Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Payer-Focused Audits Summary

March 2022 - August 2022 Updates

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as, give our colleagues and clients focused insights into the over 300 audits, performed by HHS OIG, over the last 12 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 12 months and sorts relevant audits into Payer and Provider categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

We review all OIG completed audits that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused completed audits, SunHawk has identified other audit items which we determined relevant to a limited number of Providers and Payers. We plan to publish a summary of these items in January 2021.

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

[1] HHS OIG's Semi-annual reports to Congress for the April 1, 2019 to March 31, 2020 periods reported 304 new Audits and Evaluations which was an increase of 111 more issued reports during the same prior year period.

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Payer

Medicaid

[*NEW*] South Carolina Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs

For a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. However, prior Office of Inspector General (OIG) audits found that States did not always invoice and collect all rebates due for drugs administered by physicians. OIG's objective was to determine whether South Carolina complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

OIG reviewed claims for physician-administered drugs paid between January 2016 and December 2019. OIG used the Centers for Medicare & Medicaid Services' (CMS's) Medicare Part B crosswalk and the CMS Medicaid Drug File to identify single-source and multiple-source drugs. Additionally, OIG determined whether the Healthcare Common Procedure Coding System codes were published in CMS's top-20 multiple-source drug listing.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that South Carolina did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. South Carolina did not invoice for, and collect from manufacturers, rebates associated with $14.5 million (Federal share) in physician-administered drugs. Of this amount, $14.3 million (Federal share) was for single-source drugs and $242,000 (Federal share) was for top-20 multiple-source drugs. Further, OIG was unable to determine whether, in some cases, South Carolina was required to invoice for rebates for other multiple-source physician-administered drug claims. South Carolina did not invoice the manufacturers for rebates associated with claims totaling $1.3 million (Federal share) for these multiple-source drugs

OIG recommended that South Carolina refund to the Federal Government $14.3 million (Federal share) for claims for single-source physician-administered drugs and $242,000 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommend that South Carolina work with CMS to determine the unallowable portion of $1.3 million (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determines that the drug claims are allowable. In addition, OIG recommended that South Carolina work with CMS to determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not invoiced for rebates after December 31, 2019, and continue to review and strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.

South Carolina generally concurred with OIG recommendations and described corrective actions it had taken or planned to take. South Carolina said that its drug rebate vendor had confirmed that a total of $14.1 million (Federal share) was eligible for invoicing and added that the vendor planned to submit invoices to manufacturers to secure rebates for these claims. South Carolina also identified expenditures totaling $1.4 million (Federal share) that could be refunded to the Federal Government because of deficiencies in data collection during original claim adjudication. For OIG's procedural

recommendations, South Carolina described deficiencies in its automated system and added that it planned to modify and strengthen its submission and adjudication processes. OIG maintains that their findings and recommendations remain valid.

Work Plan #: A-07-21-07003 (August 2022)
Government Program: Medicaid

[*NEW*] Iowa Medicaid Fraud Control Unit: 2021 Inspection

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and prepares public reports based on these reviews.

OIG conducted an inspection of the Iowa MFCU in November 2021. OIG's inspection covered the 3-year period of fiscal years (FYs) 2019-2021. OIG based the inspection on an analysis of data and information from 7 sources: (1) Unit documentation; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with the Unit managers and selected staff; (5) a review of a random sample of 84 case files from the 372 nonglobal case files that were open at some point during the review period; (6) a review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank during the review period; and (7) onsite review of Unit operations.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Iowa MFCU reported exceptionally strong case outcomes for FYs 2019-2021, as compared to similarly sized MFCUs. From the data OIG reviewed, they found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals and the MFCU performance standards. However, OIG found that although the Unit operated effectively and achieved high case outcomes, the Unit did not maintain staffing levels in accordance with its approved budget, maintained low staffing levels in relation to State Medicaid expenditures, and experienced significant turnover of investigators and high caseloads. OIG also made observations regarding Unit operations and practices, including that the Unit (1) took steps to maintain an adequate volume and quality of referrals, although referrals from key sources generally decreased during the review period; (2) took steps to maintain a continuous case flow and to complete cases within appropriate timeframes; and (3) maintained a positive working relationship with Federal law enforcement partners, including the Office of Inspector General and U.S. Attorney's Offices.

To address the finding, OIG recommended that the Unit assess the adequacy of existing staffing levels, and if warranted, develop a plan to expand the size of the Unit. The Unit concurred with OIG's recommendations.

Work Plan #: OEI-07-21-00340 (June 2022)
Government Program: Medicaid

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[*NEW*] Texas Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit's Cases

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. For this audit, OIG focused on Texas' Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. Texas is required to report recoveries for these MFCU-determined Medicaid overpayments to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share to the Federal Government. OIG's objective was to determine whether Texas reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2016, through September 30, 2018.

OIG determined that there were 217 cases with MFCU-determined Medicaid overpayments for OIG's audit period and that restitution was owed for 65 cases. OIG reviewed documentation supporting the reporting of the MFCU-determined Medicaid overpayments and reconciled the overpayments with the corresponding Form CMS-64s. OIG reviewed Texas' payment documentation to determine whether Texas returned the correct Federal share of its recoveries.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas did not correctly report and return the Federal share of all MFCU-determined Medicaid overpayments identified for the period October 1, 2016, through September 30, 2018. OIG determined that Texas should have reported MFCU-determined Medicaid overpayments totaling $24.3 million (at least $13.9 million Federal share) for the 65 cases with Medicaid restitution during the period that OIG reviewed. Texas correctly reported $46,369 ($26,982 Federal share) in MFCU-determined Medicaid overpayments for 2 of the 65 cases and did not correctly report the remaining 63 cases. For the 63 cases, Texas did not report and return overpayments totaling $19.0 million ($11.1 million Federal share) for 26 cases during OIG's audit period. (Texas later returned the Federal share for these cases on the fiscal year (FY) 2020 and FY 2021 Form CMS-64s as a result of OIG's audit.) In addition, Texas did not report $5.2 million (at least $2.7 million Federal share) for 37 cases within the required timeframe. These issues occurred because Texas did not have adequate internal controls to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

OIG recommended that Texas (1) report and return the Federal share for the 26 cases, totaling $19.0 million ($11.1 million Federal share); (2) strengthen internal controls by developing written policies and procedures, including procedures for recording MFCU-determined Medicaid overpayments, and reconciling case files received from the MFCU with the overpayments recorded in the State agency's accounting system; (3) ensure that it reports all MFCU-determined Medicaid overpayments in accordance with Federal regulations and within regulatory timeframes; and (4) review the MFCU-determined Medicaid overpayments for cases after OIG's audit period to ensure that all overpayments were reported on the Form CMS-64.

Work Plan #: A-06-20-04004 (May 2022)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[*NEW*] Massachusetts Implemented OIG's Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes and found that Massachusetts did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. The report contained five recommendations. OIG's objectives were to determine whether Massachusetts implemented the recommendations from the prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

OIG reviewed Massachusetts' system for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities during OIG's audit period, July 2018 through June 2019. To determine whether the five recommendations from the prior OIG report were implemented, OIG reviewed correspondence from the Centers for Medicare & Medicaid Services (CMS) and supporting documentation provided by the State. To determine whether the actions taken by Massachusetts effectively addressed OIG's previous findings, OIG reviewed 147 emergency room claims from April 2019 to June 2019 for 128 beneficiaries residing in group homes who were diagnosed with conditions that OIG determined to be indicative of high risk for suspected abuse or neglect.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Massachusetts implemented the five recommendations from OIG's prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes. However, the corrective actions for one recommendation in OIG's prior audit were not effective in addressing one of OIG's previous findings. Specifically, Massachusetts did not ensure all reasonable suspicions of abuse or neglect were reported to the Disabled Persons Protection Commission (DPPC). One possible reason that this issue occurred is because the Massachusetts Department of Developmental Services (DDS) and group home staff were only required to take mandated reporter training on reporting reasonable suspicions of abuse and neglect (a corrective action) once rather than periodically.

Because Massachusetts did not ensure that all reasonable suspicions of abuse or neglect were reported, it did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Intensive Supports waiver along with the State requirements incorporated under the waiver.

OIG recommended that Massachusetts: (1) continue to coordinate with DDS and DPPC to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed and (2) require periodic training for DDS and group home staff on reporting reasonable suspicions of abuse and neglect.

Work Plan #: A-01-20-00003 (April 2022)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[*NEW*] South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities

OIG performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors. OIG's objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

OIG reviewed South Carolina's compliance with Intellectually Disabled and Related Disabilities (IDRD) waiver requirements for reporting and monitoring critical events during the audit period. South Carolina provided comprehensive support services to 8,156 individuals with developmental disabilities who were enrolled in the IDRD waiver program. OIG limited their review to 7,161 beneficiaries who were at least 18 years old as of January 1, 2015.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that South Carolina did not fully comply with requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, South Carolina did not ensure that providers: (1) reported all critical incidents, (2) reported within 24 hours or the next business day all critical events, or (3) always submitted the results of their internal reviews within 10 working days. The detailed findings are listed in the body of the report.

OIG recommended that South Carolina work with the Department of Disabilities and Special Needs (DDSN) to: (1) ensure that providers follow the reporting requirements for critical events, (2) provide training to providers on recognizing and reporting critical incidents according to reporting requirements, (3) perform analytical procedures such as data matches on Medicaid claims data to identify any unreported critical incidents and investigate as needed, and (4) ensure that providers submit all incident reports to DDSN through the Incident Management System within 24 hours of an incident or the next business day. The detailed recommendations are listed in the body of the report.

Work Plan #: A-04-18-07078 (April 2022)
Government Program: Medicaid

[*NEW*] At A Glance: Medicaid Fraud Control Units Fiscal Year 2021 Annual Report

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. The Office of Inspector General (OIG) is the designated Federal agency that oversees and annually approves Federal funding for MFCUs through a recertification process. For this report, OIG analyzed the annual statistical data on case

outcomes—such as convictions, civil settlements and judgments, and recoveries—that the 53 MFCUs submitted for fiscal year 2021.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that most MFCU case outcomes were generally consistent with those of the previous year and MFCUs reported that the ongoing pandemic continued to present operational challenges in FY 2021. However, despite challenges posed by the pandemic, Units continued to carry out their Medicaid program integrity functions. For instance, MFCUs experienced a significant increase in criminal recoveries and nonglobal civil recoveries in FY 2021. Overall, MFCUs' efforts in FY 2021 contributed to total recoveries of $1.7 billion, with an ROI of $5.36 for every $1 spent.

Work Plan #: OEI-09-22-00020 (March 2022)
Government Program: Medicaid

[*NEW*] New Jersey's Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements

In July 2019, the Centers for Medicare & Medicaid Services (CMS) approved New Jersey's Medicaid Administrative Claiming and Special Education Medicaid Initiative Cost Settlement Process Guide (Process Guide). New Jersey has been using the methodology detailed in the Process Guide to claim Medicaid school-based costs since October 2011. In November 2019, OIG issued a report stating that the methodology did not meet Federal requirements. As of December 2021, New Jersey is seeking to use the Process Guide to claim additional Medicaid reimbursement for school-based costs for prior periods if CMS approves a related proposal by New Jersey to amend its Medicaid State plan. OIG initiated this audit because New Jersey has not corrected the deficiencies identified in the November 2019 report and seeks to use the Process Guide to claim additional funds for prior periods. The objective of OIG's audit was to determine whether New Jersey's CMS-approved Process Guide complied with Federal requirements.

To achieve the objective, OIG reviewed New Jersey's Process Guide and CMS's letter approving the Process Guide. OIG also reviewed Federal requirements, CMS documents, and information provided by New Jersey."

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Jersey's methodology for claiming Medicaid school-based costs, as described in the Process Guide, does not comply with Federal requirements. Specifically, the Process Guide's methodology for conducting random moment time studies (RMTSs) (1) does not meet Federal requirements for statistical sampling, (2) defines one Medicaid administrative activity code as including activities not necessary for the administration of the Medicaid State plan, and (3) does not ensure that RMTS responses and Medicaid cost allocation ratios are supported. In designing its Process Guide, New Jersey did not address deficiencies identified during OIG's prior audit of its school-based program, follow CMS guidance, and ensure that its Medicaid cost allocation ratios could be supported. Therefore, if CMS does not work with New Jersey to address the deficiencies identified in this report, Medicaid claims submitted for reimbursement by New Jersey school districts will not meet Federal requirements and the risk of improper payments could increase by tens of millions of dollars per year.

OIG recommended that CMS direct New Jersey to revise the Process Guide to ensure that New Jersey's methodology for claiming Medicaid school-based health care services costs complies with Federal requirements. The detailed recommendations are listed in the body of the report.

Work Plan #: A-02-20-01012 (March 2022)
Government Program: Medicaid

[*NEW*] The Centers for Medicare & Medicaid Services' Eligibility Review Contractor Adequately Determined Medicaid Eligibility for Selected States Under the Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program and produce error rates for each program, including a review of the eligibility component of Medicaid. CMS recently made substantive changes to its PERM program, which included hiring a contractor to perform PERM eligibility reviews. In addition, prior OIG audits have identified Medicaid eligibility determinations as a high-risk area. The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractor conducted eligibility reviews for selected States in accordance with Federal and State requirements.

OIG's audit covered 1,311 Medicaid claims reviewed by CMS's eligibility review contractor, totaling over $1.9 million (Federal share), included in the eligibility review component of the Reporting Year 2019 PERM program for 3 States. OIG judgmentally selected these States based on various factors, including total Medicaid payments, individual State eligibility error rates, and the types of eligibility errors identified by CMS's eligibility review contractor. OIG reviewed a random sample of 100 Medicaid claims (total) for the 3 States.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG determined that CMS's eligibility review contractor correctly determined Medicaid eligibility for the beneficiaries associated with all 100 sampled claims. Based on OIG's sample results, they concluded that CMS's eligibility review contractor adequately determined Medicaid eligibility for three States (Connecticut, Pennsylvania, and Virginia) under CMS's PERM program in accordance with Federal and State requirements.

Accordingly, this report contains no recommendations.

Work Plan #: A-02-20-01006 (March 2022)
Government Program: Medicaid

Office of Inspector General's Partnership with the Oregon Secretary of State's Audits Division: Oregon Health Authority-Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

This memo transmits the findings of the Oregon Secretary of State, Audits Division, audit report Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments (Report 2021-37), issued December 15, 2021, to the Oregon Health Authority (OHA). The Audits Division conducts audits to protect the public interest and improve Oregon Government. It ensures that public funds are properly accounted for, spent in accordance with legal requirements, and used to the best advantage. This audit was conducted as part of the Audits Division's independent oversight of Oregon's Medicaid program. The objective of the Audits Division's audit was to determine whether OHA processes Medicaid claims in accordance with program policies for services billed while a client is in an extended hospital stay. The audit covered paid Medicaid claims from January 2017 through February 2020 for clients who experienced extended inpatient hospital stays.

SunHawk Summary of OIG Audit Findings and Recommendations

The Audits Division found that OHA lacked timely notification of inpatient hospital stays, which resulted in some claims being paid when services were not provided because the Medicaid client was in the hospital. Of the 25 selected inpatient hospital stays, 80 percent had improper payments associated with them. Of the 134 Medicaid claims, OHA improperly paid providers for 118 claims, amounting to $52,344 in improper payments made to providers that billed for services that were likely not provided while Medicaid clients were in the hospital. Furthermore, the Audits Division estimated that there was approximately $1.6 million in payments for other claims that were at high risk of being improper (high-risk payments). Based on its analysis, the Audits Division determined the following:

- For in-home services, OHA made $49,875 in improper payments for 42 claims and an estimated $1.3 million in high-risk payments for more than 7,200 other claims.
- For NEMT services, OHA made $1,644 in improper payments for 73 claims and an estimated $211,507 in high-risk payments for more than 10,000 other claims.
- For private duty nursing services, OHA made $825 in improper payments for 3 claims and an estimated $5,982 in high-risk payments for 109 other claims.

