



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

**Office of  
Inspector  
General**

**Medicaid Integrity  
Program Report  
for Fiscal Year 2011**

**March 2012**

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## FY 2011 Funding for Program Integrity

### Sources of Funding

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During fiscal year (FY) 2011, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) utilized funding to oversee the integrity of Medicaid activities from three sources: the Health Care Fraud and Abuse Control (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); and the American Recovery and Reinvestment Act of 2009 (Recovery Act). Following are descriptions of each funding source.

**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.”<sup>1</sup> 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.

- **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 provided annually from FY 2006 through FY 2010 in addition to our HCFAC resources and is available until expended. In FY 2011, MIP funds were still available. Specific DRA requirements that pertain to our office are described in Appendix C.
- **OTHER MEDICAID OVERSIGHT FUNDING.** We receive funding to oversee the integrity of Medicaid activities from other sources. In 2009, the American Recovery and Reinvestment Act of 2009 (Recovery Act or ARRA) 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, was available until September 30, 2011.

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<sup>1</sup> Social Security Act, § 1817(k)(3)(A).

## 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 funding 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 2011.

**ALLOCATION OF STATUTORY FUNDING STREAMS FOR  
 MEDICAID INTEGRITY OVERSIGHT, FY 2006 – FY 2011**  
 (Dollars in Millions)

Fiscal Year	Funding Appropriated 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		
2006	\$160	\$25	\$45	–	\$45	28 %
2007	\$166	\$25	\$25	\$29	\$53	28 %
2008	\$170	\$25	\$33	\$29	\$62	31 %
2009 <sup>2</sup>	\$196	\$81	\$34	\$31	\$65	29 %
2010	\$209	\$25	\$42	\$34	\$76	32%
2011	\$228	\$0	\$37	\$39	\$76	28%

Note: Numbers have been updated and are approximate because of rounding.

The table illustrates that a sizable portion of OIG's obligated funding has been used for Medicaid oversight in recent years.

<sup>2</sup> In FY 2009, OIG received a 42-percent increase in funding available for Medicare and Medicaid program integrity activities. 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. Because of this significant increase and consistent with the purpose of the funding, OIG manages oversight work over multiple years.

## FY 2011 Medicaid-Related Audits and Evaluations

### Federal and State Medicaid Partnership

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The Federal Government and States jointly administer and fund the cost of the Medicaid medical assistance program. Although the States have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable Federal requirements to receive a Federal share of costs.

At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. At the State level, State agencies administer their Medicaid programs in accordance with broad Federal CMS-approved State plans. The Federal share of Medicaid expenditures varies from State to State. In recent years, the Federal Government has reimbursed about 57 percent of States' Medicaid expenditures. However, in FY 2010, the Federal Government reimbursed about 68 percent of such expenditures. A significant portion of the increase in the Federal share was attributable to the temporary increase in Federal Medical Assistance Percentage (FMAP) rates pursuant to the Recovery Act.<sup>3</sup> 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 FMAPs.

The sections that follow highlight significant problems, abuses, and deficiencies disclosed in reports of audits and evaluations that we issued in FY 2011. These matters were also reported in OIG's spring and fall *Semiannual Report(s) to Congress* during FY 2011. Summaries and the full text of the reports are published on our Web site at <http://www.oig.hhs.gov>.

### Prescription Drug Pricing Reviews

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**REPLACING AVERAGE WHOLESALE PRICE (AWP) AS A DRUG PRICING POINT.** ALMOST HALF OF THE 45 STATES THAT USED AWP TO SET REIMBURSEMENT FOR PRESCRIPTION DRUGS IN THE FIRST QUARTER OF 2011 DID NOT HAVE DEFINITIVE PLANS FOR HOW THEY WOULD REIMBURSE DRUGS AFTER FIRST DATABANK, A PRIMARY SOURCE OF DATA, STOPPED PUBLISHING AWPs IN SEPTEMBER 2011. Most States (44 of 51) said they would prefer a single national benchmark to set Medicaid reimbursement rates, and 24 States specifically wanted a benchmark based on pharmacy acquisition costs. We recommended that CMS develop a national benchmark that accurately approximates pharmacy acquisition costs and encourage States to consider it when determining Medicaid reimbursement for prescription drugs. *Replacing Average Wholesale Price: Medicaid Drug Payment Policy*. OEI-03-11-00060. July 2011. [Web Summary](#). [Full Text](#).

**IMPROVING TRANSPARENCY OF DATA FOR DRUGS BILLED TO MEDICAID BY 340B ENTITIES.** STATE MEDICAID AGENCIES LACK THE POLICIES AND INFORMATION THEY NEED TO OVERSEE REIMBURSEMENTS FOR DRUGS PURCHASED PURSUANT TO THE DRUG DISCOUNT PROGRAM IN THE PUBLIC HEALTH SERVICE ACT, § 340B, (340B PROGRAM). About half of States do not have

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<sup>3</sup> *CMS FY 2012 Justification of Estimates for Appropriations Committees*, p. 108.

written policies for how 340B-covered entities are to bill Medicaid for reimbursement, and none of the States have drug pricing information necessary to create prepayment system edits to prevent overpaying for 340B-purchased drugs. The 340B program requires drug manufacturers to provide covered outpatient drugs to certain eligible health care entities at or below statutorily defined discount prices. The Affordable Care Act<sup>4</sup> requires the Secretary to issue new guidance describing methodologies available to covered entities for billing 340B-purchased drugs. *State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs*. OEI-05-09-00321. Affordable Care Act. June 2011. [Web Summary](#). [Full Text](#).

## Manufacturers' Rebates for Medicaid Prescription Drugs

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- **MANUFACTURERS' REBATES REDUCE MEDICAID'S BRAND-NAME DRUG COSTS.** ALTHOUGH PRICES AND PAYMENT AMOUNTS FOR MEDICAID BRAND-NAME DRUGS INCREASED AT ABOUT THREE TIMES THE INFLATION RATE BETWEEN 2005 AND 2010, THE SIGNIFICANT INCREASE WAS OFFSET BY SAVINGS GENERATED BY MEDICAID'S DRUG REBATE PROGRAM. Medicaid's net costs for brand-name drugs actually increased at a lower rate than other points of comparison, including the inflation rate. *Medicaid Brand-Name Drugs: Rising Prices Are Offset by Manufacturer Rebates*. OEI-03-10-00260. August 2011. [Web Summary](#). [Full Text](#).
- **IMPROVING STATES' COLLECTIONS OF DRUG REBATES.** IN A NATIONWIDE FOLLOWUP TO A 2005 REVIEW OF MEDICAID DRUG REBATE PROGRAMS, WE FOUND THAT MANY STATES STILL NEED TO MAKE IMPROVEMENTS IN THEIR REBATE COLLECTION EFFORTS. States lack adequate assurance that all drug rebates due them are properly recorded and collected. Fourteen States and the District of Columbia implemented the recommendations from the previous reviews. Of the 31 remaining States with previous recommendations, 27 implemented at least 1 recommendation and 4 States did not fully implement any of the recommendations. We identified new weaknesses in four States. Forty-two States established controls over collecting rebates for single-source drugs administered by physicians as required by the DRA. The six remaining States and the District of Columbia did not establish controls over collecting these rebates. States lacked adequate assurance that all drug rebates due the States were properly recorded and/or collected. Additionally, CMS did not have reliable drug rebate billing and collection information to properly monitor the program. *Nationwide Rollup Report for Medicaid Drug Rebate Collections*. A-06-10-00011. August 2011. [Web Summary](#). [Full Text](#). See also *Multistate Review of Medicaid Drug Rebate Programs*. A-06-03-00048. July 2005. [Web Summary](#). [Full Text](#).
- **DIFFICULTY OBTAINING MANUFACTURER REBATES FOR PHYSICIAN-ADMINISTERED DRUGS.** ALTHOUGH MOST STATES SELF-REPORTED THAT THEY MET OR EXCEEDED FEDERAL REQUIREMENTS TO COLLECT REBATES FOR CERTAIN PHYSICIAN-ADMINISTERED DRUGS, 29 OF THE 49 RESPONDING STATES REPORTED DIFFICULTIES WITH OBTAINING REBATES FROM MANUFACTURERS. The States attributed the difficulty mainly to missing or potentially inaccurate drug code information that providers entered on claims or the absence of drug code information on claims. *States' Collection of Medicaid Rebates for Physician-Administered Drugs*. OEI-03-09-00410. June 2011. [Web Summary](#). [Full Text](#).
- **SYSTEMS LIMITATIONS IN INVOICING REBATES FOR MEDICAID COMPOUND DRUG EXPENDITURES.** CALIFORNIA FAILED TO INVOICE MANUFACTURERS AND COLLECT AN ESTIMATED \$26.7 MILLION IN REBATES FOR ELIGIBLE COMPOUND DRUG

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<sup>4</sup> Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-52. (Affordable Care Act or ACA)

INGREDIENTS. Pharmacists create compound drugs by combining two or more prescription or nonprescription drug products and then repackaging them into a new form. California's Rebate Accounting Information System was not designed to invoice rebates for compound drug ingredients, and its electronic claims for such expenditures did not comply with Federal requirements. *Review of California's Invoicing of Rebates for Medicaid Compound Drug Expenditures-Electronic Claims*. A-09-10-02006. May 2011. [Web Summary](#). [Full Text](#).

## Manufacturers' Rebates for Medicaid Compared to Medicare Part D

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- **MEDICAID'S HIGHER REBATES FOR BRAND-NAME DRUGS RESULTED IN LOWER NET COSTS COMPARED TO MEDICARE PART D.** MEDICAID RECOUPED 45 PERCENT OF ITS DRUG SPENDING ON SELECTED BRAND-NAME DRUGS IN MANUFACTURER REBATES WHILE PART D SPONSORS RECOUPED 19 PERCENT. Although pharmacy reimbursement amounts under Medicaid and the Medicare Part D prescription drug benefit were similar for most selected brand-name drugs, Medicaid's net unit drug costs were much lower than Part D's because Medicaid receives substantially higher manufacturer rebates for brand-name drugs. Manufacturer rebates for generic drugs under both programs were negligible. Unlike Medicaid, Part D sponsors (or contractors acting on their behalf) negotiate rebates with drug manufacturers without any statutory requirements on rebate amounts. In fact, the law establishing the Part D program expressly prohibited the Government from instituting a price structure for the reimbursement of covered Part D drugs. *Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D*. OEI-03-10-00320. August 2011. [Web Summary](#). [Full Text](#).

## State Claims for Federal Reimbursement

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- **RECONCILIATION OF STATE EXPENDITURE REPORTS TO CLAIMS DATA.** IN TWO OF FIVE STATES WE REVIEWED, MEDICAID EXPENDITURES THAT STATES REPORTED QUARTERLY TO CMS WERE NOT CORRECT OR WERE NOT ADEQUATELY SUPPORTED. State agencies claim their Medicaid expenditures on the Quarterly Medicaid Statements of Expenditures for the Medical Assistance Program (Form CMS-64), which they submit to CMS within 30 days after the end of each quarter. The form shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the quarter being reported and any prior-period adjustments. Each State must maintain an accounting system and supporting fiscal records to ensure that claims reported on the CMS-64 report are in accordance with applicable Federal requirements. We conducted reconciliation reviews as part of our oversight of increased Federal funding from the Recovery Act.<sup>5</sup> Reviews completed in FY 2011 follow.
  - OKLAHOMA – (About \$1 billion adequately supported; refund \$2.1 million; claim a \$5,000 credit; resolve \$127,000 set aside for further analysis.) *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma*. A-06-09-00097. July 2011. [Web Summary](#). [Full Text](#).

