Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Payer-Focused Audits Summary

January 2022 - February 2024 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.

Table of Contents

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicaid

[NEW] States 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 States 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.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Connecticut (A-01-21-00001)

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

The OIG reviewed Connecticut's system for reporting and monitoring of critical incidents involving Medicaid enrollees with developmental disabilities during the audit period, January 2020 through December 2020. To determine whether the four recommendations from the prior OIG report were implemented, the OIG reviewed correspondence from CMS and supporting documentation provided by the State. OIG limited the review to 163 incidents of potential abuse and neglect during the audit period for 138 enrollees between the ages of 18 and 59 who resided in group homes. OIG also reviewed 57 potential critical incidents involving 51 Medicaid enrollees between the ages of 18 and 59 who resided in group homes.

OIG found that Connecticut implemented the four recommendations from the OIG's prior audit and generally complied with Federal and State requirements for reporting and monitoring abuse, neglect, and critical incidents involving Medicaid enrollees with developmental disabilities residing in group homes. However, the corrective actions for two recommendations in the OIG's prior audit were not effective in addressing one of OIG's previous findings. Specifically, Connecticut did not ensure that group homes reported all incidents involving potential abuse and neglect to DDS. These issues occurred because: (1) Connecticut group homes experienced significant staff hiring and retention problems, and (2) the State agency and DDS did not implement new analytical procedures to detect incidents involving potential abuse and neglect during OIG's audit period.

The OIG recommended that the State agency continue to coordinate with DDS to: (1) provide training for staff of DDS and private group homes on how to monitor and report reasonable suspicions of abuse and neglect, especially in light of the significant staff hiring and retention problems in Connecticut group homes; and (2) use the new analytical procedures to

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

identify potential cases of abuse or neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

[NEW] Pennsylvania (A-03-22-00202)

OIG previously issued an audit of Pennsylvania as part of a series of audits conducted in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. In the OIG's previous audit, OIG found that Pennsylvania did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring such incidents. The previous audit report contained seven recommendations. OIG's objective was to determine whether Pennsylvania implemented the recommendations from the prior audit, *Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-03-17-00202).

OIG reviewed Pennsylvania's system for the reporting and monitoring of critical incidents involving Medicaid waiver participants with developmental disabilities who were covered by the waiver and resided in community-based settings during the audit period. OIG also reviewed correspondence and documentation to determine whether Pennsylvania implemented the previous recommendations and had taken actions that satisfied the intent of the recommendations.

Pennsylvania implemented or is in the process of implementing the seven recommendations from the previous audit but should continue to take action to further reduce unreported incidents. Since the previous audit report, Pennsylvania experienced a significant overall 74 percent reduction in the percent of hospital stay incidents not reported. However, although the percentage of incidents reported improved, Pennsylvania's changes to implement the recommendations did not ensure that community-based providers properly reported all 24-hour reportable incidents in the electronic incident management system or that supports coordinators notified providers that a 24 hour reportable incident had occurred.

Because Pennsylvania did not detect that some providers did not report all 24-hour reportable incidents, it was not always able to take prompt action to protect waiver participants' health, safety, and rights. However, Pennsylvania's actions involve a multi-year training plan for its current Incident Management Policy and a dashboard to identify unreported incidents and providers that may have incident management processes in need of systemic improvement.

The OIG made several recommendations for Pennsylvania to continue to improve its controls regarding the reporting and monitoring of 24-hour reportable incidents involving Medicaid waiver participants with developmental disabilities residing in community-based settings.

[NEW] Iowa (A-07-21-06105)

In OIG's previous audit in Iowa, OIG found that the State did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring those incidents. OIG's previous audit report contained nine recommendations, and OIG performed this follow-up audit to determine whether Iowa implemented these recommendations.

OIG reviewed claims for 1,115 emergency room visits for Medicaid members with developmental disabilities whose claims included diagnoses associated with a high likelihood that a major incident had occurred. OIG also reviewed Critical Incident Reports contained in Iowa's reporting systems.

Iowa implemented the nine recommendations from OIG's prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes. However, Iowa's corrective actions for one recommendation in OIG's prior audit were not completely effective in addressing the associated finding. Iowa did not ensure that community-based providers properly reported all major incidents involving members in waiver programs to the State. Although Iowa achieved significant progress since OIG's prior audit, its internal controls did not ensure that providers properly reported all major incidents, because the State did not periodically update the diagnosis code list it used to identify Medicaid claims involving major incidents.

OIG recommended that Iowa continue to strengthen internal controls to ensure full compliance with Federal and State requirements, to include periodically updating the list of diagnosis codes used when reviewing the Medicaid emergency room claims data to ensure that all Critical Incident Reports for major incidents were submitted as required.

Massachusetts (A-01-20-00003)

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 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.

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.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

South Carolina (A-04-18-07078)

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.

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-01-21-00001 (December 2023); A-03-22-00202 (November 2023); A-07-21-06105 (November 2022); A-01-20-00003 (April 2022); A-04-18-07078 (April 2022)
Government Program: Medicaid

[NEW] Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths

HHS-OIG has identified effectively administering the Medicaid program to improve oversight and address high improper payments as a top management challenge facing the HHS. Fourteen previous OIG audits found that State Medicaid agencies had improperly made capitation payments to managed care organizations (MCOs) on behalf of deceased enrollees. OIG's objective was to summarize the results of the previous audits of Medicaid capitation payments that States made to MCOs on behalf of deceased enrollees. In addition, OIG sought to identify steps that the Centers for Medicare & Medicaid (CMS) could take to reduce these unallowable Medicaid capitation payments.

OIG's prior 14 audits covered 450,562 Medicaid capitation payments totaling $318,167,200 that States made to MCOs on behalf of deceased enrollees during audit periods ranging from July 1, 2009, through December 31, 2019. OIG used a combination of statistical sampling and data analytics to select 50,292 Medicaid capitation payments totaling $16,270,039 for review. To identify steps that CMS could take to improve its Medicaid oversight, OIG interviewed CMS officials and assessed its internal controls related to its resolution of the audit findings as well as its internal controls specific to ensuring that States are sufficiently preventing Medicaid capitation payments from being made to MCOs on behalf of deceased enrollees.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D ï Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

In the OIGõs previous audits of 14 States, OIG identified more than $249 million ($172 million Federal share) in unallowable Medicaid capitation payments that the States made to MCOs on behalf of deceased enrollees. These unallowable payments occurred for various reasons. CMS concurred with all of the recommendations made to the States in the prior audit reports and has ensured that actions have been taken on most of the recommendations.

In this audit, OIG identified additional actions CMS could take to help States that continue to make improper capitation payments to MCOs on behalf of deceased enrollees. Specifically, CMS could develop a process to routinely match Transformed Medicaid Statistical Information System (T-MSIS) enrollment data against the Social Security Administration's (SSA's) Death Master File (DMF) data to determine States that are at a high risk of making improper payments to MCOs on behalf of deceased enrollees. CMS could then provide the results of the data match to high-risk States for further verification of whether improper payments were made, and those States could use the results of the data match review to develop corrective actions and improve controls to detect and prevent such payments.

The OIG recommended that CMS take the following steps: (1) collect the outstanding unallowable payments totaling the estimated $41,003,804 OIG previously identified, (2) ensure that States complete actions on OIGõs remaining recommendations to address the internal control weaknesses OIG identified, and (3) continue to explore opportunities for using T-MSIS and SSA's DMF data to improve its oversight of the Medicaid program. Specifically, CMS should develop a process to match enrollment and payment information in T-MSIS with the DMF and provide the results of that match to States to help reduce Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

[NEW] Virginia (A-03-22-00203)

The State agency made unallowable capitation payments after enrollees' deaths. For 67 of the 100 capitation payments in OIGõs sample, Virginia made unallowable capitation payments totaling $76,939 ($51,062 Federal share). For 30 of the remaining capitation payments in OIGõs sample, Virginia adjusted the capitation payments before OIGõs audit. OIG could not fully confirm that the remaining 3 enrollees associated with 3 of the 100 capitation payments were deceased.

Based on the OIGõs sample results, the OIG estimated that Virginia made unallowable capitation payments totaling at least $21.8 million ($15.7 million Federal share) to MCOs on behalf of 12,054 deceased enrollees during OIGõs audit period.

Virginia made unallowable capitation payments on behalf of deceased enrollees because it did not have adequate controls in place to enable it to identify all deceased enrollees and properly cancel their enrollment.

OIG recommended that Virginia: (1) refund $15.7 million to the Federal Government; (2) identify and recover unallowable capitation payments, which OIG estimate to be at least $21.8 million, made to MCOs during OIGõs audit period on behalf of deceased enrollees; and (3) identify and recover unallowable capitation payments made on behalf of deceased enrollees in 2018 and 2022 and repay the Federal share of amounts recovered. The OIG also recommended that Virginia continue to pursue development and implementation of an automated matching and eligibility update process and implement additional supervisory review. The full recommendations are in the report.

Work Plan #: A-03-22-00203 (July 2023); A-04-21-09005 (November 2023)
Government Program: Medicaid

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] States Face Ongoing Challenges in Meeting Third-Party Liability Requirements for Ensuring That Medicaid Functions as the Payer of Last Resort

Medicaid is generally the payer of last resort. This means that if a Medicaid enrollee has another source of health care coverage, that source should pay its share before Medicaid pays. Federal regulations refer to amounts owed by non-Medicaid payers as third-party liability (TPL). Prior OIG and Government Accountability Office reports identified several challenges State Medicaid agencies have encountered in their efforts to meet TPL requirements to help ensure that Medicaid functions as the payer of last resort. Some of the more recent reports suggest that many of these challenges are ongoing and that billions of dollars are at risk.

The objectives of this audit were to identify challenges States have experienced in their efforts to meet TPL requirements and actions they have taken to address those challenges. In addition, OIG were to determine whether States reported Medicaid TPL amounts on the CMS 64 statement according to Federal requirements.

OIG sent questionnaires to State agency officials from all 50 States and the District of Columbia (collectively referred to as States) to inquire about TPL challenges each State has incurred and to gather information on how they responded to those challenges. OIG also reviewed States' TPL reporting during Federal FYs 2019 and 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

States reported that they continue to experience several challenges in their efforts to meet TPL requirements, including: difficulties obtaining complete, accurate, and up-to-date coverage information from Medicaid enrollees and providers; difficulties obtaining timely and reliable coverage information from third parties; difficulties coordinating TPL with out-of-State third parties; technical issues related to third-party coverage information received and electronic billing of Medicaid claims with third parties; a lack of Federal prompt payment requirements and penalties for third parties that do not cooperate with States' efforts to meet TPL requirements; difficulties coordinating TPL with TRICARE, which is the U.S. military's health care program; and difficulties coordinating TPL with Medicare. While surveying the States, OIG found that some did not have in effect laws addressing all Deficit Reduction Act of 2005 provisions, as required. These provisions were meant to enhance States' ability to meet TPL requirements.

OIG found that States did not always report TPL amounts according to Federal requirements. Specifically, 27 States either did not report or did not correctly report TPL amounts during at least one fiscal quarter of OIG's audit period.

The OIG's primary recommendation is for CMS to develop an action plan that addresses States' ongoing TPL challenges. OIG made six additional procedural recommendations and one recommendation involving $1.25 million in questioned costs. A complete list of OIG's recommendations is included in the body of the report.

Work Plan #: A-05-21-00013 (October 2023)
Government Program: Medicaid

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns

One-third of the 1.5 million Medicaid enrollees with opioid use disorder did not receive medication treatment (referred to as MOUD) in 2021. Certain demographic groups—including Black or African American enrollees; enrollees 18 years of age and younger; and enrollees with a disability and/or blindness—were less likely to receive MOUD. In 10 States, less than half of enrollees with opioid use disorder received MOUD.

Nearly 81,000 people died from opioid overdoses in the United States in 2021, an increase of 17 percent from the previous year. Treating opioid use disorder with MOUD is essential to reducing overdose deaths; however, many individuals in need experience difficulties accessing this potentially life-saving treatment. For example, the Office of Inspector General found that fewer than one in five Medicare enrollees with opioid use disorder received MOUD in 2021. Individuals seeking treatment often face barriers such as difficulty finding providers who are authorized and/or willing to prescribe or dispense MOUD and stigma surrounding its use. For example, until recently, only providers with a Federal waiver could prescribe or administer buprenorphine for opioid use disorder in an office setting. Research also suggests that particular demographic groups, such as adolescents or people of certain races, may be less likely to receive MOUD. Medicaid covers an estimated 40 percent of nonelderly adults with opioid use disorder, underscoring the program's key role in providing access to MOUD. In this data brief, OIG examined the extent to which Medicaid enrollees with opioid use disorder received MOUD in 2021.

OIG used Medicaid claims data to determine the extent to which Medicaid enrollees with opioid use disorder received MOUD through Medicaid in 2021. Because Medicaid enrollees may be dually enrolled in Medicare, OIG also reviewed Medicare claims data to determine if enrollees who were enrolled in both programs received MOUD through Medicare. Additionally, the OIG used Medicaid enrollment and eligibility data to examine how MOUD treatment rates differed among demographic groups.

SunHawk Summary of OIG Evaluation Findings and Recommendations

The OIG's findings underscore the need for continued efforts to increase the use of MOUD in Medicaid. Accordingly, OIG recommended that the Centers for Medicare & Medicaid Services (CMS) (1) encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may be underserved; and (2) encourage States and work with Federal partners to educate Medicaid and CHIP enrollees about access to MOUD.

Work Plan #: OEI-BL-22-00260 (September 2023)
Government Program: Medicaid

[NEW] Four States Reviewed Received Increased Medicaid COVID-19 Funding Even Though They Terminated Some Enrollees' Coverage for Unallowable or Potentially Unallowable Reasons

The COVID-19 pandemic was declared a nationwide Public Health Emergency (PHE) in January 2020. In March 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA), which provided States with a temporary increase of 6.2 percentage points to their regular Federal medical assistance percentage (FMAP) rates. To qualify, States must meet certain FFCRA requirements. The increased COVID-19 FMAP became effective January 1, 2020, and extends through

December 31, 2023. The amount of the FMAP increase began phasing down April 1, 2023.OIG's objective was to determine whether selected States met the requirements to receive the increased COVID-19 FMAP.

The OIG selected four States (New York, Florida, Texas, and Minnesota) for review. These States received an additional $12.8 billion in FMAP funding during OIG's audit period (January 1, 2020, through June 30, 2021). For each State, we: (1) reviewed the PHE eligibility policies and procedures; (2) obtained and compared a list of Medicaid enrollees on March 18, 2020, and June 30, 2021; (3) analyzed enrollee terminations; (4) analyzed cost-sharing related to COVID 19 testing, services, or treatment; and (5) reviewed premiums to verify that the States met FFCRA requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

The four States OIG reviewed did not meet all of the requirements to receive the increased COVID 19 FMAP. All four States terminated Medicaid enrollees' coverage for unallowable or potentially unallowable reasons. Two States (Texas and Minnesota) terminated Medicaid coverage for 26,915 total enrollees for unallowable reasons, and three States (New York, Florida, and Minnesota) terminated Medicaid coverage for 220,113 total enrollees for potentially unallowable reasons due to a lack of support or documentation.

Additionally, Minnesota may have inappropriately charged some enrollees cost-sharing for COVID 19 testing, services, and treatment. Minnesota could not determine whether Medicaid enrollees were responsible for any cost-sharing, and enrollees may have been charged up to $951,202 for COVID 19-related testing, services, and treatment.

OIG recommended that CMS: (1) work with the four States to determine what amount, if any, of the funding they received because of the increased COVID-19 FMAP should be refunded to the Federal Government; and (2) work with Minnesota to determine whether Medicaid enrollees were responsible for any cost-sharing for COVID-19 testing, services, or treatments and, if any cost-sharing is identified, work with Minnesota to ensure that enrollees are reimbursed for any out-of-pocket expenses incurred.