The Audits Division concluded that the following factors contributed to the improper payments:

- Improper payments for most in-home services can be difficult to identify because these services are processed and paid by a different system from the one used for hospital inpatient claims. Furthermore, there were instances in which the case manager was never notified of the client's hospitalization, even though the home-care worker was required to notify the case manager when the client was hospitalized.
- There was a pattern of NEMT providers submitting claims for Medicaid clients while those clients were in the hospital, and the providers could be billing based on booked rides rather than on actual transportation provided.
- A provider may have billed for nursing services booked rather than services provided.
- The risk of improper payments is exacerbated by varying service provider submission requirements.
- The Medicaid Management Information System (MMIS) did not have edits or audits in place to prevent or detect the improper payments.

- Case managers for clients who receive in-home services have access to the OHA system that coordinates patient care and can search to see whether a client has been admitted to the hospital, but there is no proactive notification.
- OHA does not receive notification of inpatient admissions and typically would not know about an inpatient stay until the MMIS processed the hospital claim.

The Audits Division recommended that OHA:

- Reimburse the Federal Government for the Federal portion of the identified improper payment amount and
- Develop and implement cost-effective controls that would prevent or detect improper payments for unallowable services while a Medicaid client is an inpatient and consider ways that timely notification of hospital admissions could be integrated efficiently into claims processing.

Work Plan #: A-09-22-02001 (February 2022)
Government Program: Medicaid

Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries Who Did Not or May Not Have Met Eligibility Requirements

The Affordable Care Act provided States with the authority to expand Medicaid coverage to low-income adults without dependent children (newly eligible beneficiaries). It also mandated changes to Medicaid eligibility rules. These two factors led to a significant increase in applications for Medicaid coverage. Prior OIG audits of New York, California, Colorado, and Kentucky found that these States did not always determine Medicaid eligibility for newly eligible beneficiaries and individuals eligible under traditional Medicaid coverage groups (referred to as non-newly eligible beneficiaries) in accordance with Federal and State requirements.

The objective of this audit was to summarize the results of our prior audits in order to assist the Centers for Medicare & Medicaid Services (CMS) in achieving greater efficiencies in its operation of the Medicaid program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG's previous audits of 4 States' Medicaid eligibility determinations found that during 2014 and 2015 Medicaid payments were made on behalf of 109 of 460 sampled newly eligible beneficiaries and 98 of 515 sampled non-newly eligible beneficiaries who did not meet or may not have met Medicaid eligibility requirements. OIG determined that both human and system errors, as well as a lack of policies and procedures, contributed to these improper or potentially improper payments. Although the States concurred with all 31 recommendations from OIG's prior audits to address these deficiencies, 15 of these recommendations remain unimplemented. On the basis of OIG's sample results, OIG estimated that the 4 States made Federal Medicaid payments on behalf of newly eligible beneficiaries totaling almost $1.4 billion for more than 700,000 ineligible or potentially ineligible beneficiaries. OIG also estimated that the 4 States made Federal Medicaid payments on behalf of non-newly eligible totaling more than $5 billion for almost 5 million ineligible or potentially ineligible beneficiaries. OIG recommends that CMS: (1) work with States to implement all of the recommendations made in OIG's prior audits; (2)

maintain its efforts to provide training, technical advice, and guidance to States to address the causes identified in OIG's prior audits; and (3) use all available remedies to prevent and reduce the amount of improper payments made on behalf of ineligible beneficiaries.

Work Plan #: A-02-20-01018 (February 2022)
Government Program: Medicaid

States Did Not Fully Comply with Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities

OIG has performed audits in several states in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. Federal waivers permit states to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. CMS requires states to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

OIG's objective was to determine whether states complied with Federal waiver and state requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January through December 2016.

SunHawk Summary of OIG Audit Findings and Recommendations

Arkansas (A-06-17-01003)

OIG found that Arkansas did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, Arkansas did not: (1) ensure that community-based providers properly reported all incidents of suspected adult or child abuse to the appropriate hotline; (2) provide evidence of review and follow up action on all incidents of adult or child abuse; and (3) review all deaths of beneficiaries receiving waiver services. These issues occurred because Arkansas did not have controls in place to ensure that incidents of abuse, neglect, or death were investigated and reported to the appropriate authority. Additionally, Arkansas did not ensure that all incidents involving Medicaid beneficiaries, including incidents of death, were reported because it did not have waiver requirements to report incidents that occurred outside of State custody or State facilities. Also, Arkansas did not have adequate internal controls in place to detect unreported incidents.

OIG recommended that Arkansas: (1) ensure that community-based providers report all suspected adult or child abuse and neglect to the appropriate adult or child abuse hotline; (2) follow waiver guidance for incidents that appear to be abuse that require review and follow-up; (3) follow waiver guidance to conduct reviews of the deaths of beneficiaries receiving waiver services; (4) consider amending critical incident reporting requirements, including those related to incidents of death, to clearly apply to circumstances in which Arkansas employees or contractors are providing waiver services at a non-State facility, such as a private home, and a critical incident occurs; and (5) perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed.

California (A-09-19-02004)

OIG found that California did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in CCFs. Specifically, California did not ensure that: (1) all critical incidents were reported and (2) all reported critical incidents were reported in a timely manner and followed up on completely to ensure beneficiaries' health and safety. In addition, California did not ensure that reported critical incidents involving the death of a beneficiary were properly reviewed.

California provided OIG various reasons that providers and regional centers (contracted by the State to provide a wide range of services for individuals with developmental disabilities) did not properly report some critical incidents, as well as reasons that reported critical incidents were not always reported in a timely manner and followed up on completely. OIG found that, because California did not fully comply with Federal and State requirements for reporting and monitoring critical incidents, it did not ensure compliance with safeguard assurances it provided to CMS in the Federal Medicaid waiver, which could impact the health and safety of Medicaid beneficiaries.

OIG recommended that California: (1) provide additional guidance to providers, such as a standard reporting form that includes the types of incidents that are required to be reported, and provide additional training to providers on critical incident identification and reporting; (2) provide additional guidance and training to regional centers for identifying the types of incidents that are required to be reported; (3) perform additional analytical procedures, such as data matches, to identify potential critical incidents that have not been reported and follow up on them as required; (4) improve oversight to ensure that timeliness and follow-up requirements related to reported critical incidents are met; and (5) ensure that reported critical incidents involving the death of a beneficiary are reviewed by a mortality review committee as appropriate.

Louisiana (A-06-17-02005)

OIG found that Louisiana did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, Louisiana did not ensure that: (1) all hospital emergency room visits were reported as critical incidents and (2) all critical incidents were reported or followed up on, or both, within required timeframes. These issues occurred because Louisiana: (1) did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents and (2) was unaware of the extent to which community-based providers were late in reporting and following up on critical incidents.

OIG recommended that Louisiana: (1) work with community-based providers on processes to identify and report all critical incidents, (2) perform timely analytical procedures to identify unreported critical incidents, (3) ensure that beneficiaries and their families are properly educated and understand that all hospital emergency room visits are critical incidents, (4) track direct service providers' and support coordinators' compliance with the reporting timeframes outlined in the waiver, and (5) correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery.

New York (A-02-17-01026)

OIG reported that New York did not ensure that providers fully complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Of the 30 incidents of potential abuse and neglect in OIG's sample, seven incidents were not properly reported and investigated. Specifically, providers did not properly report three incidents, and, for all seven incidents, providers did not meet investigation requirements (four incidents were not investigated on time and three were not

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investigated adequately). These incidents of potential abuse and neglect were not properly reported because the individuals responsible for reporting them either initially reported them to the wrong authority or erroneously believed that another provider was responsible for reporting them. Investigations were not adequately conducted because: (1) some incidents were not reported on time, thereby delaying initiation of the investigations and (2) providers' internal policies and procedures for investigating internal incidents were either inadequate or were nonexistent. Because incidents of potential abuse and neglect were not properly reported or investigated, beneficiaries were put at an increased risk of harm.

OIG recommended that New York: (1) reinforce guidance to the provider community on various specific requirements related to the reporting and investigating of critical incidents, (2) issue guidance and/or provide training to the provider community on the importance of identifying the root cause of an incident, and identifying trends in incidents, and (3) review the three internal occurrence investigations identified in OIG report for compliance with investigative requirements, and make any necessary changes to the incident classifications in accordance with Part 624.

Texas (A-06-17-04003)

OIG reported that Texas did not ensure that all beneficiary deaths were reported and reviewed; that all complaints not closed within 10 days were tracked; and that all allegations of abuse, neglect, and exploitation were entered into the Human Services Enterprise Administration Reporting and Tracking (HEART) system. Texas had a procedure to detect unreported deaths but was not following it, did not have a system in place to track complaints not closed within 10 days, and did not have procedures to ensure that allegations were entered into the HEART system.

OIG recommended that Texas: (1) ensure that procedures are followed to detect unreported deaths, (2) implement a system to ensure that it can track complaints not closed within 10 days, and (3) implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system.

Iowa (A-07-18-06081)

OIG found that Iowa failed to ensure that community-based providers reported all major incidents to the state; ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish the probability of future occurrences; review Critical Incident Reports to determine trends, problems, and issues in service delivery; ensure that community-based providers reported all member deaths to the state; and report all known major incidents to CMS.

OIG made procedural recommendations to Iowa, including that it works with community-based providers on how to identify and report all major incidents and to ensure that they appropriately document resolution of major incidents. OIG also recommended that Iowa perform trend analysis that identifies patterns and trends to assess the health and safety of members and determine whether changes need to be made for service implementation or whether staff training is needed to prevent recurrences of major incidents and to reduce the number or severity of incidents; ensure that community-based providers report to the State all member deaths; include all major incidents reported by Medicaid Managed Care Organizations in Iowa's reports to CMS; and develop and implement internal controls adequate to ensure full compliance with Federal and State requirements.

Work Plan #: A-06-17-01003 (December 2021); A-09-19-02004 (September 2021); A-06-17-02005 (May 2021); A-02-17-01026 (February 2021); A-06-17-04003 (July 2020); A-07-18-06081 (March 2020)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

States made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers

Previous Office of Inspector General audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries. OIG's objective was to determine whether the states made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers.

SunHawk Summary of OIG Audit Findings and Recommendations

Kentucky (A-04-20-07094)

OIG found that Kentucky made unallowable capitation payments on behalf of beneficiaries with multiple Medicaid ID numbers. Of the 100 beneficiary matches in OIG's sample, Kentucky correctly made capitation payments on behalf of 3. However, it incorrectly made capitation payments that totaled $455,296 ($323,126 Federal share) on behalf of the remaining 97. OIG states that the unallowable capitation payments occurred because the beneficiaries had multiple Medicaid ID numbers. On the basis of OIG's sample results, OIG estimated that Kentucky made unallowable capitation payments totaling at approximately $2.7 million ($1.9 million Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during OIG's audit period.

OIG recommended that Kentucky: (1) refund to the Federal Government approximately $1.9 million (Federal share) in unallowable payments, (2) review capitation payments that fell outside of OIG's audit period and refund any unallowable payments, and (3) enhance or establish new controls to ensure that no beneficiary is issued multiple Medicaid ID numbers.

Florida (A-04-18-07080)

OIG reported Florida made unallowable capitation payments on behalf of beneficiaries who were assigned multiple Medicaid ID numbers. Florida incorrectly made capitation payments that totaled $383,487 ($232,520 Federal share).

OIG recommended Florida: (1) refund to the Federal Government approximately $3.9 million (Federal share) in unallowable payments, (2) review capitation payments that fell outside of OIG's audit period and refund any unallowable payments, and (3) modify its current methodology to identify beneficiaries with multiple Medicaid ID numbers.

New York (A-02-18-01020)

OIG reported New York improperly claimed Federal Medicaid reimbursement for Medicaid beneficiaries who were assigned more than one Medicaid ID number. Specifically, for 102 of the 103 beneficiary-matches in OIG's sample, New York made managed care payments to different MCOs for the same beneficiary for the same month under different Medicaid ID numbers.

OIG recommended New York (1) refund $11.3 million to the Federal Government, (2) identify and recover improper managed care payments made to different MCOs on behalf of beneficiaries with multiple Medicaid ID numbers prior to and after OIG's audit period, and repay the Federal share of the amounts recovered, and (3) strengthen its procedures for determining whether an individual applying for Medicaid already has a Medicaid ID number.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Tennessee (A-04-18-07079)

OIG reported that Tennessee incorrectly claimed capitation payments that totaled $75,738 ($49,260 Federal share) on behalf of the remaining 13 beneficiaries with multiple Medicaid ID numbers. The improper payments made on behalf of these beneficiaries occurred because Tennessee needed a significantly more complex matching algorithm than the one that it already had in place to identify beneficiary matches that existed in its system. Furthermore, Tennessee stated that, during the period of OIG's review, the process to recoup duplicate capitation payments after linking duplicate recipient records was limited to 9 months and did not include the recoupment of payments beyond that 9-month period.

OIG recommended that Tennessee: (1) refund to the Federal Government $378,137 (Federal share) in overpayments, (2) review capitation payments that fell outside of OIG's audit period and refund any overpayments, and (3) enhance or establish new controls to ensure that no beneficiary is issued multiple Medicaid ID numbers.

Work Plan #: A-04-20-07094 (December 2021); A-04-18-07080 (March 2020); A-02-18-01020 (February 2020); A-04-18-07079 (October 2019)
Government Program: Medicaid

Missouri Properly Converted Provisionally Enrolled Medicaid Providers to Permanent Providers

In response to the COVID-19 pandemic, the Secretary of HHS temporarily waived certain Medicaid provider enrollment requirements. Loosening of provider screening requirements increases Medicaid vulnerability to fraud by moderate and high-risk providers. Because of the speed with which established provider enrollment requirements have been waived or modified, OIG believes that the opportunity for abuse of the Medicaid system could result in unallowable billing, duplication of services, breach of confidentiality, identity theft, and ineffective or unsafe care. OIG's objectives were to determine whether Missouri: (1) followed up with provisionally enrolled Medicaid providers to ensure that all documentation was obtained according to applicable provider screening and enrollment requirements after regular enrollment practices resumed and (2) had effective controls over the provisional enrollment process during the public health emergency for the period of March 1, 2020, through May 15, 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Missouri correctly followed up with the provisionally enrolled Medicaid providers to ensure that all documentation was obtained in accordance with applicable provider screening and enrollment requirements, or that the Medicaid provider was terminated, after the regular enrollment practices resumed for all 100 sampled provisionally enrolled Medicaid providers. Missouri's provisional enrollment process involved tracking provisionally enrolled providers on a spreadsheet and terminating them if they did not provide the necessary documents required for a regular enrollment. Because OIG identified no errors in OIG's sample review, OIG concluded that Missouri's controls over the provisional enrollment process were effective.

Work Plan #: A-07-21-03248 (November 2021)
Government Program: Medicaid

Michigan Did Not Report Calendar Year 2019 Medicaid Third-Party Liability Cost Avoidance Data to the Centers for Medicare & Medicaid Services

If Medicaid beneficiaries have another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid pays. Federal regulations refer to this requirement as third-party liability (TPL). Prior Office of Inspector General and other reports indicated longstanding challenges States had in their TPL efforts. This audit of Michigan is similar to those previous audits. OIG's objective was to determine whether Michigan reported Medicaid TPL in accordance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Michigan did not report Medicaid TPL Medicare cost avoidance for all four quarters in calendar year 2019, totaling $3.4 billion. Inaccurate amounts reported on the CMS-64 could impact CMS' monitoring and evaluation of the effectiveness of the State's TPL activity.