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<sup>5</sup> Recovery Act, P.L. No. 111-5.

- ARKANSAS – (Resolve \$1.7 million set aside.) *Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ending December 31, 2008.* A-06-09-00093. July 2011. [Web Summary](#). [Full Text](#).
- NEW YORK STATE – (Expenditures adequately supported.) *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in New York State for the Quarter Ended September 30, 2009.* A-02-10-01020. April 2011. [Web Summary](#). [Full Text](#).
- PUERTO RICO – (Expenditures adequately supported.) *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Puerto Rico for the Quarter Ended September 30, 2009.* A-02-10-01038. April 2011. [Web Summary](#). [Full Text](#).
- INDIANA – (Expenditures adequately supported.) *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Indiana for the Quarter Ending March 31, 2009.* A-05-09-00091. December 2010. [Web Summary](#). [Full Text](#).
- **PROBLEMS WITH HOME- AND COMMUNITY-BASED SERVICES CLAIMS.** OUR FINDINGS, WHICH VARIED BY STATE, REVEALED CLAIMS IN WHICH SERVICES WERE UNALLOWABLE; DOCUMENTATION WAS MISSING, INACCURATE, OR INADEQUATE; AND SOME BENEFICIARIES WERE NOT ELIGIBLE OR WERE NOT PROPERLY ASSESSED AND CERTIFIED TO REQUIRE THE DESIGNATED LEVEL OF CARE. States may offer, under a waiver of statutory requirements, an array of home- and community-based services not otherwise furnished under the State's Medicaid plan that certain individuals need to avoid institutionalization. Services may include those that meet Federal regulations and are defined by the State and approved by CMS. One of the States we reviewed did not amend its cost allocation plan to identify administrative costs associated with the waiver program and nonwaiver activities or submit a methodology for allocating them. Other findings, which could impact beneficiary safety or quality of care, included that assessors were not always trained and certified, services were provided to beneficiaries who did not have completed and approved individual habilitation plans, or services were not in accordance with plans of care. The reviews we reported to Congress in FY 2011 follow.
  - NEW JERSEY – (Refund \$903,000.) *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Elwyn New Jersey From January 1, 2005, Through December 31, 2007.* A-02-09-01033. July 2011. [Web Summary](#). [Full Text](#).
  - NEW YORK – (Refund \$1.6 million; resolve \$2.1 million set aside.) *Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Belvedere of Albany, LLC, From January 1, 2005, Through December 31, 2007.* A-02-09-01006. May 2011. [Web Summary](#). [Full Text](#).
  - PENNSYLVANIA – (Refund \$2.1 million plus \$371,000; \$25.8 million set aside for further analysis.) *Review of Administrative Costs Claimed by Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over.* A-03-10-00202. June 2011. [Web Summary](#). [Full Text](#).
- **DOCUMENTATION, OTHER ERRORS IN PERSONAL CARE SERVICES CLAIMS (PCS).** OUR FINDINGS, WHICH VARIED BY STATE, REVEALED CLAIMS FOR PCS THAT HAD INACCURATE OR MISSING DOCUMENTATION, DOCUMENTATION THAT DIFFERED SIGNIFICANTLY FROM BENEFICIARIES' SERVICES NEEDS ASSESSMENTS, INACCURATE OR DUPLICATE PROVIDER BILLING, POTENTIALLY UNALLOWABLE COSTS, AND SERVICES BILLED DURING BENEFICIARIES' INPATIENT HOSPITAL STAYS (QUESTIONABLE OVERLAP OF SERVICES). Such errors occurred because of inadequate prepayment and postpayment claim reviews. Other deficiencies were related to physicians' orders; timesheets; attendant qualifications,



training, and background checks; and lack of nursing visits for attendant supervision. Such deficiencies could impact beneficiary safety and quality of care.

- NEBRASKA – (Refund \$169,000; \$4.5 million set aside for further analysis.) *Nebraska Medicaid Payments for Personal Care Services*. A-07-10-03152. June 2011. [Web Summary](#). [Full Text](#).
- WASHINGTON STATE – (Refund \$19.4 million; \$30.3 million set aside for further analysis.) *Review of Medicaid Personal Care Services Claimed by Washington State*. A-09-09-00030. May 2011. [Web Summary](#). [Full Text](#).
- NORTH CAROLINA – (Refund \$41.7 million.) *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina*. A-04-10-04003. June 2011. [Web Summary](#). [Full Text](#).
- NORTH CAROLINA – (Refund \$1.3 million. Based on one provider.) *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.* A-04-09-04041. February 2011. [Web Summary](#). [Full Text](#).
- DISTRICT OF COLUMBIA – (Refund \$1.1 million; \$808,000 set aside for further analysis.) *Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia*. A-03-08-00207. December 2010. [Web Summary](#). [Full Text](#).
- NEW YORK STATE – (Refund \$100.3 million.) *Review of Medicaid Personal Care Services Claims Made by Providers in New York State*. A-02-08-01005. October 2010. [Web Summary](#). [Full Text](#). SEE ALSO NEW YORK CITY – (Refund \$275.3 million.) *Review of Medicaid Personal Care Services Claims Made by Providers in New York City*. A-02-07-01054. June 2009. [Web Summary](#). [Full Text](#).
- TEN-STATE REVIEW – EIGHTEEN PERCENT OF PCS CLAIMS WERE INAPPROPRIATE BECAUSE ATTENDANTS' QUALIFICATIONS WERE UNDOCUMENTED. Medicaid paid an estimated \$724 million for the deficient claims. CMS will review the claims and take appropriate action. The qualifications most often undocumented were background checks, age, and education. We estimated that Medicaid paid an additional 2 percent of claims inappropriately because the respondents had no record of providing services to the beneficiaries. *Inappropriate Claims for Medicaid Personal Care Services*. OEI-07-08-00430. December, 2010. [Web Summary](#). [Full Text](#).
- **INELIGIBLE CLAIMS FOR ENHANCED FEDERAL SHARE OF FAMILY PLANNING SERVICES.** OUR FINDINGS, WHICH VARIED BY STATE, REVEALED CLAIMS THAT WERE NOT ELIGIBLE FOR FEDERAL REIMBURSEMENT AT THE 90-PERCENT ENHANCED RATE. The errors occurred because in some cases Medicaid Management Information Systems (MMIS) did not identify which claims were eligible for the enhanced rate; deficient claims related to child delivery, newborn services, hysterectomies, and other costs were not eligible for the enhanced rate. Reports of reviews completed in this semiannual period follow.
  - OREGON – (Refund \$1.5 million.) *Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009*. A-09-10-02043. June 2011. [Web Summary](#). [Full Text](#).
  - WASHINGTON STATE – (Refund \$8.5 million.) *Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008*. A-09-09-00049. February 2011. [Web Summary](#). [Full Text](#).
  - KANSAS – (Refund \$2.4 million.) *Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program*. A-07-10-04156. May 2011. [Web Summary](#). [Full Text](#).

- OKLAHOMA – (Refund \$3.4 million.) *Review of Medicaid Hysterectomy Expenditures Claimed as Family Planning in Oklahoma for Calendar Years 2005 to 2009.* A-06-10-00047. May 2011. [Web Summary.](#) [Full Text.](#)
- COLORADO – (Refund \$2 million.) *Review of Additional Claims for Sterilization Procedures in the Colorado Medicaid Family Planning Program.* A-07-11-01096. May 2011. [Web Summary.](#) [Full Text.](#)
- **REHABILITATIVE SERVICES CLAIMS DEFICIENT.** REVIEWS OF CLAIMS SUBMITTED BY NEW YORK AND MARYLAND REVEALED DEFICIENCIES IN DOCUMENTATION AND STATE PLAN DEFINITIONS.
  - NEW YORK STATE – (Refund \$207.6 million.) Federal Medicaid reimbursement was improperly claimed for optional rehabilitation services by community residence providers that did not comply with Federal and State requirements. Deficiencies pertained to physicians’ authorizations or reauthorizations for services, services of at least 15 minutes, and/or service plans reviewed and signed by qualified mental health staff members. The community residence rehabilitation providers included group homes and apartments providing services under a program administered by New York’s Office of Mental Health. *Review of New York’s Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers.* A-02-08-01006. December 2010. [Web Summary.](#) [Full Text.](#)
  - MARYLAND – We were unable to determine whether the documentation Maryland submitted as support for sampled claims was sufficient because its State plan was unclear about certain key definitions and requirements. Maryland includes residential rehabilitation services in its early and periodic screening, diagnostic, and treatment program for children. Specifically, the State plan, which should be amended, was unclear about the definition of a residential rehabilitative service and the requirements for documenting claims for such services. *Review of Medicaid Residential Rehabilitation Services for Children in Maryland.* A-03-08-00209. August 2011. [Web Summary.](#) [Full Text.](#)
- **IMPROVING SCHOOL-BASED SERVICES CLAIMS.** WEST VIRGINIA – (Refund \$22.8 million; determine unallowable costs for 2004 to present.) The Federal Government overpaid its share of West Virginia’s school-based services because the State included costs in the calculation of its rates that were not included in the reimbursement methodology described in the approved State plan. The errors occurred because the State did not provide adequate oversight of its consulting firm during the rate calculation process. *Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia.* A-03-05-00203. April 2011. [Web Summary.](#) [Full Text.](#)
- **ERRORS IN STATE’S ALIEN EMERGENCY MEDICAL PROGRAM CLAIMS.** WASHINGTON STATE – (Refund \$763,000; other amounts to be determined.) Washington State improperly claimed Federal reimbursement for nursing home services provided to nonqualified alien beneficiaries without prior approval from a State medical consultant or to beneficiaries who were misclassified and not eligible for the State’s Alien Emergency Medical program. The State also improperly claimed Federal reimbursement for various medical services provided to treat conditions that were not authorized. Other questionable claims were for prescription drugs and dental services that the State agency could not determine were related to treating emergency medical conditions. A nonqualified alien is an individual who is not a citizen or national of the United States and is not in a satisfactory immigration status. Federal Medicaid funding is available to States for medical services provided to nonqualified aliens only when those services are

necessary to treat an emergency medical condition. *Review of Washington State's Medicaid Claims for Nonqualified Aliens*. A-09-09-00039. December 2010. [Web Summary](#). [Full Text](#).