Work Plan #: A-06-21-09002 (September 2023)
Government Program: Medicaid

[NEW] New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid enrollees. The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid managed care organization (MCO) industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several news articles have highlighted concerns related to the Medicaid managed care program and its oversight. OIG's objective was to determine whether New York's oversight of Centers Plan for Healthy Living (CPHL) ensured compliance with Federal and State requirements when CPHL denied access to requested services that required prior authorization.

OIG's audit covered denials of prior authorization requests for CPHL long-term care services and dental services that were either overturned by New York or withdrawn by CPHL. For these requests submitted during the period from April 2018

through March 2020, CPHL reported 1,131 overturned denials and 19 withdrawn denials. OIG reviewed a judgmental sample of 70 denials to determine whether they complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

For 35 of 70 sampled denials, New York's oversight of CPHL ensured that CPHL complied with Federal and State requirements when it initially denied prior authorization requests for services and items. These denials were overturned by the State Department of Financial Services or State Office of Temporary and Disability Assistance based on additional information provided during the appeal process. However, for the remaining 35 sampled denials, OIG determined that CPHL justified the denials by citing incorrect information in denial notices issued to the associated Medicaid enrollees. Ultimately, the enrollees' access to requested services associated with these sampled claims were delayed a median of 75 days and, in one case, as many as 282 days, which may have significantly impacted the health and safety of Medicaid enrollees.

The OIG determined that New York's monitoring was not effective to ensure that CPHL complied with requirements for denying prior authorization requests. New York did not-and was not required to-regularly obtain and review information related to MCOs' initial denials and internal appeals of prior authorization requests. Rather, New York relied on its retrospective review of a sample of prior authorization denials during its biennial operational surveys and other data. Without obtaining and reviewing information related to MCOs' initial denials and internal appeals, New York had limited ability to conduct effective oversight of CPHL's prior authorization practices.

OIG recommended that New York: (1) use the finding in this report to determine whether CPHL was noncompliant and determine whether a corrective action plan or other sanctions are appropriate, (2) review CPHL's appeal process and ensure that CPHL makes any necessary changes to comply with requirements for denying services, and (3) implement procedures to obtain and review information related to MCOs' initial denials and internal appeals.

Work Plan #: A-02-21-01016 (September 2023)
Government Program: Medicaid

[NEW] Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to people enrolled in Medicaid. The Senate Special Committee on Aging asked OIG to conduct a review of the Medicaid managed care organization (MCO) industry to determine whether MCOs are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight. OIG's objective was to determine whether Amerigroup Iowa, Inc. (Amerigroup), complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, medical services that members had requested during 2018 and 2019.

During 2018 and 2019, Amerigroup denied 12,910 of the 482,937 prior authorization requests it received. OIG's audit covered the 12,910 prior authorization denials, which included 2,572 denials that members or providers subsequently appealed. OIG selected and reviewed a judgmental sample of 50 prior authorization denials and 50 appeals of prior authorization denials to determine whether Amerigroup's processes complied with Federal and State requirements.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D ï Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

Amerigroup complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, 80 of the 100 sampled prior authorization denials and appeals for medical services that members had requested during 2018 and 2019. However, it did not comply with Federal and State requirements when it denied the remaining 20 prior authorization requests and appeals that OIG sampled.

For 19 of the 20 sampled prior authorization denials and appeals that did not comply with Federal and State requirements, Amerigroup did not provide correct or any information to members regarding their State fair hearing rights. For the other 1 of the 20 sampled prior authorization denials and appeals that did not comply with requirements, Amerigroup was unable to locate or provide documentation to support a prior authorization denial.

Although Amerigroup denied only 3 percent of requested medical services during its prior authorization process, OIG noted that of the 2,572 prior authorization requests that Amerigroup denied in 2018 and 2019 and that were subsequently appealed, a total of 1,605 of those denials (62 percent) were overturned through Amerigroup's appeal process.

OIG recommended that Amerigroup coordinate with Iowa to improve its prior authorization and appeal processes to ensure that members receive correct information regarding prior authorizations, the appeal process, and State fair hearing rights, procedures, and timeframes; and review and update its prior authorization process to improve communication with providers.

Work Plan #: A-07-22-07007 (September 2023)
Government Program: Medicaid

[NEW] States Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

Previous OIG audits found that State Medicaid agencies made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State. OIG is concerned that the concurrent Medicaid enrollment identified in OIGôs previous audits could be an issue that negatively impacts Texasô Medicaid program. OIGôs objective was to determine whether States made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Florida (A-05-21-00028)

Florida made August 2020 Medicaid managed care capitation payments totaling $15.8 million on behalf of 55,164 enrollees who were concurrently enrolled for Medicaid benefits in another State. Of the 100 enrollees in the OIGôs stratified random sample, OIG determined that 56 enrollees were residing and enrolled for Medicaid benefits in Florida. However, Florida made August 2020 capitation payments totaling $22,624 ($15,336 Federal share) on behalf of 44 Florida Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of the OIGôs sample

results, OIG estimated that Florida incurred costs of $6.9 million ($4.7 million Federal share) for August 2020 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

OIG recommended that Florida resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding plan to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State when the PHE ends, and work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

[NEW] Texas (A-05-22-00018)

Texas made August 2021 Medicaid managed care capitation payments totaling $30.9 million on behalf of 61,065 enrollees who were concurrently enrolled for Medicaid benefits in Texas and another State. Of the 100 enrollees in the OIG's stratified random sample, OIG determined that 62 enrollees were residing and enrolled for Medicaid benefits in Texas. However, Texas made August 2021 capitation payments totaling $31,939 ($21,744 Federal share) on behalf of 38 Texas Medicaid managed care enrollees who were residing and concurrently enrolled for Medicaid in another State. On the basis of the OIG's sample results, OIG estimated that Texas incurred costs of $12.8 million ($8.7 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in another State.

OIG recommended that Texas resume and enhance procedures that are in accordance with Federal requirements and the State's unwinding process to identify and disenroll enrollees who are residing and enrolled in Medicaid managed care in another State, and work with CMS to consider the potential use of T-MSIS data to identify potential cases of concurrent enrollment.

Work Plan #: A-05-22-00018 (September 2023); A-05-21-00028 (February 2023)
Government Program: Medicaid

[NEW] Puerto Rico Claimed Over $7 Million in Federal Reimbursement for Medicaid Capitation Payments Made on Behalf of Enrollees Who Were or May Have Been Deceased

Previous OIG audits identified unallowable Federal Medicaid reimbursement for managed care payments (known as capitation payments) made on behalf of deceased enrollees. OIG audited the Puerto Rico Department of Health (DOH) because OIG previously identified factors that may increase the risk of similar overpayments. OIG's objective was to determine whether DOH claimed Federal Medicaid reimbursement for capitation payments to managed care organizations (MCOs) on behalf of deceased enrollees.

OIG's audit covered 31,974 Medicaid capitation payments, totaling $8.9 million, made by ASES (the Spanish acronym for the Puerto Rico Health Insurance Administration) on behalf of deceased enrollees. OIG reviewed capitation payments during OIG's audit period (April 1, 2018, through September 30, 2020). The OIG selected a stratified random sample of 105 capitation payments totaling $70,215 ($66,484 Federal share) for review. For each of these payments, the OIG used a variety of sources, including the Social Security Administration's Death Master File (DMF), the Puerto Rico Demographic Registry, Accurint (a commercial source of public records), and obituaries, to determine enrollee's month and year of death.

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

DOH claimed Federal Medicaid funds for capitation payments to MCOs on behalf of enrollees who were deceased or potentially deceased. Three of the 105 sampled capitation payments were for enrollees who were not deceased during the month covered by the capitation payment. For 90 sampled payments, OIG confirmed that the associated enrollees were deceased prior to the month covered by the capitation payment. For the remaining 12 sampled payments, the enrollees had a date of death recorded in the DMF; however, OIG could not confirm the enrollee's month and year of death.

These unallowable and potentially unallowable payments occurred because DOH's controls were not sufficient to identify deceased enrollees. Also, DOH lacked a process to ensure that ASES identified and made adjustments to correct unallowable capitation payments.

On the basis of the OIG sample results, OIG estimated that DOH claimed at least $6,979,822 in unallowable Federal Medicaid funds and $885,123 in potentially unallowable Federal Medicaid funds. The OIG made a series of recommendations to DOH, including that it: (1) refund $6,979,822 to the Federal Government and (2) review potentially unallowable payments, estimated as $885,123, and refund the Federal share of any unallowable amounts to the Federal Government. OIG also made other procedural recommendations to ensure that Puerto Rico does not make capitation payments on behalf of deceased enrollees.

Work Plan #: A-02-21-01005 (September 2023)
Government Program: Medicaid

[NEW] Puerto Rico Claimed More Than $500 Thousand in Unallowable Medicaid Managed Care Payments for Enrollees Assigned More Than One Identification Number

Previous OIG audits identified unallowable Federal Medicaid reimbursement for managed care payments (known as capitation payments) on behalf of enrollees who had more than one Medicaid identification (ID) number. The OIG audited Puerto Rico because OIG previously identified factors that may increase the risk of potential overpayments related to Medicaid enrollees assigned more than one ID number. OIG's objective was to determine whether the Puerto Rico Department of Health (DOH) claimed Federal Medicaid reimbursement for capitation payments to managed care organizations (MCOs) on behalf of enrollees who were assigned more than one ID number.

OIG's audit covered $1.4 million in Medicaid capitation payments for 578 enrollee-matches that the Puerto Rico Health Insurance Administration (referred to in Spanish as the Administracion de Seguros de Salud de Puerto Rico or ASES) made to MCOs for the same enrollee under different ID numbers for the same month from April 1, 2018, through September 30, 2020 (audit period). The OIG selected and reviewed a stratified random sample of 115 of these enrollee-matches. OIG defined an enrollee-match as more than one ID number associated with (1) the same Social Security number or (2) the same date of birth, first name (first eight characters), and last name.

SunHawk Summary of OIG Audit Findings and Recommendations

DOH improperly claimed Federal Medicaid funds for capitation payments to MCOs on behalf of enrollees assigned more than one ID number. Specifically, for all 115 enrollee-matches in OIG's sample, DOH claimed unallowable Federal Medicaid

funds. The assignment of more than one ID number occurred because DOH case workers did not effectively use search capabilities within DOH's electronic eligibility system to identify whether an applicant was already assigned an ID number, or the process was insufficient to prevent or detect errors. Also, DOH lacked policies and procedures to ensure ASES identified and recovered unallowable payments. On the basis of the OIG's sample results, the OIG estimated that DOH claimed at least $516,762 in unallowable Federal Medicaid funds during the audit period.

OIG recommended that DOH: (1) refund $516,762 to the Federal Government, (2) strengthen its process for ensuring that no person is issued more than one ID number, and (3) establish policies and procedures with ASES to ensure ASES recovers unallowable payments made on behalf of enrollees assigned more than one ID number.

Work Plan #: A-02-21-01004 (September 2023)
Government Program: Medicaid

[NEW] One Quarter of Medicaid Enrollees with HIV May Not Have Received Critical Services in 2021

In 2021, over a quarter of Medicaid enrollees with Human Immunodeficiency Virus (HIV) did not have evidence in their claims data of receiving one or more critical services—medical visits, viral load tests, and antiretroviral therapy (ART) prescriptions. These findings demonstrate that further action is needed to ensure that enrollees are receiving appropriate HIV care. Of particular concern, over 11,000 enrollees did not have evidence of receiving any of the three services the OIG reviewed. These services are recommended by the Department of Health and Human Services (HHS) for all people with HIV and are vital to their overall health as well as the prevention of HIV transmission within the general population.

HIV is a virus that infects tens of thousands of people in the United States (U.S.) each year. While HIV affects people from all walks of life, the epidemic continues to disproportionately impact gay and bisexual men; transgender people; youth ages 13-24; and Black and Hispanic/Latino people.

People diagnosed with HIV need regular care to improve their health outcomes, reduce HIV-related deaths, and ultimately reduce new HIV transmissions. The ultimate goal of HIV care is to achieve viral suppression-meaning that the amount of HIV in the body is very low or undetectable in viral load tests. At the individual level, viral suppression allows people with HIV to stay healthy, enjoy an improved quality of life, and live longer than if they were not virally suppressed. At the population level, viral suppression prevents transmission of HIV because people with HIV who reach and maintain viral suppression have effectively no risk of passing HIV to others. Lack of viral suppression among people with HIV is often attributed to appropriate care not being initiated or not being regularly received. HHS recognizes the importance of HIV care and developed guidelines on the clinical needs of people with HIV to achieve viral suppression.

The Medicaid program plays a critical role in ensuring that people with HIV receive care that can improve their ability to achieve and maintain viral suppression. In 2018, Medicaid covered an estimated 40 percent of all nonelderly people with HIV in the U.S. People with HIV who are covered by Medicaid also tend be part of populations disproportionately impacted by HIV overall, including Black and Hispanic/Latino people.

OIG reviewed the extent to which the Medicaid enrollees who had HIV diagnosis in their Medicaid or Medicare claims data had evidence of critical services to identify potential gaps in care in 2021. This review included both enrollees with Medicaid only and those who were enrolled in both Medicaid and Medicare (dual-eligible enrollees). OIG determined whether these

enrollees had evidence in their Medicaid and Medicare claims data of three medical services that are critical for all people with HIV according to HHS guidelines: (1) medical visits (in-person or telehealth), (2) viral load tests, and (3) antiretroviral therapy (ART) prescriptions.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Nationwide, 72,391 (or one in four) of the 265,493 Medicaid enrollees with HIV identified for this review did not have evidence of one or more critical services in 2021, with the absence of viral load tests being the most common gap in care. Further, 11,316 enrollees, or 4 percent of the 265,493 enrollees in Medicaid with HIV, did not have evidence of any of the three services in 2021, which may mean that they were at greater risk of negative health impacts and HIV transmission.

Enrollees with HIV in Medicaid only were more frequently missing evidence of critical services than dual-eligible enrollees in 2021. All States in this review had enrollees with HIV who did not have evidence of one or more critical services in 2021, but State rates varied widely.

Work Plan #: OEI-05-22-00240 (August 2023)
Government Program: Medicaid

[NEW] Florida Did Not Refund $106 Million Federal Share of Medicaid Managed Care Rebates It Received for Calendar Years 2015 Through 2020

Prior OIG audits found that the audited States had improperly calculated or did not refund the Federal share of recoveries from Medicaid managed care organizations (MCOs). Florida's Medicaid program operates under a managed care waiver in which MCOs are required to make achieved savings rebates (rebates) to Florida when pre-tax income exceeds certain thresholds. OIG's objective was to determine whether Florida properly calculated the rebates in accordance with Florida statutes and terms of the MCO contracts and refunded the Federal share as required.

OIG's audit covered the $449 million in MCO rebates that Florida received for calendar years 2015 through 2020 (audit period). OIG reviewed Florida's general ledger activity for the account containing MCO rebates and the CMS-64 forms Florida filed to determine whether Florida properly reported the rebates and refunded the Federal share. OIG also confirmed that the MCO rebates were properly calculated.

SunHawk Summary of OIG Audit Findings and Recommendations

Florida calculated and received the required MCO rebates totaling $448,891,916 ($292,485,420 Federal share) for OIG's audit period in accordance with Florida statutes and the terms of the Medicaid MCO contracts. However, Florida did not properly refund the Federal share of MCO rebates in accordance with Federal requirements. Florida reported only calendar year 2020 rebates on the CMS-64, which totaled $274,856,893 ($186,332,359 Federal share), but it did not report rebates for calendar years 2015 through 2019 totaling $174,035,023 ($106,153,061 Federal share).

Florida did not report the rebates it received from the MCOs for calendar years 2015 through 2019 on the CMS-64 because Florida officials erroneously believed that they were not required to do so before the Centers for Medicare & Medicaid Services (CMS) added the January 15, 2021, provision to the special terms and conditions (STCs) specifically requiring Florida to refund the Federal share of rebates. As a result, before January 15, 2021, Florida did not include a step in its

written instructions for preparing the quarterly CMS-64 to report the rebates and refund the Federal share to the Federal Government.