Michigan said the TPL Medicare cost avoidance was omitted in error because there was no process in place to ensure that the amounts were reported on the CMS-64. This error was corrected, and the full amount was reported on the CMS-64 for the third quarter of FFY 2020. Michigan said it added steps for entering TPL cost avoidance as part of its quarterly preparation checklist that must be completed and reviewed prior to certifying the CMS-64 quarterly reports.

This report contains no recommendations.

Work Plan #: A-05-20-00058 (October 2021)
Government Program: Medicaid

Tennessee Medicaid Claimed Hundreds of Millions of Federal Funds for Certified Public Expenditures That Were Not in Compliance With Federal Requirements

Under a Medicaid waiver, Tennessee was allowed to claim as certified public expenditures (CPEs) the uncompensated cost of care (UCC) at public hospitals for Medicaid enrollees and uninsured patients. For State fiscal years (SFYs) 2009–14, Tennessee claimed a total of $2 billion in CPEs. For SFYs 2010–13, Tennessee each year claimed the same amount of $373.8 million, indicating that it may not have calculated specific estimates of the CPEs for each of those years, as required. Additionally, a recent audit found that another State had improperly paid $686 million in Medicaid supplemental pool payments. The objective of OIG was to determine whether Tennessee complied with Federal requirements for claiming CPEs for public hospital unreimbursed costs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Tennessee did not comply with Federal requirements for claiming CPEs for public hospital unreimbursed costs. Of the $2 billion in CPEs that Tennessee claimed during OIG's audit period, $909.4 million was allowable and supported. However, the remaining $1.1 billion ($767.5 million Federal share) exceeded the amount allowed. This amount included $482.1 million ($337.5 million Federal share) of excess CPEs that Tennessee claimed but did not return after calculating actual CPEs. In addition, the actual CPEs that Tennessee calculated included another $609.4 million ($430

million Federal share) that exceeded the allowable amount. It was composed of $522.3 million ($370.1 million Federal share) of unsupported net costs of caring for IMD uninsured patients, $53.6 million ($37.9 million Federal share) of unallowable net costs of caring for TennCare IMD patients between the ages of 21 and 64, and $33.5 million ($22 million Federal share) of overstated costs because of incorrect calculations.

OIG recommended that Tennessee: (1) refund $397.4 million in overpayments to the Federal Government for CPEs that it claimed in excess of the allowable amount; (2) provide support for or refund to the Federal Government $370.1 million for the net costs of caring for uninsured IMD patients for which it did not provide detailed supporting documentation; and (3) establish additional policies and procedures to ensure compliance with Federal requirements.

Work Plan #: A-04-19-04070 (October 2021)
Government Program: Medicaid

More Than One-Third of Medicaid-Enrolled Children in Five States Did Not Receive Required Blood Lead Screening Tests

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit covers preventive medical services—including blood lead screening tests—for enrolled children. Previous OIG work regarding EPSDT screenings and annual EPSDT participation reports have identified deficiencies with blood lead level testing. Specifically, OIG found that many enrolled children did not receive all required components of complete medical screenings, including blood lead screening tests, potentially leaving them vulnerable to the toxic effects of lead exposure.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that many Medicaid-enrolled children in five States did not receive required blood lead screening tests on schedule during FYs 2015–18. Specifically, more than one-third of the 1 million children who were required to receive a 12-month and a 24-month blood lead screening test received neither test. Additionally, of the approximately 209,000 children who had been continuously enrolled in Medicaid from birth through age 3, 1 in 5 children in the selected States had never received a blood lead screening test by 3 years of age. Finally, stakeholders OIG interviewed called for consistent requirements for blood lead screening tests and practitioners reported challenges with providing blood lead screening tests for Medicaid-enrolled children.

To address challenges that contribute to low participation rates in the blood lead testing component of the EPSDT benefit, OIG recommended that CMS: (1) monitor national EPSDT performance data for blood lead screening tests and target efforts toward low-performing States to develop action plans for increasing the provision of blood lead screening tests, according to Medicaid's schedule; (2) ensure consistency across CMS guidance related to actionable blood lead reference values (i.e., the blood lead level at which public health actions should be initiated) and blood lead screening test definitions; and (3) coordinate with partners to develop and disseminate to State Medicaid agencies educational resources that reaffirm requirements and schedules for blood lead screening tests.

Work Plan #: OEI-07-18-00371 (October 2021)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Changes Made to States' Medicaid Programs to Ensure Beneficiary Access to Prescriptions During the COVID-19 Pandemic

On March 13, 2020, the President of the United States declared that the COVID-19 pandemic was a national emergency. That same day, in accordance with section 1135(b) of the Social Security Act (the Act), the Secretary of the Department of Health and Human Services invoked his authority to waive or modify certain requirements of Titles XVIII, XIX, and XXI of the Act. To limit the spread of the virus, Federal, State and local governments urged individuals to stay at home and for individuals who test positive to quarantine, among other preventive measures. As a result, the usual and customary ways that many individuals obtained prescription drugs were altered and access to those prescription drugs reduced. The objective was to identify actions that selected States took or planned to take to ensure that Medicaid beneficiaries continued to receive prescription drugs during the COVID-19 pandemic.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that most States from which OIG obtained information responded that, as a result of the pandemic, they had implemented changes to ease restrictions on prior authorizations and early refill requirements, made changes to their prescription quantity limits to allow pharmacies to dispense increased quantities of some prescription drugs, and removed the requirement of obtaining a signature upon receipt of a prescription. In addition, most States from which OIG obtained information responded that they have implemented changes that give physicians greater flexibility to prescribe drugs to both new and established patients following telehealth episodes during the COVID-19 pandemic.

This report contains no recommendations.

Work Plan #: A-06-20-04007 (October 2021)
Government Program: Medicaid

State Opioid Treatment Program Services Provided to Medicaid Beneficiaries

The United States currently faces a nationwide public health emergency due to the opioid crisis. Opioid treatment programs (OTPs) provide medication coupled with counseling services (referred to in this report as "OTP services") for people diagnosed with an opioid use disorder. This audit is part of OIG's oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis. To perform an initial assessment of the risk of improper Medicaid reimbursement for OTP services, OIG selected for audit an OTP provider that received the highest Medicaid reimbursement for OTP services in California for calendar year 2018. OIG's objective was to determine whether California claimed Medicaid reimbursement for the selected provider's OTP services in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Colorado (A-07-20-04118)

OIG found that Colorado's oversight during the audit period did not ensure that OTP services provided to Medicaid beneficiaries met Federal and State requirements. Of the 100 OTP services OIG sampled, 21 complied with Federal and State requirements but 79 did not meet applicable Federal and State requirements. Colorado's oversight of the OTPs consisted primarily of biennial audits conducted by the State Opioid Treatment Authority (SOTA), which were not sufficient

in scope and depth of coverage to ensure that OTPs maintained a recordkeeping system that was adequate to document and monitor patient care, or to ensure that OTP services met Federal and State requirements.

On the basis of OIG's sample results, OIG estimated that over 1.1 million OTP services, or about 79 percent, did not meet Federal and State requirements during the audit period.

OIG recommended that Colorado strengthen its biennial audits of OTPs to ensure that services provided are in accordance with Federal and State requirements, provide technical assistance to OTPs to ensure that the providers maintain adequate recordkeeping systems, and educate OTPs on the deficiencies OIG identified to increase their awareness of compliance issues regarding Federal and State requirements.

California (A-09-20-02001)

OIG reported that California did not claim Medicaid reimbursement for the selected provider's OTP services in accordance with Federal and State requirements. Of the 100 sample items, 1 sample item was allowable, but 99 sample items had services that were unallowable. The deficiencies included, among others, the following: individual counselling sessions were not supported with adequate documentation (99 sample items), take-home medications were not provided in accordance with Federal or State regulations (43 sample items), methadone dosing services were administered without proper authorization (6 sample items), and individual counselling and methadone services were provided without a treatment plan in effect (4 sample items). Based on OIG's sample results, OIG estimated that California claimed at least $2.4 million in unallowable Federal Medicaid reimbursement for OTP services during OIG audit period. These deficiencies occurred because California's oversight activities did not ensure that OTP services met Federal and State requirements. OIG also identified deficiencies in two areas in which California could improve the quality of care provided to beneficiaries receiving OTP services.

OIG recommended that California: (1) refund $2.4 million to the Federal Government for unallowable OTP services furnished by the selected provider, (2) ensure that the selected provider complies with Federal and State requirements for providing and claiming reimbursement for OTP services, (3) verify that the selected provider implements corrective action plans that were approved by California, (4) perform post payment reviews to identify disallowances for OTP services that did not comply with State requirements, and (5) work with the selected provider to improve the quality of care provided to beneficiaries by correcting deficiencies.

Work Plan #: A-07-20-04118 (September 2021); A-09-20-02001 (January 2021)
Government Program: Medicaid

State Medicaid Agencies Made Capitation Payments to Managed Care Organizations After Beneficiaries' Deaths

State Agencies pay managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries in return for a monthly fixed payment for each enrolled beneficiary (capitation payments). Previous Office of Inspector General (OIG) audits found that State Medicaid agencies had improperly made capitation payments on behalf of deceased beneficiaries. OIG's objective was to determine whether State Programs made capitation payments on behalf of deceased beneficiaries.

SunHawk Summary of OIG Audit Findings and Recommendations

Kansas (A-07-20-05125)

OIG found that Kansas made at least $17.3 million in unallowable capitation payments to MCOs on behalf of beneficiaries whose dates of death preceded the service period covered by the monthly capitation payment, for which it claimed at least $9.7 million in unallowable Federal reimbursement. Specifically, 1,383 capitation payments totaling $2.7 million ($1.5 million Federal share), made on behalf of deceased beneficiaries who had a date of death in Kansas's eligibility system that did not always agree with the information in the DMF, were unallowable. Further, 100 capitation payments in OIG's stratified random sample, totaling $192,991 ($108,657 Federal share), made on behalf of beneficiaries who had a date of death recorded in the DMF but who did not have a date of death in Kansas's system, were unallowable. On the basis of OIG's sample results, OIG estimated that Kansas made unallowable capitation payments totaling at least $14.6 million (at least $8.2 million Federal share). In addition, Kansas had previously overreported capitation payments totaling over $2 million ($1.2 million Federal share) that were related to prior-period adjustments.

OIG recommended that Kansas: (1) refund at least $10.9 million to the Federal Government; (2) recover unallowable capitation payments totaling almost $2.7 million that were made to MCOs on behalf of deceased beneficiaries who did have a date of death recorded in Kansas's system; (3) identify and recover unallowable capitation payments made to MCOs on behalf of deceased beneficiaries who did not have a date of death recorded in Kansas's system, which OIG estimated to be at least $14.6 million; and (4) identify and recover unallowable capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period and repay the Federal share of any amounts recovered. OIG made additional procedural recommendations for the strengthening of internal controls and policies and procedures regarding accurate and timely updates to Kansas's eligibility system and the accurate reporting of all Medicaid expenditures, to include prior-period adjustments.

New York (A-04-19-06223)

The New York Medicaid Assistance Program (New York Medicaid) is the second largest Medicaid program in the Nation. New York Medicaid provides health coverage to almost 6.2 million of New York's residents. Approximately 80 percent of the New York Medicaid population is enrolled in managed care.

OIG found that, for 84 payments, New York made unallowable payments totaling $269,473 ($143,643 Federal share). The unallowable payments occurred because New York did not: (1) have system edits to identify errors in the automated process that terminates beneficiaries' eligibility after dates of death were identified, (2) update the eligibility and payment systems with correct dates of death, (3) identify as deceased and disenroll beneficiaries that had a date of death in one of its death data sources, or (4) use additional sources of death information and alternative procedures similar to those that OIG used in OIG's audit to identify, verify, or determine dates of death.

Based on OIG's sample results, OIG estimated that New York made payments to MCOs on behalf of deceased beneficiaries totaling at least $23.3 million ($13.7 million Federal share) during OIG's audit period. OIG recommended that New York: (1) refund the $13.7 million to the Federal Government and (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries.

Michigan (A-05-17-00048)

OIG estimated that Michigan made unallowable capitation payments totaling at least $39.9 million ($27.5 million Federal share) to managed care entities on behalf of deceased beneficiaries during OIG's audit period. Of the 100 capitation

payments in OIG's stratified random sample, Michigan made 99 unallowable payments totaling $117,746 ($79,348 Federal share).

OIG recommended Michigan: (1) refund $27.5 million to the Federal Government, (2) identify and recover unallowable payments made to managed care entities during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $39.9 million, and (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period and repay the Federal share of amounts recovered.

Indiana (A-05-19-00007)

OIG found that Indiana made capitation payments on behalf of deceased beneficiaries and confirmed that 70 beneficiaries associated with the 100 capitation payments in OIG's stratified random sample were deceased. Of the 100 capitation payments, Indiana made 95 unallowable payments totaling $79,403 ($58,773 Federal share). Based on OIG's sample results, OIG estimated that Indiana made payments totaling at least $1.1 million ($862,097 Federal share) to MCOs on behalf of deceased beneficiaries during OIG's audit period.

OIG recommended that Indiana: (1) refund $862,097 to the Federal Government, (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the Federal Government a share of amounts recovered, and (4) ensure that dates of death are added to the MMIS and that capitation payments made after the beneficiaries' deaths are recovered.

Minnesota (A-05-17-00049)

OIG estimated that Minnesota made unallowable capitation payments totaling at least $3.7 million ($3.2 million Federal share) to MCOs on behalf of deceased beneficiaries during OIG's audit period. Of the 100 capitation payments in OIG's random sample, Minnesota made 95 unallowable payments totaling $62,665 ($55,932 Federal share).

OIG recommended Minnesota: (1) refund $3.2 million to the Federal Government, (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $3.7 million, (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the Federal share of amounts recovered, (4) ensure Minnesota Medicaid staff are properly trained to process dates of death and eligibility termination in accordance with Minnesota's internal policies, and (5) utilize additional sources to identify dates of death to help reduce unallowable payments.

Georgia (A-04-15-06183)

OIG found that only 2 capitation payments were for beneficiaries who were still alive. For 118 payments, Georgia made payments totaling $109,252 ($82,362 Federal share) after a beneficiary's death.

OIG recommended that Georgia: (1) use additional sources of date of death to help reduce the risk of making payments after a beneficiary's death, (2) implement additional controls to more effectively detect payments involving deceased beneficiaries to reduce the risk of payments after a beneficiary's death, and (3) continue to identify payments made after a beneficiary's death to prevent additional payments similar to the $2.2 million identified in this report.

Illinois (A-05-18-00026)

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

OIG estimated that Illinois did not recover unallowable MCO payments made on behalf of deceased beneficiaries during OIG's audit period, totaling at least $4.6 million ($3.2 million Federal share). OIG confirmed that 80 of the 94 beneficiaries associated with the 100 capitation payments in OIG's stratified random sample were deceased. Illinois did not recover any of the 84 sampled capitation payments made on behalf of the 80 deceased beneficiaries, totaling $74,319 ($45,032 Federal share). Illinois did not always process Medicaid beneficiaries' death information in the MMIS. Additionally, although Illinois' eligibility systems interfaced with Federal data exchanges that identify dates of death, Illinois did not enter the dates of death in the MMIS for many OIG's sampled beneficiaries.

OIG recommended Illinois: (1) refund $3.2 million to the Federal Government, (2) identify and recover unallowable payments made to MCOs during OIG's audit period on behalf of deceased beneficiaries, which OIG estimated to be at least $4.6 million, (3) identify capitation payments made on behalf of deceased beneficiaries before and after OIG's audit period, and repay the Federal share of amounts recovered, and (4) ensure that dates of death are added to the MMIS for deceased beneficiaries that were previously marked as "inactive."

