Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Payer Focus

January 2022- January 2024

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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 organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan 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 OIG Work Plan sets forth various projects, including OIG audits and evaluations, that are underway or planned to be addressed during the fiscal year and beyond. The Work Plan item summaries provided herein are referenced by their respective Work Plan numbers at the end of each abstract. SunHawk's report summarizes currently active Work Plan items and sorts relevant Work Plans items into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original Work Plan item summaries.

We review all OIG Work Plan items that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused Work Plan items, 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, we would appreciate any feedback that would make this report more valuable to you or others. 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 offertheir 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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[NEW] Timeliness of Mental Health Care Following a Suicide Attempt or Intentional Self-Harm Incident for Children Enrolled in Medicaid

Expected Issue Date: 2025
Announced or Revised: October 2023

Rates of suicide attempts and intentional self-harm among youth are on the rise. A previous suicide attempt is the most important predictor of death by suicide, and the risk of death by suicide is highest in the period immediately after a hospitalization or emergency department visit for a suicide attempt or intentional self-harm incident. As such, providing timely mental health follow-up care is critical to decreasing the likelihood of rehospitalization and preventing suicide. OIG will conduct an evaluation to assess whether children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) who had an emergency department visit or hospitalization for a suicide attempt or intentional self-harm incident received mental health follow-up care within established timeframes. OIG will also examine whether certain groups of children in the selected population were less likely to receive timely mental health follow-up care after a hospitalization or emergency department visit. Finally, OIG will interview subject matter experts to identify the challenges and best practices that States encountered when working to ensure that youth enrolled in Medicaid and CHIP receive timely mental health follow-up care.

Work Plan #: OEI-07-23-00510

[NEW] CMS Oversight of States' Preparation of the CMS-64 Report

Expected Issue Date: 2024
Announced or Revised: July 2023

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage, which varies depending on the State's relative per capita income. Within 30 days after the end of each quarter, States report expenditures and the associated Federal share on the CMS-64 report. The amounts that States report must represent actual expenditures. CMS is responsible for reviewing the CMS-64 report to ensure that the expenditures reported are consistent with Medicaid requirements and matched with the correct amount of Federal funds. CMS works with States to resolve any questionable expenditures. OIG will determine the effectiveness of CMS's oversight of Medicaid State expenditures reported on CMS-64 reports for the quarter ended September 30, 2022.

Work Plan #: WA-23-0030 (W-00-23-31572)

[NEW] State Medicaid Agencies' Perspectives of Managed Care Plans' Referral of Fraud

Expected Issue Date: 2025

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Announced or Revised: June 2023

For Medicaid managed care, States contract with and oversee private health insurance companies, known as managed care plans, which have the primary responsibility for processing, paying, and monitoring claims from providers in their networks. As such, States play a critical role in safeguarding the Medicaid program's integrity. For example, States are required to: (1) monitor plans' compliance with the program integrity provisions of their contracts (including the provisions related to fraud referrals), (2) determine whether potential fraud reflects a credible allegation of fraud, and (3) take action against providers upon the identification of a credible allegation of fraud. According to Federal regulations, States' contracts with managed care plans must require the plans to promptly refer any potential fraud, waste, or abuse to State Medicaid agencies or Medicaid Fraud Control Units. However, both OIG and CMS have ongoing concerns about States' and plans' efforts to combat fraud, including a lack of fraud referrals. This evaluation will determine whether State contractual requirements support managed care plans' submission of fraud referrals, determine how States evaluate the volume and quality of the fraud referrals made by managed care plans, identify the factors that States believe incentivize managed care plans to refer fraud, and determine the challenges States face regarding fraud referrals from managed care plans. This work may also identify ways to increase the total number of managed care plans' fraud referrals and ensure the quality and timeliness of these referrals.

Work Plan #: OEI-03-23-00340

[NEW] Securing Medicaid and Medicare Payments to Providers

Expected Issue Date: 2024
Announced or Revised: February 2023

Federal and State Governments reimburse health care providers and facilities electronically for providing health care services. Sometimes a provider or facility may change financial institutions to receive payment by using an electronic funds transfer (EFT) authorization request. However, since at least 2020 OIG has investigated schemes that have allegedly exploited vulnerabilities in EFT authorization forms to redirect provider reimbursements to their own bank accounts. Many State Medicaid agencies and Medicare Administrative Contractors (MACs) have been victims of this type of fraud over the past 3 years. OIG will collect information from States and MACs about EFT vulnerabilities and assess the feasibility of possible solutions to strengthen EFT fraud prevention efforts. In addition, OIG will collect information about any actions taken by CMS to address EFT fraud and assess the feasibility of CMS systems playing a role in fraud prevention efforts.

Work Plan #: OEI-07-23-00180

[NEW] Audit of Medicaid Collections During COVID-19 Federal Medical Assistance Percentage Increase

Expected Issue Date: 2024
Announced or Revised: January 2023

The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage (FMAP), which varies depending on a State's relative per capita income. In response to the pandemic, the Families First Coronavirus Response Act provided a temporary 6.2-percentage-point increase to each qualifying State's and Territory's FMAP effective January 1, 2020. States must refund the Federal share of overpayments and other

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collections, which decreases the amount of Federal funding States receive for a quarter. CMS instructs States to make refunds of the Federal share at the FMAP at which the original expenditures were reimbursed. OIG will audit selected States to determine whether those States used the correct FMAP when making refunds of the Federal share.

Work Plan #: WA-23-0007 (W-00-23-31569)

[NEW] Audit of Medicaid Nursing Facility Use of Funds Related to Direct Patient Care

Expected Issue Date: 2024
Announced or Revised: December 2022

Improving safety, quality, and transparency of Medicaid nursing facility care is a top priority to ensure that seniors, people with disabilities, and others living in nursing homes receive reliable, high-quality care. States have broad flexibility when establishing Medicaid base and supplemental payments to provide adequate, performance-driven nursing facility rates. OIG will judgmentally select three facilities in selected States (one each from the following facility types: for-profit, not-for-profit, and governmental) to determine what percentage of Medicaid nursing facility revenue is being expended on direct patient care.

Work Plan #: WA-23-0003 (W-00-23-31568)

[NEW] CMS's Oversight of Federal Medical Loss Ratio Requirements in Medicaid Managed Care

Expected Issue Date: 2024
Announced or Revised: December 2022

With its 2016 Medicaid managed care regulations, CMS chose medical loss ratios (MLRs) as a policy tool to ensure appropriate stewardship of managed care funds. The Federal MLR is the percentage of premium revenue that a managed care plan spent on covered health care services and quality improvement activities during a 12-month period. Federal MLR requirements help ensure that managed care plans spend most of their revenue on services related to the health of their enrollees, thereby limiting the amount that plans can spend on administration and keep as profit. As part of the process for setting capitation rates, Federal regulations require States to set their plans' capitation rates so that plans will reasonably achieve MLRs of at least 85 percent-the Federal MLR standard. States must take into account their plans reported MLRs when setting future capitation rates. OIG has previously found weaknesses in States' oversight of the completeness and accuracy of their plans' MLR reporting. CMS plays a vital role in overseeing States' implementation of Federal MLR requirements, as it is responsible for the review and approval of States' capitation rates for their managed care plans, including review of State-submitted MLR data. OIG's evaluation will determine: (1) how CMS has incorporated MLR data in its review of States' capitation rate certifications; (2) the oversight activities that CMS conducts to ensure that States submit to CMS complete and accurate MLR data; and (3) whether CMS has ensured that States have used MLR data, as required, to set actuarially sound capitation rates.