OIG recommended that Florida refund $106,153,061 to the Federal Government, representing the Federal share of rebates for calendar years 2015 through 2019 that Florida did not refund.

Work Plan #: A-04-22-04089 (August 2023)
Government Program: Medicaid

[NEW] States With Separate Children's Health Insurance Programs Could Have Collected an Estimated $641 Million Annually If States Were Required To Obtain Rebates Through the Medicaid Drug Rebate Program

Under current Federal requirements for the Medicaid Drug Rebate Program (MDRP), States must obtain drug rebates for Medicaid-covered outpatient prescription drugs that are provided through Medicaid or an expansion of its Medicaid program (Medicaid expansion). However, for separate Children's Health Insurance Program (CHIP) drugs, those Federal Medicaid drug rebate requirements do not apply. As of the preparation of this Data Brief, 40 States operate separate CHIPs, whether in combination with Medicaid expansion or on a stand-alone basis. Separate CHIP is a program under which a State receives Federal funding to provide child health assistance to uninsured, low-income children and which meets the requirements of section 2103 of the Social Security Act.

OIG's objective was to identify the total drug rebates that States could have collected under their separate CHIPs if States had been required to obtain those rebates through the MDRP. The OIG used the State agencies' responses to a survey the OIG sent to them, to estimate the total rebates that States could have collected if the MDRP's rebate requirements were to be extended to all States that operated separate CHIPs.

SunHawk Summary of OIG Audit Findings and Recommendations

If Federal law were to require States to obtain rebates under the MDRP for separate CHIP drugs, the 40 States that operated separate CHIPs could, according to OIG's estimates, have invoiced, collected, and directly received $641.2 million from the drug manufacturers for calendar year 2020. These estimated rebates totaled $125.5 million for the States and $515.7 million for the Federal Government.

Because this Data Brief contains no recommendations, CMS did not provide written comments on OIG's draft Data Brief but did furnish technical comments, which the OIG addressed as appropriate.

Work Plan #: A-07-22-06106 (August 2023)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Texas Inappropriately Claimed Nearly $1.8 Million in Federal Medicaid Funds for Private Medicaid Management Information System Contractor Costs

The Medicaid Management Information System (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 generally are required to obtain prior approval in an Advanced Planning Document (APD) to receive the higher reimbursement rates. For Federal fiscal years 2013 through 2017, 10 States claimed more than 50 percent of the total costs related to private MMIS contractor services. Texas ranked 2nd highest.

OIG's objective was to determine whether Texas followed applicable Federal and State requirements related to claiming Federal Medicaid reimbursement for private MMIS contractor costs. OIG reviewed $129.3 million ($97.7 million Federal share) in claimed MMIS private contractor costs. The OIG reviewed Texas' APDs and related supporting documents.

SunHawk Summary of OIG Audit Findings and Recommendations

Texas followed applicable Federal and State requirements related to claiming Federal Medicaid reimbursement for $126.8 million ($96 million Federal share) in private MMIS contractor costs. However, Texas incorrectly claimed the remaining $2.5 million. For those costs, Texas inappropriately received $1.8 million in Federal funds.

Texas did not have adequate policies and procedures in place to ensure that MMIS private contractor costs were tracked to the correct APDs. Texas was not able to prevent or detect when it claimed inadequately supported costs, costs allocated to Medicaid using a methodology that was not approved in a Public Assistance Cost Allocation Plan (CAP), costs that were approved for the 50- or 75-percent rate but were claimed at the 90-percent rate, and costs that were claimed twice.

OIG recommended that Texas refund the $1.8 million Federal share to the Federal Government and strengthen or establish policies and procedures to track its private MMIS contractor costs to APDs and ensure that sufficient details are provided on contractors' employees timesheets, costs are allocated to Medicaid based on an approved methodology in the CAP, the Federal match is claimed at the approved rate, and it does not claim costs when it is reimbursed for those costs by other agencies.

Work Plan #: A-06-19-09003 (August 2023)
Government Program: Medicaid

[NEW] New York Improved Its Monitoring of Medicaid Community Rehabilitation Services But Still Claimed Improper Federal Medicaid Reimbursement Totaling $20 Million

A prior OIG audit of Medicaid community rehabilitation services in New York identified significant noncompliance with Federal and State requirements and recommended that New York develop guidance to physicians. Although New York stated that it would disseminate any necessary guidance, it did not subsequently develop any guidance for physicians. Rather, New York amended State regulations that required a summary of the service plan review to be submitted to

physicians prior to the reauthorization of community rehabilitation services. As a result, there is a risk that vulnerabilities that OIG previously identified in the program still exist. The objective of the OIG's audit was to determine whether New York claimed Federal Medicaid reimbursement for community rehabilitation services in accordance with Medicaid requirements.

OIG's audit covered 325,776 claims for community rehabilitation services for which New York claimed Medicaid reimbursement totaling $1.1 billion ($621 million Federal share) during the period January 1, 2018, through December 31, 2021 (audit period). The OIG reviewed a stratified random sample of 120 claims, and for each claim, reviewed medical and billing documentation maintained by providers to determine if the associated services complied with Medicaid requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

New York generally complied with Medicaid requirements for claiming Federal reimbursement for community rehabilitation services. For 111 of the 120 sampled claims, New York properly claimed Medicaid reimbursement for all community rehabilitation services. However, New York claimed reimbursement for some unallowable community rehabilitation services for the remaining 9 sampled claims. Specifically, services were provided although service plans were not timely signed or maintained, claims did not meet Medicaid reimbursement standards, and services were not appropriately authorized.

On the basis of OIG's sample results, OIG estimated that New York improperly claimed at least $19.9 million in Federal Medicaid reimbursement for community rehabilitation services that did not comply with Medicaid requirements. Although OIG commends New York for its efforts in improving some aspects of its monitoring of providers, its overall monitoring activities were still not adequate to ensure that providers complied with Medicaid requirements.

The OIG recommended that New York refund $19.9 million to the Federal Government. OIG also recommends that New York improve its monitoring activities by increasing the number of case files reviewed when conducting monitoring visits at providers, and by providing formal guidance or training to providers to clarify Medicaid requirements related to providing community rehabilitation services.

Work Plan #: A-02-22-01011 (July 2023)
Government Program: Medicaid

[NEW] High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

As Medicaid managed care enrollment continues to grow, Medicaid managed care organizations (MCOs) play an increasingly important role in ensuring that people with Medicaid have access to medically necessary, covered services. In recent years, allegations have surfaced that some MCOs inappropriately delayed or denied care for thousands of people enrolled in Medicaid, including patients who needed treatment for cancer and cardiac conditions, elderly patients, and patients with disabilities who needed in-home care and medical devices. Ensuring access to appropriate care for people in Medicaid managed care is a priority for OIG. In addition, OIG received a congressional request to evaluate whether MCOs are providing medically necessary health care services to their enrollees.

OIG identified and selected the seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all States. These 7 parent companies operated 115 MCOs in 37 States, which enrolled a total of 29.8 million people in 2019. OIG collected data from the selected parent companies about prior authorization denials and

related appeals for each MCO they operated. OIG also surveyed State Medicaid agency officials from the 37 States to examine selected aspects of State oversight of MCO prior authorization denials and appeals, along with State processes for external medical reviews and fair hearings.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Overall, the MCOs included in OIG's review denied one out of every eight requests for the prior authorization of services in 2019. Among the 115 MCOs in OIG's review, 12 had prior authorization denial rates greater than 25 percent-twice the overall rate. Despite the high number of denials, most State Medicaid agencies reported that they did not routinely review the appropriateness of a sample of MCO denials of prior authorization requests, and many did not collect and monitor data on these decisions. The absence of robust mechanisms for oversight of MCO decisions on prior authorization requests presents a limitation that can allow inappropriate denials to go undetected in Medicaid managed care.

Although the appeals process is intended to act as a potential remedy to correct inappropriate denials, several factors may inhibit its usefulness for this purpose in Medicaid managed care. Most State Medicaid agencies reported that they do not have a mechanism for patients and providers to submit a prior authorization denial to an external medical reviewer independent of the MCO. Although all State Medicaid agencies are required to offer State fair hearings as an appeal option, these administrative hearings may be difficult to navigate and burdensome on Medicaid patients. OIG found that Medicaid enrollees appealed only a small portion of prior authorization denials to either their MCOs or to State fair hearings.

In contrast to State oversight of prior authorization denials in Medicaid managed care, in Medicare managed care (called Medicare Advantage) CMS's oversight of denials by private health plans is more robust. For example, each year CMS reviews the appropriateness of a sample of prior authorization denials and requires health plans to report data on denials and appeals. Further, Medicare Advantage enrollees have access to automatic, external medical reviews of denials that plans uphold at the first level of appeal. These differences in oversight and access to external medical reviews between the two programs raise concerns about health equity and access to care for Medicaid managed care enrollees.

OIG recommend that CMS: (1) require States to review the appropriateness of a sample of MCO prior authorization denials regularly, (2) require States to collect data on MCO prior authorization decisions, (3) issue guidance to States on the use of MCO prior authorization data for oversight, (4) require States to implement automatic external medical reviews of upheld MCO prior authorization denials, and (5) work with States on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials.

Work Plan #: OEI-09-19-00350 (July 2023)
Government Program: Medicaid

[NEW] Montana Generally Complied With Requirements for Telehealth Services During the COVID-19 Pandemic

Medicaid telehealth refers to the services performed via a telecommunication system. A Medicaid patient at an originating site uses audio and video equipment to communicate with a health professional at a distant site. Because of the speed with which the use of telehealth has expanded during the COVID-19 pandemic, opportunities exist for inefficiencies and potential abuse in the telehealth system. Rapid expansion of telehealth may pose challenges for providers and State agencies, including State oversight of these services. OIG's objective was to determine whether Montana and Medicaid providers

complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic.

OIG's audit covered 440,003 Medicaid telehealth paid claim lines (lines), totaling $43.2 million (Federal share), that Montana claimed with paid dates of March 1 through December 31, 2020. OIG asked Montana to review the procedure codes paid as telehealth and identify which were allowable for billing as telehealth. OIG reviewed the supporting documentation to determine whether the providers had documentation to support that the services were rendered.

SunHawk Summary of OIG Audit Findings and Recommendations

Montana and Medicaid providers generally complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic. Over 99.9 percent of the lines OIG reviewed complied with Federal and State requirements. However, some Medicaid providers claimed services that did not comply with requirements for telehealth services. Specifically, OIG identified 121 lines totaling $9,589 (Federal share), each of which had 1 of the following types of errors: documentation did not support that services were performed; services were required to be face-to-face but were instead performed and billed as telehealth; or services were performed but providers incorrectly added a modifier or place of service code to indicate that the services were performed via telehealth.

These errors occurred because Montana's claim payment system did not have edits to ensure that only specific procedure codes eligible to be performed via telehealth were billed as telehealth.

OIG recommended that Montana develop and implement edits in its claim payment system so that it pays only telehealth claims whose procedure codes denote the associated services as eligible to be performed via telehealth.

Work Plan #: A-07-21-03250 (May 2023)
Government Program: Medicaid

[NEW] States Medicaid Fraud Control Unit: 2022 Inspection

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, 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 issues public reports of its findings.

SunHawk Summary of OIG Evaluation Findings and Recommendations

[NEW] District of Columbia (OEI-06-22-00420)

OIG conducted the review of the District of Columbia MFCU in September 2022. OIG's review covered the 3-year period of fiscal years (FYs) 2019-2021. OIG based the review on an analysis of data and information from seven sources: (1) a review of Unit documentation; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with Unit management and selected staff; (5) a review of a random sample of case files that were open at any point during the review period; (6) a review of convictions submitted to OIG for program exclusion and adverse actions submitted to the National Practitioner Data Bank during the review period; and (7) observation of Unit operations.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

OIG made two findings based on the review of areas of concern identified during the ongoing administration and oversight activities: the Unit's law enforcement authority and fraud referrals from managed care organizations (MCOs). OIG found that the Unit's limited law enforcement authority and the lack of adequate policies and procedures to address its limited authorities posed challenges during the OIG's review period of FYs 2019-2021. A few months after the onsite review, the District of Columbia OIG succeeded in obtaining a legislative amendment from the District of Columbia Council. The legislation, which was enacted in January 2023 as the Inspector General Enhancement Amendment Act of 2022, provides Unit investigators with enhanced law enforcement authorities. Despite the challenges associated with its limited law enforcement authority, OIG observed that the Unit maintained strong working relationships with Federal and District partners, including the U.S. Department of Health and Human Services OIG, the Federal Bureau of Investigation, the U.S. Attorney's Office, and the District's Department of Healthcare Finance's Division of Program Integrity. Further, OIG found that the Unit received few fraud referrals from MCOs during the review period but has begun to take steps to increase these referrals. OIG also made two findings related to other aspects of the Unit's operations. OIG found that, for cases open longer than 90 days, 41 percent lacked documentation of periodic supervisory reviews consistent with Unit policy. OIG also found that the Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes. These operational issues have persisted since the OIG's previous onsite review in 2015; however, the OIG found that the Unit has improved in both areas since that time.

To address the findings, the OIG recommended that the Unit (1) develop policies and procedures to implement the District of Columbia OIG's expanded law enforcement authority and ensure that Unit investigators receive training on the new authorities; (2) build upon its efforts with the District's Medicaid agency to increase fraud referrals from the MCOs; (3) ensure that supervisory reviews of case files are conducted and documented in accordance with Unit policy; and (4) ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.

[NEW] Minnesota (OEI-06-22-00430)

OIG conducted an onsite inspection of the Minnesota MFCU in October-November 2022. OIG's inspection covered Federal fiscal years (FYs) 2020-2022. The 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 Unit management and selected staff; (5) a review of a random sample of 86 case files from the Unit's 442 nonglobal case files that were open at any 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) an onsite review of Unit operations.

OIG found that the Minnesota MFCU operated in accordance with applicable laws, regulations, and policy transmittals, and reported strong case outcomes for FYs 2020-2022. From the data OIG reviewed, OIG found that the Unit maintained positive working relationships with Federal partners and investigated cases jointly. The Unit also reported nearly all convictions and adverse actions to Federal partners within the appropriate timeframes, including cases of patient abuse or neglect that were investigated and prosecuted by local authorities. However, OIG made four findings regarding the Unit's adherence to the MFCU performance standards and compliance with Federal regulations. First, OIG found that the director was the only supervisor in the Unit, which limited the oversight of Unit operations. Second, OIG found that, although the Unit took steps to coordinate with other State agencies, it received few referrals of patient abuse or neglect. Third, OIG found that the Unit lacked a case management system that allowed efficient and secure access to case information and case outcomes data, which posed challenges for locating documents and tracking case statuses. Finally, OIG found that the Unit did not

consistently conduct periodic supervisory reviews or document supervisory approvals in its case files. In addition to these findings, OIG made several observations regarding Unit operations and practices.

To address the findings, OIG recommend that the Unit (1) continue efforts to hire a second-line supervisor and assess whether additional supervisors are warranted to meet the Unit's oversight needs; (2) build upon its efforts to increase referrals of patient abuse or neglect; (3) implement a comprehensive case management system that allows for efficient access to case documents and information; and (4) take steps to ensure that periodic supervisory reviews are conducted on a consistent basis and that case files include documentation of supervisory approvals.

[NEW] Rhode Island (OEI-07-22-00370)

OIG conducted an inspection of the Rhode Island MFCU in August 2022. OIG's inspection covered the 3-year period of fiscal years 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's managers and other selected staff; (5) a review of a random sample of 51 criminal and nonglobal civil 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) an onsite review of Unit operations.

The Rhode Island MFCU maintained strong working relationships and investigated cases jointly with OIG and the U.S. Attorney's Office. The Unit also took steps to maintain an adequate volume and quality of fraud and patient abuse or neglect referrals, including maintaining strong relationships with State partners.