Work Plan #: A-07-20-05125 (September 2021); A-04-19-06223 (July 2020); A-05-17-00048 (February 2020); A-05-19-00007 (January 2020); A-05-17-00049 (October 2019); A-04-15-06183 (August 2019); A-05-18-00026 (August 2019); A-04-15-06190 (December 2017); A-06-16-05004 (November 2017); W-00-19-31497
Government Program: Medicaid

States Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs

For a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. However, a prior Office of Inspector General review found that States did not always invoice and collect all rebates due for drugs administered by physicians. OIG's objective was to determine whether States complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

SunHawk Summary of OIG Audit Findings and Recommendations

Colorado (A-07-17-06075)

OIG found that Colorado did not comply with Federal Medicaid requirements because it did not collect National Drug Codes (NDCs) and invoice manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. Because the information OIG received from Colorado lacked NDC-level detail, OIG identified the physician-administered drugs that would have been eligible for a drug rebate and calculated that Colorado did not invoice for, and collect from manufacturers, an estimated $2 million ($1 million Federal share) in rebates that were associated with these physician-administered drugs.

OIG recommended that Colorado work with CMS to determine the total amount of claims that were eligible for rebates as well as the unallowable portion of the physician-administered drug claims, invoice drug manufacturers for the calculated rebates, and refund the Federal share of rebates collected for the years covered by OIG's audit period and for years after OIG's audit period. OIG also recommended that Colorado develop and implement policies and procedures to ensure that all eligible physician-administered drugs, including those dispensed to MCO enrollees, are invoiced for rebate.

New Mexico (A-06-16-00001)

OIG found that New Mexico did not bill for and collect from manufacturers rebates for 70,131 claim lines totaling at least $1.5 million ($1.1 million Federal share) for physician-administered drugs. In addition, the State agency did not bill for rebates for 183,859 claim lines for other physician-administered drugs that may have been eligible for rebates. These errors occurred because the State agency's internal controls did not always ensure that it billed manufacturers to secure rebates and because the State agency did not always collect the utilization data necessary to bill the manufacturers.

OIG recommended that New Mexico (1) bill for and collect manufacturers' rebates for the 44,790 claim lines related to single-source and top-20 multiple-source physician-administered drugs that OIG calculated to be at least $1.2 million ($900,971 Federal share) and refund the Federal share of rebates collected; (2) work with CMS to determine whether the 25,341 claim lines related to non-top-20 multiple-source physician-administered drugs that OIG calculated to be at least $226,644 ($164,793 Federal share) were eligible for rebates and, if so, determine the rebates due and, upon receipt of the rebates, refund the Federal share of rebates collected; and (3) work with CMS to determine whether the other physician-administered drugs, associated with 183,859 claim lines and rebates of at least $170,674 ($124,097 Federal share), were eligible for rebates and, if so, determine the rebates due and, upon receipt of the rebates, refund the Federal share of the rebates collected.

Massachusetts (A-06-18-04001)

OIG found that Massachusetts did not invoice manufacturers for rebates associated with $11.4 million (Federal share) in physician-administered drugs. Of this amount, $10.5 million was for single-source drugs, and $883,000 was for top 20 multiple-source drugs. Of the $11.4 million, $9.7 million was related to claims identified as hospital outpatient. Massachusetts did not invoice for rebates for any physician-administered drug claims identified as hospital outpatient claims. In addition, some claims identified as physician claims were not invoiced for rebates. Because Massachusetts' internal controls did not always ensure that it invoiced manufacturers to secure rebates, Massachusetts improperly claimed Federal reimbursement for these single-source drugs and top-20 multiple-source drugs.

OIG recommended that Massachusetts refund $11.4 million and work with CMS to determine the proper resolution of the other claims in question.

Minnesota (A-05-17-00018)

OIG reported that Minnesota did not bill for and collect manufacturers' rebates that OIG calculated to be $6.1 million (Federal share). Specifically, it did not bill for and collect manufacturers' rebates that OIG calculated to be (1) $5.9 million (Federal share) for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that were eligible for rebates and (2) $173,780 (Federal share) for physician-administered drugs that may have been eligible for rebates. Minnesota did not always bill for and collect manufacturers' rebates because Minnesota and its contractor did not identify all the rebate-eligible drugs in the utilization data submitted by the MCOs.

OIG recommended that Minnesota (1) bill for and collect manufacturers' rebates for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that OIG calculated to be $5.9 million (Federal share) and refund the Federal Government and (2) work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates that OIG calculated to be $173,780 (Federal share) and, if so, upon receipt of the rebates, refund the Federal share. OIG also made a recommendation related to pharmacy and physician-administered drugs that were not billed for rebates after OIG's audit period and a procedural recommendation to ensure that all rebate-eligible drugs are properly identified and billed for rebate.

Maine (A-07-18-06079)

OIG found that Maine did not invoice for and collect from manufacturers rebates associated with $4.3 million (Federal share) in physician-administered drugs as required. Of this amount, $4.0 million was for single-source drugs and $276,000 was for top-20 multiple-source drugs. Further, Maine did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $606,000 (Federal share). Finally, Maine could have invoiced manufacturers for rebates totaling $10.8 million (Federal share) that were associated with physician-administered drugs dispensed at non-Critical Access Hospitals.

OIG recommended that Maine refund to the Federal Government $4.0 million (Federal share) for claims for single-source physician-administered drugs and $276,000 for claims for top-20 multiple-source physician-administered drugs. OIG also recommended that Maine work with CMS to determine the unallowable portion of $606,000 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determined that the drug claims are allowable. In addition, OIG recommended that Maine consider invoicing drug manufacturers for rebates totaling $10.8 million (Federal share) for claims for physician-administered drugs dispensed at non-Critical Access Hospitals, and that Maine strengthen its internal controls.

Vermont (A-07-19-06086)

OIG found that Vermont did not invoice for and collect from manufacturers rebates associated with $483,458 (Federal share) in physician-administered drugs. Of this amount, $357,706 (Federal share) was for single-source drugs and $47,389 (Federal share) was for top-20 multiple-source drugs. Further, OIG was unable to determine whether, in some cases, Vermont was required to invoice for rebates for other multiple-source physician-administered drug claims. Vermont did not invoice the manufacturers for rebates associated with claims totaling $78,363 (Federal share) for these multi-source drugs.

OIG recommended that Vermont refund to the Federal Government $357,706 (Federal share) for claims for single-source physician-administered drugs and $47,389 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommended that Vermont work with CMS to determine the unallowable portion of $78,363 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determines that the drug claims are allowable. In addition, OIG recommended that Vermont work with CMS to determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not invoiced for rebates after December 31 2017, and strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.

Michigan (A-05-17-00017)

OIG reported that Michigan did not fully comply with Federal Medicaid requirements for billing manufacturers for rebates for drugs dispensed to MCO enrollees. Michigan did not bill for and collect manufacturers' rebates that OIG calculated to be at least $31.5 million (Federal share). Specifically, it did not bill for and collect manufacturers' rebates that OIG calculated to be at least (1) $30 million (Federal share) for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that were eligible for rebates and (2) $1.5 million (Federal share) for physician-administered drugs that may have been eligible for rebates that OIG set aside for CMS resolution. Michigan did not always bill for and collect manufacturers' rebates because Michigan and its contractor did not identify all the rebate-eligible drugs in the utilization data submitted by the MCOs.

OIG recommended that Michigan: (1) bill for and collect manufacturers' rebates for pharmacy drugs and for single-source and top-20 multiple-source physician-administered drugs that OIG calculated to be at least $30.0 million (Federal share) and refund the Federal Government and (2) work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs and other physician-administered drugs without NDCs were eligible for rebates that OIG calculated to be at least $1.5 million (Federal share) and, if so, upon receipt of the rebates, refund the Federal share. OIG also made a recommendation related to pharmacy and physician-administered drugs that were not billed for rebates after OIG's audit period and a procedural recommendation to improve the processes for determining drug rebate eligibility.

Alaska (A-09-19-02001)

OIG found that Alaska did not bill for and collect from manufacturers rebates associated with about $1 million (Federal share) in claims for physician-administered drugs. Of this amount, $939,361 was for single-source drugs, and $73,892 was for top-20 multiple-source drugs. Because Alaska's internal controls did not always ensure that it billed manufacturers to secure rebates, Alaska improperly claimed Federal reimbursement for these single-source drugs and top-20 multiple-source drugs. In addition, Alaska did not submit the drug utilization data necessary to secure rebates for other physician-administered drugs that did not have valid NDCs, totaling $3,615 (Federal share). Furthermore, claims totaling $185,066 (Federal share), which contained NDCs, could have been eligible for rebates.

OIG recommended that Alaska: (1) refund to the Federal Government $939,361 (Federal share) for claims for single-source physician-administered drugs, (2) refund to the Federal Government $73,892 (Federal share) for claims for top-20 multiple-source drugs, (3) work with CMS to determine the unallowable portion of $188,681 (Federal share) for claims for other physician-administered drugs that did not have valid NDCs or could have been eligible for rebates, and make the appropriate refunds, (4) work with CMS to determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not billed for rebates after December 31, 2017; and (5) strengthen its internal controls to ensure that it bills manufacturers for rebates for all physician-administered drugs that are eligible for rebates.

New York (A-02-18-01016)

OIG reported that New York did not bill for and collect from manufacturers estimated rebates of more than $10.8 million (Federal share) for pharmacy and physician administered drugs that were eligible or may have been eligible for rebates during OIG's audit period. For drugs that were eligible for rebates, New York did not bill for estimated rebates of $7.8 million (Federal share) for single-source and top-20 multiple-source pharmacy and physician-administered drugs. For drugs that may have been eligible for rebates, New York did not bill for estimated rebates of $3 million (Federal share) for other pharmacy and physician-administered drugs. Although its policies and procedures require the collection of drug utilization data necessary to invoice for rebates on all claims, New York's internal controls did not always ensure that the data were used to invoice manufacturers to secure rebates.

OIG recommended that New York (1) bill for and collect from manufacturers rebates for single-source and top-20 multiple-source pharmacy and physician administered drugs and refund the estimated $7.8 million (Federal share), (2) work with CMS to determine whether the other pharmacy and physician administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to an estimated $3 million (Federal share) of rebates collected, and (3) strengthen its internal controls to ensure that all pharmacy and physician-administered drugs eligible for rebates are invoiced.

Connecticut (A-07-18-06078)

OIG reported Connecticut did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. Connecticut did not invoice manufacturers for rebates associated with $1.1 million

(Federal share) in physician-administered drugs. Of this amount, $1.07 million was for single-source drugs, and $46,210 was for top-20 multiple-source drugs. Further, Connecticut did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $2.8 million (Federal share).

OIG recommended Connecticut refund to the Federal Government $1.07 million (Federal share) for claims for single-source physician administered drugs, and $46,210 for claims for top-20 multiple-source physician-administered drugs, and work with CMS to determine the unallowable portion of the $2.8 million (Federal share) for other claims for outpatient physician-administered drugs that were at issue.

Texas (A-06-17-04001)

OIG found that Texas did not bill for and collect manufacturer rebates totaling $4.4 million ($2.6 million Federal share) for physician-administered drugs. For drugs that were eligible for rebates, Texas did not bill and collect rebates totaling $2.2 million (Federal Share) for single-source and top-20 multiple-source physician-administered drugs. For drugs that may have been eligible for rebates, Texas did not bill for rebates totaling $366,578 (Federal share) for other physician-administered drugs. In addition, Texas did not bill for rebates on 160,579 claim lines for other physician-administered drugs that may have been eligible for rebates. These errors occurred because Texas's internal controls did not always ensure that it billed manufacturers to secure rebates, and Texas did not always collect the utilization data necessary to bill the manufacturers.

OIG recommended that Texas: (1) bill manufacturers for the $2.2 million (Federal share) in rebates for single-source and top-20 multiple-source physician administered drugs, and refund the Federal share of rebates collected, (2) work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates and, if so bill manufacturers for the $366,578 (Federal share) in rebates, and refund the Federal share of rebates collected, (3) work with CMS to determine whether the other physician administered drugs, associated with 160,579 claim lines, were eligible for rebates and, if so, determine the rebates due and upon receipt of the rebates refund the Federal share of the rebates collected, and (4) strengthen internal controls to ensure that all eligible physician administered drugs are billed for rebate.

New Jersey (A-02-16-01011)

OIG found that New Jersey did not fully comply with Federal Medicaid requirements for billing manufacturers for rebates for drugs dispensed to MCO enrollees. Specifically, New Jersey did not bill for and collect from manufacturers estimated rebates of $75.5 million (Federal share) for pharmacy and physician-administered drugs that were eligible or may have been eligible for rebates for OIG's audit period. For drugs that were eligible for rebates, New Jersey did not bill for estimated rebates of $28.1 million (Federal share) for single-source and top-20 multiple-source pharmacy and physician-administered drugs. For drugs that may have been eligible for rebates, New Jersey did not bill for estimated rebates of $47.4 million (Federal share) for other pharmacy and physician-administered drugs. New Jersey did not always bill for and collect from manufacturers' rebates because it did not have a system edit to ensure that NDCs were submitted for physician-administered drugs before January 1, 2015. Even after New Jersey implemented the edit on January 1, 2015, this edit did not ensure that NDCs or valid NDCs were captured for all physician administered drugs.

OIG recommended that New Jersey: (1) bill for and collect from manufacturers' rebates for single-source and top-20 multiple-source pharmacy and physician-administered drugs and refund the estimated $28.1 million (Federal share) and (2) work with CMS to determine whether the other pharmacy and physician-administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to an estimated $47.4 million (Federal share) for OIG's audit period and $119.6 million (Federal share) for the nearly four-year period before OIG's audit period.

Work Plan #: A-07-17-06075 (September 2021); A-06-16-00001 (June 2021); A-06-18-04001 (October 2020); A-05-17-00018 (October 2020); A-07-18-06079 (September 2020); A-07-19-06086 (September 2020); A-05-17-00017 (August 2020); A-09-19-02001 (July 2020); A-02-18-01016 (April 2020); A-07-18-06078 (August 2019); A-06-17-04001 (August 2019); A-02-16-01011 (August 2019); A-09-16-02031 (February 2018); A-06-16-00004 (December 2017); A-09-16-02028 (September 2017)
Government Program: Medicaid

Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets

Managed care has replaced fee-for-service as the predominant payment model in Medicaid. State and Federal spending on Medicaid managed care is growing and totaled $360 billion in 2020, accounting for more than half of total Medicaid spending that year. Federal requirements for medical loss ratios (MLRs) were established to ensure that Medicaid managed care plans spend most of their revenue on health care services and quality improvements, thereby limiting the amount that plans can spend on administration and keep as profit. An MLR is the percentage of revenue that a managed care plan spends on services related to the health of its enrollees. MLR requirements also enhance fiscal stewardship of Medicaid expenditures by helping to ensure that States have sufficient information to oversee spending by their Medicaid managed care plans.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Although Federal MLR regulations do not require States to set minimum MLRs, 34 States had established minimum MLRs for 434 Medicaid managed care plans for annual reporting periods ending in 2017, 2018, or 2019. Ninety-one percent of plans met these State-set minimum MLRs. However, 39 plans failed to meet their State-set minimum MLRs for the period reviewed. Nineteen of these plans reported owing a total of $198 million to States that had opted to require their plans to return money to the State when minimum MLRs were not met. For all but one plan, the owed amount covered a 12 month MLR reporting period. Finally, 92 percent of Medicaid managed care plans (471 of 513) achieved MLRs that met or exceeded the Federal 85 percent MLR standard regardless of whether their States had established minimum MLR requirements.

Work Plan #: OEI-03-20-00230 (August 2021)
Government Program: Medicaid

Medicaid Fraud Control Unit: 2020 Inspection

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies the Units, and oversees the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and prepares public reports based on these reviews.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Mississippi (OEI-12-20-00200)

OIG found that reporting requirements contained in the Mississippi Vulnerable Persons Act imposed a significant workload on the Unit that led to many convictions of patient abuse or neglect but also presented challenges to Unit operations. The Unit received about 2,000 complaints of patient abuse or neglect for each year of the review period and devoted half of its investigative staff and 90 percent of its caseload to patient abuse or neglect. The Unit's chief investigator devoted more than half of his time to screening complaints and encountered difficulties conducting periodic supervisory reviews of the large caseload. OIG also found significant unexplained investigative delays in 18 percent of cases.