- **CLAIMS FOR NONCOMPLIANT STATE-OWNED PSYCHIATRIC HOSPITAL.** ILLINOIS – (Refund \$82.9 million; \$12.6 million set aside for further analysis.) Illinois improperly claimed Federal reimbursement for payments it made to a State-owned psychiatric hospital that failed to demonstrate compliance with special Medicare Conditions of Participation (CoP). The State agency did not believe that such demonstration was necessary. *Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31, 2009*. A-05-10-00046. August 2011. [Web Summary](#). [Full Text](#).
- **MEDICAID EXPENDITURES FOR MEDICARE PART A AND PART B PREMIUMS.** MISSOURI – (Refund \$1.5 million.) Missouri improperly claimed Federal reimbursement for the Federal share of Medicare Part B premiums that the State paid under the buy-in program. The errors occurred because the State made calculation and duplication errors. Federal law allows States to pay Medicare premiums on behalf of certain individuals who are entitled to both Medicare and some form of Medicaid benefits. The State can then claim the Federal share of such premium expenditures under Medicaid. This provision, called buy-in, has the effect of transferring part of the medical costs for eligible individuals from the federally and State-funded Medicaid program to the federally financed Medicare program. The State's claims for the Federal share of its Part A premium payments were claimed correctly. *Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri*. A-07-10-03158. July, 2011. [Web Summary](#). [Full Text](#).
- **UNALLOWABLE MMIS EXPENDITURES.** OREGON – (Refund \$566,000; \$1.7 million set aside for further analysis.) Oregon improperly claimed Federal Reimbursement of certain expenditures reported as being related to its MMIS, including employee salaries and fringe benefits, contractor and postage expenditures claimed at incorrect Federal reimbursement rates, and unallowable contractor and employee expenditures. We set aside for further analysis and resolution additional contractor expenditures and employee salaries and fringe benefits that may have been unallowable. Of the \$31 million in expenditures we reviewed, Oregon claimed \$27.4 million correctly. *Audit of Oregon's Medicaid Management Information System Expenditures for the Period October 1, 2007, Through September 30, 2009*. A-09-10-02017. August, 2011. [Web Summary](#). [Full Text](#).
- **NON-MEDICAID ADMINISTRATIVE COSTS IMPROPERLY CLAIMED.** PENNSYLVANIA improperly claimed Federal Medicaid reimbursement for administrative costs not associated with Medicaid operations.
  - PENNSYLVANIA – (Refund \$1.7 million; resolve additional amounts.) Pennsylvania improperly claimed Federal Medicaid reimbursement for unauthorized administrative costs for the Direct Care Worker Initiative, a recruitment and retention program of the State's Department of Aging. The costs were not incurred to operate the Medicaid program, and CMS specifically prohibits claiming them as administrative costs. Local agencies operating the initiative reported that the funds were spent on bonuses, training, and recognition events. *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging's Direct Care Worker Initiative*. A-03-10-00206. July 2011. [Web Summary](#). [Full Text](#).
  - PENNSYLVANIA – (Refund \$1.2 million; resolve additional amounts.) Pennsylvania improperly claimed Federal Medicaid Reimbursement for administrative costs of the Healthy Steps for Older Adults (Healthy Steps) program. The claimed costs were for the Department of Aging's payments for services to help older adults remain active and were not for the administration of the Medicaid

program. *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging's Healthy Steps Program*. A-03-10-00205. July 2011. [Web Summary](#). [Full Text](#).

## Other Payment-Related Reviews

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- **SERVICES PROVIDED IN AN ADULT DAY HEALTH SETTING.** FOR THE 12 STATE MEDICAID PROGRAMS THAT ALLOW NURSING- AND THERAPY-FOCUSED ADULT DAY HEALTH SERVICES, APPROXIMATELY 43 PERCENT OF THERAPY SERVICES WERE PROVIDED BY STAFF WHO LACKED REQUIRED SUPERVISION. On 34 percent of service days, meals and/or snacks were the only documented services provided. In some cases, documentation lacked appropriate physician orders or was inconsistent with plans of care. Within broad Federal Medicaid requirements, individual States establish the specific requirements that must be met for Medicaid reimbursement of adult day health services. *Medicaid Services Provided in an Adult Day Health Setting*. OEI-09-07-00500. July 2011. [Web Summary](#). [Full Text](#).
- **AFTER-HOURS SERVICES CODES GENERALLY COMPLIANT.** IN GENERAL, WE DID NOT FIND A LARGE PROBLEM WITH INAPPROPRIATELY PAID AFTER-HOURS ADD-ON CODES. After-hours add-on codes compensate providers for the additional costs associated with providing services outside posted or normal business hours. Our findings included that only three States—North Carolina, Kentucky, and Massachusetts—made 77 percent of the \$8.1 million total in payments for after-hours add-on codes. Each State Medicaid program decides whether and under what circumstances providers may be reimbursed for after-hours services. *Medicaid Payments for After-Hours Services*. OEI-07-11-00050. May 2011. [Web Summary](#). [Full Text](#).
- **MEDICAID HOSPITAL OUTLIER PAYMENTS FOLLOWUP REVIEW.** EIGHT STATE AGENCIES WE REVIEWED DID NOT CALCULATE MEDICAID INPATIENT HOSPITAL COST OUTLIER PAYMENTS IN A WAY THAT WOULD EFFECTIVELY LIMIT PAYMENTS TO EXTRAORDINARILY HIGH-COST CASES. If the States had used the most recent cost reports to calculate the cost-to-charge ratios for the 27 hospitals we reviewed, those States could have, between FYs 2004 and 2006, more effectively limited payments to extraordinarily high-cost cases, thereby reducing those Medicaid outlier payments by about \$320 million. To protect hospitals against large financial losses from extraordinarily high-cost cases, States may supplement base payments with an additional “outlier” payment. Medicaid outlier payments are calculated using formulas that vary by State. The States we reviewed used outdated cost-to-charge ratios and did not reconcile Medicaid outlier payments upon settlement of cost reports. The review is a followup to similar audits we conducted in 2004. *Medicaid Hospital Outlier Payment Followup for Fiscal Years 2004 Through 2006*. A-07-10-04160. July 2011. [Web Summary](#). [Full Text](#).
- **INDIANA’S REPORTING OF FUND RECOVERIES AND INTEREST INADEQUATE.** (Refund \$38.9 million and \$39,000 interest.) Indiana did not report Medicaid overpayments and the interest it collected on overpayment recoveries in accordance with Federal requirements. Federal law requires States to refund the Federal share of Medicaid overpayments. In addition, Federal regulations require States to refund interest earned on overpayment recoveries before requesting additional Federal funds. *Review of Indiana’s Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008*. A-05-09-00021. October 2010. [Web Summary](#). [Full Text](#).

- **NONCOMPLIANCE WITH RECOVERY ACT REQUIREMENTS.** REVIEWS OF THREE STATES REVEALED NONCOMPLIANCE OR POTENTIAL NONCOMPLIANCE WITH PROMPT-PAY AND OTHER FEDERAL REQUIREMENTS FOR RECEIVING INCREASED FUNDING PURSUANT TO THE RECOVERY ACT.
  - ILLINOIS – (REFUND \$2.6 MILLION.) Illinois improperly received \$2.6 million in increased Federal reimbursements from February 18, 2009, through September 30, 2009, because it did not always comply with prompt-pay requirements. The State agency’s initial prompt-pay calculations included several inaccuracies related to the 30/90-day prompt-pay requirements and the inclusion in, or exclusion from, of certain claims in the daily prompt-pay compliance calculation. The State also failed to adjust the Form CMS-64 for the quarter ended June 30, 2009, for expenditures not eligible for the increased Federal share. *Review of Illinois’ Prompt Pay Compliance Under the American Recovery and Reinvestment Act of 2009 From January 1, 2009, Through September 30, 2009.* A-05-09-00083. December 2010. [Web Summary.](#) [Full Text.](#)
  - NEW HAMPSHIRE – We could not determine whether New Hampshire fully complied with prompt-pay requirements for receiving the increased Federal medical assistance percentage because the State did not always appropriately record claims’ receipt dates. *Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire.* A-01-10-00009. December 2010. [Web Summary.](#) [Full Text.](#)
  - ALABAMA – Alabama complied with the Recovery Act requirement that amounts attributable to increased funding not be deposited or credited to any reserve (rainy day) fund. However, as an additional matter, the State drew down about \$2.4 million in Federal Recovery Act funds that exceeded the amount of the Recovery Act expenditures reported on its Form CMS-64 reports for the audit period. The State agency did not provide an explanation for the excessive drawdown of Recovery Act funds, and we were unable to determine whether the excessive drawdowns were used for allowable Recovery Act purposes. *Review of Alabama’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-04-10-03058. January 2011. [Web Summary.](#) [Full Text.](#)

## States’ Program Management and Oversight

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- **FY 2008 PAYMENT ERROR RATE MEASUREMENT PROGRAM DATA FLAWED.** STATES’ MEDICAID FEE-FOR-SERVICE AND MANAGED CARE UNIVERSES FOR THE FY 2008 PAYMENT ERROR RATE MEASUREMENT PROGRAM (PERM) WERE OR MAY HAVE BEEN INCOMPLETE OR INACCURATE. AS A RESULT, CMS COULD NOT BE ASSURED THAT THE PERM PROGRAM PRODUCED A REASONABLE ESTIMATE OF IMPROPER PAYMENTS FOR THAT YEAR. CMS developed the PERM program to comply with Federal requirements for measuring improper Medicaid and Children’s Health Insurance Program (CHIP) payments. *Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program.* A-06-09-00037. October, 2010. [Web Summary.](#) [Full Text.](#)
- **OVERSIGHT OF MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PAYMENTS LIMITED.** STATES’ ABILITY TO ENSURE THE INTEGRITY OF MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PAYMENTS IS LIMITED. States must verify that health care practitioners and hospitals are eligible for incentive payments. Although the States we reviewed said they plan to verify at least half of eligibility requirements prior to making EHR incentive payments, we found that depending on the requirement, States may have none, some, or all of the data

they need prior to making payments. The lack of data limits both the number of eligibility requirements that States plan to verify prior to payment and the completeness of those verifications. All the States we reviewed said they plan to audit eligibility requirements after payment. Between 2011 and 2019, the Federal Government will spend an estimated \$13.4 billion for Medicaid EHR programs. *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight*. OEI-05-10-00080. July 2011. [Web Summary](#). [Full Text](#).

- **REFUNDS FOR FLORIDA'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) WERE UNDERPAID.** (Credit \$2 million Federal share of refunds.) Because insurers incorrectly reported premium payments, Florida did not receive all refunds due in connection with the CHIP Program. The underpaid refunds occurred primarily because Florida and its agent did not have policies and procedures requiring personnel to review insurers' reports and reconcile them to supporting records. *Review of Florida's Children's Health Insurance Program Experience Adjustment and Refund Submission Reports*. A-04-10-06123. June 2011. [Web Summary](#). [Full Text](#).

## FY 2011 Medicaid-Related Legal and Investigative Outcomes

### Education and Outreach

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**INTRODUCING THE ROADMAP FOR NEW PHYSICIANS.** IN RESPONSE TO AN OIG SURVEY, ALMOST HALF OF MEDICAL SCHOOLS AND MORE THAN TWO-THIRDS OF INSTITUTIONS OFFERING RESIDENCY AND FELLOWSHIP PROGRAMS REPORTED INSTRUCTING PARTICIPANTS ABOUT COMPLIANCE WITH MEDICARE AND MEDICAID FRAUD AND ABUSE LAWS. Because nearly all who responded to our survey were interested in having OIG provide instructional materials, we developed a guide called *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* (Roadmap). The package also includes a slide presentation and speaker notes. The Roadmap summarizes the five main Federal fraud and abuse laws (the False Claims Act (FCA), the anti-kickback statute, the physician self-referral law (Stark Law), OIG's exclusion authorities, and civil monetary penalties authorities). It instructs physicians how to uphold these laws in their relationships with payers, such as Medicare and Medicaid; vendors, such as drug, biologic, and medical device companies; and other providers, such as hospitals, nursing homes, and physician colleagues. The [survey](#) and [Roadmap](#) are available on our Web site at <http://www.oig.hhs.gov>.