Work Plan #: WA-23-0003 (W-00-23-31568)

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[NEW] Medicaid Managed Care Plans' Focus on Fraud Referrals

Expected Issue Date: 2024
Announced or Revised: September 2022

For Medicaid managed care, States contract with private health insurance companies, or managed care plans, that have the primary responsibility for processing, paying, and monitoring the claims of providers in their networks. As such, managed care plans play a critical role in safeguarding Medicaid program integrity. According to Federal regulations, State contracts with managed care plans must require that plans promptly refer any potential fraud, waste, or abuse to State Medicaid agencies or Medicaid Fraud Control Units (MFCUs). However, both OIG and CMS have ongoing concerns about managed care plans' efforts to combat fraud, including concerns about a lack of fraud referrals. This evaluation will determine the number of potential fraud referrals managed care plans made to States, MFCUs, and other entities; determine whether managed care plan processes support the referral of potential fraud; and identify the factors that influence whether managed care plans make referrals. This work may identify ways to increase the total number of managed care plan referrals and ensure the quality and timeliness of referrals.

Work Plan #: OEI-03-22-00410

[NEW] States' Medicaid Eligibility and Enrollment Actions Concluding the COVID-19 Public Health Emergency

Expected Issue Date: 2024
Announced or Revised: August 2022

In response to the COVID-19 pandemic, section 6008 of the Families First Coronavirus Response Act (FFCRA) provides a temporary increase of 6.2 percentage points to each qualifying State's and Territory's Federal Medical Assistance Percentage (FMAP), effective January 1, 2020. To receive the increased FMAP, FFCRA requires States to provide benefits to individuals who were enrolled in Medicaid at the start of the COVID-19 public health emergency (PHE) or become enrolled in Medicaid during the emergency period. These individuals should remain eligible for Medicaid through the last day of the month in which the COVID-19 PHE ends (continuous enrollment period), unless the individual requests a voluntary termination of eligibility, or the individual ceases to be a resident of the State. Within the 12-month period in which the COVID-19 PHE ends, States must initiate all renewals, post-enrollment verifications, and redeterminations for all individuals enrolled when the continuous enrollment expires. At the conclusion of the COVID-19 PHE, OIG will review the States' required Medicaid eligibility and enrollment actions. OIG will determine whether States completed pending Medicaid eligibility and enrollment actions in accordance with CMS requirements that take effect after the COVID-19 PHE.

Work Plan #: WA-22-0012 (W-00-22-31567)

Medicaid Rehabilitation Services Made by Community Residence Providers

Expected Issue Date: 2023
Announced or Revised: April 2022

States can provide optional rehabilitation services under Medicaid programs available to adults with developmental disabilities and children and adolescents with serious emotional issues in certain community residential settings (e.g., group homes or supervised apartments). These residential rehabilitation services may include training and assistance with daily

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living skills, medication management, socialization, substance use disorder services, and parental training. Services are designed to improve or maintain the beneficiary's ability to remain and function in the community, as well as develop greater independence. Prior OIG audits of these services, over a decade ago, identified significant deficiencies. OIG will determine whether States claimed Federal Medicaid reimbursement for rehabilitation services provided by community residence providers in accordance with Federal and State requirements. In addition, OIG will determine whether previously audited States have made improvements to their Medicaid community residence rehabilitation programs based on the prior recommendations.

Work Plan #: A-02-22-01011 (July 2023); W-00-22-31563

Electronic Visit Verification System for Medicaid In-Home Services

Expected Issue Date: 2024
Announced or Revised: April 2022

All States must implement electronic visit verification (EVV) for personal care services (PCS) by January 1, 2020, and for home health services (HHSC) by January 1, 2023, as required by the 21st Century Cures Act. CMS granted 1-year extensions (to January 1, 2021) for the vast majority of States to meet the EVV requirements for PCS. Once implemented, EVV could increase the risk that Medicaid beneficiaries' needs are not being met, potentially compromising their health and safety. OIG's objectives will be to determine whether the State: (1) has implemented an EVV system in accordance with Federal and State requirements, and (2) has developed policies and procedures when using EVV to ensure that Medicaid beneficiaries receive their required in-home services.

Work Plan #: W-00-22-31564

Identifying Gaps in the Receipt of Recommended Care Among Medicaid Beneficiaries with HIV

Expected Issue Date: 2024
Announced or Revised: April 2022

People with HIV can improve their health and prevent HIV transmissions by receiving recommended HIV care. But certain groups with HIV, such as African Americans, are less likely to receive regular HIV care compared to other groups. Medicaid plays an important role in providing care to people with HIV, as it is the single largest source of insurance for people living with HIV. This study will identify the extent to which Medicaid beneficiaries diagnosed with HIV receive care that aligns with the widely used Federal performance measures, both overall and by selected demographic factors that include race/ethnicity, sex, and location. Identification of potential gaps and disparities in care can help CMS, States, and managed care organizations identify areas for improvement to ensure that Medicaid beneficiaries with HIV receive care that improves health outcomes and reduces HIV transmission.

Work Plan #: OEI-05-22-00240 (August 2023); OEI-05-22-00242

Achieved Savings Rebate Program-Offset of Rebates on CMS-64

Expected Issue Date: 2024

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Announced or Revised: March 2022

The Social Security Act (the Act) Section 1115 gives CMS authority to approve experimental, pilot or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. States may then use CMS-approved waivers to have Managed Care Organizations (MCOs) provide care to Medicaid beneficiaries. Under these arrangements, States make capitation payments to the MCOs in return for the MCOs providing the patient care for the Medicaid beneficiaries. Some States place limitations on MCOs' earnings, for example, limiting the profits they may earn or requiring a certain percentage of their revenues to be spent on medical expenses. States with such limitations may require the MCOs to return a portion of the capitation payments when the MCOs exceed those limitations. According to the Act, § 1903(d)(3)(A) States are required to refund to the Federal Government the Federal share of any amounts recovered during any fiscal quarter. Additionally, 45 CFR § 75.406(a) requires recipients of Federal awards (which includes State Medicaid agencies) to credit to the Federal award the Federal share of reduction-of-expenditure type transactions, such as rebates, purchase discounts, or allowances when those transactions relate to allowable costs. For selected States, OIG will determine whether the States properly offset against CMS-64 expenditures refunds of capitation payments received from MCOs.

Work Plan #: A-04-22-04089 (August 2023); W-00-22-31562

Medicaid Estate Recovery Program

Expected Issue Date: 2024
Announced or Revised: March 2022

Several States have not implemented all the requirements of their Medicaid Estate Recovery Programs; therefore, they might be running the programs ineffectively and not recovering certain long-term care costs due from the applicable estates of deceased Medicaid recipients. OIG will determine whether State agencies, under their Medicaid Estate Recovery Programs: (1) had policies and procedures to comply with Federal and State requirements, (2) attempted to recover the applicable reimbursement costs for certain long-term care, (3) accurately reported Medicaid estate recovery amounts associated with certain long-term care services on the CMS-64, and (4) identified the costs incurred to recover from the estates.

Work Plan #: W-00-22-31561

Medicaid Partial Care Program

Expected Issue Date: 2024
Announced or Revised: December 2021

Prior audit work identified a State agency's Medicaid adult partial care program as at high risk for improper payments. The purpose of the adult partial care program is to provide Medicaid beneficiaries with serious mental illnesses individualized outpatient clinic services to reduce unnecessary hospitalizations. OIG's prior audit made a financial recommendation and procedural recommendations to the State agency to improve its guidance and monitoring. This audit work will determine whether the State agency adequately implemented OIG's prior recommendations. OIG will also review claims for compliance with Federal and State requirements, including the State agency's implementation of telehealth services due to the COVID-19 pandemic.