However, OIG made three findings related to the Unit's management of case files and case information. First, OIG found that the Unit did not have an information management system with the functionality to manage and track case information from initiation to resolution, which posed challenges for monitoring cases and reporting case information and performance data. Further, OIG found that the Unit did not have adequate policies or procedures, or consistent practices, for effectively maintaining case files. OIG also found that 60 percent of applicable case files contained no documentation of periodic supervisory reviews and that the Unit's policies and procedures manual did not describe the procedures for or frequencies of supervisory reviews.

OIG made four additional findings related to other aspects of the Unit's operations. OIG found that some parts of the Unit's policies and procedures manual lacked adequate guidance and some parts did not describe the Unit's current practices. In addition, the OIG found that the Supervisor of Investigations performed auditing duties and carried an investigative caseload in addition to his managerial responsibilities, which may have impeded the efficiency and effectiveness of the Unit's operations. OIG also found that the Unit did not consistently report convictions and adverse actions to Federal partners within the appropriate timeframes. Finally, OIG found that Unit supervisors did not track and verify that staff met training requirements.

To address the findings, the OIG recommend that the Unit (1) assess whether the Office of the Attorney General's case management system can be modified to fully meet the Unit's needs, and if appropriate, seek approval to implement its own case management system; (2) establish policies and/or procedures to ensure that case files are maintained in an effective manner; (3) develop a plan to ensure that case files include documentation of periodic supervisory reviews and update the Unit's policies and procedures manual to describe the Unit's current practices for periodic supervisory reviews; (4) update

its policies and procedures manual to reflect current practices; (5) assess the duties of the Supervisor of Investigations, and if warranted, develop a plan to reduce his nonmanagerial duties; (6) take steps to ensure that convictions and adverse actions are reported to Federal partners within the appropriate timeframes; and (7) take steps to track and verify that Unit staff meet requirements in its training plan.

Work Plan #: OEI-06-22-00420 (September 2023); OEI-06-22-00430 (September 2023); OEI-07-22-00370 (March 2023)
Government Program: Medicaid

[NEW] Missouri's Oversight of Certified Individualized Supported Living Provider Health and Safety Could Be Improved in Some Areas

States operate home and community-based services (HCBS) waiver programs under a waiver to their respective Medicaid State plans. States must ensure the health and welfare of the recipients of the service. Media coverage nationwide has highlighted injuries and deaths of these individuals, which were caused by abuse, neglect, and medical errors. OIG's objectives were to determine whether Missouri: (1) exercised adequate oversight of individualized supported living (ISL) providers to ensure the health and safety of Medicaid recipients with developmental disabilities residing in ISL settings and (2) established infection control and prevention standards to prepare ISL providers for an emergency situation similar to the COVID-19 pandemic.

OIG identified 218 Missouri-certified ISL providers that claimed a total of $132 million in Medicaid reimbursement during the quarter ended September 30, 2020. OIG selected 30 ISL providers and reviewed their most recent certification survey documentation and health and safety policies. OIG then selected 17 of those ISL providers for in-person site visits to their offices to review additional documentation.

SunHawk Summary of OIG Audit Findings and Recommendations

Missouri exercised oversight of ISL providers to ensure the health and safety of Medicaid recipients with developmental disabilities residing in ISL settings; however, improvements could be made. The State could not locate some of the certification survey supporting documentation for some of the providers, and the State completed some of the providers' certification surveys several months after the expiration of the providers' 2-year certification period. Furthermore, Missouri did not require providers to perform periodic background screenings of staff after hire. In addition, most of the 17 providers that OIG selected for site visits were missing at least some documentation of staff training, staff background screenings, staff driver's licenses, recipient rights reviews, or recipient monitoring. For OIG's second objective, Missouri had infection control and prevention guidelines in place, and all 30 ISL providers had related policies, but the State did not have guidelines for refresher training of provider staff periodically after hire. Although Missouri established health and safety requirements and guidelines for ISL providers and exercised related oversight, some of those requirements and guidelines could be strengthened and Missouri's oversight could be improved to ensure the health and safety of recipients.

OIG recommended that Missouri: (1) maintain all supporting documentation for certification surveys, (2) work to improve completion timeliness of the surveys, (3) consider strengthening background screening requirements for ISL providers to include periodic screenings of staff after hire; (4) continue to monitor ISL providers to ensure that they maintain documentation to support recipient health and safety; and (5) consider strengthening infection control and prevention guidelines for ISL providers to include periodic training of staff after hire.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Work Plan #: A-07-21-03247 (March 2023)
Government Program: Medicaid

[NEW] The District of Columbia Has Taken Significant Steps To Ensure Accountability Over Amounts Managed Care Organizations Paid to Pharmacy Benefit Managers

Spread pricing occurs when a managed care organization (MCO) contracts with a pharmacy benefit manager (PBM) to manage its prescription drug benefits, and the PBM keeps a portion of the amount the MCO paid to it for prescription drugs instead of passing the full payment on to the pharmacy. Several States have conducted audits of PBM spread pricing practices due to concerns about the transparency and appropriateness of spread pricing in the Medicaid program. Other States, including New York, Texas, and Virginia, have enacted or drafted legislation to increase transparency and change the contracting process with PBMs. OIG's objective was to determine whether the District of Columbia provided oversight of its MCOs to ensure adequate accountability over amounts paid to PBMs for prescription benefits.

OIG reviewed the contracts between the District and its five MCOs and the seven contracts between those MCOs and PBMs from October 1, 2016, through September 30, 2019 (audit period). OIG also reviewed the five MCOs' claims for prescription drugs dispensed during the audit period and obtained the amounts the PBMs reimbursed pharmacies for the prescription drugs dispensed during the audit period.

SunHawk Summary of OIG Audit Findings and Recommendations

The District provided some oversight of its MCOs with the intent of ensuring adequate accountability over amounts paid for prescription benefits to its PBMs. This oversight consisted of guidance requiring MCOs to report spread pricing. However, the amounts reported were aggregated with other amounts and as a result did not provide transparency over the amount of the funds that was attributable to spread pricing. OIG found that PBMs kept $23.3 million in spread pricing during OIG's audit period. Spread pricing may increase the cost of Medicaid prescriptions for both the MCO and the Medicaid program and, if not correctly accounted for, inflate the cost of the drugs. Limiting spread pricing may decrease Federal and State spending through lower payments to MCOs.

OIG recommended that the District develop policies and procedures for validating MCO, PBM, and pharmacy transactions on a periodic basis to ensure transparency of costs associated with the prescription drug program.

Work Plan #: A-03-20-00200 (March 2023)
Government Program: Medicaid

[NEW] Georgia Did Not Comply With Federal Waiver and State Requirements at All 20 Adult Day Health Care Facilities Reviewed

The Georgia Home and Community-Based Services Waiver program (the program) funds home and community-based services for people 65 and older and individuals with disabilities under 65 who are eligible for medical assistance and require the level of care provided in a nursing home but choose to live in the community. Georgia operates the program under a

Federal waiver to its Medicaid State plan. The program funds adult day health care services for Medicaid beneficiaries who reside at home and attend adult day health care facilities (facilities). OIG have conducted various health and safety reviews nationwide and wanted to determine whether vulnerable adults participating in this program were at risk. The objective of this review was to determine whether Georgia complied with Federal waiver and State requirements in overseeing facilities that serve vulnerable adults who receive services through the program.

Of the 102 facilities providing program services (providers) in Georgia as of December 31, 2021, OIG selected 20 for review based on their geographic location and number of participants. OIG conducted unannounced site visits from July 11 through 15, 2022.

SunHawk Summary of OIG Audit Findings and Recommendations

Georgia did not fully comply with Federal waiver and State requirements in overseeing providers that serve vulnerable adults receiving adult day health care services through the program. Of the 20 providers that OIG reviewed, 19 did not comply with 1 or more health and safety requirements, and 18 did not comply with 1 or more administrative requirements. OIG found 312 instances of provider noncompliance, including 126 instances of noncompliance with health and safety requirements. The remaining 186 instances related to administrative requirements, some of which could significantly affect health and safety.

Georgia did not fully comply with Federal waiver and State requirements because its inspections of facilities were insufficient to ensure a continuously safe and non-hazardous environment.

OIG recommended that Georgia ensure that providers correct the 312 instances of provider noncompliance identified in this report; improve its oversight and monitoring of providers; and work with providers to improve their facilities, staffing, and training.

Work Plan #: A-04-22-00134 (March 2023)
Government Program: Medicaid

[NEW] States Did Not Always Invoice Rebates to Manufacturers for Pharmacy and 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 OIG audits found that States did not always invoice and collect all rebates due for drugs administered by pharmacies and physicians. OIG's objective was to determine whether States complied with Federal Medicaid requirements for invoicing manufacturers for rebates for pharmacy and physician-administered drugs.

OIG used the Centers for Medicare & Medicaid Services's (CMS's) Medicare Part B crosswalk and the CMS Medicaid Drug File to identify single-source and multiple-source drugs. In addition, OIG determined whether the Healthcare Common Procedure Coding System codes were published in CMS's top-20 multiple-source drug listing.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Alabama (A-04-21-08090)

Alabama did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for pharmacy and physician-administered drugs. Alabama did not invoice for, and collect from manufacturers, rebates associated with $21 million ($14.9 million Federal share) in single-source and $62,043 ($43,981 Federal share) in top-20 multiple-source physician-administered drug claims. Further, OIG were unable to determine whether, in some cases, Alabama was required to invoice for rebates for other multiple-source physician-administered drug claims. Alabama did not invoice the manufacturers for rebates associated with the claims totaling $410,454 ($290,455 Federal share) for these multiple-source drugs. Lastly, the OIG identified $6,568 ($4,719 Federal share) in single-source and $219,220 ($157,395 Federal share) in multiple-source pharmacy drug claims where Alabama did not collect a rebate from manufacturers.

OIG recommended that Alabama refund to the Federal Government $14.9 million (Federal share) for claims for single-source physician-administered drugs and $43,981 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommends that Alabama work with CMS to determine and refund the unallowable portion of $290,455 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement and consider invoicing drug manufacturers for rebates for those drug claims that CMS determines are allowable. Additionally, OIG recommended that Alabama complete the process for rebating pharmacy drugs totaling $6,568 ($4,719 Federal share) for single-source and $219,220 ($157,395 Federal share) for multiple-source drugs that it had not previously collected a rebate on or refund the Federal share. The OIG also made two additional recommendations.

[NEW] Georgia (A-04-21-08089)

Georgia did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for pharmacy and physician-administered drugs. Georgia did not invoice for, and collect from manufacturers, rebates associated with $953,067 ($644,802 Federal share) in single-source and $13,785 ($9,325 Federal share) in top-20 multiple-source physician-administered drug claims. Further, OIG were unable to determine whether, in some cases, Georgia was required to invoice for rebates for other multiple-source physician-administered drug claims. Georgia did not invoice the manufacturers for rebates associated with the claims totaling $78,013 ($52,837 Federal share) for these multiple-source drugs. Additionally, the OIG identified $1.8 million ($1.2 million Federal share) in single-source and $526,240 ($360,454 Federal share) in multiple-source pharmacy drug claims that were not rebated for prior to the OIG's audit.

OIG recommended that Georgia refund to the Federal Government $644,802 (Federal share) for claims for single-source physician-administered drugs and $9,325 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommends that Georgia work with CMS to determine and refund the unallowable portion of $52,837 (Federal share) for other claims for multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement, and consider invoicing drug manufacturers for rebates for those drug claims that CMS determines are allowable. The OIG also made three additional recommendations.

Work Plan #: A-04-21-08090 (September 2023); A-04-21-08089 (March 2023)
Government Program: Medicaid

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] At A Glance: Medicaid Fraud Control Units Fiscal Year 2022 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 2022. Those MFCUs operated in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

SunHawk Summary of OIG Evaluation Findings and Recommendations

MFCUs play a vital role in holding wrongdoers accountable for Medicaid provider fraud and protecting patients from abuse or neglect. Medicaid, as a Federal-State partnership that provides health insurance for over 80 million individuals, requires skilled and effective oversight from both the Federal and State governments. MFCUs, which report to, or work closely with, the State Attorney General, and which receive funding and oversight from OIG, are uniquely positioned to investigate and prosecute provider fraud and patient abuse or neglect in coordination with Federal and State law enforcement and oversight agencies.

Work Plan #: OEI-09-23-00190 (March 2023)
Government Program: Medicaid

[NEW] States' MMIS and E&E Systems Security Controls Were Generally Effective, but Some Improvements Are Needed

OIG is conducting a series of audits of State Medicaid Management Information Systems (MMISs) and Eligibility and Enrollment (E&E) systems of selected States to determine how well these systems are protected when subjected to cyberattacks. OIG's objectives were to determine whether: (1) security controls in operation in selected States' MMIS and E&E system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needs to compromise the selected States' Medicaid System or its data, and (3) the selected States' ability to detect cyberattacks against its Medicaid MMIS and E&E system and respond appropriately.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Maryland (A-18-21-09003)

The Maryland MMIS and E&E system had security controls in place that were partially effective to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, improvements are needed to better prevent certain cyberattacks. Maryland did not correctly implement seven security controls from the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4.

In addition, OIG estimated that the level of sophistication needed by an adversary to compromise the Maryland MMIS and E&E system was limited. At this level, an adversary would need a limited level of expertise, with limited resources and opportunities to support a successful attack. Finally, Maryland demonstrated a partial ability to detect some of OIG's cyberattacks against its MMIS and E&E system and respond appropriately.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

A potential reason why Maryland did not implement these security controls correctly may be that system administrators were not aware of government standards or industry best practices that require securely configured systems before deployment to production. Maryland also may not have considered the latest email phishing tactics used by cyber adversaries in developing the cybersecurity awareness training provided to its employees and contractors. Additionally, Maryland's procedures for periodically assessing the implementation of the NIST security controls above were not effective. As a result of Maryland not correctly implementing these controls, an attacker could potentially extract sensitive data and PII, impersonate other users, and redirect users to malicious websites which facilitates an attacker's ability to get an initial foothold and potentially move deeper into the network, thereby exposing critical systems and data to attack and compromise.

OIG recommended that Maryland: (1) remediate the seven control findings OIG identified; (2) assess the effectiveness of all required NIST SP 800-53 controls according to the organization's defined frequency; (3) assess at least annually and if necessary, adjust baseline configurations for its MMIS and E&E public servers; and (4) perform periodic phishing exercises and enhance employee and contractor cybersecurity awareness training based on the results of the phishing exercises, if needed.

[NEW] Massachusetts **(**A-18-20-08003**)**

The Massachusetts MMIS and E&E system had generally effective security controls in place to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, some of those security controls could be further enhanced to better prevent certain cyberattacks. Massachusetts did not correctly implement three security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4.

In addition, OIG estimated that the level of sophistication needed by an adversary to compromise the Massachusetts MMIS and E&E system was moderate. At this level, an adversary would need a moderate level of expertise, with moderate resources and opportunities to support multiple successful coordinated attacks. Finally, based on the results of certain simulated cyberattacks that OIG conducted, OIG determined that some improvements were needed in Massachusetts detection controls to better identify cyberattacks against its MMIS and E&E system and respond appropriately.

A potential reason why Massachusetts did not implement these security controls correctly may be that system administrators were not aware of certain published vendor security advisories or mitigation guidance. Additionally, Massachusetts's procedures for periodically assessing the implementation of the weak NIST security controls OIG identified were not effective. Because Massachusetts did not correctly implement these controls, an attacker could potentially collect sensitive server information to facilitate exploitation of an application or web server or cause a denial-of-service.

OIG recommended that Massachusetts: (1) remediate the three security control findings OIG identified, (2) assess the effectiveness of all required NIST SP 800-53 controls according to the organization's defined frequency, and (3) assess and adjust, if necessary, vulnerability management procedures to ensure any pertinent publicly disclosed computer security vulnerabilities are assessed for risk and remediated promptly, if necessary.