### Criminal and Civil Enforcement

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#### PRESCRIPTION DRUGS, PHARMACIES, AND MANUFACTURERS

- **MISSOURI – Cardinal Health, Inc.**, a pharmaceutical distributor, agreed to pay the United States \$8 million to resolve a lawsuit filed by two individuals, a former pharmacy owner and pharmacy consultant, pursuant to the *qui tam*, or whistleblower, provisions of the FCA. The pharmacy owner alleged that Cardinal Health paid him \$440,000 in exchange for an agreement that he purchase prescription drugs for



his pharmacies from Cardinal Health. The inducement allegedly constituted an up-front payment, or “prebate,” in violation of the Federal health care anti-kickback statute; thereby causing the pharmacies to submit potentially tainted or false claims to Medicare and Medicaid.

- **MICHIGAN – eTEL-Rx, Inc.**, a pharmacy that provides drugs to nursing home facilities throughout the State, entered into a settlement agreement that includes restitution in the amount of \$650,000 to resolve its alleged liability under the civil FCA. Between January 1999 and December 2007, eTEL-Rx allegedly billed Medicaid directly for the medications and nutritional supplements of terminally ill patients that should have been billed to the appropriate hospice providers. In addition, eTEL-Rx accepted the return of unused drugs paid for by Medicaid without crediting Medicaid for the returns. The pharmacy subsequently redispensed the returned drugs, resulting in Medicaid's paying eTEL-Rx again for the drugs already reimbursed by Medicaid. As part of the settlement, eTEL-Rx entered into a [corporate integrity agreement](#) (CIA) with OIG.
- **OHIO – James Matheny, Jr.**, and a Walgreens Pharmacy Technician, **Jacob McCoy**, were sentenced to 27 months and 12 months and 1 day of incarceration, respectively, and ordered to pay \$6,131, jointly and severally, for their roles in a scheme to obtain controlled substances through using stolen identities and fraudulent prescriptions. Specifically, McCoy and Matheny obtained blank prescription pads in the name of **Columbus Pain Management**, a fictitious medical practice, and then wrote prescriptions for Class 2 controlled substances to include OxyContin and Percocet. McCoy also used his pharmacy's computer system to obtain the identities of customers who possessed insurance benefits through Medicare, Medicaid, and Medicaid managed care entities. McCoy and Matheny then used this information to obtain the controlled substances at reduced prices. Matheny subsequently sold the prescription drugs on the street. Between March 2009 and June 2009, McCoy and Matheny diverted approximately 4,000 units of the prescription drugs.
- **GEORGIA – Allergan, Inc.**, and **Allergan USA, Inc.** (collectively, Allergan), agreed to pay \$600 million and enter a global criminal, civil, and administrative settlement in connection with the improper marketing and promotion of the drug Botox. Under the civil settlement agreement, Allergan agreed to pay the Federal Government \$225 million to resolve its FCA liability. Botox is a neurotoxin and a biologic that was approved by the Food and Drug Administration (FDA) for several uses, including blepharospasm (uncontrollable closing of the eyelids); cervical dystonia (muscle spasm and pain in the neck and shoulder); and temporary improvement in the appearance of moderate to severe glabellar lines (facial age wrinkles) in adults up to age 65. The settlement resolves allegations that Allergan promoted the sale and use of Botox for a variety of conditions, such as headache, pain, spasticity, and overactive bladder, which were uses not approved by FDA and were therefore not covered by the State Medicaid programs. The settlement also resolves additional allegations of misleading physicians, causing miscoding, and offering illegal remuneration to health care professionals. Allergan entered into a comprehensive [5-year CIA](#) with OIG, which included several provisions intended to increase transparency about Allergan's promotional practices and which required Allergan to establish internal monitoring programs to review promotional activities.

#### HOSPITALS

- **CONNECTICUT – Masonicare Health Center** (Masonicare) agreed to pay \$447,776 to resolve its liability for allegations under the FCA. The settlement agreement resolved allegations that Masonicare improperly

overcharged Medicare and Medicaid from January 1, 2001, through May 31, 2010, for Lupron injections, which are commonly used to treat prostate cancer in men and manage endometriosis in women. Using the Healthcare Common Procedure Coding System (HCPCS), Masonicare allegedly billed Medicare and Medicaid for Lupron injections provided to its male patients under an HCPCS code designated for female beneficiaries, which is reimbursed at double the rate.

- **OKLAHOMA – AHS Hillcrest Medical Center, LLC; AHS Tulsa Regional Medical Center, LLC; Ardent Health Services, LLC; and Ardent Medical Services, Inc.** (collectively the Ardent Entities), entered into an FCA settlement agreement and agreed to pay \$3.85 million to resolve allegations that between January 2003 and December 2009, the Ardent Entities caused false claims to be submitted to Oklahoma Medicaid. Specifically, the Children and Adolescent Behavioral Health Services Unit of the Tulsa Regional Medical Center (renamed Oklahoma State University Medical Center in 2006) allegedly failed to provide inpatient psychiatric services to patients under the age of 21 in the intervals of time required by State regulations. Instead, shorter therapy sessions were allegedly provided and documented as if they had been appropriately provided. In connection with this settlement, AHS Hillcrest Medical Center, which assumed ownership and operation of the Unit in 2009, entered into a [5-year CIA](#). The obligations include oversight by a board of directors and an Independent Review Organization's review of the Unit's claims and quality control systems.
- **INDIANA – St. John's Health System** (St. John's) agreed to pay the United States \$318,364 to resolve its liability under the FCA for submitting fraudulent claims to Medicare and Medicaid for psychotherapy services. The settlement resolves allegations that from January 1, 2005, through December 31, 2008, St. John's billed for multiple units of psychotherapy services under the code for group medical psychotherapy. The Government contends that the services provided were not psychotherapy sessions but were group counseling meetings, including Alcoholics Anonymous meetings conducted by unqualified professionals. The settlement also resolved allegations that St. John's billed for services provided by lower level practitioners without using modifier codes to indicate who provided the services, resulting in 25-percent higher payments under Medicare and Medicaid.

## CLINICS

**NORTH CAROLINA – Dr. Michael Nunn, d/b/a Community Wellness Center**, was ordered to pay restitution in the amount of \$297,215 and his practice was ordered to pay a fine of \$700,000 for health care fraud and money laundering. The court order also barred Nunn from engaging in business with HHS, the Department of Veterans Affairs (VA), and any other agency impacted by his offense. Between May 2003 and December 2004, Nunn operated three clinics in New Bern, Winterville, and Morehead City, North Carolina. Medicare, Medicaid, and VA patients frequently visited his clinics to obtain prescriptions for controlled substances. As a condition for receiving the prescriptions, Nunn required the patients to undergo various forms of physical and psychological therapy that were performed by unlicensed and unqualified personnel or provided by qualified practitioners without proper supervision. The therapy was subsequently billed to Medicare, Medicaid, and VA.

**VERMONT – Dartmouth Hitchcock Clinic, Mary Hitchcock Memorial Hospital**, and related entities (collectively Dartmouth), agreed to pay \$2.2 million to resolve its liability under the FCA for allegedly submitting improper claims to Medicare, Medicaid, TRICARE, and VA. Between February 1, 2001, and September 30, 2007, Dartmouth's Anesthesiology Department (AD) allegedly submitted improper claims for services not



supervised by attending physicians in the AD's Pain Clinic, submitted improper claims for services not supervised by attending physicians related to bedside procedures, and submitted improper claims for time-based billings in the AD's Critical Care Unit. Pursuant to Federal regulations and related guidelines, physicians are allowed to bill for certain services provided by residents, but only if those services are performed while a physician is present and the medical record documents physician presence. In addition, Dartmouth allegedly submitted improper supervision and interpretation claims for services provided by its Radiology Department. These claims were improper because they did not have sufficient medical record documentation to support the supervision component of these claims.

#### HOME HEALTH SERVICES

- **NEW JERSEY – Maxim Healthcare Services** (Maxim) agreed to pay \$121 million plus interest over 8 years and enter into a [CIA](#) to resolve its liability under the FCA. In addition, Maxim paid \$20 million in criminal fines. The settlement resolves allegations that between 1998 and 2009, Maxim, one of the country's largest home health care agencies, filed false claims with State Medicaid programs and VA for services that were not provided, were not sufficiently documented to show that they had been provided, or were delivered from unlicensed offices.
- **MISSISSIPPI – Telandra Jones and Theddis Pearson**, owners of **Statewide Physical Medicine** (Statewide), were each sentenced to 120 months of incarceration and ordered to pay \$18 million in restitution, jointly and severally, for making false statements relating to a health care matter, theft of Government funds, and conspiracy to commit money laundering. Between 2001 and 2004, Statewide submitted false claims for in-home physical therapy and physical medicine services to Medicare and Medicaid falsely purporting that the services had been rendered by a physician or a qualified employee under the physician's direct supervision. Statewide also inflated the time billed by claiming that beneficiaries received as many as 10 hours of therapy per session.

#### SKILLED NURSING FACILITY

**WEST VIRGINIA – Genesis Rehabilitation Services** (GRS), an affiliate of **Genesis HealthCare LLC**, agreed to pay \$1.5 million to resolve its liability under the FCA for allegedly submitting claims to Medicare and Medicaid for services provided by an unlicensed speech therapist. Between October 2006 and June 2010, GRS allegedly employed an unlicensed speech therapist, who provided forged licenses and documentation to GRS to maintain her employment. GRS failed to verify the documentation. As a result, GRS routinely submitted claims to Medicare and Medicaid for services for licensed speech therapy services that were provided by an unlicensed therapist.

#### TRANSPORTATION FRAUD

- **NORTH CAROLINA – Dr. Janet Johnson-Hunter** was sentenced to 28 months' incarceration and ordered to pay restitution to Medicare and Medicaid in the amount of \$428,924 and \$46,165, respectively. Johnson-Hunter and her husband, also a physician, owned **Coastline Care, Inc.** (CCI), an ambulance company based in Magnolia, North Carolina. Between January 2002 and August 2005, CCI, under Johnson-Hunter's direction, routinely conducted unnecessary transportation of patients to and from dialysis centers by ambulance that should have been conducted by other means. Johnson-Hunter further instructed

emergency medical technicians to omit the true condition of these patients from the ambulance call reports when she knew their conditions would not meet the Medicare and Medicaid reimbursement requirements.

- **TEXAS – Claudette Read and Robert Earl Read**, owners of **Priority One EMS** (Priority One), were sentenced to 108 months of incarceration and ordered to pay \$1.7 million in restitution, jointly and severally, for submitting false claims to Medicare and Medicaid. Priority One was an ambulance transport business. Between January 2004 and November 2007, the Reads submitted, and instructed others to submit, claims to Medicare and Medicaid to obtain reimbursements for transporting dialysis patients who did not meet the criteria for ambulance transportation. The Reads instructed employees on what information to include in the “reason for transport” section of the emergency medical service run sheets to ensure that the transports qualified for reimbursement by Medicare and Medicaid. The Reads also submitted claims for ambulance transportation to and from dialysis that falsely represented that the patients were transported individually when, in fact, multiple patients had been transported simultaneously in one ambulance. This was a joint investigation with the Texas Medicaid Fraud Control Unit (MFCU).
- **TEXAS – The City of Dallas** agreed to pay \$2.47 million and enter a 3-year [CIA](#) to resolve its liability under the FCA related to allegations that it and ambulance billing company **Southwest General Services of Dallas, LLC**, improperly billed and obtained reimbursements from Medicare and Texas Medicaid for improperly coded ambulance transports. The transports were provided by Dallas emergency management services between January 2006 and May 2010. OIG alleged that Dallas submitted false claims to Federal programs that were improperly coded as advanced life support when, in fact, no such services were rendered and the patient did not require an advanced life support transport.