Work Plan #: W-00-22-31559

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Race and Ethnicity Data for Medicaid Beneficiaries

Expected Issue Date: 2024
Announced or Revised: December 2021

Complete and consistent race and ethnicity data for Medicaid beneficiaries are critical to identifying and addressing health disparities. As the COVID-19 pandemic has highlighted disparities among racial and ethnic groups, the availability and quality of data on race and ethnicity warrants a closer look in order to accurately and appropriately mitigate health disparities within the Medicaid population. This study will evaluate the extent to which Medicaid's race and ethnicity data for beneficiaries as reported to T-MSIS are complete and consistent across States. OIG will also determine the extent to which the data align with Federal data collection standards for race and ethnicity.

Work Plan #: OEI-02-22-00130

States' Use of Local Provider Participation Funds as the State Share of Medicaid Payments

Expected Issue Date: 2024
Announced or Revised: November 2021

Local units or jurisdictions of government have the option to use Local Provider Participation Funds (LPPFs) to generate and collect local funding to finance the State share of Medicaid supplemental and directed payment programs. In the past several years, some States and local units of governments have increasingly used LPPFs to fund the State share of Medicaid payments. As such, OIG will determine whether the LPPFs the State agency used as the State share of Medicaid payments were permissible and in accordance with applicable Federal and State requirements.

Work Plan #: W-00-22-31557

Audit of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism

Expected Issue Date: 2024
Announced or Revised: June 2021

Autism spectrum disorder (autism) is a developmental disability that can cause significant social, communication, and behavioral challenges for children. According to the Centers for Disease Control and Prevention, there is currently no cure for autism; however, research has shown that early intervention and treatment can improve a child's development. A common treatment for autism is Applied Behavior Analysis (ABA). ABA can help an autistic child improve social interaction, learn new skills, maintain positive behaviors, and minimize negative behaviors. In the past few years, some Federal and State agencies have identified questionable billing patterns by some ABA providers as well as Federal and State payments to providers for unallowable services. OIG will audit Medicaid claims for ABA services provided to children diagnosed with autism to determine whether a State Medicaid agency's ABA payments complied with Federal and State requirements.

Work Plan #: W-00-21-31555

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Medicaid Claims for Federal Reimbursement Using Managed-Care Proxy Methodology

Expected Issue Date: 2024
Announced or Revised: January 2021

Federal health care benefits are generally allowable when provided to a beneficiary who is a U.S. citizen, U.S. national, or qualified alien. Generally, a qualified alien is ineligible for full-scope Medicaid services before 5 years have passed from the date he or she enters the United States with qualifying status (5-year bar). Medicaid eligibility for most qualified aliens who are subject to the 5-year bar is generally limited to emergency services (restricted-scope services). States may choose to provide full-scope services to qualified aliens who are subject to the 5-year bar using their own State funds. Furthermore, States may choose to cover full-scope services to aliens permanently residing in the United States under color of law and to children under the age of 19 regardless of immigration status. However, the costs related to nonemergency services provided to non-citizens in these groups without satisfactory immigration status are not eligible for Federal reimbursement. OIG will review whether States properly claimed Federal Medicaid reimbursement related to services provided to non-citizens who lacked satisfactory immigration status.

Work Plan #: W-00-21-31554

Comparison of T-MSIS Prescription Drug Payment Data to Actual Pharmacy Reimbursements for Medicaid Managed Care

Expected Issue Date: 2024
Announced or Revised: December 2020

Effective oversight of growing prescription drug costs in Medicaid requires accurate and consistent data. Managed Care Organizations (MCOs) are responsible for the majority of Medicaid enrollment and prescription drug reimbursements. The Centers for Medicare and Medicaid Services (CMS) established the Transformed Medicaid Statistical Information System (T-MSIS) to provide CMS, states, and other stakeholders with accurate and reliable Medicaid claims and encounter data to safeguard the Medicaid program. However, states' Managed Care drug claims data reported in T-MSIS may not uniformly represent drug payments across the Medicaid program. The data may contain the amounts MCOs or their pharmacy benefit managers (PBMs) paid to pharmacies or the amounts MCOs paid to their PBMs, which could include certain PBM fees known as "spread." CMS and states have expressed concerns that the use of spread pricing by PBMs lacks transparency and may inflate Medicaid drug costs. This evaluation will identify how states report managed care drug payment data to T-MSIS and determine the extent to which the data represents pharmacy reimbursements. Furthermore, OIG will identify how states ensure the accuracy of their T-MSIS managed care drug claims data and use these data to oversee managed care prescription drug expenditures and the PBMs' spread 'pricing practices.

Work Plan #: OEI-03-20-00560

State Medicaid Agency Risk Assessments

Risk Assessment at a State Medicaid Agency (W-00-21-31552)

Expected Issue Date: 2024

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Announced or Revised: December 2020

One goal of the President's Management Agenda is to maximize grant funding by applying a risk-based, data-driven framework that balances compliance requirements with demonstrating successful results to the American taxpayer. Enterprise Risk Management-based risk assessments can help organizations quickly understand and prioritize critical, enterprise-wide risks, and develop plans to maximize as well as mitigate and manage risk. OIG will perform an Enterprise Risk Management-based risk assessment at one state Medicaid agency to identify internal control weaknesses and process risks.

Work Plan #: W-00-21-31552

Risk Assessment of Puerto Rico Medicaid Program (W-00-20-31544)

Expected Issue Date: 2024
Announced or Revised: October 2020

The Puerto Rico Medicaid program is a 100-percent managed care program that provides health services to more than 1 million beneficiaries. In December 2019, Congress provided Puerto Rico additional funding under the Further Consolidated Appropriations Act of 2020 (P.L. 116—94). P.L. 116—94 also contains anticorruption measures including requirements for OIG to develop and submit to Congress a report identifying payments made under Puerto Rico's Medicaid program to managed care organizations that are at high risk for waste, fraud, or abuse, and a plan for auditing such payments.

Work Plan #: A-02-21-01004 (September 2023); A-02-21-01005 (September 2023); W-00-20-31544; W-00-21-31552; W-00-23-31544; W-00-24-31544

Nationwide Review of the Administration and Oversight of Physician-Administered Drugs

Expected Issue Date: 2024
Announced or Revised: October 2020

States are required to collect rebates on covered outpatient drugs administered by physicians in order to be eligible for Federal matching funds (SSA § 1927(a)). Previous OIG work identified significant concerns with States' efforts in obtaining rebates for these physician-administered drugs. OIG will summarize the results and issues identified in these audits and examine CMS's policies and procedures to ensure States appropriately collect Medicaid rebates on physician-administered drugs.

Work Plan #: W-00-20-35860

Joint Work with State Agencies

Expected Issue Date: 2024
Announced or Revised: October 2020

To strengthen program integrity and efficiently use audit resources, OIG will enhance their efforts to provide broader oversight of the Medicaid program by partnering with State auditors, State comptroller's general, and State inspectors general. Federal-State partnerships will provide effective methods that address improper payments in fee-for-service

programs such as home health, hospice, and durable medical equipment, and in managed care. OIG will partner with States to: (1) address known vulnerabilities that it has identified in both Medicare and Medicaid to curb such vulnerabilities in Medicaid nationwide and (2) identify new areas that put the integrity of the Medicaid program at risk.

Work Plan #: W-00-21-40002

Penetration Tests of State Medicaid Management Information Systems and Eligibility & Enrollment Systems

Expected Issue Date: 2024
Announced or Revised: June 2020

State Medicaid agencies use the Medicaid Management Information System (MMIS) for administrating the Medicaid program, processing beneficiary and provider inquiries and services, operating claims control and computer capabilities, and managing reporting for planning and control. State Medicaid Eligibility & Enrollment (E&E) systems support processes related to a determination of Medicaid coverage and required procedures necessary for registration. State agencies are responsible for the security of MMIS and E&E systems. HHS OIG will perform a series of penetration tests in select State MMIS or Medicaid E&E environments to identify cybersecurity vulnerabilities on high-risk information systems and networks.