[NEW] Michigan **(**A-18-20-08004**)**

The Michigan MMIS and E&E System had reasonable security controls in place to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, some of those security controls could be further enhanced to better prevent certain cyberattacks. Michigan did not correctly implement six security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

In addition, OIG estimated that the level of sophistication required to compromise the Michigan MMIS and E&E system was significant. At this level, an adversary would need a sophisticated level of expertise, with significant resources and opportunities to support multiple successful coordinated attacks. Finally, based on the results of OIG's simulated cyberattacks, some improvements were needed in Michigan's detection controls to better identify cyberattacks against its MMIS and E&E system and respond appropriately. Potential reasons why Michigan did not implement these security controls correctly may be that software developers did not follow secure coding standards to prevent security vulnerabilities or system administrators were not aware of government standards or industry best practices that require securely configuring systems before deployment to production. Michigan also may not have properly factored in cybersecurity risks during the design and implementation of authentication management for their MMIS and E&E systems. Additionally, Michigan's procedures for periodically assessing the implementation of the weak NIST security controls OIG identified were not effective. By addressing the root causes of the security control failures OIG identified, Michigan can bolster its ability to detect and prevent certain cyberattacks.

OIG recommended that Michigan (1) remediate the six security control findings OIG identified, (2) assess the effectiveness of all required NIST SP 800-53 controls according to the organization's defined frequency, and (3) assess the cryptographic configurations of public servers at least annually and adjust if the requirements have changed.

[NEW] Puerto Rico (A-18-20-08005)

The Puerto Rico MMIS and E&E system had reasonable security controls in place to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, some of those security controls could be further enhanced to better prevent certain cyberattacks. Puerto Rico did not correctly implement five security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4.

In addition, OIG estimated that the level of sophistication required by an adversary to compromise the Puerto Rico MMIS and E&E system was significant. At this level, an adversary would need a sophisticated level of expertise, with significant resources and opportunities to support multiple successful coordinated attacks. Finally, based on the results of OIG's simulated cyberattacks, some improvements were needed in Puerto Rico detection controls to better identify cyberattacks against its MMIS and E&E system and respond appropriately.

Potential reasons why Puerto Rico did not implement these security controls correctly may be that software developers did not follow secure coding standards to prevent security vulnerabilities or system administrators were not aware of government standards or industry best practices that require securely configuring systems before deployment to production Puerto Rico also may not have properly factored in cybersecurity risks during the design and implementation of authentication management for their MMIS and E&E systems. Additionally, Puerto Rico's procedures for periodically assessing the implementation of the NIST security controls above were not effective. By addressing the root causes of the security control failures OIG identified, Puerto Rico can bolster its ability to detect and prevent certain cyberattacks.

OIG recommended that Puerto Rico: (1) remediate the vulnerabilities related to the five security control findings identified by properly implementing and regularly assessing the associated NIST SP 800-53 controls and (2) assess the cryptographic configurations of public servers at least annually and adjust if the requirements have changed.

[NEW] South Dakota (A-18-21-09004)

The South Dakota MMIS and E&E system had security controls in place that were partially effective to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, some of those security controls could be further enhanced to better prevent certain cyberattacks. South Dakota did not correctly implement six security controls from the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4.

In addition, OIG estimated that the level of sophistication needed by an adversary to compromise the South Dakota MMIS and E&E system was moderate. At this level, an adversary would need a moderate level of expertise, with moderate resources and opportunities to support a successful attack. Finally, based on the results of OIG's simulated cyberattacks, South Dakota would need to improve its monitoring controls to better detect cyberattacks against its MMIS and E&E system and respond appropriately.

Potential reasons why South Dakota did not implement these security controls correctly may be that system developers and system administrators were not aware of government standards or industry best practices that require securely configured systems or did not correct flaws in systems before deployment to production. Additionally, South Dakota's procedures for periodically assessing the implementation of the NIST security controls above were not effective. As a result of South Dakota not correctly implementing these controls, an attacker could potentially extract sensitive data and PII, impersonate other users, and redirect users to malicious websites.

OIG recommended that South Dakota remediate the six control findings OIG identified.

Work Plan #: A-18-21-09004 (October 2023); A-18-21-09003 (May 2023); A-18-20-08003 (May 2023); A-18-20-08004 (March 2023); A-18-20-08005 (November 2022)
Government Program: Medicaid

[NEW] Texas Could Not Support the Permissibility of the Funds Used as the State Share of the Medicaid Delivery System Reform Incentive Payment Program

Delivery System Reform Incentive Payment (DSRIP) Program payments are incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families served. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost $10 billion for demonstration years 1 through 5. OIG's objective was to determine whether Texas used permissible funds as the State share of DSRIP Program payments.

OIG's audit covered the State share of $294.1 million of the $694.2 million in total DSRIP Program payments made to one provider for December 12, 2011, through September 30, 2016. OIG calculated the DSRIP payments and required State share and traced them to the financial records to determine the source and amount of funds used as the State share for the DSRIP payments.

SunHawk Summary of OIG Audit Findings and Recommendations

Texas could not support that the $294.1 million in funds that it used as the State share of Parkland Hospital's (Parkland's) DSRIP Program payments were derived from permissible sources. This occurred because Texas did not provide any guidance to the Dallas County Hospital District, dba Parkland Health & Hospital System (Hospital District), for identifying

and documenting the funding sources used for the DSRIP intergovernmental transfers (IGTs). Consequently, the Hospital District did not put controls in place to identify the source of funds or maintain documentation to support the permissibility of the funds used for the DSRIP IGTs.

The State has the burden to document the allowability and allocability of its claims for Federal Financial Participation, and this burden is based on the requirement in Federal cost principles that costs claimed must be documented adequately and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation. Without such documentation, OIG could not determine whether Texas was entitled to the full $400.1 million Federal share Texas received for Parkland's DSRIP Program payments.

OIG recommended that Texas (1) work with CMS to determine how much of the $294.1 million transferred by the Hospital District and used by the State agency as the State share of Parkland's DSRIP Program payments were derived from impermissible sources and refund up to the $400.1 million Federal share received and (2) provide its IGT entities with guidance on identifying and documenting the permissibility of the funds they transfer to cover the State share of Medicaid expenditures, emphasizing that the State is required to maintain records that adequately identify the source and application of funds for federally funded activities.

Work Plan #: A-06-17-09004 (March 2023)
Government: Medicaid

[NEW] States Did Not Invoice Manufacturers for Some Rebates for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

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 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 States complied with requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to Medicaid managed-care organization (MCO) enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Florida (A-04-21-07098)

Florida generally complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. However, the State agency did not invoice for, and collect from manufacturers, an estimated $57,700 ($35,126 Federal share) in rebates for single-source physician-administered drugs. Furthermore, OIG were unable to determine whether, in some cases, Florida was required to invoice for rebates for other multiple-source physician-administered drug claims. Florida did not invoice manufacturers for rebates totaling $40,635 ($24,772 Federal share) for these multiple-source drugs.

OIG recommended that Florida that invoice for, and collect from manufacturers, an estimated $57,700 ($35,126 Federal share) in rebates for single-source physician-administered drugs and refund the Federal share of rebates collected. OIG also recommends that Florida work with CMS to determine whether the other claims for multiple-source physician-

administered drugs, totaling $40,635 ($24,772 Federal share), were eligible for rebates and, if so, determine the rebates due and refund the Federal share of the rebates collected. In addition, OIG recommended that Florida ensure that all physician-administered drugs eligible for rebates.

[NEW] Kentucky (A-04-22-07102)

Kentucky did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. Kentucky did not invoice for, and collect from manufacturers, rebates totaling $21.6 million ($15.5 million Federal share) for physician-administered drugs dispensed to MCO enrollees. Of this amount, $15.6 million ($11.2 million Federal share) was for drugs that were required to be rebated. In addition, Kentucky did not invoice for rebates associated with $6.0 million ($4.3 million Federal share) in other multiple-source physician-administered drugs that were eligible for rebates.

Although the State agency's managed care contracts with its MCOs required the collection of drug utilization data necessary to invoice for rebates on all claims, Kentucky's internal controls did not always ensure that the data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to enrollees of MCOs.

OIG recommended that Kentucky: (1) invoice for and collect from manufacturers' rebates totaling $15,611,770 ($11,209,642 Federal share) 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 other claims for multiple-source physician administered drugs, totaling $5,967,128 ($4,281,678 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; (3) strengthen internal controls to ensure that all eligible physician-administered drugs are invoiced for rebate; and (4) ensure that all physician-administered drugs eligible for rebates after the OIG's audit period are processed for rebates.

[NEW] Mississippi (A-07-21-06103)

Mississippi did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. Mississippi did not invoice for, and collect from manufacturers, estimated rebates totaling $13.7 million ($10.4 million Federal share) for physician-administered drugs during OIG's audit period. Of this amount, $12.5 million ($9.5 million Federal share) was for single-source and top-20 multiple-source drugs, which were required to be rebated, and $1.2 million ($887,816 Federal share) represented other multiple-source physician-administered drugs that could have been eligible for rebates.

Although its policies required the collection of drug utilization data necessary to invoice for rebates on all physician-administered drug claims, Mississippi's internal controls did not always ensure that the collected data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to enrollees of MCOs.

OIG recommended that Mississippi: (1) work with CMS to calculate the rebate amount for claims identified in OIG's findings, 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; and (2) strengthen internal controls to facilitate the invoicing of all physician-administered drugs for rebate.

[NEW] Tennessee (A-07-21-06096)

Tennessee did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. Tennessee did not invoice for, and collect from manufacturers, rebates totaling $18.4 million ($12.0 million Federal share) for physician-administered drugs dispensed to MCO enrollees. Of this amount, $16.8 million ($11.0 million Federal share) was for single-source and top-20 multiple-source drugs that were required to be rebated, and $1.6 million ($1.0 million Federal share) was for other multiple-source drugs that were eligible for rebates. In addition, Tennessee did not invoice for, and collect from manufacturers, $43.3 million ($28.4 million Federal share) in rebates for physician-administered drugs invoiced on crossover claims, for which beneficiaries are eligible for both Medicare and Medicaid services.

Although its policies required the collection of drug utilization data necessary to invoice for rebates on all claims, Tennessee's internal controls did not always ensure that the data were used to invoice manufacturers and collect rebates for physician-administered drugs dispensed to enrollees of MCOs.

OIG recommended that Tennessee: (1) invoice for and collect manufacturers' rebates and refund to the Federal Government $11.0 million (Federal share) for single-source and top-20 multiple-source drugs; (2) work with the Centers for Medicare & Medicaid Services to determine the portion of the $1.0 million (Federal share) for other multiple-source drugs that were eligible for rebate, invoice manufacturers, and refund the Federal share; (3) strengthen internal controls for non-crossover claims to ensure that all eligible physician-administered drugs are invoiced for rebate; and (4) consider revising its methodology going forward regarding payments for crossover claims.

Work Plan #: A-07-21-06103 (October 2023); A-04-22-07102 (September 2023); A-04-21-07098 (March 2023); A-07-21-06096 (September 2022)
Government Program: Medicaid

[NEW] Missouri Claimed Federal Medicaid Reimbursement for Tens of Millions in Consumer-Directed Personal Care Assistance Services That Did Not Comply With Federal and State Requirements

Consumer-directed personal care assistance (PCA) services assist Medicaid recipients by allowing the consumer (i.e., the recipient) to direct his or her care by hiring, training, supervising, and directing the service worker. In Missouri, the service worker provides assistance with activities of daily living, instrumental activities of daily living, or both, as an alternative to nursing facility placement to persons with a physical disability. OIG's objectives were to determine whether Missouri: (1) ensured that consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during fiscal years (FYs) 2018 and 2019 complied with Federal and State requirements, and (2) established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program.

OIG's audit covered $918 million ($597 million Federal share) in Medicaid payments for consumer-directed PCA services provided and paid for in Missouri during FYs 2018 and 2019. OIG reviewed documentation for a stratified random sample of 150 consumer-directed PCA net claim lines of $25 or more (sampled items) to determine whether the services provided were allowable and adequately supported.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

Missouri did not always ensure that the consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during FYs 2018 and 2019 complied with Federal and State requirements. Specifically, 17 of the 150 sampled items were at least partially unallowable because of errors related to: timesheets that could not be provided or that lacked detail; units of service charged that exceeded the number authorized; lack of documentation that attendants were registered, screened, and employable; and recipients with plans of care that were not signed. Based on OIG's sample results, OIG estimated that Missouri claimed at least $52.5 million ($34.2 million Federal share) for unallowable consumer-directed PCA services during FYs 2018 and 2019. In addition, timesheets for 46 of the 150 sampled items did not identify the specific services that were performed in accordance with the plans of care. OIG are setting aside, for Centers for Medicare & Medicaid Services (CMS) resolution, an estimated $133.8 million ($87.0 million Federal share) associated with these 46 items.

For OIG's second objective, Missouri did not have established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program. Most providers for the sampled items did not have any emergency preparedness documentation for a pandemic response.

OIG recommended that Missouri refund the $34.2 million (Federal share) in overpayments to the Federal Government and work with CMS to determine the allowability of the $87.0 million (Federal share) and refund any amount that is determined to be unallowable. OIG also makes procedural recommendations regarding the monitoring of PCA providers and the State's establishment of and adherence to policies and procedures.

Work Plan #: A-07-20-03243 (February 2023)
Government Program: Medicaid

[NEW] Illinois Generally Complied With Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19

Medicaid telehealth refers to the services provided via a telecommunication system. A Medicaid patient at an originating site uses audio and video equipment to communicate with a health professional at a distant site. Medicaid programs saw a significant increase in telehealth services due to the COVID-19 public health emergency. OIG's objective was to determine whether Illinois complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth payments during COVID-19.

OIG reviewed 584,492 Medicaid fee-for-service telehealth payments, totaling $21,052,452 ($13,980,157 Federal share), that Illinois claimed on their March 1, 2020, through March 1, 2021, Federal financial participation Reports. OIG analyzed the payments looking for trends in the services provided and categorized any unusual or duplicative billing issues. OIG researched procedure codes and the types of services that can be performed via telecommunication systems. OIG also contacted providers and reviewed medical records for 230 payments.

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Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

Illinois generally made telehealth payments that were in accordance with Federal and State requirements. Of the 584,492 Medicaid fee-for-service telehealth payments in OIG's population, 583,960 payments were in compliance with the requirements, but the remaining 532 payments were not in compliance with applicable requirements. For 249 payments, the same provider was paid both the originating site and distant site fee. There were 146 payments made as duplicate payments for the same services provided to the same recipient on the same day. Also, 22 of the payments were inaccurately billed as both originating and distant site fees. Finally, providers incorrectly used the telehealth modifier with 35 different procedure codes that are for in-person services. A total of 115 telehealth payments were identified with these codes that could not be performed via telecommunication systems. This noncompliance occurred because the State agency did not adequately monitor compliance. The State agency also did not establish a list of acceptable telehealth procedure codes. Based on OIG's testing, OIG calculated the unallowable payments totaled approximately $16,154 ($9,832 Federal share) during the audit period.

OIG recommended that Illinois refund up to $9,832 to the Federal Government and enhance the monitoring of provider compliance by conducting periodic reviews of telehealth payments for compliance with requirements. Also, OIG recommended that Illinois establish a list of acceptable telehealth procedure codes.

Work Plan #: A-05-21-00035 (December 2022)
Government Program: Medicaid

[NEW] Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid beneficiaries. The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid managed care organization (MCO) industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight. OIG's objective was to determine whether Keystone First HealthChoices complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required prior authorization.

During 2018 and 2019, Keystone First denied 136,022 physical health service requests that required a prior authorization. OIG's audit covered 2,482 denied pediatric skilled nursing requests and 1,702 dental, radiology, pharmacy, and medical denials overturned by Keystone First during the appeals process. OIG selected and reviewed a judgmental sample of 100 denied service requests that required a prior authorization to determine whether they complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Keystone First did not comply with Federal and State requirements when denying 76 of the sampled denied service requests. Specifically, Keystone First should not have denied the overnight care portion of 10 denied sampled pediatric skilled nursing service requests on the basis that it had not received work or school verification documentation for the

caregiver. For 72 denied service requests, Keystone First's denial letter, based on Pennsylvania's required form, did not inform beneficiaries of their right to request a State fair hearing after exhausting the MCO's appeals process.