## Oversight of and Joint Investigations With Medicaid Fraud Control Units

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Under a delegation from the Secretary, OIG oversees and distributes funding to 50 Medicaid Fraud Control Units (MFCUs, which investigate and prosecute Medicaid provider fraud and patient abuse and neglect. As part of its oversight responsibility, OIG ensures that the MFCUs are operating effectively and operating in a manner consistent with legal requirements, including those in the Social Security Act and in Federal regulations. OIG’s Web site provides [information](#) about MFCUS, including common characteristics, regulations and statutes, performance standards, policy transmittals, expenditures and statistics, annual reports, and contact information.

OIG and State MFCUs also work as law enforcement partners and frequently work joint investigations. The following are examples of FY 2011 outcomes from cases jointly investigated by OIG and MFCUs.

- **PENNSYLVANIA – Ronald Bailey, Ed.D.**, a behavioral specialist consultant, was sentenced to 18 months of incarceration and ordered to pay \$164,640 in restitution for health care fraud. Bailey was employed by the Chester County Regional Educational Services, Inc. (CCRES), which contracted with the Chester County Intermediate Unit (CCIU). During that same time, Bailey was also employed with an organization called Devereux. While providing behavioral services to Devereux and CCIU, Bailey routinely prepared and submitted invoices that overstated the amount of time he spent with clients. Bailey’s scheme

included forging signatures of parents of Medicaid beneficiaries on encounter forms to appear as though he had spent the number of hours with the clients as listed on the forms. Bailey also prepared and submitted separate invoices to both Devereux and CCIU which, on many occasions, reflected that he was at two different locations at the exact same time seeing different Medicaid beneficiaries. Relying on the fraudulent invoices submitted by Bailey, CCIU, through CCRES, and Devereux issued check payments to Bailey for the claimed services with funds issued by Medicaid. This was a joint investigation with the Pennsylvania MFCU.

- **CONNECTICUT – Dr. Mark W. Izard** and his corporation, **Mark W. Izard, M.D., P.C.**, agreed to pay \$2.2 million to resolve Izard's liability under the FCA for allegedly submitting improper claims to Medicaid and Medicare. Between July 2004 and April 2009, Izard allegedly billed for services provided to patients at nursing homes when, in fact, the patients were in the hospital on the alleged dates of services. In addition, Izard and his professional corporation allegedly submitted claims for attending physician services provided to hospital inpatients when the medical records did not support CMS's physical presence requirements for such claims. Izard allegedly billed for services that, according to the medical notes in the patients' charts, were performed by advanced-practice registered nurses or Hartford Hospital medical residents. Allegedly, it was Izard's regular practice to countersign the medical notes and not include his own note reflecting services he allegedly performed as the attending physician. This was a joint investigation with the FBI and the MFCU of Connecticut.
- **MASSACHUSETTS – Aloysius Nsonwu**, owner of **Egleston Square Pharmacy** (Egleston), was sentenced in U.S. District Court to 9 months of time served and ordered to pay \$101,520 in restitution to Medicare and \$46,278 to Medicaid. In Massachusetts State Court, Nsonwu was sentenced to 4 years and 1 day in State prison, to be followed by 5 years of probation. He was also ordered to pay \$555,502 in restitution to Medicaid. Nsonwu's scheme included paying customers to bring their Medicare Part D and Medicaid cards to the pharmacy so that he could submit claims to CMS in their names. Nsonwu billed for prescription and refills of HIV/AIDS medications without physically dispensing the medication to the individuals. Many of the individuals whose Medicare and Medicaid cards were used to improperly submit bills were not, in fact, HIV positive. Nsonwu further used the identity of a licensed practicing physician without his knowledge to forge prescriptions for the medications. Nsonwu additionally paid cash to Medicaid beneficiaries in exchange for legitimate prescriptions. This was a joint investigation with the Medicaid Fraud Division of the Massachusetts Attorney General's Office and the Massachusetts State Police.
- **MICHIGAN – Specialized Pharmacy Services** (Specialized) agreed to pay \$11.6 million and enter into a settlement agreement with the State of Michigan Attorney General's Office to settle liability under the FCA. The settlement resolves allegations that from 2002 to 2009, Specialized charged Medicaid a greater amount for prescription medications than it did private insurance companies by providing nursing homes the services of their consultant pharmacists at a rate well below market price. Under Michigan law, a pharmacy cannot bill Medicaid more than it customarily accepts from a private health insurer for prescription medications. This case was jointly investigated with the Federal Bureau of Investigation (FBI) and the Michigan MFCU.
- **TEXAS – Muhammad Usman**, owner of **Royal Ambulance Service, Inc.** (Royal Ambulance), and **First Choice EMS, Inc.** (First Choice), was sentenced to 15 years of incarceration and ordered to pay \$1.3 million in restitution after being convicted of 12 counts of health care fraud, conspiracy to commit health care fraud, and money laundering. Royal Ambulance and First Choice provided medically

unnecessary transports of Medicare and Medicaid beneficiaries to and from dialysis treatments. This case was investigated jointly with the Internal Revenue Service (IRS), the FBI, the Texas MFCU, and the Office of Personnel Management.

- **INDIANA – Ali Abdelaziz Ahmed**, owner of **United Transportation** (United), pleaded guilty to health care fraud and was ordered to pay restitution in the amount of \$42,668. United and Ahmed had been under investigation, along with numerous other subjects, for upcoding ambulatory transportation services as wheelchair van transports. This upcoding scheme paid the provider twice the amount it should have received as reimbursement for the services provided. This case was jointly investigated with the Indiana MFCU.

## Appendix A

### OIG Medicaid Audits Issued in Fiscal Year 2011

The majority of reports listed in this appendix are available on the Office of Inspector General (OIG) Web site at <http://www.oig.hhs.gov>. To access the reports, query on the report number shown after each title. Reports not posted to the Web site may be requested through the Freedom of Information Act (FOIA). To make a request under FOIA, please use the following link: <http://www.oig.hhs.gov/foia/submit.asp>.

#### Medicaid Hospitals

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- *Review of Medicaid High-Dollar Payments for Inpatient Services in New York State From January 1, 2008, Through November 30, 2009*, A-02-10-01036
- *Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007—Hospitals With Five or More High-Dollar Payments*, A-05-09-00049
- *Review of Medicaid High-Dollar Payments for Inpatient Services in Michigan From January 1, 2007, Through March 31, 2009*, A-05-09-00095
- *Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31, 2009*, A-05-10-00046
- *Review of Louisiana Medicaid Inpatient Hospital Family Planning Services*, A-06-10-00076
- *Medicaid Hospital Outlier Payment Followup for Fiscal Years 2004 Through 2006*, A-07-10-04160
- *Review of Medicaid Credit Balances at Natividad Medical Center as of October 31, 2010*, A-09-11-02000

#### Medicaid Home, Community, and Nursing Home Care

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- *Followup Review of Medicaid Cost-of-Care Overpayments Made to Nursing Facilities in the State of Maine*, A-01-10-00008
- *Review of Medicaid Personal Care Services Claims Made by Providers in New York State*, A-02-08-01005
- *Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia*, A-03-08-00207
- *Review of Medicaid Payments to Senior Solutions Healthcare Management and Consulting, LLC for State Fiscal Years 2007 Through 2010*, A-01-11-00003

- *Review of New York’s Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers, A-02-08-01006*
- *Review of Medicaid Payments for Services Provided Under New York’s Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007, A-02-09-01005*
- *Review of Medicaid Payments for Services Provided Under New York’s Section 1915(c) Traumatic Brain Injury Waiver at Belvedere of Albany, LLC, From January 1, 2005, Through December 31, 2007, A-02-09-01006*
- *Review of Medicaid Payments for Services Provided Under New Jersey’s Section 1915(c) Community Care Waiver by Elwyn New Jersey From January 1, 2005, Through December 31, 2007, A-02-09-01033*
- *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc., A-04-09-04041*
- *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina, A-04-10-04003*
- *Review of Medicaid Personal Care Service Claims Submitted by Clarity Care, Inc., and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008, A-05-10-00019*
- *Review of Colorado Medicaid Payments for Home Health Agency Claims, A-07-10-01083*
- *Review of Nebraska Medicaid Payments for Home Health Agency Claims, A-07-09-01077*
- *Review of Colorado Medicaid Payments for Home Health Agency Claims Paid to Personal Assistance Services of Colorado, A-07-10-01087*
- *Nebraska Medicaid Payments for Personal Care Services, A-07-10-03152*
- *Review of Medicaid Personal Care Services Claimed by Washington State, A-09-09-00030*
- *Unidentified and Unreported Federal Deficiencies in California’s Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs, A-09-09-00114*

## Medicaid Prescription Drug Claims

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- *Review of Arkansas Medicaid Prescription Drug Claims for the Quarter Ended December 31, 2008, A-06-09-00093*
- *Review of Medicaid Prescription Drug Claims at Freds Pharmacy #1621, A-06-10-00040*
- *Review of Medicaid Prescription Drug Claims at Harps Pharmacy #349, A-06-10-00065*
- *Review of Medicaid Prescription Drug Claims at USA Express Pharmacy #1021, A-06-10-00042*
- *Nationwide Rollup Report for Medicaid Drug Rebate Collections, A-06-10-00011*
- *Review of California’s Invoicing of Rebates for Medicaid Compound Drug Expenditures—Electronic Claims, A-09-10-02006*

## Other Medicaid Services

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- *Review of Louisiana Medicaid Physician Family Planning Services, A-06-10-00075*
- *Review of Medicaid Credit Balances at Private Diagnostic Clinic, PLLC, at Duke University Medical Center as of March 31, 2010, A-04-10-04007*
- *Review of Medicaid Hospice Payments Made by Massachusetts for State Fiscal Years 2007 and 2008, A-01-10-00004*
- *Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009, A-01-10-00012*
- *Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia, A-03-05-00203*
- *Review of Medicaid Residential Rehabilitation Services for Children in Maryland, A-03-08-00209*
- *Family Planning Services Claimed by Ohio From October 1, 2007, Through September 30, 2009, A-05-10-00035*
- *Review of District of Columbia Medicaid Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provider Enrollment Practices, A-03-10-00203*
- *Review of Provider Compliance With the District of Columbia's Medicaid Durable Medical Equipment Program Standards for Physical Presence, A-03-11-00202*
- *Review of Medicaid Services to Incarcerated Juveniles in the State of South Carolina During Federal Fiscal Years 2004 and 2005, A-04-07-00034*
- *Family Planning Services Claimed by Illinois From October 1, 2007, Through September 30, 2009, A-05-10-00053*
- *Review of Indiana Medicaid Intraoral Radiographs Paid in Excess of Reimbursement Limits During the Period January 1, 2009, through December 31, 2009, A-05-10-00070*
- *Review of Nonemergency Medical Transportation Costs in the State of Texas (Transportation Provided by the League of United Latin American Citizens – Project Amistad), A-06-09-00090*
- *Review of Medicaid Hysterectomy Expenditures Claimed as Family Planning in Oklahoma for Calendar Years 2005 to 2009, A-06-10-00047*
- *Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program, A-07-10-04156*
- *Review of Sterilization Procedures in the Kansas Family Planning Program, A-07-10-04162*
- *Review of Costs Claimed by the State of Nebraska for Non-Emergency Medical Transportation Services Provided by Shared Mobility Coach, A-07-10-04172*
- *Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008, A-09-09-00049*