Work Plan #: A-18-21-09003 (May 2023); A-18-20-08003 (May 2023); A-18-20-08004 (March 2023); A-18-20-08005 (November 2022); W-00-20-42028; W-00-21-42028

States' Oversight of Medicaid Managed Care Medical Loss Ratios

Expected Issue Date: 2021
Announced or Revised: April 2020

Medical loss ratio (MLR) requirements in Medicaid managed care are a method to address State and Federal concerns about the growth in Medicaid spending. Federal MLR requirements are intended to ensure that Medicaid managed care plans spend the majority of the Medicaid capitation payments that they receive from the State on beneficiaries' medical care rather than on administration and profit. Pursuant to the May 2016 Medicaid managed care final rule, States must include requirements in managed care plan contracts for plans to collect MLR data, calculate an MLR percentage, and report that percentage and related, underlying data to the State. States' collection of complete and accurate MLR data from their managed care plans is a critical first step for determining Medicaid managed care MLR performance nation-wide. Complete and accurate MLR data will also enable States to set appropriate managed care payment rates to control Medicaid costs. This work will provide timely, nation-wide data on MLR performance in Medicaid managed care and identify the actions that States have taken to ensure the completeness and accuracy of their managed care plans' MLR data.

Work Plan #: OEI-03-20-00230

Medicaid MCO PBM Pricing

Expected Issue Date: 2024
Announced or Revised: February 2020

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The State Medicaid agency and the Federal Government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services including prescription drugs. MCOs may contract with pharmacy benefit managers (PBMs) to manage or administer the prescription drug benefits on their behalf. Spread pricing is a practice where a PBM charges an MCO more for a drug than the amount a PBM pays a pharmacy. OIG's audit will determine whether States provide adequate oversight of Medicaid MCOs to ensure accountability over amounts paid for prescription drug benefits to its PBMs.

Work Plan #: A-03-20-00200 (March 2023); W-00-20-31542

MCO Payments for Services After Beneficiaries' Deaths

Expected Issue Date: 2024

Previous OIG reports found that Medicare paid for services that purportedly started or continued after beneficiaries' dates of death. OIG identified Medicaid managed care payments made on behalf of deceased beneficiaries. OIG also identified trends in Medicaid claims with service dates after beneficiaries' dates of death.

Work Plan #: A-03-22-00203 (July 2023); A-07-20-05125 (September 2021); A-04-19-06223 (July 2020); A-05-19-00007 (January 2020); A-04-15-06190 (December 2017); A-06-16-05004 (November 2017); A-04-15-06190; W-00-20-31497; W-00-19-31497; W-00-22-31497; W-00-23-31497

Medicaid Concurrent Eligibility

Expected Issue Date: 2024

State Medicaid agencies contract with managed care organizations (MCOs) to make services available to enrolled Medicaid beneficiaries. The contractual arrangement shifts financial risk for the cost of care to the MCO. State Medicaid agencies pay MCOs on a per-beneficiary per-month basis, and MCOs are at financial risk if the costs of care exceed those payments. If a beneficiary who resides in one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end and the MCO should not receive payments for that beneficiary. OIG's review will determine whether States made capitation payments on behalf of beneficiaries who established residency in another State.

Work Plan #: A-05-22-000189 (September 2023); A-05-21-00028 (February 2023); A-05-20-00025 (September 2022); A-05-19-00032 (May 2021); A-05-19-00031 (February 2021); A-05-19-00023 (November 2020); W-00-19-31539; W-00-21-31539; W-00-21-35726; W-00-22-31539; W-00-23-31539; W-00-24-31539;

Specialty Drug Coverage and Reimbursement in Medicaid

Expected Issue Date: 2021
Announced or Revised: September 2019

Medicaid spending on specialty drugs has rapidly increased. There is no standard definition for specialty drugs. They may be expensive, difficult to handle, monitor or administer; or treat rare, complex or chronic conditions. OIG will describe States' definitions of, and payment methodologies for, Medicaid specialty drugs and determine how much States paid for specialty drugs. OIG will also review strategies that States use to manage specialty drug costs, such as formularies, cost sharing, step therapy, and prior authorization.

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Work Plan #: OEI-03-17-00430

Opioids in Medicaid: Review of Extreme Use and Overprescribing in the Appalachian Region

Expected Issue Date: 2021
Announced or Revised: August 2019

Opioid abuse and overdose deaths remain at crisis levels in the United States and the Appalachian region. In 2017, opioids were involved in nearly 48,000 overdose deaths nation-wide, and the opioid overdose death rate was 72 percent higher in Appalachian counties than non-Appalachian counties. These issues are of particular concern for Medicaid beneficiaries, who are more likely to have chronic conditions and comorbidities that require pain relief, especially those beneficiaries who qualify through a disability. Consistent with previous OIG work in Medicaid and Medicare Part D, OIG will identify beneficiaries who received extreme amounts of opioids through Medicaid, beneficiaries who appear to be doctor or pharmacy shopping, and prescribers associated with these beneficiaries.

Work Plan #: OEI-05-19-00410

States' Collection of Rebates for Drugs Dispensed to Medicaid MCO Enrollees

Expected Issue Date: 2024

Medicaid MCOs are required to report enrollees' drug utilization to the State for the purpose of collecting rebates from manufacturers. Section 2501(c) of the Patient Protection and Affordable Care Act expanded the rebate requirement to include drugs dispensed to MCO enrollees. OIG will determine whether States are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid MCOs. Drugs dispensed by Medicaid MCOs were excluded from this requirement until March 23, 2010.

Work Plan #: A-06-16-00001 (June 2021); A-02-16-01011 (August 2019); A-09-16-02031 (February 2018); A-06-16-00004 (December 2017); A-09-16-02028 (September 2017); A-09-16-02029 (September 2017); A-09-16-02027 (September 2017); A-07-16-06065 (May 2017); A-07-17-06075; W-00-17-31483; W-00-16-31483; various reviews

Recovery of Federal Funds Through Judgments/Settlements

Expected Issue Date: 2024

Any State action taken because of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. On October 28, 2008, CMS issued a letter (SHO #08-004) to State health officials that clarified language from Section 1903(d) of the Social Security Act, stating that the Federal Government is entitled to the Federal Medical Assistance Percentages (FMAP) proportionate share of a States entire settlement or final judgment amount. OIG will determine whether selected States reported and returned the applicable FMAP share of the settlement and judgment amounts to the Federal Government.
Work Plan #: A-06-20-04004 (May 2022); A-07-21-02834 (October 2022); A-07-18-02814 (June 2021);A-03-17-00203 (June 2019); A-05-17-00041 (December 2018); W-00-17-31522; A-05-17-00000; W-00-21-31374

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

States' Collection of Rebates on Physician-Administered Drugs

Expected Issue Date: 2024

States are required to collect rebates on covered outpatient drugs administered by physicians in order to be eligible for Federal matching funds (SSA § 1927(a)). Previous OIG work identified concerns with States' collection and submission of data to Centers for Medicare & Medicaid Services, including national drug codes that identify drug manufacturers, thus allowing States to invoice the manufacturers responsible for paying rebates (Deficit Reduction Act of 2005). OIG will determine whether States have established adequate accountability and internal controls for collecting Medicaid rebates on physician-administered drugs. OIG will assess States' processes for collecting national drug code information on claims for physician-administered drugs and subsequent processes for billing and collecting rebates.