OIG recommended that the Unit (1) examine the Unit's intake process for complaints of patient abuse or neglect and identify improvements; (2) take steps to avoid investigation delays and ensure that delays are documented in the case files; (3) develop and implement a plan to increase fraud referrals from the Medicaid agency and other sources; and (4) improve communication and coordination with OIG investigators and other Federal partners.

Louisiana (OEI-12-20-00650)

OIG found that the Louisiana Unit generally complied with applicable legal requirements, except that OIG found one case in OIG's review of case files that was ineligible for Federal matching funds during the review period.

OIG recommended that the Louisiana Unit repay the Federal matching funds spent on the case that was ineligible for Federal funding.

Work Plan #: OEI-12-20-00200 (August 2021); OEI-12-20-00650 (August 2021)
Government Program: Medicaid

Oklahoma's Oversight of Medicaid Outpatient Services for Opioid Use Disorder Was Generally Effective

The United States currently faces a nationwide public health emergency due to the opioid crisis. The high potential for misuse of opioids has led to alarming trends, including record numbers of people developing opioid use disorders (OUDs). In 2018, there were 46,802 opioid-related overdose deaths (69.5 percent of all drug overdose deaths) in the United States. This is one of several nationwide reviews of opioid treatment services in State Medicaid programs. OIG chose Oklahoma because it has one of the highest prescribing rates of opioids in the United States. Other audits looked at Opioid Treatment Program (OTP) services, but Oklahoma OTP providers were not Medicaid-compensable during OIG's audit period because they provided methadone.

OIG's objective was to determine whether Oklahoma's oversight of Medicaid OUD drugs and outpatient OUD services from July 1, 2018, through June 30, 2019, was effective.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Oklahoma's oversight of Medicaid OUD drugs and outpatient services was generally effective. Specifically, Oklahoma ensured that facilities and staff met the requirements to provide services, recipients were approved to receive services, and payments were accurate. However, OIG identified a couple of areas that could be improved. Specifically, most of the people who received OUD drugs did not also receive outpatient counseling services because Oklahoma does not emphasize counseling in conjunction with OUD drugs. In addition, Medicaid beneficiaries are not

included in behavioral health contract reviews conducted by ODMHSAS because it focuses on services that are paid with non-Medicaid funds.

OIG recommended that Oklahoma consider whether more of an emphasis on counseling could improve OUD outcomes and, if so, take steps to increase the appropriate use of counseling with OUD drugs in outpatient OUD treatment, and develop policies and procedures to ensure that Medicaid behavioral health services are reviewed on an ongoing basis.

Work Plan #: A-06-20-08000 (August 2021)
Government Program: Medicaid

Almost 15 Percent of Arkansas' Private Contractor Costs Were Either Unallowable or Claimed at Higher Federal Matching Rates Than Eligible, resulting in Arkansas Inappropriately Claiming $4.4 Million in Federal Medicaid Funds

The Medicaid Management Information Systems (MMIS) is an integrated group of procedures and computer processing operations designed to meet principal objectives, such as processing medical claims. States report costs related to private MMIS contract services as administrative costs. Generally, the Federal Government reimburses States 50 percent of their administrative costs; however, for certain approved MMIS costs, the Federal Government reimburses 90 percent or 75 percent. States are required to obtain prior approval in an Advanced Planning Document (APD) to receive the higher reimbursement rates. OIG's objective was to determine whether Arkansas followed applicable Federal and State requirements related to procuring private MMIS contractor services and claiming Federal Medicaid reimbursement.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Arkansas followed applicable Federal and State requirements related to procuring private MMIS contractor services and correctly claimed $72.1 million ($69.6 million Federal share) in private MMIS contractor costs. However, Arkansas incorrectly claimed the remaining $12.4 million, or almost 15 percent of its costs. For those costs, Arkansas inappropriately received $4.4 million in Federal funds. Arkansas did not have policies and procedures in place to ensure that MMIS private contractor costs were tracked to the correct APDs. Due to the lack of policies and procedures, Arkansas was not able to prevent or detect when it claimed costs that exceeded funding or time-period limits, contractor costs that were not approved, costs that were for programs other than Medicaid, and costs at incorrect matching rates.

OIG recommended that Arkansas refund the $4.4 million Federal share to the Federal Government and establish policies and procedures to track its private MMIS contractor costs to APDs and to ensure that it adheres to the funding and time-period limits established in those APDs.

Work Plan #: A-06-18-09002 (July 2021)
Government Program: Medicaid

Texas Made Unallowable Children's Health Insurance Program Payments for Beneficiaries Assigned More Than One Identification Number

Previous OIG audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one identification number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries. An analysis of the Texas Children's Health Insurance Program (CHIP) data indicated that Texas may have made unallowable CHIP payments to MCOs for beneficiaries assigned more than one identification number. OIG's objective was to determine whether Texas claimed Federal reimbursement for unallowable CHIP payments made to MCOs on behalf of beneficiaries who were assigned more than one identification number.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas claimed Federal reimbursement for unallowable CHIP payments made to MCOs on behalf of beneficiaries who were assigned more than one identification number. For the 599 beneficiary-matches, Texas improperly paid MCOs $922,557 ($856,456 Federal share) on behalf of 572 beneficiaries. Texas made the unallowable payments to MCOs under the different identification numbers for the same month. The remaining 27 beneficiary-matches were different individuals.

OIG recommended that Texas (1) refund $856,456 to the Federal Government, (2) identify and recover additional unallowable CHIP payments made before and after OIG's audit period for the 572 beneficiary-matches and repay the Federal share, (3) identify any other beneficiaries who are assigned more than one identification number and refund any unallowable CHIP payments associated with those beneficiaries, and (4) strengthen its procedures for determining whether applicants are enrolled in any medical or public assistance benefit programs throughout the State and ensure that no beneficiary is assigned more than one identification number.

Work Plan #: A-06-20-10003 (July 2021)
Government Program: Medicaid

New York Improperly Claimed $439 Million In Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures

As part of its oversight activities the Office of Inspector General (OIG) is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs). The objective of this audit was to determine whether New York properly claimed Federal funds based on time studies and costs used for its Medicaid school-based health services certified public expenditures claiming methodology.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York claimed unallowable Federal funds because it did not support that all random moments coded as health care were for Medicaid-eligible health services. New York also did not provide support that it did not double-claim for services when a student in one school district received services from another school district. In addition, New York improperly claimed excess costs for 1 year. Finally, New York did not follow Federal RMTS requirements and used an unsupported method to claim Medicaid costs.

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Additionally, OIG found that New York and its contractor developed complex methods that were difficult or impossible to correctly implement and support with documentation. As a result, New York claimed estimated unallowable Federal funds totaling $98 million. In addition, New York claimed $32 million in Federal funds because it did not follow Federal RMTS requirements or document that CMS approved its allocation methodology, and $309 million in Federal funds using ratios that were not supported.

OIG made several recommendations to New York, including that it refund $98 million in unallowable funds and support or refund the $32 million and the $309 million. OIG also made procedural recommendations to assist New York in preparing accurate, supportable claims.

Work Plan #: A-02-18-01019 (July 2021)
Government Program: Medicaid

Nebraska Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for 76 Percent of the State's Medicaid Fraud Control Unit Cases

This audit is one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper Medicaid claims amounts and damages. For this audit, OIG focused on Nebraska's Medicaid Fraud Control Unit (MFCU) actions related to Medicaid overpayments from legal judgments and settlements that the State had pursued under relevant Medicaid fraud statutes. Nebraska is required to report recoveries for these MFCU-determined Medicaid overpayments to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share to the Federal Government.

OIG's objective was to determine whether Nebraska reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Nebraska did not report and return the correct Federal share of MFCU-determined Medicaid overpayments identified during the period October 1, 2011, through September 30, 2018. Nebraska reported $943,162 ($498,299 Federal share) for this period. However, OIG determined that Nebraska should have reported MFCU-determined Medicaid overpayments totaling $5.6 million ($3.1 million Federal share) for the 66 MFCU cases that OIG reviewed. Therefore, Nebraska did not report $4.6 million ($2.6 million Federal share) of MFCU-determined Medicaid overpayments for this period. In addition, Nebraska did not report $595,723 ($311,352 Federal share) in a timely manner. Nebraska did not have adequate policies and procedures to ensure that it always reported MFCU-determined Medicaid overpayments in accordance with Federal requirements.

OIG recommended that Nebraska refund $1.8 million (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to paid claims and that it report and refund up to $781,732 (Federal share) of the unreported MFCU-determined Medicaid overpayments that related to court-ordered awards if and when collected. OIG also recommended that Nebraska determine the value of overpayments identified after OIG's audit period that have been collected but not reported, report them to CMS, and refund the Federal share of the collected overpayments.

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Work Plan #: A-07-18-02814 (June 2021)
Government Program: Medicaid

Office of Inspector General's Partnership with the Office of the New York State Comptroller: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare

The State Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies and their compliance with relevant statutes and is responsible for performing audits of the Medicaid program. The objective of the State Comptroller's audit was to determine whether the New York State Department of Health (DOH) made improper Medicaid payments to providers on behalf of dually eligible individuals (individuals enrolled in both Medicare and Medicaid) receiving hospice care covered by Medicare during the period January 1, 2015, through July 31, 2019.

SunHawk Summary of OIG Audit Findings and Recommendations

Based on its analysis, the State Comptroller identified approximately $50 million in actual and potential Medicaid overpayments, cost-saving opportunities, and questionable payments for services provided to dually eligible individuals receiving Medicare-covered hospice care. Specifically, the State Comptroller identified $5.5 million in overpayments for services that are not allowable in conjunction with hospice and services that were covered by the Medicare hospice benefit, $370,506 in overpayments for personal care services in excess of 24 hours in a single day, $39.8 million in payments for personal care and durable medical equipment and supplies that may have been covered by the Medicare hospice benefit, and $4.3 million in unnecessary payments for nursing home room and board under managed care.

The State Comptroller concluded that the actual and potential overpayments it identified were made because DOH has not established sufficient controls to ensure Medicaid payments are appropriate for dually eligible individuals receiving Medicare-covered hospice care. Specifically, while Medicare requires non-hospice providers who bill Medicare to document the diagnoses or conditions unrelated to the terminal illness, DOH does not. Additionally, DOH does not have a process to identify, track, or monitor dually eligible individuals who elect the Medicare hospice benefit. Further, although DOH has issued guidance stating hospice providers must notify Medicaid Long-Term Care plans when a recipient has elected hospice, and to coordinate care of those recipients, it has not taken any additional steps to verify that this is done.

The State Comptroller recommended that DOH review the actual and potential overpayments identified in the audit report and ensure proper recoveries are made. In addition, the State Comptroller made several other recommendations to DOH, including that it improve controls to prevent improper payments for services provided to dually eligible individuals receiving Medicare-covered hospice care and that it coordinate with CMS, as appropriate, to design and implement a process to identify and track all Medicaid beneficiaries who elect Medicare-covered hospice care.

Work Plan #: A-02-21-01008 (May 2021)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

New York Made Unallowable Payments Totalling More Than $9 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number

A recent OIG audit found that New York made more than $10 million in unallowable Federal Medicaid payments to different managed care organizations (MCOs) for the same month for beneficiaries assigned more than one Medicaid identification (ID) number. Using computer matching and other data analysis techniques, OIG determined that Medicaid payments to the same MCO were at risk for similar noncompliance with Medicaid requirements.

OIG's objective was to determine whether New York claimed Federal Medicaid reimbursement for managed care payments made to the same MCO on behalf of beneficiaries who were assigned more than one Medicaid ID number.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York improperly claimed Federal Medicaid reimbursement for Medicaid beneficiaries who were assigned more than one Medicaid ID number. Specifically, for 100 of the 105 beneficiary-matches in OIG's sample, New York made managed care payments to the same MCO for the same beneficiary for the same month under different Medicaid ID numbers.

OIG reported that the assignment of more than one Medicaid ID number and resulting improper payments occurred because (1) New York's procedures for identifying whether an individual applying for Medicaid had already been assigned a Medicaid ID number were not always followed, (2) system queries were not adequate to ensure that all individuals with existing Medicaid ID numbers were identified, and (3) local district and Marketplace staff did not use all available resources to ensure that qualified applicants were not issued more than one Medicaid ID number. OIG noted that, in 2019 and 2020, New York took steps to improve its processes for identifying beneficiaries assigned more than one Medicaid ID number.

Based on OIG's sample results, OIG estimated that New York claimed at least $10.6 million in Federal Medicaid reimbursement for managed care payments made to the same MCO on behalf of beneficiaries assigned more than one Medicaid ID number. OIG reduced OIG's recommended financial disallowance to reflect payments New York refunded after OIG's fieldwork.

OIG made a series of recommendations to New York, including that it refund $9,325,338 to the Federal Government and identify and recover improper managed care payments made to the same MCO on behalf of beneficiaries with more than one Medicaid ID number prior to and after OIG's audit period.

Work Plan #: A-02-20-01007 (May 2021)
Government Program: Medicaid

States Made Capitation Payments to Managed Care Organizations for Medicaid Beneficiaries with Concurrent Eligibility in Another State

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

A previous Office of Inspector General (OIG) audit found that a State Medicaid agency had improperly paid capitation payments on behalf of beneficiaries with concurrent eligibility in another State. OIG's objective was to determine whether Illinois made capitation payments on behalf of Medicaid beneficiaries who were residing and enrolled in Medicaid in another State.

SunHawk Summary of OIG Audit Findings and Recommendations

Minnesota (A-05-19-00032)

OIG found that Minnesota made an estimated $1.1 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 106 capitation payments in OIG's stratified random sample, 71 were associated with beneficiaries who were residing and eligible for Medicaid benefits in Minnesota. However, for the remaining 35 capitation payments, totaling $15,084 ($9,167 Federal share), Minnesota made capitation payments on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Minnesota because they were concurrently eligible and residing in another State. Based on OIG's sample results, OIG estimated that Minnesota could have saved $1.1 million ($665,000 Federal share) for August 2018 capitation payments made to managed care organizations on behalf of beneficiaries with concurrent eligibility.

OIG recommended that Minnesota: (1) develop new procedures or enhance current ones to identify beneficiaries with concurrent eligibility in another State, which could have saved Minnesota an estimated $1.1 million ($665,000 Federal share) in capitation payments for the month of August 2018; and (2) ensure that county caseworkers follow procedures to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

Illinois (A-05-19-00031)

OIG reported that Illinois made an estimated $3.8 million in August 2018 capitation payments on behalf of beneficiaries who were concurrently eligible and residing in another State. Of the 100 capitation payments in OIG stratified random sample, 34 capitation payments, totaling $11,867 ($6,562 Federal share), Illinois made on behalf of beneficiaries who should not have been eligible for Medicaid benefits in Illinois because they were concurrently eligible and residing in another State. On the basis of OIG's sample results, OIG estimated that Illinois could have saved $3.8 million ($2.1 million Federal share) for August 2018 capitation payments made to managed care organizations on behalf of beneficiaries with concurrent eligibility.

OIG recommended that Illinois: (1) develop or enhance current procedures to identify beneficiaries with concurrent eligibility in another State, which could have saved Illinois an estimated $3.8 million ($2.1 million Federal share) in capitation payments for the month of August 2018, and (2) ensure that procedures are in place for caseworkers to timely review and terminate eligibility for beneficiaries who were identified as concurrently eligible in another State.