- *Review of Additional Claims for Sterilization Procedures in the Colorado Medicaid Family Planning Program, A-07-11-01096*
- *Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009, A-09-10-02043*

## Medicaid Administration

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- *Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire, A-01-10-00009*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in New York State for the Quarter Ended September 30, 2009, A-02-10-01020*
- *Review of the Maine Department of Health and Human Services Buy-In of Medicare Parts A and B for the Period July 1, 2008, Through December 31, 2009, A-01-10-00013*
- *Review of the Massachusetts Executive Office of Health and Human Services Buy-In of Medicare Parts A and B for the Period July 2008 Through December 2009, A-01-11-00004*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Puerto Rico for the Quarter Ended September 30, 2009, A-02-10-01038*
- *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging’s Healthy Steps Program, A-03-10-00205*
- *Review of Administrative Costs Claimed for Pennsylvania’s Home and Community-Based Waiver for Individuals Aged 60 and Over, A-03-10-00202*
- *Review of Medicaid Administrative Costs Claimed for the Pennsylvania Department of Aging’s Direct Care Worker Initiative, A-03-10-00206*
- *Reconciliation of North Carolina Division of Medical Assistance’s Form CMS-64 for the Medicaid Family Planning Program, A-04-10-01092*
- *Review of Alabama’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-04-10-03058*
- *Review of Florida’s Children’s Health Insurance Program Experience Adjustment and Refund Submission Reports, A-04-10-06123*
- *Review of Indiana’s Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008, A-05-09-00021*
- *Review of Illinois’ Prompt Pay Compliance Under the American Recovery and Reinvestment Act of 2009 From January 1, 2009, Through September 30, 2009, A-05-09-00083*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Indiana for the Quarter Ending March 31, 2009, A-05-09-00091*



- *Review of State of Minnesota Reporting Medicaid Fraud Control Unit Recoveries on the CMS-64 for the Period October 1, 2005, Through December 31, 2008, A-05-10-00043*
- *Review of Michigan’s Payment Error Rate Measurement Corrective Action Plan, A-05-10-00062*
- *Review of Ohio’s Payment Error Rate Measurement Corrective Action Plan, A-05-10-00063*
- *Oversight and Evaluation of the Fiscal Year 2008 Payment Error Rate Measurement Program, A-06-09-00037*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma, A-06-09-00097*
- *Review of Medicaid Payments for Deceased Recipients in New Mexico, A-06-10-00093*
- *Review of Kansas’s Compliance With the Federal Prompt Payment Requirements, A-07-10-01084*
- *Review of South Dakota’s Buy-In of Medicare Part B Premiums for Medicaid Beneficiaries from October 2008 Through September 2009, A-07-10-02757*
- *Review of Medicaid Excluded Providers in Iowa, A-07-10-03149*
- *Review of Medicaid Excluded Providers in Missouri, A-07-10-03153*
- *Review of Medicaid Expenditures for Medicare Part A and Part B Premiums in Missouri, A-07-10-03158*
- *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Iowa for the Quarter Ended March 31, 2009, A-07-11-03165*
- *Review of Washington State’s Medicaid Claims for Nonqualified Aliens, A-09-09-00039*
- *Audit of Oregon’s Medicaid Management Information System Expenditures for the Period October 1, 2007, Through September 30, 2009, A-09-10-02017*

## Medicaid Information Technology Reviews

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- *MMIS Business Associate Agreements - New Jersey, A-02-08-03002*
- *Review of Medicaid Information Technology Controls at the State of Illinois as of March 2010, A-05-09-00058*
- *Review of Information System Controls at the Texas Health and Human Services Commission, A-06-10-00035*
- *Review of Network Security Controls for Medicaid Eligibility Determinations at Iowa Department of Human Services, A-07-10-00325*
- *Followup Audit of General Control for Medicaid Eligibility Determinations and Claims Processing at Kansas Department of Social and Rehabilitations Services, A-07-10-00328*
- *Review of Network Security Controls for Medicaid Eligibility Determinations at Kansas Department of Social and Rehabilitation Services, A-07-10-00339*

- *Followup Audit of General Controls for Kansas Medicaid Claims Processing at Electronic Data Systems, an HP Company, A-07-10-00340*
  - *Review of Security Controls for Kansas Medicaid Claims Processing at Hewlett-Packard Enterprise Services, A-07-10-00341*
  - *Review of General Controls Over First Health Services Corporation (Nevada's MMIS Fiscal Agent), A-09-09-00133*
  - *Review of Data Security Controls over Oregon's Medicaid Claims Processing, A-09-10-03003*
  - *Review of Data Security Controls Over Hawaii's Medicaid Claims Processing System, A-09-11-03005*
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## OIG Medicaid Program Evaluation Reports Issued in Fiscal Year 2011

- *FDA's Approval Status of Drugs Paid for by Medicaid, OEI-03-08-00500*
- *States' Collection of Medicaid Rebates for Physician-Administered Drugs, OEI-03-09-00410*
- *Replacing Average Wholesale Price: Medicaid Drug Payment Policy, OEI-03-11-00060*
- *Brand-Name Drugs: Rising Prices Are Offset by Manufacturer Rebates, OEI-03-10-00260*
- *State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs, OEI-05-09-00321*
- *Inappropriate Claims for Medicaid Personal Care Services, OEI-07-08-00430*
- *Nursing Facilities' Employment of Individuals With Criminal Convictions, OEI-07-09-00110*
- *Medicaid Payments for After-Hours Services, OEI-07-11-00050*
- *Medicaid Services Provided in an Adult Day Health Setting, OEI-09-07-00500*

## Appendix B

### Medicaid Projects From the Fiscal Year 2012 OIG Work Plan

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) Office of Inspector General (OIG) *Work Plan for Fiscal Year 2012* (Work Plan) provides brief descriptions of new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the next 12 months and beyond. OIG's Work Plans are available on our Web site at: <http://www.oig.hhs.gov/reports-and-publications/workplan/index.asp>

#### Medicaid Prescription Drug Pricing, Reimbursement, and Rebates

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**CALCULATION OF AVERAGE MANUFACTURER PRICES.** We will review selected drug manufacturers to evaluate methodologies they use to calculate the average manufacturer price (AMP) and the best price for the Medicaid drug rebate program and for drug reimbursement. *(OAS; W-00-11-31202; various reviews; expected issue date: FY 2012; new start)*

**RECALCULATION OF BASE-DATE AVERAGE MANUFACTURER PRICES.** We will review changes to base-date AMPs and assess the impact of such changes on Medicaid rebates. *(OEI; 00-00-00000; expected issue date: FY2012; new start)*

**FEDERAL UPPER PAYMENT LIMIT (FUL) DRUGS.** We will review prescription drug claims to determine whether pharmacies have altered prescriptions to maximize reimbursements by avoiding certain dosage forms for drugs that have FULs on reimbursements. *(OAS; W-00-12-31333; various reviews; expected issue date: FY 2012; new start)*

**STATE MAXIMUM ALLOWABLE COST PROGRAMS.** We will review State Maximum Allowable Cost (State MAC) programs to determine how State MAC lists are developed, how State MAC prices are set, and how State MAC prices compare to the FUL amounts. *(OEI; 03-11-00640; expected issue date: FY 2012; work in progress)*

**APPROPRIATENESS OF FUL AMOUNTS (NEW).** We will compare FUL amounts under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) methodology to an estimate of pharmacy acquisition costs for selected drugs. *(OEI; 03-11-00650; expected issue date: FY 2012; work in progress; Affordable Care Act)*

**UPDATE OF MANUFACTURER COMPLIANCE WITH AMP REPORTING REQUIREMENTS (NEW).** We will review manufacturer compliance with AMP reporting requirements and determine what percentage of manufacturers complied with AMP reporting requirements in 2011. *(OEI; 00-00-00000; expected issue date: FY 2012; new start)*

**STATES' MEDICAID DRUG CLAIMS.** We will review the accuracy of States' submissions of Medicaid drug claims to the Centers for Medicare & Medicaid Services (CMS) for reimbursement. *(OAS; W-00-10-31203; W-00-11-31203; various reviews; expected issue date: FY 2012; work in progress)*

**COMPOUND DRUG CLAIMS.** We will review a State agency’s Medicaid claims for compound drugs to determine whether the drugs’ components complied with Federal requirements for reimbursement and collection of rebates. (OAS; W-00-12-31317; various reviews; expected issue date: FY 2012; work in progress)

**MEDICAID CLAIMS FOR DRUGS PURCHASED UNDER RETAIL DISCOUNT GENERIC PROGRAMS.** We will review Medicaid claims for generic drugs to determine the extent to which large chain pharmacies are billing Medicaid the usual and customary charges for drugs provided under their retail discount generic programs. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

**IMPACT OF THE DEFICIT REDUCTION ACT OF 2005 ON REBATES FOR AUTHORIZED GENERIC DRUGS.** We will review drug-pricing and rebate data that drug manufacturers report to State Medicaid agencies to determine the extent to which manufacturers are reporting pricing data and paying rebates for authorized generic drugs. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

**ZERO-DOLLAR UNIT REBATE AMOUNTS.** We will determine whether States are effectively collecting drug rebates from manufacturers for drugs with zero-dollar unit rebate amounts. (OEI; 03-11-00470; expected issue date: FY 2012; work in progress)

**STATES’ EFFORTS AND EXPERIENCES WITH RESOLVING REBATE DISPUTES.** We will review the causes of and resolutions to Medicaid rebate disputes and the methods States use to resolve such disputes. (OEI; 05-11-00580; expected issue date: FY 2012; work in progress)

**STATES’ COLLECTION OF REBATES FOR DRUGS PAID BY MANAGED CARE ORGANIZATIONS (NEW).** We will review whether Medicaid managed care organizations (MCO) are providing State Medicaid agencies with the utilization data needed to collect rebates for drugs used by Medicaid MCOs enrollees. (OEI; 03-11-00480; expected issue date: FY 2012; work in progress)

**FEDERAL SHARE OF REBATES (NEW).** We will review States’ reporting of the Federal share of Medicaid rebate collections. (OAS; W-00-12-31450; various reviews; expected issue date: FY 2012; new start; Affordable Care Act)

**REBATES ON NEW FORMULATIONS (NEW).** We will review drug manufacturers’ compliance with Medicaid drug rebate requirements for drugs that are new formulations of existing drugs. (OAS; W-00-12-31451; various reviews; expected issue date: FY 2012; new start; Affordable Care Act)

## Home, Community, and Personal Care Services

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**HOME HEALTH SERVICES: SCREENINGS OF HEALTH CARE WORKERS.** We will review health-screening records of Medicaid home health care workers to determine whether the workers were screened in accordance with Federal and State requirements. (OAS; W-00-11-31387; various reviews; expected issue date: FY 2012; new start)