Work Plan #: A-04-22-07102 (September 2023); A-04-21-08090 (September 2023); A-04-21-07098 (March 2023); A-04-21-08089 (March 2023); A-07-21-07002 (February 2023); A-07-21-06101 (October 2022); A-07-21-06096 (September 2022); A-07-21-07003 (August 2022); A-07-21-07003 (August 2022); A-07-21-07003 (August 2022); A-02-16-01012 (May 2019); A-05-16-00014 (March 2019); A-06-16-00018 (February 2018); A-05-16-00013 (November 2017); W-00-16-31400; W-00-21-31400; various reviews

Review of State Uncompensated Care Pools

Expected Issue Date: 2024

Some State Medicaid agencies operate uncompensated care pools (UCPs) under waivers approved by CMS. Section 1115 of Title XIX of the Social Security Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to help promote the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations. To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State. The purpose of the UCPs is to pay providers for uncompensated cost incurred in caring for low-income (Medicaid and uninsured) patients. Through UCPs, States pay out hundreds of millions of dollars to providers and receive Federal financial participation. However, in some States there has previously been little oversight of the payments. OIG will determine whether selected States' Medicaid agencies made payments to hospitals under the UCPs that were in accordance with the STCs of the waiver and with applicable Federal regulations.

Work Plan #: A-04-19-04070 (October 2021); W-00-19-31537

Medicaid Managed Care Organization Denials

Expected Issue Date: 2024
Announced or Revised: April 2019

The State Medicaid agency and the Federal Government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO, which can create an incentive to deny beneficiaries' access to

covered services. OIG's review will determine whether Medicaid MCOs complied with Federal requirements when denying access to requested medical and dental services and drug prescriptions that required prior authorization.

Work Plan #: A-02-21-01016 (September 2023); A-07-22-07007 (September 2023); A-03-20-00201 (December 2022); W-00-19-31535; W-00-20-31535; W-00-21-31535; W-00-22-31535; W-00-24-31535

Government Program: Medicaid Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid

Expected Issue Date: 2020
Announced or Revised: January 2019

Medicare Home Health Agency (HHA) coverage requirements state that an HHA is responsible for providing all services either directly or under arrangement while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare pays a single HHA overseeing that plan. "Dual eligible beneficiaries" generally describes beneficiaries eligible for both Medicare and Medicaid. Medicare pays covered medical services first for dual eligible beneficiaries because Medicaid is generally the payer of last resort. OIG will determine whether States made Medicaid payments for home health services for dual eligible beneficiaries who are also covered under Medicare.

Work Plan #: W-00-19-31141

ACF Child Care Development Fund: Program Integrity

Expected Issue Date: 2020
Announced or Revised: August 2018

The Child Care and Development Fund (CCDF) program provides subsidized childcare to low-income families, families receiving temporary public assistance, and families transitioning from public assistance so family members can work or attend training or education. Each State must develop and submit to the Administration for Children and Families (ACF) for approval, a plan that identifies the purposes for which CCDF funds will be spent for a 3-year grant period and designates a lead agency responsible for administering childcare programs. States receive block grants and other Federal funds (approximately $5.77 billion annually) to operate their childcare programs. Prior OIG work identified vulnerabilities in States' internal controls for the CCDF program and a national CCDF payment error rate of 5.74 percent. OIG will determine whether State agencies complied with Federal and State requirements when making payments to licensed providers under these childcare programs for Federal fiscal years 2016 through 2018.

Work Plan #: W-00-18-20019

Medicaid School-Based Costs Claimed Based on Contingency Fee Contractor Coding

Expected Issue Date: 2024

Several State Medicaid agencies retain consultants to assist with preparing Medicaid claims for school-based activities. Consultants often are paid a contingency fee based on the percentage of Federal funds reimbursed to the State. During a

prior review, OIG found that one consultant developed unsupported time studies that it used to develop payment rates for school-based health services. Based on those rates, the State claimed unallowable Federal funds. Consultants developed time studies using a similar methodology in many other States. OIG will initiate a multiple State review with a roll-up report to CMS to determine whether consultants developed school-based Medicaid rates based on unsupported time studies and unallowable costs in these States.

Work Plan #: A-02-20-01012 (March 2022); A-02-18-01019 (July 2021); A-04-18-07075 (November 2020); W-00-18-31529

Duplicate Payments for Beneficiaries with Multiple Medicaid Identification Numbers

Expected Issue Date: 2024

During a preliminary data match, OIG identified a significant number of individuals who were assigned more than one Medicaid identification number and for whom multiple Medicaid payments were made for the same period. OIG will review duplicate payments made by States on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and identify States' procedures or other controls for preventing such payments.

Work Plan #: A-04-21-07097 (October 2022); A-04-20-07094 (December 2021); A-06-20-10003 (July 2021); A-02-20-01007 (May 2021); A-04-16-07061 (December 2017); W-00-20-31374; W-00-16-31374; W-00-21-31374; various reviews

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Third-Party Liability Payment Collections in Medicaid

Expected Issue Date: 2024

Medicaid beneficiaries may have additional health insurance through third-party sources. Previous OIG work described problems that State Medicaid agencies had in identifying and collecting third-party payments. States are to take all reasonable measures to ascertain the legal liabilities of third parties with respect to health care items and services (SSA § 1902(a)(25)). Medicaid is the payer of last resort and providers are to identify and refund overpayments received. OIG will determine if States have taken action to ensure that Medicaid is the payer of last resort by identifying whether a third-party payer exists and if the State correctly reports the third-party liability to Centers for Medicare & Medicaid Services.

Work Plan #: A-05-21-00013 (October 2023); A-05-20-00058 (October 2021); W-00-17-31517; A-05-17-00000; W-00-22-31517

Accountable Care in Medicaid

Expected Issue Date: 2020
Announced or Revised: November 2016

The Medicaid program is experiencing a shift toward new models that promote accountability for the cost and quality of care delivered to patients and focus on better, more efficient coordination of care. Several delivery system reform initiatives in Medicaid, including, for example, medical homes and accountable care organizations, focus on accountable care and include elements such as implementing value-based payment structures, measuring quality improvement, and collecting

and analysing data. OIG will review selected accountable care models in Medicaid for compliance with relevant State and Federal requirements.

Work Plan #: W-00-17-31518; various reviews

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Medicare Part D – Prescription Drug Program

Medicare Part C – Advantage

[NEW] Medicare Payments Compared to the Prices Available to Consumers and Suppliers for Continuous Glucose Monitors and Sensors

Expected Issue Date: 2025
Announced or Revised: November 2023

OIG will compare Medicare payments to suppliers' acquisition costs and prices otherwise available to consumers for selected continuous glucose monitors (CGMs) and their sensors to determine if there are potential cost savings for Medicare and enrollees. In 2022, Medicare Part B allowed more than $1.1 billion in payments for CGMs and sensors. If OIG finds that Medicare payments for CGMs greatly exceed their acquisition costs, then CMS has authority to adjust payment rates for CGMs and sensors through two methods: CMS can adjust the fee schedule prices using its inherent reasonableness authority, or it can introduce an item into the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program.

Work Plan #: OEI-04-23-00430

[NEW] Medicare Part C Audits of Documentation Supporting Specific Diagnosis Codes

Expected Issue Date: 2026
Announced or Revised: November 2023

Payments to Medicare Advantage (MA) organizations are risk-adjusted based on each enrollee's health status (SSA § 1853(a)). MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. In general, MA organizations receive higher payments for enrollees with more complex diagnoses. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. OIG will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and to determine whether the diagnoses submitted complied with Federal requirements.