Work Plan #: A-05-19-00032 (May 2021); A-05-19-00031 (February 2021)
Government Program: Medicaid

Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate

Effective oversight of Medicaid requires a national system with complete and accurate data. The Centers for Medicare & Medicaid (CMS) established the Transformed Medicaid Statistical Information System (T-MSIS) for this purpose. Payment

data are a critical component of T-MSIS. These data include the amounts paid, billed, and allowed for every service provided to Medicaid enrollees, including those services provided through managed care.

Managed care has become the primary delivery system for Medicaid. Each managed care plan provides the State with data about what the plan paid providers for their encounters with Medicaid enrollees. The State is then required to submit these data to T-MSIS. The Office of Inspector General (OIG) and others have consistently identified deficiencies in the quality of T-MSIS data, including particular concerns with the quality of data for managed care. CMS and others rely on T-MSIS data to provide oversight; to identify trends; and to detect fraud, waste, and abuse. States also use payment data to set the capitation rates paid to managed care plans for each enrollee and to monitor the services provided by the plans.

OIG analyzed the payment data from the encounter claims in T-MSIS for January 2020 for the largest managed care plan in each of the 39 States that provide comprehensive, risk-based managed care.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that most States did not provide complete or accurate payment data in T-MSIS on managed care payments to providers; two States failed to provide any data for January 2020. Notably, about half of States did not provide complete or accurate information about the amounts that managed care plans pay to providers for services-the amount paid. Almost three-quarters of the States provided incomplete or inaccurate information about the maximum amounts that managed care plans allow for services-the amount allowed. Over a quarter of the States provided incomplete or inaccurate information about the amounts that providers bill managed care plans for services-the amount billed.

OIG recommended that CMS review States' managed care payment data in T-MSIS and ensure that States have corrective action plans to improve data completeness and quality, as appropriate. Further, CMS should make public its reviews of States' managed care data. Finally, CMS should clarify and expand its initiative on payment data. CMS did not concur with any of OIG's three recommendations. CMS noted that it has already set priority areas for improving the reporting of T-MSIS data and it will continue to assess how to further expand data quality improvement efforts. OIG will continue to press CMS to take the recommended actions to improve the managed care payment data in T-MSIS so that these data can be used to effectively monitor and oversee the Medicaid program.

Work Plan #: OEI-02-19-00180 (March 2021)
Government Program: Medicaid

States Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries

The Patient Protection and Affordable Care Act gave States the option to expand Medicaid coverage to low-income adults without dependent children. It also mandated changes to Medicaid eligibility rules and established a higher Federal reimbursement rate for services provided to these beneficiaries, which led OIG to review whether States were correctly determining eligibility for these newly eligible beneficiaries. OIG's objective was to determine whether States determined Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State eligibility requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Louisiana (A-06-18-02000)

OIG found that Louisiana made payments on behalf of four beneficiaries who did not meet requirements and one beneficiary who may not have met requirements. Based on OIG's sample results, OIG estimated that Louisiana made Medicaid payments of $20.1 million (100 percent Federal share) on behalf of 16,358 beneficiaries who did not meet requirements. These deficiencies occurred because Louisiana did not always meet Federal and State requirements when making eligibility determinations because analysts did not always follow the State's established procedures.

OIG recommended that Louisiana: (1) promptly provide notice and cancel the eligibility of beneficiaries identified with income over the allowable limit, (2) educate State analysts on established policies and procedures regarding requirements to promptly provide notice and cancel eligibility, verify income, and provide retroactive eligibility, and (3) redetermine, if necessary, the current Medicaid eligibility status of the sampled beneficiaries for whom income or dependent verifications did not meet Federal and State requirements.

Ohio (A-05-18-00027)

OIG reported that Ohio did not determine eligibility for 18 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify that the remaining 66 potentially ineligible beneficiaries were newly eligible. (The total exceeds 150 because 3 beneficiaries were found to be ineligible for 1 determination period and found to be potentially ineligible for another period.) These deficiencies occurred because Ohio's eligibility determination system lacked the necessary system functionality, and eligibility caseworkers made errors. In addition, Ohio did not always maintain documentation to support eligibility determinations. Based on sample results, OIG estimated that Ohio made Medicaid payments of $77.5 million (Federal share) on behalf of 51,219 ineligible beneficiaries and $746.4 million (Federal share) on behalf of 241,998 potentially ineligible beneficiaries.

OIG recommended that Ohio: (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure that its eligibility determination system has the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; (3) educate eligibility caseworkers about relevant Federal and State eligibility requirements; and (4) ensure that documentation supporting eligibility determinations is maintained in beneficiaries' records. The "Recommendations" section in the body of the report lists OIG recommendations in more detail.

Work Plan #: A-06-18-02000 (January 2021); A-05-18-00027 (November 2020)
Government Program: Medicaid

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part C – Advantage

[*NEW*] Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment. As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.

OIG selected a stratified random sample of 250 prior authorization denials and 250 payment denials issued by 15 of the largest MAOs during June 1-7, 2019. Health care coding experts conducted case file reviews of all cases, and physician reviewers examined medical records for a subset of cases. From these results, OIG estimated the rates at which MAOs denied prior authorization and payment requests that met Medicare coverage and MAO billing rules. OIG also examined the reasons that these denials occurred and the types of services associated with these denials in the sample.

SunHawk Summary of OI0G Audit Findings and Recommendations

OIG's case file reviews determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials that OIG reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and post-acute facility stays (e.g., inpatient rehabilitation).

Prior authorization requests. OIG found that, among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules; in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service). OIG identified two common causes of these denials. First, MAOs used clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that the physician reviewers determined were medically necessary. Although the review determined that the requests in these cases did meet Medicare coverage rules, CMS guidance is not sufficiently detailed to determine whether MAOs may deny authorization based on internal MAO clinical criteria that go beyond Medicare coverage rules.

Second, MAOs indicated that some prior authorization requests did not have enough documentation to support approval, yet OIG reviewers found that the existing beneficiary medical records were sufficient to support the medical necessity of the services.

Payment requests. OIG found that, among the payment requests that MAOs denied, 18 percent of the requests met Medicare coverage rules and MAO billing rules. Most of these payment denials in the sample were caused by human error during manual claims processing reviews (e.g., overlooking a document) and system processing errors (e.g., the MAO's system was not programmed or updated correctly).

OIG also found that MAOs reversed some of the denied prior authorization and payment requests that met Medicare coverage and MAO billing rules. Often the reversals occurred when a beneficiary or provider appealed or disputed the denial, and in some cases MAOs identified their own errors.

OIG's findings about the causes and circumstances under which MAOs denied prior authorization or payment for requests that met Medicare coverage and MAO billing rules provide an opportunity for improvement to ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately. Therefore, OIG recommended that CMS issues new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews, update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types, and direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

Work Plan # OEI-09-18-00260 (April 2022)
Government Agency: Medicare Part C - Advantage

Medicare Advantage Compliance Audit of Specific Diagnosis Codes Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

OIG's objective was to determine whether selected diagnosis codes that MA Organizations submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] WellCare of Florida (A-04-19-07084)

With respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that WellCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 97 of the 250

sampled enrollee-years, the medical records supported the diagnosis codes that WellCare submitted to CMS. However, for the remaining 153 enrollee-years, the diagnosis codes were not supported in the medical records and resulted in net overpayments of $410,110. These errors occurred because the policies and procedures that WellCare had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of their sample results, OIG estimated that WellCare received at least $3.5 million of net overpayments in 2015 and 2016.

OIG recommended that WellCare: (1) refund to the Federal Government the $3.5 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after their audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

WellCare disagreed with some of the findings and with OIG's first recommendation. WellCare did not agree with OIG's findings for 4 enrollee-years identified in the draft report and did not directly address OIG's findings for the remaining enrollee-years. WellCare also disagreed with OIG's audit methodology and stated that OIG improperly implied that MA organizations are expected to assure that 100 percent of the diagnosis codes received from providers and submitted to CMS are accurate. WellCare added that it would consider OIG's second and third recommendations to evaluate and enhance its compliance procedures. After reviewing WellCare's comments and coordinating with the independent medical review contractor, OIG revised the number of enrollee-years in error from 156 (in their draft report) to 153, and reduced the amount in their first recommendation from $3.6 million to $3.5 million, for this final report.

[NEW] Cigna HealthSpring (A-03-18-00002)

Cigna HealthSpring did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that Cigna HealthSpring submitted were supported in the medical records and therefore validated 1,401 of the 1,470 sampled enrollees' HCCs, the remaining 69 HCCs were not validated and resulted in overpayments. These 69 unvalidated HCCs included 7 HCCs for which OIG identified 7 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 18 HCCs for which the medical records supported diagnosis codes that Cigna HealthSpring should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,470 HCCs. Rather, the risk scores should have been based on 1,426 HCCs (1,401 validated HCCs + 7 other HCCs + 18 additional HCCs). As a result, Cigna HealthSpring received $39,612 of net overpayments for 2015 for the sampled enrollees. As demonstrated by the errors found in their sample, Cigna HealthSpring's policies to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommended that Cigna HealthSpring refund to the Federal Government the $39,612 of net overpayments and improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

[NEW] Cariten Health Plan (A-02-20-01009)

With respect to the nine high-risk groups covered by the audit, most of the selected diagnosis codes that Cariten submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

For 206 of the 270 enrollee-years, the diagnosis codes that Cariten submitted to CMS were not supported in the medical records and resulted in net overpayments of $557,250.

These errors occurred because the policies and procedures that Cariten had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of their sample results, OIG estimated that Cariten received at least $9.2 million in net overpayments for these high-risk diagnosis codes in 2016 and 2017.

OIG recommended that Cariten (1) refund to the Federal Government the $9.2 million of net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after the audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

Cariten disagreed with OIG findings and recommendations. Cariten provided additional information for 12 sampled enrollee-years which, according to Cariten, supported either the reviewed diagnosis code or a related diagnosis code. Cariten also stated that OIG audit methodology departed from governing statistical and actuarial principles and the statutory requirements of the MA program. Additionally, Cariten disagreed that it should perform audits of high-risk diagnoses and stated that its compliance program satisfies all legal and regulatory requirements. After reviewing Cariten's comments and additional information that it provided, OIG revised the number of enrollee-years in error from 208 to 206 for this final report. OIG also revised the amount of the first recommendation from $9.3 million (in OIG's draft report) to $9.2 million but made no change to the other recommendations. OIG followed a reasonable audit methodology and correctly applied applicable Federal requirements underlying the MA program.

[NEW] Peoples Health Network (A-06-18-05002)

Most of the selected diagnosis codes that Peoples Health submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 98 of the 242 sampled enrollee-years, the medical records validated the reviewed Hierarchical Condition Categories (HCCs). However, for the remaining 144 enrollee-years, the diagnosis codes were not supported in the medical records or could not be supported because Peoples Health could not locate the medical records. These errors occurred because the policies and procedures that Peoples Health had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, the HCCs for some of the high-risk diagnosis codes were not validated. On the basis of their sample results, OIG estimated that Peoples Health received at least $3.3 million in overpayments for 2015 and 2016.

OIG recommended that Peoples Health (1) refund to the Federal Government the $3.3 million in overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after their audit period and refund any resulting overpayments to the Federal Government; and (3) enhance its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

SCAN Health Plan (A-07-17-01169)

SCAN did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that SCAN submitted were supported in the medical records and therefore validated 1,413 of the 1,577 sampled enrollees' HCCs, the remaining 164 HCCs were not validated and resulted in overpayments. These 164 unvalidated HCCs included 20 HCCs for which OIG identified 20 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 21 HCCs for which the medical records supported diagnosis codes that SCAN should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,577 HCCs. Rather, the risk scores should have been based on 1,454 HCCs (1,413 validated HCCs plus 20 other HCCs plus 21 additional HCCs). As a result, OIG estimated that SCAN received at least $54.3 million in net overpayments for 2015. As demonstrated by the errors found in OIG's sample, SCAN's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommends that SCAN refund to the Federal Government the $54.3 million of net overpayments and continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. SCAN disagreed with OIG's findings and with both of OIG's recommendations, which SCAN believed contained errors and were unsupported. Specifically, SCAN stated that OIG's independent medical review contractor erred in its determinations by not validating certain HCCs. In addition, SCAN stated that OIG's report was seriously flawed because of, among other things, errors in the approaches that OIG used to identify the sample of SCAN enrollees for audit and for extrapolation. After reviewing SCAN's comments and the additional information that it provided, OIG revised the number of unvalidated HCCs and, accordingly, the recommended refund, for this final report. OIG also revised the wording of the second recommendation. OIG followed a reasonable audit methodology, properly executed the sampling methodology, and correctly applied applicable Federal requirements underlying the MA program.

Tufts Health Plan (A-01-19-00500)

Most of the selected diagnosis codes that Tufts submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 58 of the 212 sampled enrollee-years, the medical records validated the reviewed Hierarchical Condition Categories (HCCs). However, for the remaining 154 enrollee-years, the diagnosis codes were not supported in the medical records. These errors occurred because the policies and procedures that Tufts had to ensure compliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the HCCs for some of the high-risk diagnosis codes were not validated. On the basis of the sample results, OIG estimated that Tufts received at least $3.7 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

OIG recommends that Tufts: (1) refund to the Federal Government the $3.7 million of net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after the audit period and refund any resulting overpayments to the Federal Government; and (3) continue to improve its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

UPMC Health Plan, Inc. (A-07-19-01188)

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

OIG found that, with respect to the 10 high-risk groups covered by OIG's audit, most of the selected diagnosis codes that UPMC submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 194 of the 280 enrollee-years, the diagnosis codes that UPMC submitted to CMS were not supported in the medical records and resulted in $681,099 of net overpayments for the 194 enrollee-years. These errors occurred because the policies and procedures that UPMC had to ensure compliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of OIG's sample results, OIG estimated that UPMC received at least $6.4 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

OIG recommended that UPMC refund to the Federal Government the $6.4 million of estimated net overpayments; identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; and continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Coventry (A-07-17-01173)

OIG found that most of the selected diagnosis codes that Coventry submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 226 of the 275 enrollee-years, the diagnosis codes that Coventry submitted to CMS were not supported in the medical records. These errors occurred because the policies and procedures that Coventry had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. As a result, Coventry received $548,852 of net overpayments for 2014 through 2016.

OIG recommended that Coventry refund to the Federal Government the $548,852 of net overpayments; identify, for the diagnoses included in this report, similar instances of noncompliance that occurred during the audit period that OIG did not review and outside of OIG's audit period and refund any resulting overpayments to the Federal Government; and enhance its compliance procedures to focus on diagnosis codes that are at high risk for being miscoded by: (1) educating its providers about the proper use and documentation of these diagnoses and (2) determining whether these diagnosis codes (when submitted to CMS for use in CMS's risk adjustment program) comply with Federal requirements.

Work Plan #: A-04-19-07084 (August 2022); A-03-18-00002 (August 2022); A-02-20-01009 (July 2022); A-06-18-05002 (May 2022); (A-07-17-01169 (February 2022); A-01-19-00500 (February 2022); A-07-19-01188 (November 2021); A-07-17-01173 (October 2021)
Government **Program:** Medicare Part C - Advantage

Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments

CMS risk-adjusts payments by using beneficiaries' diagnoses to pay higher capitated payments to companies with contracts under Medicare Advantage (MA companies) for beneficiaries expected to have higher-than-average medical costs. This may create financial incentives for MA companies to make beneficiaries appear as sick as possible. For CMS to risk-adjust payments, MA companies report beneficiaries' diagnoses-based on services provided to beneficiaries - to CMS's MA encounter data system and the Risk Adjustment Processing System.

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Chart reviews and health risk assessments (HRAs) are allowable sources of diagnoses for risk adjustment. A chart review is an MA company's review of a beneficiary's medical record to identify diagnoses that a provider did not submit or submitted in error. An HRA occurs when-in order to diagnose a beneficiary and identify possible gaps in care-a health care professional collects information from a beneficiary about the beneficiary's health.