**HOME HEALTH SERVICES CLAIMS.** We will review home health agency claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria. (OAS; W-00-10-31304; W-00-11-31304; various reviews; expected issue date: FY 2012; work in progress)

**HOME HEALTH SERVICES: HOMEBOUND REQUIREMENTS (NEW).** We will review CMS policies and practices for reviewing the sections of Medicaid State plans related to eligibility for home health services and describe how

CMS intends to enforce compliance with appropriate eligibility requirements for home health services. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

**HOME- AND COMMUNITY-BASED SERVICES: FEDERAL AND STATE OVERSIGHT OF QUALITY OF CARE.** We will review CMS and State oversight of home- and community-based services (HCBS) waiver programs to determine the extent to which CMS oversees States' efforts to ensure the quality of care provided under such waiver programs. (OEI; 02-08-00170; expected issue date: FY 2012; work in progress)

**HOME- AND COMMUNITY-BASED SERVICES: FEDERAL AND STATE OVERSIGHT OF ASSISTED-LIVING FACILITIES.** We will determine the extent to which assisted-living facilities provide HCBS to their Medicaid-eligible residents. (OEI; 09-08-00360; expected issue date: FY 2012; work in progress)

**HOME- AND COMMUNITY-BASED SERVICES: VULNERABILITIES IN PROVIDING SERVICES (NEW).** We will determine the extent to which HCBS waiver participants have plans of care, receive the services in their plans, and receive services from qualified providers. We will also identify recipient concerns about the quality of care they receive. (OEI; 02-11-00700; expected issue date: FY 2013; work in progress)

**HOME- AND COMMUNITY-BASED SERVICES: WAIVER PROGRAM ADMINISTRATIVE COSTS.** We will determine the reasonableness of Medicaid HCBS waiver program administrative costs. (OAS; W-00-11-31332; various reviews; expected issue date: FY 2012; work in progress)

**HOME- AND COMMUNITY-BASED SERVICES: ADULT DAY CARE SERVICES FOR ELDERLY INDIVIDUALS WHO HAVE CHRONIC FUNCTIONAL DISABILITIES.** We will determine whether Medicaid payments to providers for adult day care services complied with Federal and State regulations. (OAS; W-00-11-31386; various reviews; expected issue date: FY 2012; new start)

**COMMUNITY RESIDENCE REHABILITATION SERVICES.** We will review Medicaid payments for beneficiaries who reside in community residences for people who have mental illnesses to determine whether States improperly claimed FFP. (OAS; W-00-09-31087; W-00-10-31087; W-00-11-31087; various reviews; expected issue date: FY 2012; work in progress)

**CONTINUING DAY TREATMENT PROVIDERS.** We will review Medicaid payments to continuing day treatment (CDT) providers in one State to determine whether Medicaid payments to CDT providers in that State are adequately supported. (OAS; W-00-09-31128; W-00-11-31128; various reviews; expected issue date: FY 2012; work in progress)

**MEDICAID SCHOOL-BASED SERVICES.** We will review Medicaid payments for school-based services in selected States to determine whether the costs claimed for such services are reasonable and properly allocated. (OAS; W-00-11-31391; various reviews; expected issue date: FY 2012; work in progress)

**PERSONAL CARE SERVICES.** We will review Medicaid payments for personal care services (PCS) to determine whether States have appropriately claimed the FFP. (OAS; W-00-09-31035; W-00-10-31035; W-00-11-31035; various reviews; expected issue date: FY 2012; work in progress)

## Other Medicaid Services and Payments

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**HOSPICE SERVICES: COMPLIANCE WITH REIMBURSEMENT REQUIREMENTS.** We will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. (OAS; W-00-11-31385)

*various reviews; expected issue date: FY 2012; new start. OEI; 00-00-00000; expected issue date: FY 2013; new start)*

**POTENTIALLY EXCESSIVE MEDICAID PAYMENTS FOR INPATIENT AND OUTPATIENT SERVICES.** We will review State controls to detect potentially excessive Medicaid payments to institutional providers for inpatient and outpatient services. *(OAS; W-00-11-31127; various reviews; expected issue date: FY 2012; work in progress)*

**PAYMENTS FOR PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES.** We will determine the extent to which payments for Medicaid physical, occupational, and speech therapy services comply with State standards and limits on coverage. *(OEI; 07-10-00370; expected issue date: FY 2012; work in progress)*

**MEDICAID MEDICAL EQUIPMENT.** We will determine whether Medicaid payments for medical supplies and equipment were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines. *(OAS; W-00-11-31390; various reviews; expected issue date: FY 2012; new start)*

**MEDICAID FAMILY PLANNING SERVICES.** We will review family planning services in several States to determine whether enhanced Federal funding was improperly claimed for such services and the resulting financial impact on Medicaid. *(OAS; W-00-10-31078; W-00-11-31078; various reviews; expected issue date: FY 2012; work in progress)*

**PAYMENTS FOR TRANSPORTATION SERVICES.** We will review payments to providers for transportation services to determine the appropriateness of State Medicaid agencies' payments for such services. *(OAS; W-00-09-31121; W-00-10-31121; W-00-11-31121; various reviews; expected issue date: FY 2012; work in progress)*

**STATE-OPERATED FACILITIES: REASONABLENESS OF PAYMENT RATES (NEW).** We will determine whether Medicaid payment rates to State-operated facilities are reasonable and in accordance with Federal and State requirements. *(OAS; W-00-11-31398; various reviews; expected issue date: FY 2012; work in progress)*

**PAYMENTS FOR HEALTH-CARE-ACQUIRED CONDITIONS (NEW).** We will determine whether selected State agencies made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions. *(OAS; W-00-12-31452; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)*

**SUPPLEMENTAL PAYMENTS TO PRIVATE HOSPITALS.** We will review Medicaid supplemental payments by States to private hospitals to determine whether errors exist involving such payments. *(OAS; W-00-10-31126; W-00-11-31126; various reviews; expected issue date: FY 2012; work in progress)*

**SUPPLEMENTAL PAYMENTS TO PUBLIC PROVIDERS (NEW).** We will review Medicaid supplemental payments by States to public providers (State and Non-State government operated facilities) and determine whether they comply with Federal upper payment limit requirements. *(OAS; W-00-12-31453; various reviews; expected issue date: FY 2013; new start)*

**MEDICAID NURSING FACILITY INCENTIVE PAYMENTS.** We will review Medicaid incentive payments by States to nursing facilities based on the facilities' quality-of-care performance measures. *(OAS; W-00-10-31331; W-00-11-31331; various reviews; expected issue date: FY 2012; work in progress)*



**EMERGENCY PAYMENTS BY STATE MEDICAID AGENCIES (NEW).** We will determine whether emergency payments to providers made by State Medicaid agencies were adequately supported. *(OAS; W-00-12-31454; various reviews; expected issue date: FY 2012; new start)*

## Medicaid Integrity and Accountability

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**EARLY RESULTS FROM MEDICAID INTEGRITY CONTRACTORS.** We will review the progress of CMS's Medicaid Integrity Contractors (MIC) in completing program integrity tasks outlined in their contracts. *(OEI; 05-10-00200; 05-10-00210; expected issue date: FY 2012; work in progress)*

**MEDICARE AND MEDICAID DATA MATCHING PROJECT.** We will review CMS's oversight and monitoring of the Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi task orders. *(OEI; 09-08-00370; expected issue date: FY 2012; work in progress)*

**ADDRESSING VULNERABILITIES IDENTIFIED DURING MEDICAID STATE PROGRAM INTEGRITY REVIEWS (NEW).** We will review corrective actions that State Medicaid agencies have implemented to address the findings and recommendations from State Medicaid program integrity reviews conducted by CMS. *(OEI; 00-00-00000; expected issue date: FY 2012; new start)*

**CLAIMS WITH INACTIVE OR INVALID PHYSICIAN IDENTIFIER NUMBERS.** We will review Medicaid claims to determine the extent to which State agencies have controls in place to identify claims associated with inactive or invalid national provider identifiers (NPI), including claims for services alleged to have been provided after the dates of the referring physicians' deaths. *(OAS; W-00-11-31338; various reviews; expected issue date: FY 2012; new start)*

**BENEFICIARIES WITH MULTIPLE MEDICAID IDENTIFICATION NUMBERS.** We will review duplicate payments on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and the procedures for preventing such payments. *(OAS; W-00-11-31374; various reviews; expected issue date: FY 2012; work in progress)*

**STATE MEDICAID FRAUD CONTROL UNITS PERFORMANCE STANDARDS.** We will review the overall management, operations, and performance of a State Medicaid Fraud Control Unit (MFCU). *(OEI, 02-11-00440, expected issue date: FY 12; work in progress; multiple reviews; new start)*

**STATE AGENCIES' TERMINATIONS OF PROVIDERS TERMINATED UNDER MEDICARE OR BY OTHER STATES (NEW).** We will review States' compliance with a new requirement that State Medicaid agencies terminate providers that have been terminated under Medicare or by another State. *(OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)*

**FEDERALLY EXCLUDED PROVIDERS AND SUPPLIERS.** We will review Medicaid payments to providers and suppliers to determine the extent to which payments were for services provided during periods of exclusion from Medicaid. *(OAS; W-00-10-31337; W-00-11-31337; various reviews; expected issue date: FY 2012; work in progress)*

**STATES' CONTINGENCY FEE PAYMENT ARRANGEMENTS.** We will determine the extent to which State Medicaid agencies have contracted with consultants through contingency fee payment arrangements and determine how the arrangements have affected the submission of questionable or improper claims to the Federal

Government. (OAS; W-00-07-31045; W-00-08-31045; W-00-11-31045; various reviews; expected issue date: FY 2012; work in progress)

**FEDERAL FUNDS GENERATED THROUGH MEDICAID PROVIDER TAXES (NEW).** We will review State health-care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable Federal requirements. (OAS; W-00-12-31455; various reviews; expected issue date: FY 2013; new start)

**IMPACT OF CERTIFIED PUBLIC EXPENDITURES.** We will determine whether States are complying with Federal regulations for claiming certified public expenditures (CPE). (OAS; W-00-12-31110; various reviews; expected issue date: FY 2012; new start)

**OVERPAYMENTS: MEDICAID CREDIT BALANCES.** We will review patient accounts of providers to determine whether there are Medicaid overpayments in the accounts with credit balances. (OAS; W-00-10-31311; W-00-11-31311; various reviews; expected issue date: FY 2012; work in progress)

**STATES' EFFORTS TO IMPROVE THIRD-PARTY LIABILITY PAYMENT COLLECTIONS IN MEDICAID.** We will review States' procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries to determine the extent to which States' efforts have improved since our last review. (OEI; 05-11-00130; expected issue date: FY 2012; work in progress)

**PROPER ALLOCATION OF MEDICAID ADMINISTRATIVE COSTS.** We will review administrative costs claimed by several States to determine whether they were properly allocated and claimed or directly charged to Medicaid. (OAS; W-00-10-31123; W-00-11-31123; various reviews; expected issue date: FY 2012; work in progress)

**FORM CMS-64: OVERSIGHT OF STATE DATA REPORTING.** We will review CMS's oversight of State quarterly expenditure reporting on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). (OEI; 00-00-00000; expected issue date: FY 2012; new start)