Work Plan #: WA-24-0004 (W-00-24-35906)

[NEW] Audits of Medicare Part C Health Risk Assessment Diagnosis Codes

Expected Issue Date: 2025
Announced or Revised: November 2023

Payments to Medicare Advantage (MA) organizations are risk-adjusted based on each enrollee's health status (SSA § 1853(a)). One tool that MA organizations use to collect risk-adjusted data is the health risk assessment (HRA), which gathers information about enrollees, including health status and health risks. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. For these audits, the focus is on enrollees whose diagnoses, reported only on HRAs, mapped to a hierarchical condition category and resulted in increased risk-adjusted payments from CMS to MA organizations. OIG will determine whether these diagnosis codes, as submitted by MA organizations to CMS for use in CMS's risk-adjustment program, complied with Federal requirements.

Work Plan #: WA-24-0003 (W-00-24-35905)

[NEW] Audits of Medicare Part C Unlinked Chart Review Diagnosis Codes

Expected Issue Date: 2026
Announced or Revised: September 2023

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of each enrollee's health status (SSA § 1853(a)). MA organizations are required to submit risk adjustment data to CMS according to CMS instructions (42 CFR § 422.310(b)). CMS allows MA organizations to conduct chart reviews of enrollee medical record documentation to identify diagnosis codes that providers either: (1) did not originally provide the MA organization or (2) provided the MA organization in error. For some chart reviews known as unlinked chart reviews, CMS does not require that the MA organization identify the specific date of service for previously unidentified diagnosis codes. CMS also allows MA organizations to submit chart review results to CMS for inclusion in calculating each enrollee's risk score. Miscoded diagnoses may cause CMS to pay MA organizations improper amounts. For these audits, OIG will focus on enrollees who had diagnoses identified from unlinked chart reviews that resulted in increased risk-adjusted payments from CMS to MA organizations. For these enrollees, OIG will determine whether all of the diagnosis codes that the MA organizations submitted to CMS for use in CMS's risk adjustment program, including the diagnosis codes submitted via unlinked chart reviews, complied with Federal requirements.

Work Plan #: WA-23-0037 (W-00-23-35903)

[NEW] Medicare Part C High-Risk Diagnosis Codes Tool Kit

Expected Issue Date: 2024
Announced or Revised: July 2023

Payments to Medicare Advantage (MA) organizations are risk adjusted on the basis of each enrollee's health status (SSA § 1853(a)). MA organizations are required to submit risk adjustment data to CMS according to CMS instructions (42 CFR § 422.310(b)). Miscoded diagnoses may cause CMS to pay MA organizations improper amounts. For this toolkit, OIG will develop a resource that will provide highly technical information to assist MA organizations with analyzing the accuracy of the risk adjustment data that they receive from their providers and submit to CMS. OIG will provide this information as a starting point to allow MA organizations to research enrollees who receive diagnoses that are at high risk for being miscoded and to take appropriate action if needed.

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Medicare Part D – Prescription Drug Program

Work Plan #: WA-23-0025 (W-00-23-35899)

[NEW] CMS May Make Increased Payments to MA Organizations for Diagnoses That Were Reported on Physicians' Claims But Were Not Confirmed on a Concurrent Inpatient Stay

Expected Issue Date: 2024
Announced or Revised: July 2023

Payments to Medicare Advantage (MA) organizations are risk adjusted on the basis of each enrollee's health status (SSA § 1853(a)). MA organizations are required to submit risk adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. For this review, OIG will focus on enrollees who had a diagnosis on a physician or outpatient claim that did not appear on a concurrent inpatient claim. In these instances, the diagnosis codes from the physician or outpatient claim-ostensibly, potentially unconfirmed diagnosis codes that misrepresented the health status of the enrollee-were submitted to CMS and resulted in increased payments to MA organizations. If these occurrences were reviewed as part of a Risk Adjustment Data Validation (RADV) audit (or during a subsequent RADV appeals process), CMS could potentially review the claims collectively, instead of separately, in order to ensure the accuracy of the enrollee's health status. OIG will identify the increased payments to MA organizations that were based on any unconfirmed and inaccurate diagnoses.

Work Plan #: WA-23-0032 (W-00-23-35900)

[NEW] Medicare Advantage Payments Generated by Health Risk Assessments for 2023

Expected Issue Date: 2024
Announced or Revised: July 2023

Health risk assessments (HRAs) are conducted by physicians or other health care professionals to collect information about patients' health status, health risks, and daily activities. Prior OIG work has highlighted concerns about the extent to which Medicare Advantage Organizations (MAOs) use HRAs to improve care, as intended, and the sufficiency of oversight by CMS. This prior work found that diagnoses that MAOs reported only on HRAs-and on no other service records that year-resulted in an estimated $2.6 billion in risk-adjusted payments for 2017. OIG's findings raised concerns about the quality and coordination of care for enrollees, the validity of diagnoses reported on HRAs, and the appropriateness of payments generated by HRAs for 2017. For this data snapshot, we will determine the extent to which diagnoses reported only on HRAs (or added to HRAs by chart reviews) generated estimated risk-adjusted payments for 2023. We also will determine whether enrollees with certain demographic characteristics were overrepresented among the enrollees who had diagnoses reported only on HRAs (or added to HRAs by chart reviews) that generated payments. Finally, we will interview CMS to identify the actions it has taken to address the impact of HRAs on Medicare Advantage payment integrity and quality of care.

Work Plan #: OEI-03-23-00380

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes

Expected Issue Date: 2024
Announced or Revised: June 2023

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each enrollee. MA organizations are required to submit risk-adjustment data to CMS according to CMS instructions (42 CFR § 422.310(b)). Miscoded diagnoses may cause CMS to pay MA organizations improper amounts (The Act §§ 1853(a)). For these audits, OIG will focus on enrollees who received diagnoses that are at high risk for being miscoded and resulted in increased risk-adjusted payments from CMS to MA organizations. OIG will determine whether these diagnosis codes, as submitted by MA organizations to CMS for use in CMS's risk-adjustment program, complied with Federal requirements.

Work Plan #: WA-23-0019 (W-00-23-35896)

[NEW] Use of Remote Patient Monitoring Services in Medicare

Expected Issue Date: 2024
Announced or Revised: April 2023

The use of remote patient monitoring services in Medicare has the potential to exponentially expand. However, there is currently limited research on the use of remote patient monitoring services, such as the types of patients and providers who use these services, and the health conditions that are monitored through these services, among other details. This review will be based on Medicare fee-for-service claims and Medicare Advantage encounter data for remote patient monitoring services. It will look at the extent to which the use of remote patient monitoring services has changed, the nature of remote patient monitoring services being used by Medicare enrollees, and the characteristics of enrollees using remote patient monitoring services. This review will also determine the extent to which provider billing for remote patient monitoring services may indicate fraud, waste, or abuse.

Work Plan #: OEI-02-23-00260

[NEW] Medicare Advantage Organizations' Efforts To Reduce Racial and Ethnic Health Disparities

Expected Issue Date: 2025
Announced or Revised: January 2023

HHS, in alignment with the 2021 Executive Order 13985 Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, has pursued addressing health disparities among members of certain racial and ethnic communities. CMS has developed a plan that aims to build the capacity of health care stakeholders, including Medicare Advantage Organizations (MAOs), to take action to reduce health disparities. CMS has provided MAOs with a variety of resources and tools for addressing racial and ethnic health disparities including annual reports, technical assistance, and trainings. This evaluation will identify the actions that MAOs have developed to reduce racial and ethnic disparities in access to care, quality of care, and health outcomes. OIG will also identify any challenges and successes MAOs have experienced in their efforts to reduce these health disparities.