OIG undertook this evaluation because of concerns that MA companies may leverage both chart reviews and HRAs to maximize risk adjusted payments, without beneficiaries receiving care for those diagnoses. Unsupported risk adjusted payments have been a major driver of improper payments in the MA program. The risk adjustment program is an important payment mechanism for MA. It levels the playing field for MA companies that enroll beneficiaries who need a costlier level of care, which helps to ensure that these beneficiaries have continued access to MA plans. Chart reviews and HRAs can be tools for improving the MA program. However, two prior OIG evaluations found that the diagnoses that MA companies reported only on chart reviews or HRAs in the 2016 encounter data - i.e., on no other service records - resulted in billions in risk-adjusted payments for 2017. These prior evaluations raised concerns about the completeness of encounter data; the validity of submitted diagnoses on chart reviews or HRAs; and the quality of care provided to MA beneficiaries. The current evaluation builds on those two evaluations to identify MA companies that disproportionately drove increases in risk adjusted payments from both chart reviews and HRAs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 20 of the 162 MA companies drove a disproportionate share of the $9.2 billion in payments from diagnoses that were reported only on chart reviews and HRAs, and on no other service records. These companies' higher share of payments could not be explained by the size of their beneficiary enrollment. Each company generated a share of payments from these chart reviews and HRAs that was more than 25 percent higher than its share of enrolled MA beneficiaries. Among these 20 MA companies, one company further stood out in its use of chart reviews and HRAs to drive risk adjusted payments without encounter records of any other services provided to the beneficiaries for those diagnoses. This company had 40 percent of the risk-adjusted payments from both mechanisms yet enrolled only 22 percent of MA beneficiaries. In addition, this company accounted for about a third of all payments from diagnoses reported solely on chart reviews and more than half of all payments from diagnoses reported solely on HRAs. Further, almost all of its HRAs were conducted in beneficiaries' homes. Since in - home HRAs are often conducted by vendors hired by MA companies (and not likely conducted by beneficiaries' primary care providers), this raises particular concerns about the quality of care coordination for these beneficiaries and the validity of diagnoses that were reported on the HRAs.

OIG recommended that CMS should (1) provide oversight of the 20 MA companies that had a disproportionate share of the risk-adjusted payments from chart reviews and HRAs; (2) take additional actions to determine the appropriateness of payments and care for the one MA company that substantially drove risk adjusted payments from chart reviews and HRAs; and (3) perform periodic monitoring to identify MA companies that had a disproportionate share of risk adjusted payments from chart reviews and HRAs. To assist CMS with its efforts, OIG will provide information on which companies had a substantially disproportionate share of risk adjusted payments from diagnoses that were reported only on chart reviews and HRAs.

Work Plan #: OEI-03-17-00474 (September 2021)
Government Program: Medicare Part C - Advantage

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Advantage Compliance Audit of Diagnosis Codes

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees who would be expected to require fewer health care resources.

To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

SunHawk Summary of OIG Audit Findings and Recommendations

Anthem Community Insurance Company (A-07-19-01187)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Anthem submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 123 of the 203 enrollee-years, the diagnosis codes that Anthem submitted to CMS were not supported in the medical records and resulted in $354,016 of net overpayments for the 203 enrollee-years. These errors occurred because the policies and procedures that Anthem had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. Based on OIG's sample results, OIG estimated that Anthem received at least $3.47 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

OIG recommended that Anthem refund to the Federal Government the $3.47 million of net overpayments; identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; and enhance its compliance procedures to focus on diagnosis codes that are at high risk for being miscoded by (1) determining whether these diagnosis codes (when submitted to CMS for use in CMS's risk adjustment program) comply with Federal requirements and (2) educating its providers about the proper use of these diagnosis codes.

Humana (A-07-16-01165)

OIG found that Humana did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that Humana submitted were supported in the medical records and therefore validated 1,322 of the 1,525 sampled enrollees' HCCs, the remaining 203 HCCs were not validated and resulted in overpayments. These 203 unvalidated HCCs included 20 HCCs for which OIG identified 22 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 15 HCCs for which the medical records supported diagnosis codes that Humana should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,525 HCCs. Rather, the risk scores should have been based on 1,359 HCCs (1,322 validated HCCs + 22 other HCCs + 15 additional HCCs). As a result, OIG estimated that Humana received at least $197.7 million in net overpayments for 2015. These errors occurred because

Humana's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective.

OIG recommended that Humana refund to the Federal Government the $197.7 million of net overpayments and enhance its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

Work Plan #: A-07-19-01187 (May 2021); A-07-16-01165 (May 2021)
Government Program: Medicare Part C - Advantage

Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc. Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). CMS makes higher payments for enrollees who receive diagnoses that map to HCCs.

For this audit, OIG reviewed one of the contracts that Humana, Inc., has with CMS with respect to the diagnosis codes that Humana submitted to CMS. OIG's objective was to determine whether Humana submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Humana did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that Humana submitted were supported in the medical records and therefore validated 1,322 of the 1,525 sampled enrollees' HCCs, the remaining 203 HCCs were not validated and resulted in overpayments. These 203 unvalidated HCCs included 20 HCCs for which OIG identified 22 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 15 HCCs for which the medical records supported diagnosis codes that Humana should have submitted to CMS but did not. The risk scores for the 200 sampled enrollees should not have been based on the 1,525 HCCs. Rather, the risk scores should have been based on 1,359 HCCs (1,322 validated HCCs + 22 other HCCs + 15 additional HCCs). As a result, OIG estimated that Humana received at least $197.7 million in net overpayments for 2015. These errors occurred because Humana's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective.

OIG recommended that Humana refund to the Federal Government the $197.7 million of net overpayments and enhance its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. Humana disagreed with OIG's findings and with both of OIG's recommendations. Humana provided additional medical record documentation which, Humana said, substantiated specific

HCCs. Humana also questioned OIG's audit and statistical sampling methodologies and said that OIG's report reflected misunderstandings of legal and regulatory requirements underlying the MA program. After reviewing Humana's comments and the additional information that it provided, OIG revised the number of unvalidated HCCs for this final report. OIG followed a reasonable audit methodology, properly executed its sampling methodology, and correctly applied applicable Federal requirements underlying the MA program. OIG revised the amount in its first recommendation from $263.1 million (in its draft report) to $197.7 million but made no change to its second recommendation.

Work Plan #: A-07-16-01165 (April 2021)
Government Program: Medicare Part C - Advantage

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS. For this audit, OIG reviewed one MA organization, Blue Cross Blue Shield of Michigan (BCBSM), and focused on seven groups of high-risk diagnosis codes. OIG's objective was to determine whether selected diagnosis codes that BCBSM submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that most of the selected diagnosis codes that BCBSM submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 188 of the 248 enrollee-years, the diagnosis codes that BCBSM submitted to CMS were not supported in the medical records and resulted in net overpayments of $668,264.

These errors occurred because the policies and procedures that BCBSM had to detect and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, were not always effective. On the basis of OIG sample results, OIG estimated that BCBSM received at least $14.5 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

OIG recommended that BCBSM: (1) refund to the Federal Government the $14.5 million of net overpayments, (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after OIG audit period and refund any resulting overpayments to the Federal Government and (3) examine its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

Work Plan #: A-02-18-01028 (February 2021)
Government Program: Medicare Part C – Advantage

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Incorrect Acute Stroke Diagnosis Codes Submitted by Traditional Medicare Providers Resulted in Millions of Dollars in Increased Payments to Medicare Advantage Organizations

This audit involved individuals eligible for Medicare who were covered under traditional Medicare in one year but chose to enroll in Medicare Advantage (MA) the following year (transferred enrollees). The Centers for Medicare & Medicaid Services (CMS) maps certain diagnosis codes into Hierarchical Condition Categories (HCCs). For transferred enrollees who, while covered under traditional Medicare, receive a diagnosis that maps to an HCC, CMS makes higher payments to MA organizations for the following year. Through data mining and discussions with medical professionals, OIG has identified several diagnosis codes that were at high risk of being miscoded and resulting in inaccurate payments. For this audit, OIG focused only on selected acute stroke diagnosis codes (which map to the Ischemic or Unspecified Stroke HCC) that were reported on one physician's claim without being reported on a corresponding inpatient claim. OIG's objective was to determine whether selected acute stroke diagnosis codes submitted by physicians under traditional Medicare that CMS later used to make payments to MA organizations on behalf of transferred enrollees complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that almost all of the selected acute stroke diagnosis codes that physicians submitted to CMS under traditional Medicare and that CMS later used to make payments to MA organizations for 2015 or 2016 on behalf of the 582 transferred enrollees did not comply with Federal requirements. For 580 of the transferred enrollees, the medical records did not support the acute stroke diagnosis codes. Thus, the Ischemic or Unspecified Stroke HCCs were not validated.

These errors originated from physicians submitting incorrect acute stroke diagnosis codes on claims billed under traditional Medicare. However, these errors were unnoticed and caused inaccurate payments in MA because CMS did not have policies and procedures to (1) identify beneficiaries who transferred from traditional Medicare to MA and (2) evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare on their behalf complied with Federal requirements. As a result, OIG estimated that CMS made inaccurate payments of just over $14.4 million to MA organizations.

OIG recommended that CMS: (1) educate physicians on how to correctly submit acute stroke diagnosis codes and how these diagnosis codes may impact the MA program and (2) develop and implement policies and procedures to identify beneficiaries transferring from traditional Medicare to MA and evaluate whether the acute stroke diagnosis codes submitted under traditional Medicare comply with Federal requirements.

Work Plan #: A-07-17-01176 (September 2020)
Government Program: Medicare Part C – Advantage

Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns

OIG undertook this study because of concerns that Medicare Advantage organizations (MAOs) may use health risk assessments (HRAs) to increase risk adjusted payments inappropriately. The Medicare Advantage (MA) program provided coverage to 23 million beneficiaries in 2019 at a cost of $264 billion. Unsupported risk adjusted payments have been a major driver of improper payments in the MA program. CMS risk-adjusts payments by using beneficiaries' diagnoses to pay

higher capitated payments to MAOs for sicker beneficiaries, which may create financial incentives for MAOs to make beneficiaries appear as sick as possible. For CMS to risk adjust payments, MAOs report beneficiaries' diagnoses, based on services provided to beneficiaries, to CMS's MA encounter data system and the Risk Adjustment Processing System. HRAs are an allowable source of diagnoses for risk adjustment. An HRA occurs when a physician or other health care professional collects information from beneficiaries about their health to diagnose and identify gaps in care. However, CMS and the Medicare Payment Advisory Commission have raised concerns that MAOs may use HRAs mainly as a tool to collect diagnoses and increase payments to MAOs rather than to improve the health of beneficiaries.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG's findings highlight concerns about the extent to which MAOs are using HRAs to improve care, as intended, and about the sufficiency of CMS's oversight. From OIG's analysis of 2016 MA encounter data, OIG found that diagnoses that MAOs reported only on HRAs-and on no other service records-resulted in an estimated $2.6 billion in risk-adjusted payments for 2017. In addition, in-home HRAs generated 80 percent of these estimated payments. Most in home HRAs were conducted by companies that partner with or are hired by MAOs to conduct these assessments-and therefore are not likely conducted by the beneficiary's own primary care provider. Twenty MAOs generated millions in payments from in-home HRAs for beneficiaries for whom there was not a single record of any other service being provided in all of 2016. OIG's findings raise concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on HRAs, and the quality-of-care coordination for beneficiaries. Despite potential issues regarding HRAs, CMS has not yet reviewed the impact of HRAs on risk adjusted payments or quality of care.

OIG recommended that CMS: (1) require MAOs to implement best practices to ensure care coordination for HRAs, (2) provide targeted oversight of the 10 parent organizations that drove most of the risk-adjusted payments resulting from in-home HRAs, (3) provide targeted oversight of the 20 MAOs that drove risk-adjusted payments resulting from in-home HRAs for beneficiaries who had no other service records in the 2016 encounter data, (4) reassess the risks and benefits of allowing in-home HRAs to be used as sources of diagnoses for risk adjustment, and reconsider excluding such diagnoses from risk-adjustment, and (5) require MAOs to flag any MAO initiated HRAs in their MA encounter data.

Work Plan #: OEI-03-17-00471 (September 2020)
Government Program: Medicare Part C – Advantage

CMS's Encounter Data Lack Essential Information That Medicare Advantage Organizations Have the Ability to Collect

Prior OIG work found that ordering provider NPIs were absent from 63 percent of Medicare Advantage (MA) encounter records for DMEPOS and for laboratory, imaging, and home health services, and recommended that CMS establish and enforce requirements for MA Organizations (MAOs) to submit ordering provider NPIs for these types of items and services. Findings from an OIG survey of MAOs may be useful as CMS weighs the program integrity benefits of requiring NPIs for ordering providers against the potential burden that MAOs would experience from establishing and enforcing these requirements. To determine the extent to which MAOs submitted ordering provider NPIs on encounter records for DMEPOS and for laboratory, imaging, and home health services, OIG extracted and analyzed 2018 MA encounter data from CMS's Integrated Data Repository in February 2020. OIG also sent an online survey to a stratified random sample of 200 MAOs and received responses from 179 MAOs.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that CMS's MA encounter data continued to lack ordering provider NPIs on records for DMEPOS and for laboratory, imaging, and home health services. However, OIG found that almost all MAOs have data systems that can receive and store these NPIs when providers submit them to MAOs on claims or encounter records. In addition, a substantial portion of MAOs reported that providers are already submitting the ordering provider NPIs on claims or encounter records for DMEPOS, laboratory services, and imaging services. Further, a majority of MAOs require NPIs to be submitted for their other lines of business (such as commercial and private health insurance, Medicaid, and the Children's Health Insurance Program). Finally, almost half of MAOs believe that NPIs for ordering providers are critical for combating fraud.

OIG recommended that CMS require MAOs to submit the ordering provider NPI on encounter records for DMEPOS and for laboratory, imaging, and home health services; and establish and implement "reject edits" that (1) reject encounter records in which the ordering provider NPI is not present when required and (2) reject encounter records that contain an ordering provider NPI that is not a valid and active NPI in the NPPES registry.

Work Plan #: OEI-03-19-00430 (August 2020)
Government Program: Medicare Part C – Advantage

Medicare Part D - Prescription Drug Program

[*NEW*] Part D Plan Preference for Higher-Cost Hepatitis C Drugs Led to Higher Medicare and Beneficiary Spending

In the last decade, Medicare Part D and its beneficiaries spent billions of dollars on revolutionary yet costly hepatitis C drugs. In response to concerns over the affordability of hepatitis C treatments, drug manufacturer Gilead introduced authorized generic versions of two of its brand-name hepatitis C drugs in 2019 (authorized generics are brand-name drugs that are sold without the brand name on their label). Despite the availability of these authorized generics, as well as other lower-cost brand options, preliminary research suggested that Part D beneficiaries continued to be more likely to use higher-cost hepatitis C drugs than Medicaid beneficiaries, leading to higher spending in Part D. Reflecting on OIG's goal of identifying opportunities to lower prescription drug spending for patients and programs, OIG conducted this review to explore possible incentives created by Part D's programmatic structure that may be influencing use of higher-cost hepatitis C drugs in Medicare.

OIG used claims data to compare utilization of hepatitis C drugs in Medicare Part D to utilization in Medicaid in 2019 and 2020. OIG also compared inclusion of higher-cost versus lower-cost hepatitis C drugs in 2020 Part D plan formularies. OIG then examined the effects utilization trends have on Medicare and beneficiary spending.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that following the introduction of authorized generic versions of two brand-name hepatitis C drugs-Epclusa and Harvoni-in 2019, use of the authorized generic versions increased in Medicaid at greater rates than in Medicare Part D. In 2020, some Part D plans did not cover the authorized generics, limiting beneficiary access to less costly options. Medicare beneficiaries also were less likely to use other lower-cost brand-name options in 2020 compared to Medicaid beneficiaries.