Denying overnight care that should be approved could place the health and safety of the beneficiary at risk. If beneficiaries do not receive information about their right to request a State fair hearing, they may not have the information needed to enable them to understand the totality of the appeals process and their rights and options within that process.

OIG recommended that Keystone First coordinate with Pennsylvania to: (1) update Keystone First's administrative process to require that medical directors assess whether overnight care requests meet the medical necessity requirement, even if some documentation is missing; (2) review all pediatric skilled nursing service requests for which overnight care was completely denied and determine whether overnight care requests meet the medical necessity requirement; and (3) implement a revised initial denial notice to explain that a beneficiary has the right to request a State fair hearing after exhausting the MCO's appeals process. OIG also recommends that Pennsylvania revise its denial notice template. The full recommendations are in the report.

Work Plan #: A-03-20-00201 (December 2022)
Government Program: Medicaid

[NEW] For Medicaid-Enrolled Children Diagnosed With Lead Toxicity in Five States, Documentation Reviewed for Diagnoses and Treatment Services Raises Concerns

In five States, most of the medical records that OIG's study reviewed for children with a lead toxicity diagnosis in their Medicaid claims lacked adequate information to confirm a diagnosis of lead toxicity, highlighting potential concerns for oversight of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Among children for whom there was sufficient medical record documentation to confirm their diagnosis, many did not receive comprehensive follow-up testing and treatment services, as recommended, for their identified blood lead level.

Lead toxicity is an environmental health concern that can have lasting effects on the lives of children. Although there is no safe level of lead exposure for young children, exposure is preventable. Children's exposure to lead can be minimized through actions such as regular cleaning of the home; washing of hands and toys; and preventive care to support early detection of lead toxicity and timely follow-up testing and treatment services.

An OIG report issued in October 2021 found that more than one-third of Medicaid-enrolled children in five States (California, New York, Ohio, Pennsylvania, and Texas) did not receive required blood lead screening tests during fiscal years (FYs) 2015-2018, which potentially left children vulnerable to the toxic effects of lead exposure. This study expands on that work.

The Centers for Medicare & Medicaid Services' (CMS's) Medicaid program offers comprehensive preventive medical screening services for millions of children annually through the EPSDT benefit. This benefit also includes treatment services to correct issues (e.g., lead toxicity) identified through screenings, such as blood lead testing. When young children with confirmed blood lead levels do not receive timely follow-up testing and treatment services, they could be left vulnerable to continuing lead exposure and permanent developmental effects.

For the same five States, OIG reviewed Medicaid claims data for FYs 2015-2018. From this data, OIG selected a sample of 625 enrolled children with a diagnosis indicating lead toxicity, and reviewed children's medical records from the date of diagnosis through 6 months later. The review examined whether children received follow-up testing and treatment services for their identified blood lead levels (FYs 2015-2019), as recommended by CMS and the Centers for Disease Control and Prevention (CDC). OIG also collected public health data from four States to account for services provided exclusive of Medicaid payment and received outside clinical settings, and OIG asked medical reviewers to consider the respective State medical management guidance. Finally, OIG interviewed stakeholders regarding follow-up testing and treatment services for children exposed to lead.

SunHawk Summary of OIG Evaluation Findings and Recommendations

In this evaluation of medical records for Medicaid-enrolled children with a diagnosis of lead toxicity in Medicaid claims, medical reviewers could not identify adequate information to confirm that diagnosis in the majority of records (415 out of 581 children).

It is unclear why this many medical records, across five States, lacked information to confirm the diagnosis of lead toxicity identified in the Medicaid claims. According to the American Academy of Pediatrics, it could be a matter of confusion about appropriate diagnosis codes. Nonetheless, the lack of documentation in the medical records to confirm children's lead toxicity diagnoses raises concerns regarding the accuracy of using Medicaid claims data, solely, to identify children being treated for lead toxicity. It may also have implications for States' annual EPSDT reporting to CMS regarding treatment services.

Because there is no safe lead level for children, even very low blood lead levels may indicate in some instances a need for treatment, based on individual factors (e.g., age, environment, increasing blood lead level trend). However, without adequate information in the medical record of a blood lead level at or above 5 µg/dL, or signs, symptoms, and/or notes regarding an elevated blood lead level, medical reviewers could not objectively distinguish children whose medical records indicated a need for follow-up testing and treatment services during the 6-month review period. Similarly, without accurate data, CMS may be unable to accurately measure EPSDT performance and ensure that Medicaid enrolled children with lead toxicity are given the best possible health care.

For this review, medical reviewers determined appropriate services for lead toxicity using their professional judgment, with reference to follow-up testing and treatment services recommended by CMS and CDC, and in consideration of State medical management guidance for children's identified blood lead levels. Among the 166 children with sufficient medical record documentation to confirm their diagnoses, medical reviewers determined that half of the children did not receive comprehensive follow-up testing and treatment services (e.g., environmental assessments to determine the source of exposure) as recommended.

OIG recommended that—to address concerns related to the accuracy of claims data for Medicaid enrolled children diagnosed with lead toxicity, and related to the treatment component of EPSDT for these children—CMS (1) explore the discrepancy between Medicaid claims data and medical documentation for lead toxicity and implement solutions to ensure better oversight of the EPSDT program; and (2) issue guidance to reiterate State obligations under the EPSDT benefit to ensure access to services to correct or ameliorate confirmed blood lead levels identified during screenings.

Work Plan #: OEI-07-18-00370 (December 2022)
Government Program: Medicaid

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] The Centers for Medicare & Medicaid Services' Review Contractor Did Not Document Medicaid Managed Care Payment Review Determinations Made Under the Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds are appropriately spent. CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP). This is the third in a series of three OIG audits that assessed the adequacy of the PERM program by reviewing the accuracy of determinations for each of its three components. The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractor conducted Medicaid Managed Care (MMC) payment reviews that were in accordance with Federal requirements.

OIG's audit covered 407 PERM MMC payments reviewed by CMS's PERM contractor, totaling $476,065 ($291,356 Federal share), included in the MMC component of the Reporting Year (RY) 2019 PERM program for 3 States. OIG judgmentally selected these States based on the total amount of the MMC payments and the number of MMC payments reviewed by CMS's review contractor. OIG reviewed a random sample of 100 PERM MMC payments for the 3 States.

SunHawk Summary of OIG Audit Findings and Recommendations

CMS's review contractor conducted the majority of its MMC payment reviews in accordance with Federal requirements. Of the 100 sampled MMC payments OIG reviewed, 60 were correctly determined. However, OIG were not able to determine whether the remaining 40 payment review determinations were correct because the payment reviews were not documented and therefore may be incorrect. Based on the sample results, OIG estimated 40 percent of the sampled MMC payment determinations made by CMS's review contractor may not have been correct. OIG also estimated the total amount related to these 40 claims to be $229,435 ($123,520 Federal share) during the audit period.

CMS's review contractor did not maintain documentation of its payment review determinations because CMS did not include specific contract and statement of work language requiring its review contractor to maintain all documentation to support its MMC payment review determinations for non-errors.

OIG is not making recommendations because CMS took action to address the deficiencies the OIG identified. Specifically, after the audit period, for RY 2020, 2021 and 2022 PERM cycles, CMS exercised an optional task for the contract with the review contractor, which added language requiring the review contractor to maintain relevant documentation for non-error (i.e., correct) payments. In its contract renewal occurring in March 2021, CMS replaced the optional task with a permanent requirement for the review contractor to maintain relevant documentation for non-error payments.

Work Plan #: A-04-21-09003 (December 2022)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] The Centers for Medicare & Medicaid Services' Review Contractors Generally Conducted Medicaid Fee-for-Service Claim Reviews for Selected States Under the Payment Error Rate Measurement Program in Accordance with Federal and State Requirements

The Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds are appropriately spent. CMS developed the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP). This is the second in a series of three OIG audits that will assess the adequacy of the PERM program by reviewing the accuracy of determinations for each of its three components. The objective of this audit was to assess the adequacy of the PERM program by determining whether CMS's contractors conducted Medicaid fee-for-service (FFS) reviews in accordance with Federal and State requirements.

OIG's audit covered 1,653 Medicaid FFS claims reviewed by CMS's PERM contractors, totaling over $2.9 million (Federal share), included in the Medicaid FFS 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 FFS error rates, and the types of errors identified by CMS's review contractors. OIG reviewed a random sample of 100 Medicaid FFS claims (total) for the 3 States.

SunHawk Summary of OIG Audit Findings and Recommendations

CMS's contractors generally conducted Medicaid FFS reviews in accordance with Federal and State requirements. Of the 100 sampled Medicaid PERM FFS claims OIG reviewed, 90 claims were correctly determined and adequately documented. However, claim review determinations for the remaining 10 claims were not documented and therefore may be incorrect. Based on OIG's sample results, OIG estimated that 10 percent of the sampled Medicaid FFS claims reviewed by CMS's contractors were not documented and claim review determinations for these claims may not have been correct. OIG also estimated the total amount paid related to these claims to be $6,411 (Federal share) during the audit period.

CMS's contractors did not always maintain documentation of their claim review determinations because CMS did not include specific contract language requiring its contractors to maintain all documentation to support the contractors' Medicaid FFS claim review determinations for non-error claims.

OIG is not making recommendations because CMS took action to address the deficiencies the OIG identified. Additionally, OIG's sample estimates indicated that these potential errors were immaterial when applied to OIG's sampling frame.

Work Plan #: A-04-21-00132 (November 2022)
Government Program: Medicaid

[NEW] California Made Almost $16 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Client Index 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 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 California Department of Health Care Services (California) made unallowable capitation payments on behalf of beneficiaries with multiple Client Index Numbers (CINs).

OIG's audit covered approximately $112.1 million ($56.1 million Federal share) in Medicaid capitation payments California made to MCOs from July 1, 2015, through June 30, 2019, for the 12,686 beneficiary matches that OIG identified. The OIG selected and reviewed a stratified random sample of 100 of these beneficiary matches.

SunHawk Summary of OIG Audit Findings and Recommendations

California made unallowable capitation payments on behalf of beneficiaries with multiple CINs. Of the 100 beneficiary matches in OIG's sample, California correctly made capitation payments on behalf of individuals associated with 24 beneficiary matches. However, it incorrectly made capitation payments that totaled $657,057 ($328,529 Federal share) on behalf of individuals associated with the remaining 76 beneficiary matches.

The unallowable capitation payments occurred because the associated beneficiaries had multiple CINs. According to California, human error caused it to assign multiple CINs to these beneficiaries. Specifically, during the file clearance process, California county staff made data entry errors that included misspelling beneficiaries' names. Also, staff transposed Social Security numbers, failed to identify and link multiple records, and did not always identify and resolve variations in beneficiaries' names. In addition, the algorithm that California used to create the Beneficiary Name and Date of Birth (DOB) Match Report was too broad and, thus, not effective. Further, California did not require county staff to review training materials.

On the basis of OIG's sample results, the OIG estimated that California made unallowable capitation payments totaling approximately $31.4 million ($15.7 million Federal share) on behalf of beneficiaries with multiple CINs during the audit period.

OIG recommended that California: (1) refund to the Federal Government approximately $15.7 million in unallowable payments, (2) review capitation payments that fell outside of the audit period and refund any unallowable payments, (3) ensure that the algorithm used to create its revised Beneficiary Name and DOB Match Reports is effective at detecting individuals with multiple records, (4) require county staff to review training materials on the prevention of issuing multiple CINs, and (5) enhance its controls to ensure that no beneficiary is issued multiple CINs.

Work Plan#: A-04-21-07097 (October 2022)
Government Program: Medicaid

[NEW] CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios

State and Federal expenditures on Medicaid managed care are growing and totaled $360 billion in 2020, which was 55 percent of total Medicaid expenditures in that year. With its 2016 Medicaid managed care regulations, the Centers for Medicare & Medicaid Services (CMS) chose medical loss ratios (MLRs) as a policy tool to apply across the program to

ensure appropriate stewardship of managed care funds. States' oversight of their plans' annual MLR reporting is critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care.

Managed care has replaced fee for service as the predominant payment model in Medicaid. Federal MLR requirements were established to ensure that Medicaid 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.

The Federal MLR is the percentage of premium revenue that a managed care plan spent on covered health care services and quality-improvement activities in a 12-month period. Plans must submit annual MLR reports to the State with 13 data elements, including the MLR, the data needed to calculate the MLR, and other numeric and descriptive data. In turn, States must take into account plans' calculated MLRs as part of the process for setting plans' future capitation rates. States must set capitation rates so that plans would "reasonably achieve" the Federal MLR standard of at least 85 percent.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG administered an online survey to and requested information from all States with Medicaid managed care plans subject to Federal MLR requirements as of September 1, 2020. Between September 2020 and December 2020, 43 States submitted survey responses and plans' annual MLR reports. OIG reviewed and summarized States' survey responses and analyzed plans' MLR reports for completeness.

States reported that most Medicaid managed care plans submitted MLR reports as required. However, OIG found that 49 percent of the 495 MLR reports reviewed were incomplete. These incomplete MLR reports were missing at least one of seven numeric data elements that are essential to the MLR calculation. This missing data occurred across four of the seven MLR report data elements-non claims costs; taxes and fees; member months; and quality improvement activity expenses. Two thirds of the incomplete MLR reports did not contain fields for plans to even enter amounts for at least one of these data elements.

The data element for non-claims costs, generally defined as plans' expenses for administrative services, accounted for the majority of incomplete MLR reports. Missing data on non-claims costs may reduce transparency on managed care spending and limit States' ability to ensure that plans are appropriately spending Medicaid dollars on the health of enrollees rather than excessive administrative expenses. Even when the data element for non-claims costs appeared in MLR reports, plans did not report this data in a consistent manner.

States indicated that they review MLR reports for completeness, but few States identified incomplete reports. In addition, although 26 States reported that they review MLR data elements for accuracy for all of their plans, 16 States responded that they did not review the accuracy of selected MLR data elements for all or some of their plans.

OIG recommended that-to strengthen States' oversight of MLR reporting and better ensure that plans are using Federal dollars for patient care-CMS (1) design an annual MLR reporting template for States to provide to their Medicaid managed care plans; (2) clarify that States should verify the completeness of their plans' MLR reports; (3) clarify that States should review their plans' MLR reports to verify the accuracy of reported data elements; and (4) provide additional guidance to States regarding plans' reporting of non-claims costs in MLR reports.

Work Plan #: OEI-03-20-00231 (September 2022)
Government Program: Medicaid

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Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] New York Generally Determined Eligibility for Its Basic Health Program Enrollees in Accordance With Program Requirements

The Affordable Care Act gave States the option of creating a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. To date, New York is one of only two States that have established BHPs. OIG audited New York's BHP because OIG considered program funds to be at risk due to the significant amount of Federal funds allocated to the initiative. New York's BHP is funded primarily by Federal funds with some State funding. OIG's objective was to determine whether New York determined eligibility for BHP enrollees in accordance with applicable Federal and State eligibility requirements.

OIG's audit covered eligibility determinations for 966,693 BHP policies for which New York received Federal funding totaling $4.7 billion during the period April 1, 2018, through March 31, 2019 (audit period). OIG selected a stratified random sample of 150 policies. OIG reviewed eligibility data for each policy to determine whether eligibility verifications and determinations were performed in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

New York generally determined eligibility for its BHP enrollees in accordance with Federal and State requirements. Specifically, for 145 of 150 sampled policies, New York correctly determined that the associated enrollees were eligible for the program. However, for five sampled policies, New York enrolled individuals who were ineligible or potentially ineligible for the program and received improper monthly payments totaling $8,615. Specifically, for three sampled policies, New York enrolled individuals who were eligible for Medicaid. For one sampled policy, New York did not properly verify income. For the remaining sampled policy, New York received BHP payments from the Centers for Medicare & Medicaid Services on behalf of a disenrolled deceased enrollee. According to New York, system defects prevented controls that were in place from working as intended.