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Work Plan #: OEI-03-23-00060

Identifying Denied Claims in Medicare Advantage Encounter Data

Expected Issue Date: 2023
Announced or Revised: November 2021

CMS requires Medicare Advantage organizations (MAOs) to submit records of all services provided to beneficiaries to CMS's Medicare Advantage (MA) Encounter Data System. These records often (although not always) begin as claims for payments that health care providers submit to MAOs. MAOs must submit all records of services to CMS, including records of denied claims-i.e., claims for which an MAO determines it had no responsibility to pay the health care provider. CMS does not require MAOs to differentiate between paid and denied claims when submitting encounter records. In the absence of requiring a denied claims indicator, CMS requires each MAO to submit claim adjustment reason codes that contain information about how the MAO processed the claim and may be a helpful, but not definitive, method for identifying denied claims. The lack of a definitive method to identify denied claims in the MA encounter data may limit the use of these data to ensure MA program integrity and quality of care. This work will: (1) determine the extent to which the MA encounter data contained potentially denied claims and (2) identify any challenges to MA program oversight that result from the lack of a denied claim indicator on services in the MA encounter data.

Work Plan #: OEI-03-21-00380 (February 2023)

Ineligible Providers in Medicare Part C and Part D

Expected Issue Date: 2022
Announced or Revised: October 2020

CMS contracts with Medicare Advantage plans and private prescription drug plans (collectively known as "sponsors") to offer Part C and Part D managed care benefits to eligible beneficiaries. Federal law prohibits Medicare payments for services provided or prescriptions written by individuals or entities who are excluded from Federal health care programs (excluded providers) when the sponsor knows or has reason to know of the exclusion. Federal regulations also prohibit Medicare payments to ineligible providers whose billing privileges have been deactivated, denied, or revoked. OIG will conduct a nationwide audit of Medicare Part C and Part D managed care data for calendar years 2018 and 2019 to identify ineligible providers that had been excluded, precluded, or deactivated as Medicare providers but provided services through Part C and D sponsors. OIG's audit will determine whether Part C and Part D sponsors complied with Federal requirements on preventing ineligible providers from rendering services to Medicare beneficiaries.

Work Plan #: A-02-20-01027 (October 2022); W-00-20-35859

Rates of Estimated Payments from Chart Reviews and Health Risk Assessments Across Medicare Advantage Organizations

Expected Issue Date: 2021
Announced or Revised: August 2020

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The Medicare Advantage (MA) program provided coverage to 23 million beneficiaries in 2019 at a cost of $264 billion. CMS risk-adjusts these payments by using beneficiaries' diagnoses to pay higher capitated payments to MA organizations (MAOs) for beneficiaries expected to have greater health care needs. This payment policy may create financial incentives for MAOs to misrepresent beneficiaries' health status and make them appear to have additional illnesses and other conditions that would command higher payment. A previous OIG evaluation identified $6.7 billion in estimated 2017 risk-adjusted payments resulting from diagnoses that MAOs reported only on chart reviews, and not on any records of services provided to beneficiaries in 2016. Findings from this evaluation raise concerns about the completeness of payment data that MAOs submit to CMS, the validity of diagnoses on chart reviews, and the quality of care provided to beneficiaries. A current OIG evaluation examines the extent to which diagnoses solely generated by health risk assessments (HRAs) were associated with higher risk scores and higher MA payments. OIG will combine data from these evaluations to perform new analyses that will determine whether certain MAOs and parent organizations had higher or lower amounts of risk-adjusted payments from both chart reviews and HRAs relative to their peers.

Work Plan #: OEI-03-17-00474

Medicare Advantage Risk-Adjustment Data - Targeted Review of Documentation Supporting Specific Diagnosis Codes

Expected Issue Date: 2022

Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause CMS to pay MA organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, MA organizations receive higher payments for sicker patients. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations. Prior OIG reviews have shown that some diagnoses are more at risk than others to be unsupported by medical record documentation. OIG will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

Work Plan #: A-07-20-01202 (July 2023); A-07-20-01197 (August 2023); A-03-20-00001 (May 2023); A-05-19-00013 (April 2023); A-02-20-01008 (March 2023); A-07-19-01192 (March 2023); A-09-21-03011 (March 2023); A-09-19-03001 (November 2022); A-01-20-00500 (November 2022); A-07-19-01193 (December 2022); A-09-20-03009 (September 2022); A-02-20-01009 (July 2022); A-07-19-01195 (September 2022); A-05-19-00039 (September 2022); A-03-19-00001 (September 2022); A-04-19-07084 (August 2022); A-03-18-00002 (August 2022); A-06-18-05002 (May 2022); A-02-18-01029 (January 2022); A-01-19-00500 (February 2022); A-07-19-01188 (November 2021); A-07-17-01173 (October 2021); A-07-19-01187 (May 2021); W-00-20-35079; W-00-19-35079; W-00-17-35079; W-00-21-35079; various reviews

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Inappropriate Denial of Services and Payment in Medicare Advantage

Expected Issue Date: 2022
Announced or Revised: June 2019

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Medicare Part D – Prescription Drug Program

Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services to increase profits for managed care plans. OIG will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, OIG will determine the reasons for any inappropriate denials and the types of services involved.

Work Plan #: OEI-09-18-00260 (April 2022)

Review of CMS Systems Used to Pay Medicare Advantage Organizations

Expected Issue Date: 2021
Announced or Revised: December 2017

Medicare Advantage (MA) organizations submit to CMS diagnoses on their beneficiaries; in turn, CMS categorizes certain diagnoses into groups of clinically related diseases called hierarchical condition categories (HCC). For instances in which a diagnosis maps to a HCC, CMS increases the risk-adjusted payment. CMS has designed its Medicare Part C systems to capture the necessary data in order to make these increased payments to MA organizations. As CMS transitions to a new data system to make these payments, OIG will conduct analysis to inform both use of current systems and the transition to a new system. OIG will review the continuity of data maintained on current Medicare Part C systems. Specifically, OIG will review instances in which CMS made an increased payment to an MA organization for an HCC and determine whether CMS's systems properly contained a requisite diagnosis code that mapped to that HCC.

Work Plan #: W-00-18-35804

Risk Adjustment Data - Sufficiency of Documentation Supporting Diagnoses

Expected Issue Date: 2023

Payments to Medicare Advantage organizations are risk adjusted based on the health status of each beneficiary. Medicare Advantage organizations are required to submit risk adjustment data to Centers for Medicare & Medicaid Services in accordance with Centers for Medicare & Medicaid Services instructions (42 CFR § 422.310(b)), and inaccurate diagnoses may cause Centers for Medicare & Medicaid Services to pay Medicare Advantage organizations improper amounts (SSA §§ 1853(a)(1)(C) and (a)(3)). In general, Medicare Advantage organizations receive higher payments for sicker patients. Centers for Medicare & Medicaid Services estimates that 9.5 percent of payments to Medicare Advantage organizations are improper, mainly due to unsupported diagnoses submitted by Medicare Advantage organizations. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to Centers for Medicare & Medicaid Services by Medicare Advantage organizations. OIG will review the medical record documentation to ensure that it supports the diagnoses that Medicare Advantage organizations submitted to Centers for Medicare & Medicaid Services for use in Centers for Medicare & Medicaid Services' risk score calculations and determine whether the diagnoses submitted complied with Federal requirements.

Work Plan #: A-04-18-03085 (July 2022); A-05-18-00020 (September 2022); A-03-18-00002 (August 2022); A-07-17-01169 (February 2022); A-07-16-01165 (April 2021); A-09-18-03007; W-00-16-35078; various reviews; W-00-18-35078

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Medicare Part D - Prescription Drug Program

[NEW] Audits of Pharmacy Support for Prescription Drug Event Data

Expected Issue Date: 2025
Announced or Revised: December 2023

Medicare Part D plan sponsors must submit prescription drug event (PDE) records, which are summary records of pharmacy drug claims, for the Secretary of Health and Human Services to determine payments to the plans (SSA § 1860D-15(f)(1)). For selected pharmacies, OIG will determine whether PDE records were adequately supported by inventory purchases and complied with applicable Federal requirements.