Although rebates from manufacturers reduced overall Part D spending for higher-cost hepatitis C drugs (like Epclusa and Harvoni), they provided little relief to beneficiaries or the Medicare program. Part D beneficiaries without financial assistance paid, on average, $2,200 more out of pocket for higher-cost hepatitis C drugs in 2020. Further, Medicare's average catastrophic coverage payment for a beneficiary prescribed a higher-cost drug was over $8,000 more compared to a beneficiary prescribed a lower-cost drug. As a result, Medicare spent $155 million more in catastrophic coverage payments for higher-cost hepatitis C drugs, despite a similar number of beneficiaries in each cost group reaching catastrophic coverage.

OIG's findings about utilization trends for higher-cost hepatitis C drugs in Medicare align with experts' suggestions that certain programmatic factors, such as manufacturer rebates, may be providing incentives for Part D plan sponsors to prefer their enrollees use higher-cost drugs.

OIG recommended that-to reduce out-of-pocket costs for beneficiaries and combat rising drug spending in Medicare Part D-CMS encourage Part D plans to increase access to and use of the authorized generic versions of Epclusa and Harvoni, within the authorities granted under statute. OIG also recommended that CMS pursue additional strategies-such as educating providers and pharmacies-to increase access to and use of lower-cost hepatitis C drugs in Part D.

Work Plan # OEI-BL-21-00200 (August 2022)
Government Agency: Medicare Part D - Prescription Drug Program

[*NEW*] Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2022

This data snapshot fulfills for 2022 the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA). The ACA requires OIG to conduct a study of the extent to which formularies used by Medicare Part D plans include prescription drugs commonly used by dual eligible individuals (i.e., individuals who are covered by both Medicare and Medicaid). These individuals generally get drug coverage through Medicare Part D. Pursuant to the ACA, OIG must annually issue a study with recommendations as appropriate. This is the twelfth study that OIG has produced to meet this mandate.

For this data snapshot, OIG determined whether the 449 unique formularies used by the 5,288 Part D plans operating in 2022 cover the 200 prescription drugs most commonly used by dual eligibles. To create the list of the 200 drugs most commonly used by dual eligibles, OIG used the 2019 Medicare Current Beneficiary Survey-the most recent data available at the time of their study. Of the top 200 drugs, OIG analyzed 195 drugs. Three drugs are not eligible for Part D coverage, and OIG excluded two additional drugs from their analysis because OIG could not confidently project the use of these drugs to the entire dual-eligible population.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that dual eligibles have access to the majority of commonly used prescription drugs in 2022 via Part D plans, as OIG also found in previous years. A majority of the 449 Part D plan formularies covered almost all (at least 97 percent) of the drugs most commonly used by dual eligibles. Similarly, among Part D plans with premiums below the regional benchmark, a majority of formularies (95 of 132) covered at least 97 percent of the drugs commonly used by dual eligibles. This is important because when dual eligibles do not select their own Part D plans, CMS randomly assigns them to plans with premiums below the regional benchmark without considering their specific prescription drug needs. If dual eligibles' plans do not cover specific drugs, they have several options (switching plans, using an exceptions and appeals process, finding an alternative drug, or paying out of pocket), but these options require beneficiaries to take administrative actions and do not guarantee access to the drugs.

In general, dual eligibles have access to nearly all of the most commonly used prescription drugs via Part D plan formularies in 2022. A majority of these formularies covered almost all commonly used drugs, and only a small number of commonly used drugs were not covered by most formularies. These findings are largely unchanged from OIG's findings reported from 2011 through 2021. As mandated by the ACA, OIG will continue to monitor and produce annual reports on the extent to which Part D plan formularies cover drugs that dual eligibles commonly use. OIG has no recommendations at this time.

Work Plan # OEI-05-22-00230 (June 2022)
Government Agency: Medicare Part D - Prescription Drug Program

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Medicare Part D and Beneficiaries Could Realize Significant Spending Reductions With Increased Biosimilar Use

Biologics—usually large, complex molecules produced in a living system—are some of the most expensive drugs available, and spending for biologics is growing in Medicare Part D because they treat diseases common among Medicare beneficiaries. Biologics are estimated to cost Part D upwards of $12 billion annually. A biosimilar is a lower cost biologic that is highly similar to an existing biologic approved by the Food and Drug Administration (i.e., the biosimilar's "reference product"). Although a limited number of biosimilars are currently available for Part D covered reference products, multiple biosimilars for Humira—the best-selling prescription drug in the world—are expected to be available in 2023, thereby presenting an opportunity to significantly decrease Part D drug costs.

OIG analyzed biosimilar utilization and spending in Part D from 2015 to 2019. OIG also calculated multiple estimates to explore how Part D and beneficiary spending in 2019 could have changed with increased utilization of biosimilars.

Lastly, OIG determined the extent to which Part D plan formularies encouraged the use of biosimilars rather than reference products. Specifically, OIG examined whether biosimilars were included on Part D plan formularies and, if so, whether they were on a less preferential tier or subject to different utilization management requirements than their reference products.

SunHawk Summary of OIG Audit Findings and Recommendations

Since biosimilars were introduced in 2015, use of and spending on these drugs in Part D has steadily increased. However, they are still used far less frequently than their higher cost reference product alternatives. In 2019, biosimilars' reference products were still prescribed about five times more frequently than biosimilars in Part D.

OIG estimated that with increased use of biosimilars instead of reference products, Part D and beneficiary spending could have been considerably reduced in 2019. Specifically, Part D spending on biologics with available biosimilars could have decreased by $84 million, or 18 percent, if all biosimilars had been used as frequently as the most used biosimilars. Additionally, beneficiaries' out of pocket costs for these drugs could have decreased by $1.8 million, or 12 percent. Although these amounts are modest in the context of overall Part D spending, far greater spending reductions will be possible as additional biosimilars become available.

Biosimilars have the potential to significantly reduce costs for Part D and beneficiaries if their use becomes more widespread, particularly with the expected launches of biosimilars for blockbuster drugs Humira and Enbrel. However, a lack of biosimilar coverage on Part D formularies could limit this wider utilization. In 2019, not all plan formularies covered available biosimilars. Moreover, those formularies that did cover biosimilars rarely encouraged their use over reference products through preferential formulary tier placement and utilization management tools.

Without further changes to the Part D program, the impact of limited coverage and promotion of biosimilars on formularies may be magnified as biosimilars for blockbuster drugs become available. To help ensure that Part D and beneficiaries can capitalize on potential savings, OIG recommended that CMS encourage plans to increase access to and use of biosimilars in Part D. OIG also recommended that CMS monitor biosimilar coverage on formularies to identify concerning trends.

Work Plan #: OEI-05-20-00480 (March 2022)
Government Program: Medicare Part D - Prescription Drug Program

CMS Should Strengthen Its Prescription Drug Event Guidance to Clarify Reporting of Sponsor Margin for Medicare Part D Bids

Every time a beneficiary fills a prescription covered under Medicare Part D the Part D sponsor must submit a summary record called a prescription drug event (PDE) record to the Centers for Medicare & Medicaid Services (CMS). To offer a drug plan, a sponsor submits a bid that must receive CMS approval. Amounts reported in PDE records are used in formulating these sponsor bids. In 2016, a CMS-contracted audit found that a Part D sponsor (Sponsor) included, within the Part D total allowed dollars in several of its Part D bids, a margin for prescriptions from pharmacies wholly owned by the Sponsor.

The objective of this audit was to determine whether the Sponsor complied with Federal requirements for reporting PDE information during calendar year 2015 that supported cost information included in its 2017 Medicare Part D bid.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Sponsor complied with CMS's PDE reporting requirements. However, OIG also found that CMS's PDE reporting guidance does not adequately address a sponsor service delivery model in which a sponsor owns the pharmacy it uses and does not have a negotiated contract with the pharmacy. CMS clarified that it does not consider pharmacy margin to be sponsor margin, and CMS's current guidance allows pharmacy margin but not sponsor margin to be included in the PDE record. However, in this type of integrated service delivery model, the margin included in the ingredient costs in the PDE record for wholly owned pharmacies goes to the sponsor. Any sponsor margin included in the PDE record cannot be identified and separated from pharmacy costs. Ingredient costs in the PDE records are the basis for drug costs reported in the Part D bidding process. Ingredient costs in the PDE record for any one-year impact the Part D bidding process in a future year. In sponsors' Part D bid submissions, sponsor margin is reported separately from ingredient costs. Any sponsor margin included in PDE records may not be evaluated during the bid review.

OIG recommended that CMS update its PDE guidance to address margin under sponsor delivery models in which a sponsor owns a pharmacy. OIG did not make any recommendations to the Sponsor because it followed PDE guidance for the period OIG audited.

Work Plan #: A-03-17-00001 (November 2021)
Government Program: Medicare Part D – Prescription Drug Program

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Concerns Persist about Opioid Overdoses and Medicare Beneficiaries' Access to Treatment and Overdose-Reversal Drugs

The coronavirus disease 2019 (COVID-19) pandemic and its effects on the provision of health care have heightened concerns about opioid use and access to treatment. The pandemic has put people with opioid use disorder at particular risk, as they are at higher risk of developing COVID-19 and are more likely to experience hospitalizations or death from the illness. These increased risks posed by COVID-19 make urgent the need to monitor opioid use as well as access to treatment and to the opioid overdose-reversal drug naloxone.

OIG has been tracking opioid use and access to treatment and naloxone in Part D for the past several years. Before 2020 and the COVID-19 pandemic, there were consistent decreases in opioid use in Part D. There was also growth in the use of medications to treat opioid use disorder—referred to as medication-assisted treatment (MAT) drugs—and naloxone. This data brief provides important information on opioid use, MAT drugs, and naloxone in Medicare Part D in 2020. It builds on a previously released OIG data snapshot about opioid use during the onset of the pandemic.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported the following:

- More than 43,000 Medicare Part D beneficiaries suffered an opioid overdose—from prescription opioids, illicit opioids, or both—in 2020.
- Nearly 1 in 4 Part D beneficiaries received opioids during 2020. The number of beneficiaries receiving short-term opioid prescriptions dropped sharply in the early months of the pandemic, likely the result of a decrease in elective surgeries at that time.
- The number of beneficiaries who received MAT drugs through Part D increased, but at a slower rate in 2020 than in prior years. And, unlike in other recent years, there was no growth in the number of beneficiaries receiving prescriptions for naloxone through Part D. These changes are likely related to COVID-19—patients may have avoided seeing their health care providers during the pandemic, reducing the opportunity for providers to offer treatment.
- The slower growth rates in the numbers of beneficiaries receiving MAT drugs and naloxone add to ongoing concerns about access to MAT drugs and naloxone.

Work Plan #: OEI-02-20-00401 (August 2021)
Government Program: Medicare Part D – Prescription Drug Program

Audit of Medicare Part D Pharmacy Fees

Medicare Part D is an optional program to help Medicare beneficiaries pay for prescription drugs. For drugs dispensed to Part D beneficiaries, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that decrease the costs that a sponsor incurs for a Part D drug. Part D sponsors or their pharmacy benefit managers (PBMs) may negotiate with pharmacies to charge various fees, and these fees are included as DIR. Part D sponsors are required to report their DIR to the Centers for Medicare & Medicaid Services each year.

SunHawk Summary of OIG Audit Findings and Recommendations

Group Health Cooperative (A-03-19-00002)

OIG found that For CYs 2014 and 2015, GHC did not have adequate support for the point-of-sale fees that its PBM charged to pharmacies. For CYs 2014 and 2015, its PBM reported it received at least $52,076 and $36,346 respectively in point-of-sale fees. GHC refiled its DIR reports twice, and the refiled amounts were not supported by other documentation that its PBM provided. As a result, OIG could not validate whether the amounts GHC reported to CMS were accurate. For CY 2016, GHC's PBM did not charge pharmacy fees, and, for CY 2017, OIG determined that GHC correctly reported the pharmacy fees collected by its PBM.

OIG recommended that Kaiser Permanente, which acquired GHC in 2017: (1) validate the point-of-sale fee amounts for CYs 2014 and 2015 and refile the CY 2014 and 2015 DIR reports if appropriate, and (2) develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS.

Horizon Blue Cross Blue Shield, Inc. (A-03-18-00007)

OIG reported that for CYs 2013 through 2016, Horizon complied with Federal requirements for reporting pharmacy fees in its DIR reports. For CY 2013, 2015, and 2016, Horizon appropriately reported pharmacy fees that its PBMs charged to pharmacies. During CY 2014, Horizon's PBM did not charge pharmacy fees for Horizon claims because Horizon was not part of its preferred network.

OIG found that Horizon reported pharmacy fees appropriately. Accordingly, this report contains no recommendations.

Work Plan #: A-03-19-00002 (July 2021); A-03-18-00007 (September 2020)
Government Program: Medicare Part D – Prescription Drug Program

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Opioid Use in Medicare Part D During the Onset of the COVID-19 Pandemic

Concerns about the use of opioids in Medicare Part D and the availability of treatment for opioid use disorder have heightened with the onset of the coronavirus disease 2019 (COVID-19) pandemic. COVID-19 poses specific dangers for people using opioids, as respiratory diseases like COVID-19 can increase the risk of fatal overdose among those taking opioids and those with opioid use disorder are more likely to contract COVID-19 and suffer complications.

It is imperative that the Department of Health and Human Services (HHS) closely monitor opioid use during this unprecedented time. From 2016 to 2019, Medicare Part D saw a steady decline in opioid use, along with an increased use of drugs for treatment of opioid use disorder. This data snapshot describes opioid use in Part D during the onset of COVID-19, focusing on the first 8 months of 2020. For context, this snapshot also provides data on the first 8 months of 2019.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported the following:

- As the pandemic took hold, about 5,000 Medicare beneficiaries per month suffered an opioid overdose during the first 8 months of 2020.
- The number of beneficiaries receiving short-term opioid prescriptions dipped, with a particularly sharp decline in April.
- About 220,000 beneficiaries received high amounts of opioids in the first 8 months of 2020.
- At the same time, the number of beneficiaries receiving drugs for medication-assisted treatment of opioid use disorder increased slightly.
- The number of beneficiaries receiving naloxone—a drug that can reverse an opioid overdose-declined through April but increased in the following months.

Work Plan #: OEI-02-20-00400 (February 2021)
Government Program: Medicare Part D – Prescription Drug Program

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Opioid Use in Medicare Part D Continued to Decline in 2019, but Vigilance Is Needed as COVID-19 Raises New Concerns

The United States has been grappling with the opioid crisis for several years. In 2018, nearly 47,000 opioid-related overdose deaths occurred in the United States. OIG has been tracking opioid use in Medicare Part D since 2016. OIG has identified beneficiaries at serious risk of opioid misuse or overdose and prescribers with questionable opioid prescribing for these beneficiaries. This data brief provides important information on opioid use in Medicare Part D in 2019, before the coronavirus disease 2019 (COVID-19) pandemic. data brief will also provide comparison points for a forthcoming OIG data brief, which will examine changes in opioid use that occurred during the pandemic in 2020.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that about one in four Medicare Part D beneficiaries received opioids in 2019, a decrease from the prior three years. At the same time, the number of beneficiaries receiving drugs for medication-assisted treatment (MAT drugs) for opioid use disorder has steadily increased in recent years, reaching 209,000 in 2019. The number of beneficiaries receiving prescriptions through Part D for naloxone-a drug that can reverse the effects of an opioid overdose-has also continued to grow. Nearly 267,000 beneficiaries received high amounts of opioids in 2019, with almost 34,000 of them at serious risk of opioid misuse or overdose. About 140 prescribers had questionable opioid prescribing for beneficiaries at serious risk.

Work Plan #: OEI-02-20-00320 (August 2020)
Government Program: Medicare Part D - Prescription Drug Program