On the basis of OIG's sample results, OIG estimated that the financial impact of the incorrect or potentially incorrect eligibility determinations made by New York for its BHP during the audit period totaled $69.9 million.

OIG recommended that New York reimburse its BHP Trust Fund $8,615 associated with the improper monthly payments identified in OIG's sample. In addition, OIG recommended that New York identify and reimburse the BHP Trust Fund all improper payments, which OIG estimates to total $69.9 million, resulting from system defects identified in OIG's report. OIG also made recommendations for New York to improve its system for enrolling individuals in its BHP.

Work Plan #: A-02-20-01028 (September 2022)
Government Program: Medicaid

[NEW] Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States

Most State Medicaid agencies pay managed care organizations to make services available to eligible Medicaid beneficiaries in return for a monthly fixed payment (capitation payment) for each enrolled beneficiary. Previous OIG audits found that States had improperly made capitation payments on behalf of beneficiaries who were residing and enrolled in Medicaid in another State. OIG are concerned that the concurrent Medicaid enrollment identified in the previous audits could be an

issue that negatively impacts the Medicaid program nationwide. OIG's objective was to determine whether States made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States.

OIG's audit covered $145.7 million and $234.2 million in Medicaid managed care capitation payments for August 2019 and August 2020, respectively, made by States on behalf of beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States during the periods of July through September 2019 and July through September 2020. To identify OIG's population of concurrently enrolled beneficiaries, OIG compared CMS's Transformed Medicaid Statistical Information System (T MSIS) data from 45 States, the District of Columbia, and Puerto Rico (together referred to as "47 States"). OIG then identified all associated August 2019 and August 2020 capitation payments that were made by two States for the same beneficiary.

SunHawk Summary of OIG Audit Findings and Recommendations

All 47 States reviewed made capitation payments on behalf of Medicaid beneficiaries who were concurrently enrolled in two States. Specifically, capitation payments were made on behalf of 208,254 concurrently enrolled beneficiaries in August 2019 and 327,497 concurrently enrolled beneficiaries in August 2020. The Medicaid program incurred costs of approximately $72.9 million in August 2019 and $117.1 million in August 2020 for capitation payments associated with beneficiaries in one of the two concurrently enrolled States. The significant increase in these payments from August 2019 to August 2020 coincided with an overall increase in Medicaid enrollment during that time, and new Federal requirements and flexibilities that were available to States during the COVID-19 public health emergency.

CMS does not actively monitor beneficiaries' concurrent Medicaid managed care enrollments; instead, it relies on the individual States to identify concurrent enrollments and potential erroneous payments. CMS does not provide States with T-MSIS national enrollment data that would assist them in identifying beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States. Two States often made capitation payments for the same Medicaid beneficiary in part because States did not have full access to data they needed to identify beneficiaries who were concurrently enrolled in another State. Therefore, CMS does not take all available steps, either directly or through the States, to identify and prevent State capitation payments for non-resident beneficiaries.

OIG recommended that CMS provide States with matched T-MSIS enrollment data that identify Medicaid beneficiaries who were concurrently enrolled in a Medicaid managed care program in two States, and assist States with utilizing the data as needed to reduce future capitation payments made on behalf of beneficiaries concurrently enrolled in two States.

Work Plan #: A-05-20-00025 (September 2022)
Government Program: Medicaid

[NEW] New York Claimed $196 Million, Over 72 Percent of the Audited Amount, in Federal Reimbursement for NEMT Payments to New York City Transportation Providers That Did Not Meet or May Not Have Met Medicaid Requirements

An OIG audit issued in 2011 identified major deficiencies with New York's oversight of its nonemergency medical transportation (NEMT) program. In response to that audit, New York indicated that it planned to implement a quality assurance program for NEMT services provided in the New York City area. OIG conducted this follow-up audit to determine

whether the quality assurance program implemented by New York was adequate to ensure compliance with Federal and State requirements related to claiming Medicaid reimbursement for NEMT services. OIG's objective was to determine whether New York's claims for Medicaid reimbursement for NEMT payments to transportation providers in New York City complied with Federal and State requirements.

OIG's audit covered 4,768,858 payments totaling $269,584,249 (Federal share) for NEMT services provided during calendar years 2018 and 2019 by transportation providers in New York City. OIG selected a stratified random sample of 100 payments for review. Specifically, OIG reviewed documentation maintained by the contractor hired by New York to manage its NEMT program as well as documentation from medical and transportation services providers.

SunHawk Summary of OIG Audit Findings and Recommendations

Seventeen of the 100 sampled payments complied with Federal and State requirements. However, for 41 sampled payments, NEMT payments did not comply with Federal and State requirements and were therefore unallowable. For the remaining 42 sampled payments, OIG could not determine whether the services complied with Federal and State requirements.

On the basis of the OIG sample results, the OIG estimated that New York improperly claimed at least $84,329,893 in Federal Medicaid reimbursement for payments to NEMT providers that did not comply with certain Federal and State requirements. In addition, OIG estimated that New York claimed $112,028,279 in Federal Medicaid reimbursement for payments to NEMT providers that may not have complied with certain Federal and State requirements.

OIG made a series of recommendations to New York, including that it refund $84,329,893 to the Federal Government for the payments that did not comply with certain Federal and State requirements and work with the transportation manager to review the $112,028,279 in Federal Medicaid reimbursement for payments to NEMT providers that may not have complied with certain Federal and State requirements and refund to the Federal government any unallowable amounts. OIG also made recommendations for New York to improve its monitoring of its NEMT program.

Work Plan #: A-02-21-01001 (September 2022)
Government Program: Medicaid

[NEW] Montana Claimed Federal Medicaid Reimbursement for More Than $5 Million in Targeted Case Management Services That Did Not Comply With Federal and State Requirements

Targeted Case Management (TCM) services assist specific State-designated Medicaid groups in gaining access to medical, social, educational, and other types of services. Previous Office of Inspector General (OIG) audits found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements. OIG's objective was to determine whether Montana claimed Federal Medicaid reimbursement for TCM services during Federal fiscal years (FYs) 2018 through 2020 in accordance with Federal and State requirements.

OIG's audit covered $42.1 million ($27.5 million Federal share) in Medicaid payments for TCM services provided and paid for in Montana during FYs 2018 through 2020 (October 1, 2017, through September 30, 2020). OIG reviewed documentation for a stratified random sample of 150 unique TCM grouped line items (sample items) from the 4 largest target groups in the

State to determine whether the services provided were allowable, case managers providing services were qualified, and recipients receiving services were eligible. OIG reviewed payment rates to determine whether they matched the approved rates for the period. OIG compared TCM documentation provided by Montana to applicable Federal regulations and the State plan supplements governing Montana's TCM program.

SunHawk Summary of OIG Audit Findings and Recommendations

Montana did not always claim Federal Medicaid reimbursement for TCM services during FYs 2018 through 2020 in accordance with Federal and State requirements. Of the 150 randomly sampled grouped line items, 43 sample items were at least partially unallowable because they had at least 1 error related to case managers lacking required experience or qualifications, unsupported services, unallowable services, or an ineligible recipient.

Montana had policies and procedures in place for the administration of TCM services that, if followed, would have ensured compliance with Federal and State requirements. Based on OIG's sample results, OIG estimated that Montana claimed at least $7.7 million (more than $5 million Federal share) in unallowable Medicaid reimbursement for these services.

OIG recommended that Montana refund to the Federal Government the more than $5 million (Federal share) in overpayments. OIG also makes procedural recommendations that Montana always follows its established policies and procedures regarding: (1) TCM providers' case manager hiring practices, (2) verification that billed services were allowable and properly documented, and (3) verification that all individuals receiving services were eligible. Furthermore, OIG makes procedural recommendations that Montana require TCM providers to comply with established policies and procedures.

Work Plan #: A-07-21-03246 (August 2022)
Government Program: Medicaid

[NEW] 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.

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.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Mississippi (A-07-21-06101)

Mississippi did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. Mississippi did not invoice for, and collect from manufacturers, rebates associated with $2.2 million (Federal share) in physician-administered drugs. Of this amount, $820,732 (Federal share) was for single-source drugs and $395,621 (Federal share) was for top-20 multiple-source drugs.

Further, OIG were unable to determine whether Mississippi was required to invoice for rebates associated with claims totaling $1.0 million (Federal share) for other multiple-source physician-administered drug claims. In addition, Mississippi did not invoice for, and collect from manufacturers, $35.6 million (Federal share) in rebates for physician-administered drugs invoiced on crossover claims, for which beneficiaries are eligible for both Medicare and Medicaid services. Although its policies required the collection of drug utilization data necessary to invoice for rebates, Mississippi's internal controls did not always ensure that the collected data were used to invoice manufacturers and collect rebates for physician-administered drugs for these claims.

OIG recommended that Mississippi: (1) refund to the Federal Government $820,732 (Federal share) for single-source physician-administered drugs and (2) $395,621 (Federal share) for top-20 multiple-source physician-administered drugs; (3) work with CMS to determine the unallowable portion of $1.0 million (Federal share) for other multiple-source physician-administered drugs that may have been ineligible for reimbursement, refund that amount, and consider invoicing drug manufacturers for rebates for these drugs if CMS determines that the drug claims are allowable; (4) strengthen internal controls for non-crossover claims to ensure that all eligible physician-administered drugs are invoiced; and (5) consider revising its payment methodology going forward regarding payments for crossover claims.

[NEW] North Carolina (A-07-21-07002)

North Carolina did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs. North Carolina did not invoice for, and collect from manufacturers, rebates associated with $3.1 million (Federal share) in physician-administered drugs. Of this amount, $2.3 million (Federal share) was for single-source drugs and $734,000 (Federal share) was for top-20 multiple-source drugs. Further, OIG were unable to determine whether, in some cases, North Carolina was required to invoice for rebates for other multiple-source physician-administered drug claims. North Carolina did not invoice the manufacturers for rebates associated with claims totaling $685,000 (Federal share) for these multiple-source drugs.

OIG recommended that North Carolina refund to the Federal Government $2.3 million (Federal share) for claims for single-source physician-administered drugs and $734,000 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommends that North Carolina work with CMS to determine the unallowable portion of $685,000 (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 determines that the drug claims are allowable. In addition, OIG recommended that North 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 strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.

South Carolina (A-07-21-07003)

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-07-21-07002 (February 2023); A-07-21-06101 (October 2022); A-07-21-07003 (August 2022)
Government Program: Medicaid

[NEW] States Medicaid Fraud Control Unit: 2021 Inspection

OIG administers the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertifies each Unit, 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 issues public reports of its findings.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Connecticut (OEI-06-21-00360)

OIG conducted an onsite inspection of the Connecticut MFCU in November 2021. OIG's review period covered Federal fiscal years 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

Unit management and selected staff; (5) a random sample of 62 case files from the Unit's 121 nonglobal case files that were open at any point during the review period; (6) a review of convictions submitted to OIG for program exclusion and adverse actions submitted to the National Practitioner Data Bank during the review period; and (7) an onsite review of Unit operations.

From the information OIG reviewed, OIG found that the Unit generally operated in accordance with applicable laws, regulations, policy transmittals, and MFCU performance standards. However, OIG found that, during the 3-year review period, the Unit did not receive referrals of patient abuse or neglect and was unable to take sufficient steps to ensure that it received such referrals. OIG also found that the Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient. Finally, OIG found that the Unit did not adhere to its policy of documenting supervisory reviews monthly and that the Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes.

To address the four findings, OIG recommended that the Unit (1) develop and implement outreach efforts to ensure that the Unit regularly receives referrals of patient abuse and neglect; (2) seek approval from the Office of the Chief State's Attorney to implement a new case management system; (3) conduct and document supervisory reviews of case files in accordance with Unit policy; and (4) ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit concurred with all four recommendations.

[NEW] Michigan (OEI-06-21-00270)

OIG conducted the review of the Michigan MFCU in September 2021. OIG's review covered the 3-year period of FYs 2018-2020. OIG based the review 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 Unit management and selected staff; (5) a random sample of 90 case files from the Unit's 493 nonglobal case files that were open at any point during the review period; (6) a review of convictions submitted to OIG for program exclusion and adverse actions submitted to the National Practitioner Data Bank during the review period; and (7) an onsite review of Unit operations.

OIG found that the Unit reported strong case outcomes for FYs 2018-2020, with over $47 million in combined criminal and civil recoveries. However, the OIG identified several operational challenges that warrant further attention. OIG made nine findings for which OIG are making recommendations to improve the Unit's adherence to the MFCU performance standards. OIG found that (1) the Unit received few fraud referrals from the State Medicaid agency, and despite the Unit taking steps to increase these referrals, they remained low; (2) the Department of Attorney General repeatedly submitted the MFCU's financial reports late, lacked support for some MFCU expenditures, and lacked accounting procedures, raising concerns about the MFCU's fiscal controls; (3) despite the Unit's request for additional resources to increase its staffing levels, Unit staffing remained constant and did not align with the growing Medicaid expenditures; (4) although the Unit coordinated with Federal partners, it worked few joint cases with them, missing opportunities for sharing resources and training; (5) the Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes;

(6) 62 percent of the Unit's case files lacked documentation of periodic supervisory reviews; (7) although the Unit maintained an annual training plan for its staff, Unit supervisors did not consistently track or verify that staff documented their training; (8) the Unit's case management system made it difficult for Unit staff to retrieve case information and performance data; and (9) the Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect current practice or law.

To address the findings and further improve Unit operations, OIG recommended that the Unit

(1) build upon its efforts to increase fraud referrals from the State Medicaid agency; (2) refund the Federal grant for unsupported expenditures and establish processes to ensure Unit involvement and oversight of fiscal controls and reporting; (3) assess the adequacy of existing staffing levels and, if appropriate, develop a plan to expand the size of the Unit; (4) seek opportunities, as appropriate, to investigate more joint cases with Federal partners; (5) develop and implement processes to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes; (6) ensure that supervisory reviews of case files are documented in accordance with Unit policy; (7) ensure that Unit supervisors track and verify that all staff in professional disciplines document their training; (8) implement a new, comprehensive case management system that allows for efficient access to case documents and information; and (9) revise its MOU with the State Medicaid agency to reflect current practice and law. The Unit concurred with all nine recommendations.

Iowa (OEI-07-21-00340)

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.

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-06-21-00270 (September 2022); OEI-06-21-00360 (September 2022); OEI-07-21-00340 (June 2022)
Government Program: Medicaid

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

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

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

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 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

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

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

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

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.

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 recommended 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

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

Medicare Part C – Advantage

[NEW] The Inability To Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight

Although most 2019 Medicare Advantage (MA) encounter records contained a payment adjustment, identifying whether these adjustments are payment denials is challenging and imprecise. Requiring MA organizations (MAOs) to definitively identify payment denials on encounter records submitted for MA would enhance program oversight and help combat fraud.

This issue brief summarizes results from OIG's evaluation of MA encounter data and examines whether the lack of an indicator to identify payment denials in the data hinders efforts to combat fraud, waste, and abuse. (In this issue brief, OIG uses the term "denied claim" to refer to a record that contains a service for which the payer denied payment to the provider.) Detailed data about the services provided to enrollees are essential for combating fraud and abuse in Medicare and Medicaid. The oversight entities tasked with safeguarding these programs rely on service-level data to detect potentially inappropriate billing patterns and investigate suspected fraud and abuse. In the MA program, the Centers for Medicare & Medicaid Services (CMS) does not require MAOs to include an indicator that identifies denied claims in their MA encounter data. Instead, MAOs must submit claim adjustment reason codes (hereafter adjustment codes) when MAOs do not pay the actual amount billed by the provider (e.g., the MAO pays a lesser amount). Adjustment codes explain reasons for any payment adjustments to the claim, including denials, reductions, or increases in payment. In contrast, for Medicare fee-for-service and Medicaid (including Medicaid managed care), CMS's records of services do include denied-claim indicators.