**FORM CMS-64: PHARMACY PRESCRIPTION DRUG CLAIMS.** We will review Medicaid pharmacy prescription drug claims for selected State Medicaid agencies to determine whether States accurately reported Medicaid expenditures for prescription drugs and whether the claims related to the expenditures were adequately supported by pharmacy records. (OAS; W-00-09-31318; W-00-11-31318; various reviews; expected issue date: FY 2012; work in progress)

**FORM CMS-64: MEDICAID MONETARY DRAWDOWNS (NEW).** We will review the Medicaid monetary drawdowns that States received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the States on the Form CMS-64. (OAS; W-00-12-31456; various reviews; expected issue date: FY 2012; new start)

**FORM CMS-64: MEDICAID OVERPAYMENT REPORTING AND COLLECTIONS (NEW).** We will determine whether States are reporting overpayments identified by Federal audits on the Form CMS-64, as Federal regulations require. (OAS; W-00-11-31399; various reviews; expected issue date: FY 2012; work in progress)

**FORM CMS-64: ACCURACY OF MEDICAID COLLECTIONS AND FEDERAL SHARE (NEW).** We will determine whether States accurately captured Medicaid collections on their Form CMS-64, as well as returned the correct Federal share related to those collections. (OAS; W-00-12-31457; various reviews; expected issue date: FY 2012; new start)



**PAYMENT ERROR RATE MEASUREMENT: FISCAL YEAR 2008 ERROR RATE.** We will evaluate certain aspects of CMS's Medicaid Payment Error Rate Measurement (PERM) process for determining the FY 2008 Medicaid fee for service (FFS) payment error rate. (OAS; W-00-10-40045; W-00-11-40045; *expected issue date: FY 2012; work in progress*)

**PAYMENT ERROR RATE MEASUREMENT PROGRAM: ERROR RATE ACCURACY AND HEALTH INFORMATION SECURITY.** We will review CMS's implementation of the PERM process to determine whether it has produced valid and reliable error rate estimates for Medicaid and Children's Health Insurance Program (CHIP) FFS, managed care, and eligibility. (OAS; W-00-11-40046; *various reviews; expected issue date: FY 2012; new start*)

**PAYMENT ERROR RATE MEASUREMENT PROGRAM: ELIGIBILITY DETERMINATIONS IN ONE STATE.** We will review compliance in one State with PERM requirements for reviewing eligibility in its Medicaid and CHIP programs. (OAS; W-00-12-40038; *expected issue date: FY 2012; new start*)

## Program Administration, Information Systems, and Data Security

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**STATE BUY-IN OF MEDICARE COVERAGE.** We will review States' Medicaid buy-in programs for Medicare Part B to determine whether States have adequate controls to ensure that Medicare premiums are paid only for individuals eligible for State buy-in coverage of Medicare services. (OAS; W-00-10-31220; W-00-11-31220; *various reviews; expected issue date: FY 2012; work in progress*)

**PROVIDER ENROLLMENT: COLLECTION AND VERIFICATION OF PROVIDER OWNERSHIP INFORMATION BY STATE MEDICAID AGENCIES.** We will review State practices for collection and verification of Medicaid provider ownership information, assess the accuracy of the information on file, and assess the effectiveness of the practices. (OEI; 04-11-00590; *expected issue date: FY 2012; work in progress*)

**BENEFICIARY ELIGIBILITY: STATE AGENCIES' REDETERMINATIONS OF MEDICAID ELIGIBILITY (NEW).** We will review State agencies' procedures for redetermining the eligibility status of Medicaid beneficiaries and determine the amount of unallowable payments associated with beneficiaries who did not receive the required Medicaid eligibility redeterminations. (OAS; W-00-11-31140; *various reviews; expected issue date: FY 2012; work in progress*)

**STATE MEDICAID PLANS' VACCINES FOR CHILDREN PROGRAM: STORAGE AND MANAGEMENT OF VACCINES.** We will determine the extent to which providers in the Vaccines for Children program (which is a required part of each State's Medicaid plan) are properly storing and managing vaccines. (OEI; 04-10-00430; *expected issue date: FY 2012; work in progress*)

**CHILDREN'S HEALTH INSURANCE PROGRAM: DUALY ENROLLED BENEFICIARIES IN A STATE.** We will assess the appropriateness of a State's claims for FFP under the State's CHIP program for individuals who were enrolled in the State's Medicaid program. (OAS; W-00-10-31314; W-00-11-31314; *various reviews; expected issue date: FY 2012; work in progress*)

**CHILDREN'S HEALTH INSURANCE PROGRAM: STATE COMPLIANCE WITH ELIGIBILITY AND ENROLLMENT NOTIFICATION AND REVIEW REQUIREMENTS.** We will review State compliance with the CHIP eligibility and enrollment notification and review requirements. (OEI; 00-00-00000; *expected issue date: FY 2012; new start*)

**CHILDREN’S HEALTH INSURANCE PROGRAM ADMINISTRATIVE COSTS.** We will determine whether States are complying with CHIP’s 10-percent cap on administrative costs. (OAS; W-00-10-31226; W-00-11-31226; various reviews; expected issue date: FY 2012; work in progress)

**MEDICAID MANAGEMENT INFORMATION SYSTEM COSTS.** We will review Medicaid Management Information System (MMIS) costs in selected States to determine whether costs allocated to Medicaid are allowable. (OAS; W-00-10-31312; W-00-11-31312; various reviews; expected issue date: FY 2012; work in progress)

**STATES’ USE OF THE PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM TO REDUCE MEDICAID BENEFITS RECEIVED FROM MORE THAN ONE STATE.** We will review eligibility data from the Public Assistance Reporting Information System (PARIS) to determine the extent to which States use PARIS to identify Medicaid recipients who are simultaneously receiving Medicaid benefits in more than one State. (OEI; 09-11-00780; expected issue date: FY 2012; work in progress)

**MEDICAID NATIONAL CORRECT CODING INITIATIVE EFFECTIVENESS (NEW).** We will review selected States’ implementation of National Correct Coding Initiative (NCCI) edits for Medicaid claims. (OAS; W-00-12-31459; various reviews; expected issue date: FY 2013; new start; OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)

**MEDICAID MANAGEMENT INFORMATION SYSTEMS BUSINESS ASSOCIATE AGREEMENTS.** We will review CMS’s oversight activities related to data security requirements of State MMIS, which process and pay claims for Medicaid benefits. (OAS; W-00-11-41015; various reviews; expected issue date: FY 2012; work in progress)

**CMS OVERSIGHT AND ACCURACY OF NURSING HOME MINIMUM DATA SET DATA.** We will review CMS’s oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

**MEDICAID SECURITY CONTROLS OVER STATE WEB-BASED APPLICATIONS.** We will review States’ security controls over Web-based applications that allow Medicaid providers to electronically submit claims to determine whether they contain any vulnerabilities that could affect the confidentiality, integrity, and availability of the Medicaid claims’ protected health information. (OAS; W-00-12-41016; various reviews; expected issue date: FY 2012; new start)

**MEDICAID SECURITY CONTROLS AT THE MAINFRAME DATA CENTERS THAT PROCESS STATES’ CLAIMS DATA.** We will review security controls at States’ mainframe data centers that process Medicaid claims data. (OAS; W-00-10-40019; W-00-11-40019; expected issue date: FY 2012; work in progress, new start)

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## Medicaid Managed Care

**COMPLETENESS AND ACCURACY OF MANAGED CARE ENCOUNTER DATA (NEW).** We will determine the extent to which Medicaid managed care encounter data included in Medicaid Statistical Information System (MSIS) submissions to CMS accurately represent all services provided to beneficiaries. (OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)

**MANAGED CARE ENTITIES’ MARKETING PRACTICES.** We will review State Medicaid agencies’ oversight policies, procedures, and activities to determine the extent to which States monitor Medicaid managed care entities’

(MCE) marketing practices and compliance with Federal and State contractual marketing requirements. *(OEI; 00-00-00000; expected issue date: FY 2012; new start)*

**STATE OVERSIGHT OF PROVIDER CREDENTIALING BY MANAGED CARE ENTITIES.** We will determine how States ensure that Medicaid MCEs (specifically MCOs), prepaid inpatient health plans, and prepaid ambulatory health plans comply with credentialing and recredentialing requirements. *(OEI; 09-10-00270; expected issue date: FY 2012; work in progress)*

**EXCLUDED INDIVIDUALS EMPLOYED BY MANAGED CARE NETWORKS.** We will determine the extent to which OIG-excluded individuals were employed by entities that provide services through MCE provider networks in 2009. *(OEI; 07-09-00632; expected issue date: FY 2012; work in progress)*

**MANAGED CARE FRAUD AND ABUSE SAFEGUARDS.** We will review Medicaid MCO fraud and abuse safeguards and State Medicaid agencies' oversight plans and procedures and determine the extent to which States monitor such safeguards for compliance with Federal requirements. *(OEI; 01-09-00550; expected issue date: FY 2012; work in progress)*

**MANAGED CARE ORGANIZATIONS' USE OF PREPAYMENT REVIEW TO DETECT AND DETER FRAUD AND ABUSE.** We will determine the extent to which Medicaid MCOs use prepayment reviews to detect and deter fraud and abuse. *(OEI; 00-00-00000; expected issue date: FY 2013; new start)*

**MEDICAID MANAGED CARE PLANS' MEDICAL LOSS RATIO.** We will review managed care plans with contact provisions that require a minimum percentage of total costs to be expended for medical expenditures (medical loss ratio) to determine whether a refund was made to the State agency when the minimum medical loss ratio threshold was not met. *(OAS; W-00-11-31372; various reviews; expected issue date: FY 2012; work in progress)*

## Appendix C

### Deficit Reduction Act of 2005 Requirements Pertaining to HHS OIG

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

#### Section 6001: Drug Payment Provisions

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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 an August 2009 report 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: State False Claims Acts

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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 11 States that had submitted their laws for review. OIG did not approve any of the 11 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. OIG has informally reviewed numerous States' draft legislation submitted in response to that invitation.

## Section 6034: Medicaid Integrity Program

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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. In FY 2011, MIP funds were still available. 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 2011.

## Appendix D

### Acronyms and Abbreviations

Selected acronyms and abbreviations used in this report are defined below.

ALJ	administrative law judge
AMP	average manufacturer price
AWP	average wholesale price
CDT	continuing day treatment
CHIP	Children’s Health Insurance Program
CIA	corporate integrity agreement
CMS	Centers for Medicare & Medicaid Services
CoP	conditions of participation
CPE	certified public expenditures
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
EHR	electronic health record
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
HCBS	home- and community-based services
HCFAC	Health Care Fraud and Abuse Control program
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
MCE	managed care entity

MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity contractor
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
NCCI	National Correct Coding Initiative
OAS	Office of Audit Services
OEI	Office of Evaluation and Inspections
OIG	Office of Inspector General
PARIS	Public Assistance Reporting Information System
PCS	personal care services
PERM	Payment Error Rate Measurement program
State	
MAC	State Maximum Allowable Cost
VA	Department of Veterans Affairs

**Public Laws**

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

Recovery Act	American Recovery and Reinvestment Act of 2009, P.L. No. 111-5
Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-52.

**Not Abbreviated**

Supplemental Appropriations Act of 2008, P.L. 110-252
Public Health Service Act of 1944