of Medicaid expenditures. MIP’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 FY 2006 through FY 2010, \$25 million shall be appropriated to OIG for the Medicaid activities of OIG in addition to any other amounts appropriated or made available for Medicaid oversight. Such funds shall remain available until expended. This section also requires OIG to 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 2010.

Appendix F:
Acronyms and Abbreviations

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Acronyms and Abbreviations

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

AMP	average manufacturer price
CCA	certification of compliance agreement
CHIP	Children’s Health Insurance Program
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DSH	disproportionate share hospital
E&M	Evaluation & Management services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFP	Federal financial participation
FFS	fee for service
FMAP	Federal Medical Assistance Percentage

FUL	Federal upper limit
FY	fiscal year
HCFAC	Health Care Fraud and Abuse Control program
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health & Human Services
IMD	institutions for mental disease
IRS	Internal Revenue Service
LTC	long-term care
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
OPM	Office of Personnel Management
PERM	Payment Error Rate Measurement program
SDAC	School District Administrative Claiming program
SNF	skilled nursing facility
UCCP	uncompensated care pool

Other Abbreviations

DRA	Deficit Reduction Act of 2005, P.L. No. 109-171
FCA	False Claims Amendments Act of 1986, P.L. No. 99-562
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
IDEA	Individuals with Disabilities Education Act of 2004, P.L. No. 108-446

IPIA Improper Payments Information Act of 2002, P.L. No. 107-300

Recovery Act American Recovery and Reinvestment Act of 2009, P.L. No. 111-5