Work Plan #: WA-24-0014 (W-00-24-35907)

[NEW] Medicare Part D Formulary Coverage of Humira Biosimilars

Expected Issue Date: 2025
Announced or Revised: November 2023

Humira-one of the best-selling prescription drugs in the world and one of the most costly drugs for the Medicare Part D program-faced its first competition in the United States in 2023, ending nearly 20 years of market exclusivity. Launches of multiple biosimilars for Humira in 2023, including one interchangeable version, have presented an opportunity to increase access to lower cost drugs and, ultimately, significantly reduce Part D drug spending. However, a lack of Part D formulary coverage for Humira's biosimilars, or preferential formulary placement for Humira, could limit the wider use of these biosimilars, as well as limit any potential spending reductions for the Part D program and its enrollees. OIG's study will determine how often Part D formularies covered Humira biosimilars after they became available and describe differences in cost-sharing or utilization management requirements, as well as list prices, for Humira and its biosimilars.

Work Plan #: OEI-05-23-00520

[NEW] Opioid Use in Medicare Part D in 2022: Annual Review

Expected Issue Date: 2024
Announced or Revised: May 2023

The opioid crisis remains a public health emergency. In 2021, an estimated 82,310 opioid-related overdose deaths occurred in the United States. Identifying patients who are at risk for overdose or abuse is key to addressing this crisis. This data brief, Opioid Use in Medicare Part D in 2022: Annual Review, builds on OIG's series of annual reports and provides information on opioid utilization among people enrolled in Medicare Part D in 2022. It provides 2022 data on the number of enrollees who received extreme amounts of opioids through Part D and those who appeared to be doctor shopping. It also identifies prescribers who ordered opioids for large numbers of these enrollees.

Work Plan #: OEI-02-23-00250

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Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Ensuring Dual-Eligible Beneficiaries' Access to Drugs Under Part D: Mandatory Review

Expected Issue Date: 2022
Announced or Revised: February 2022

Dual-eligible beneficiaries are enrolled in Medicaid but qualify for prescription drug coverage under Medicare Part D. As long as Part D plans meet certain limitations outlined in 42 CFR § 423.120, Part D plan sponsors have discretion to include different Part D drugs and drug utilization tools in their formularies. OIG will review the extent to which drug formularies developed by Part D plan sponsors include drugs commonly used by dual-eligible beneficiaries as required. The Affordable Care Act, § 3313, requires OIG to conduct this review annually.

Work Plan #: OEI-05-22-00230 (June 2022)

How Part D Plans' Preference for Higher Cost Hepatitis C Drugs Affects Medicare Beneficiaries

Expected Issue Date: 2022
Announced or Revised: April 2021

In 2019, Medicare Part D spent approximately $2.5 billion for hepatitis C drugs to treat 50,000 beneficiaries with the disease. Three drugs—Harvoni, Epclusa, and Mavyret—accounted for 93 percent of expenditures, with annual Medicare costs ranging from $28,000 to $77,000 per beneficiary. A portion of these totals was shared by Medicare beneficiaries who faced thousands of dollars in out-of-pocket costs for hepatitis C drugs under Part D. In early 2019, Gilead—the manufacturer of Harvoni and Epclusa—launched authorized generic versions of both drugs with the expressed goal of reducing patients' out-of-pocket costs. The retail price of authorized generic versions is $24,000, which is significantly less than the prices of Harvoni and Epclusa, and even less than Mavyret. These lower list prices should in turn lead to lower out-of-pocket costs, as authorized generics are as effective as branded versions but sell for only a fraction of the cost. However, a preliminary analysis indicates that Medicare utilization has not shifted from brand name versions of Harvoni and Epclusa to their significantly cheaper, authorized generic versions or to Mavyret. This study will examine the utilization of hepatitis C drugs under Part D and the financial impact on Medicare Part D and beneficiaries.

Work Plan #: OEI-BL-21-00200 (August 2022)

Medicare Part D Payments During Covered Part A SNF Stay

Expected Issue Date: 2024
Announced or Revised: January 2021

Medicare Part A prospective payments to skilled nursing facilities (SNFs) cover most services, including drugs and biologicals furnished by the SNF for use in the facility for the care and treatment of beneficiaries. Accordingly, Medicare Part D drug plans should not pay for prescription drugs related to posthospital SNF care because these drugs are already

included in the consolidated payment for Part A SNF stays. OIG will determine whether Medicare Part D paid for drugs that should have been paid under Part A SNF stays.

Work Plan #: W-00-21-35866

Medicare Part D Compounded Drugs

Expected Issue Date: 2024
Announced or Revised: November 2020

In 2016, OIG called attention to significant growth in spending for compounded drugs. Specifically, OIG found that Medicare Part D spending for compounded topical drugs grew by 625 percent during 2006—2015. OIG has been involved in an increasing number of fraud investigations related to compounded drugs. OIG will conduct a risk assessment of CMS's oversight of pharmacies compounding drugs for beneficiaries to determine whether systemic vulnerabilities affecting the integrity of Medicare Part D. Specifically, OIG will assess the risk that pharmacies did not meet Federal and State requirements.

Work Plan #: W-00-21-35415

Medicare Part D Payments for Transmucosal Immediate-Release Fentanyl Drugs

Expected Issue Date: 2023
Announced or Revised: May 2020

Transmucosal Immediate-Release Fentanyl (TIRF) drugs are a Schedule II controlled substance. Medicare Part D covers TIRF drugs only for managing breakthrough pain in adult cancer patients who are already receiving and are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. OIG will determine whether TIRF drugs were appropriately dispensed in Medicare Part D in accordance with Medicare requirements.

Work Plan #: A-09-20-03033 (February 2023); W-00-20-35846

Nationwide Audit of Medicare Part D Eligibility Verification Transactions

Expected Issue Date: 2024
Announced or Revised: February 2020

An E1 transaction is a Medicare Part D eligibility verification transaction that the pharmacy submits to the Part D transaction facilitator to bill for a prescription or determine drug coverage billing order. The Part D transaction facilitator returns information to the pharmacy that is needed to submit the prescription drug event. OIG will review CMS's oversight of E1 transactions processed by contractors and determine whether the E1 transactions were created and used for intended purposes.

Work Plan #: W-00-20-35751

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Part D Sponsors Reporting of Direct and Indirect Remunerations

Expected Issue Date: 2024

Medicare calculates certain payments to sponsors based on amounts actually paid by the Part D sponsors, net of direct and indirect remuneration (DIR). (42 CFR pt. 423, subpart G.) DIR includes all rebates, subsidies, and other price concessions from sources (including, but not limited to, manufacturers and pharmacies) that decrease the costs incurred by Part D sponsors for Part D drugs. CMS requires that Part D sponsors submit DIR reports for use in the payment reconciliation process. OIG will determine whether Part D sponsors complied with Medicare requirements for reporting DIR.

Work Plan #: A-03-19-00002 (July 2021); A-03-18-00007 (September 2020); A-03-18-00006 (October 2019); W-00-18-35514

Documentation of Pharmacies' Prescription Drug Event Data

Expected Issue Date: 2022

Drug plan sponsors must submit prescription drug event records, which is a summary record of individual drug claim transactions at the pharmacy, for the HHS Secretary to determine payments to the plans (SSA § 1860D-15(f)(1)). OIG will determine whether Medicare Part D prescription drug event records submitted by the selected pharmacies were adequately supported and complied with applicable Federal requirements. OIG will also conduct additional reviews of selected retail pharmacies identified in a prior OIG report as having questionable Part D billing.

Work Plan #: A-07-16-06068 (November 2018); various reviews