OIG analyzed 2019 MA encounter records to determine the extent to which these records contained adjustment codes. OIG reviewed adjustment code descriptions and MAO payment amounts to identify records that may contain payment denials. OIG interviewed and/or administered questionnaires to CMS staff regarding the methods used to identify payment denials in the Medicare and Medicaid data. To identify how the lack of a denied-claim indicator affects their work, OIG interviewed and/or administered questionnaires to staff from oversight entities tasked with safeguarding MA program integrity. These oversight entities include staff from CMS's Center for Program Integrity and the Medicare Drug Integrity Contractors (MEDICs) (hereafter CMS program integrity staff); OIG investigators and data analysts; and health care fraud staff at the Department of Justice (DOJ). Finally, OIG also interviewed staff from CMS's Medicare Plan Payment Group (hereafter CMS's MA payment group) to determine the reasons why CMS does not require MAOs to submit a denied-claim indicator on MA encounter records.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that adjustment codes are not a definitive method for identifying denied claims in the MA encounter data. The descriptions for some adjustment codes are too vague to clearly identify whether the MAO denied payment for a service. For example, adjustment code 261 ("The procedure or service is inconsistent with the patient's history") does not specify whether payment was denied. The descriptions for other adjustment codes seem to indicate that the MAO denied payment for the service, yet OIG found instances in which MAOs reported payments for these services. OIG also found that most 2019 MA encounter records contained at least 1 adjustment code and 55 million of these records contained codes that may indicate the denial of payments by MAOs. However, without a definitive method for identifying denied claims in the MA encounter data, the full scope of payment denials in the data is unclear.

In addition, oversight entities—including CMS program integrity staff; OIG investigators and analysts; and DOJ health care fraud staff—reported that a denied-claim indicator in the MA encounter data would improve the efficiency, scope, and accuracy of their efforts to combat fraud, waste, and abuse. Once identified, denied claims may be (1) analyzed to detect potential fraud schemes or (2) removed from analyses of inappropriate billing patterns among paid claims. Without an indicator, oversight entities must make separate requests to MAOs asking them to identify denied claims in a subset of their data, which adds time and burden to investigations. The lack of an indicator limits the scope of efforts to determine the full impact of potential fraud activities in MA. For example, without an indicator, it is challenging or impossible for oversight entities to:

- exclude denied claims and review only paid claims in the MA encounter data;
- calculate financial exposure due to fraud;
- investigate complaints that certain MAOs inappropriately deny payments to their providers; and
- examine suspected providers' billing activities across many plans.

However, for Medicare fee for-service and Medicaid, oversight entities can use the available denied claim indicators to analyze data and perform enhanced program oversight.

Despite oversight entities reporting the potential benefits of a denied-claim indicator to MA program integrity, CMS's MA payment group reported that MAOs are not required to submit a denied-claim indicator in MA because the MA payment group does not need this indicator to determine MA payments or to understand which services were provided to enrollees. CMS's MA payment group raised concerns about the potential burden on MAOs of requiring a denied-claim indicator on their encounter records. However, the private companies that cover most MA enrollees also have contracts for Medicaid managed care—where CMS requires a denied-claim indicator on encounter records-and thus have demonstrated their ability to make accommodations in their systems and report these indicators. Once any initial challenges of modifying MAOs' systems are addressed, the inclusion of a denied-claim indicator in the MA encounter data may reduce the burden on MAOs of providing denied-claim information to oversight entities for fraud analyses. Finally, CMS may eventually need a denied-claim indicator to determine MA payments if it transitions to using the MA encounter data to estimate costs and set MA payments, as it has previously stated that it will do in the future.

To strengthen MA program oversight and combat fraud, OIG recommended that CMS require MAOs to definitively indicate on MA encounter data records when they have denied payment for a service on a claim.

Work Plan #: OEI-03-21-00380 (March 2023)
Government Program: Medicare Part C – Advantage

[NEW] 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] MediGold (A-07-20-01198)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that MediGold submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 189 of the 210 sampled enrollee-years, the medical records that MediGold provided did not support the diagnosis codes and resulted in $469,907 in net overpayments. As demonstrated by the errors found in OIG's sample, MediGold's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of OIG's sample results, OIG estimated that MediGold received at least $3.7 million of net overpayments for 2017 and 2018. Because of Federal regulations that limit the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward, OIG is reporting the overall estimated overpayment amount but are recommending a refund of $2.2 million in net overpayments ($224,001 for the sampled enrollee-years from 2017 and an estimated $2 million for 2018).

OIG recommended that MediGold: (1) refund to the Federal Government the $2.2 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its 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 and take the necessary steps to enhance those procedures.

[NEW] SelectCare of Texas, Inc. (A-06-19-05002)

OIG found that, with respect to the 10 high-risk groups covered by OIG's audit, most of the selected diagnosis codes that SelectCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 220 of the 285 sampled enrollee-years, the diagnosis codes were not supported in the medical records or could not be supported because SelectCare could not locate the medical records and resulted in $482,601 in net overpayments. As demonstrated by the errors in OIG's sample, the policies and procedures that SelectCare had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG's sample results, OIG estimated that SelectCare received at least $5.1 million in net overpayments for 2015 and 2016.

OIG recommended that SelectCare (1) refund to the Federal Government the $482,601 in net overpayments; (2) 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 (3) review 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 current procedures.

[NEW] CarePlus Health Plans, Inc. (A-04-19-07082)

OIG found that CarePlus 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 CarePlus submitted were supported in the medical records and therefore validated 1,210 of the 1,656 sampled enrollees' HCCs, the remaining 446 HCCs were not validated and resulted in overpayments. These 446 unvalidated HCCs included 64 HCCs for which OIG identified 64 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 52 HCCs for which the medical records supported diagnosis codes that CarePlus should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,656 HCCs. Rather, the risk scores should have been based on 1,326 HCCs (1,210 validated HCCs plus 64 other HCCs plus 52 additional HCCs) and resulted in $641,467 in net overpayments. On the basis of OIG's sample results, OIG estimated that CarePlus received at least $117.3 million in net overpayments for 2015. As demonstrated by the errors found in OIG's sample, CarePlus's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommended that CarePlus refund to the Federal Government $641,467 of net overpayments and ensure that its policies and procedures have been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that are used to calculate risk-adjusted payments.

[NEW] Aetna, Inc. (A-01-18-00504)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Aetna submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 155 of the 210 sampled enrollee-years, the medical records that Aetna provided did not support the diagnosis codes and resulted in $632,070 in overpayments. On the basis of OIG's sample results, OIG estimated that Aetna received at least $25.5 million in overpayments for 2015 and 2016. As demonstrated by the errors found in OIG's sample, Aetna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommended that Aetna: (1) refund to the Federal Government the $632,070 of overpayments; (2) determine, for the remaining 159 enrollee-years in the potentially mis-keyed diagnosis code high-risk group not reviewed as part of this audit, whether the medical records in each case support the diagnosis for the unrelated condition and refund any resulting overpayments to the Federal Government; (3) 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 (4) continue to examine and improve its compliance procedures.

[NEW] Health Net of California, Inc. (A-09-18-03007)

OIG found that Health Net 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 Health Net submitted were supported in the medical records and therefore validated 1,103 of the 1,333 sampled enrollees' HCCs, the remaining 230 HCCs were not

validated and resulted in overpayments. These 230 unvalidated HCCs included 46 HCCs for which OIG identified 46 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 123 HCCs for which the medical records supported diagnosis codes that Health Net should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,333 HCCs. Rather, the risk scores should have been based on 1,272 HCCs (1,103 validated HCCs plus 46 other HCCs plus 123 additional HCCs). As a result, Health Net received $69,182 in net overpayments for 2015 for the sampled enrollees. As demonstrated by the errors found in OIG's sample, Health Net's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommended that Health Net: (1) refund to the Federal Government the $69,182 of net overpayments and (2) 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.

[NEW] Presbyterian Health Plan, Inc. (A-07-20-01197)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 198 of the 211 sampled enrollee-years, the medical records that PHP provided did not support the diagnosis codes and resulted in $442,454 in net overpayments. As demonstrated by the errors found in OIG's sample, PHP's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG sample results, OIG estimated that PHP received at least $2.2 million in net overpayments for 2017 and 2018. Because of Federal regulations (updated after OIG issued the draft report) that limit the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward, OIG is reporting the overall estimated overpayment amount but are recommending a refund of $1.3 million ($206,048 for the sampled enrollee-years from 2017 and an estimated $1.1 million for 2018).

OIG recommended that PHP: (1) refund to the Federal Government the $1.3 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 OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its 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.

[NEW] Excellus Health Plan, Inc. (A-07-20-01202)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Excellus submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 202 of the 210 sampled enrollee-years, the medical records that Excellus provided did not support the diagnosis codes and resulted in $479,487 in overpayments. As demonstrated by the errors found in OIG's sample, Excellus's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of OIG's sample results, OIG estimated that Excellus received approximately $5.4 million in overpayments for 2017 and 2018. Because of Federal regulations (updated after OIG issued the draft report) that limit the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward,

OIG is reporting the overall estimated overpayment amount but are recommending a refund of $3.1 million ($235,453 for the sampled enrollee-years from 2017 and an estimated $2.9 million for 2018).

OIG recommended that Excellus: (1) refund to the Federal Government the $3.1 million of estimated overpayments; (2) 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 (3) continue its examination of its 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 and take the necessary steps to enhance those procedures.

[NEW] Keystone Health Plan East, Inc. (A-03-20-00001)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Keystone submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 205 of the 270 sampled enrollee-years, the medical records that Keystone provided did not support the diagnosis codes and resulted in $550,391 in overpayments. As demonstrated by the errors in OIG's sample, Keystone's policies and procedures to prevent, detect, and correct noncompliance with CMS program requirements could be improved. On the basis of OIG's sample results, OIG estimated that Keystone received at least $11.3 million in overpayments for 2016 and 2017.

OIG recommended that Keystone: (1) refund to the Federal Government the $550,391 for overpayments; (2) identify, for the high-risk diagnoses included in the report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; (3) continue its examination of existing compliance procedures to identify areas in which 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; and (4) ensure that it collects, for audits of risk adjustment data, medical records that comply with CMS requirements.

[NEW] HumanaChoice- Contract H6609 (A-05-19-00013)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that HumanaChoice submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 157 of the 210 sampled enrollee-years, the diagnosis codes that HumanaChoice submitted to CMS were not supported in the medical records and resulted in $480,295 of net overpayments for the 210 enrollee-years. These errors occurred because the policies and procedures that HumanaChoice had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG's sample results, OIG estimated that HumanaChoice received at least $27.3 million of net overpayments for 2015 and 2016.

OIG recommended that HumanaChoice: (1) refund to the Federal Government the $480,295 of net overpayments; (2) 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 (3) examine its 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 and take the necessary steps to enhance those procedures.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Cigna- HealthSpring Life and Health Insurance Co., Inc. (A-07-19-01192)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Cigna submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 200 of the 300 sampled enrollee-years, the medical records that Cigna provided did not support the diagnosis codes and resulted in $468,372 in overpayments. As demonstrated by the errors found in OIG's sample, Cigna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of OIG's sample results, OIG estimated that Cigna received at least $6.24 million in overpayments for 2016 and 2017.

OIG recommended that Cigna: (1) refund to the Federal Government the $468,372 of overpayments; (2) 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 (3) continue its examination of its 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 and take the necessary steps to enhance those procedures.

[NEW] MCS Advantage, Inc. (A-02-20-01008)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the enrollee-years that MCS submitted to CMS for use in CMS's risk adjustment program selected in OIG's sample did not comply with Federal requirements. For 183 of the 280 sampled enrollee-years, the diagnosis codes were not supported in the medical records, resulting in $220,577 of net overpayments.

These errors occurred because MCS's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations could be improved. On the basis of OIG's sample results, OIG estimated that MCS received at least $6.2 of net overpayments for these high-risk diagnosis codes in 2016 and 2017.

OIG recommended that MCS (1) refund to the Federal Government the $220,577 of net overpayments; (2) 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 (3) continue its examination of its 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 and take the necessary steps to enhance those procedures.

[NEW] Geisinger Health Plan (A-09-21-03011)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Geisinger submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 224 of the 270 sampled enrollee-years, either the medical records that Geisinger provided did not support the diagnosis codes or Geisinger could not locate the medical records to support the diagnosis codes, resulting in $566,476 of net overpayments. As demonstrated by the errors found in OIG's sample, Geisinger's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of OIG's sample results, OIG estimated that Geisinger received at least $6.5 million of net overpayments for 2016 and 2017.

OIG recommended that Geisinger: (1) refund to the Federal Government the $566,476 of net overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after OIG's 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 that diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures.

[NEW] Cigna- HealthSpring of Tennessee, Inc. (A-07-19-01193)

OIG found that, with respect to the 10 high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Cigna submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 195 of the 279 sampled enrollee-years, the medical records that Cigna provided did not support the diagnosis codes and resulted in $509,194 in overpayments.

As demonstrated by the errors found in OIG's sample, Cigna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG's sample results, OIG estimated that Cigna received at least $5.9 million in overpayments for 2016 and 2017.

OIG recommended that Cigna: (1) refund to the Federal Government the $5.9 million of estimated overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its 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.

[NEW] BlueCross BlueShield of Rhode Island (A-01-20-00500)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that BCBS RI submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 58 of the 270 sampled enrollee-years, the medical records validated the reviewed Hierarchical Condition Categories (HCCs). For the remaining 212 enrollee-years, however, either the medical records that BCBS RI provided did not support the diagnosis codes or BCBS RI could not obtain the medical records to support the diagnosis codes and the associated HCCs were therefore not validated. As demonstrated by the errors found in OIG's sample, BCBS RI's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the HCCs for these high-risk diagnosis codes were not validated. On the basis of OIG's sample results, OIG estimated that BCBS RI received at least $4.8 million in net overpayments for 2016 and 2017.

OIG recommended that BCBS RI: (1) refund to the Federal Government the $4.8 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 OIG's 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.

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] California Physicians' Service, Inc. (A-09-19-03001)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that CPS submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 117 of the 196 sampled enrollee-years, the diagnosis codes that CPS submitted to CMS were not supported in the medical records and resulted in net overpayments of $319,945. As demonstrated by the errors in OIG's sample, the policies and procedures that CPS used to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG's sample results, OIG estimated that CPS received at least $2 million of net overpayments for these high-risk diagnosis codes for 2015 and 2016.

OIG recommended that CPS: (1) refund to the Federal Government the $2 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 OIG's 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 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.

[NEW] HumanaChoice- Contract R5826 (A-05-19-00039)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that HumanaChoice submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 207 of the 270 sampled enrollee-years, the diagnosis codes that HumanaChoice submitted to CMS were not supported in the medical records and resulted in $574,430 of overpayments for the 270 enrollee-years.

These errors occurred because the policies and procedures that HumanaChoice had to prevent, detect, and correct noncompliance with CMS's program requirements as mandated by Federal regulations could be improved. On the basis of OIG's sample results, OIG estimated that HumanaChoice received at least $34.4 million of overpayments for these high-risk diagnosis codes in 2016 and 2017.

OIG recommended that HumanaChoice (1) refund to the Federal Government the $34.4 million of overpayments; (2) 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 (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.

[NEW] BlueCross BlueShield of Tennessee (A-07-19-01195)

OIG found that, with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that BCBST submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 210 of the 270 sampled enrollee-years, the medical records that BCBST provided did not support the diagnosis codes and resulted in $491,269 in overpayments.

As demonstrated by the errors found in OIG's sample, BCBST's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis

of OIG's sample results, OIG estimated that BCBST received approximately $7.8 million in overpayments for 2016 and 2017.

OIG recommended that BCBST: (1) refund to the Federal Government the $7.8 million of estimated overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its 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.

[NEW] Highmark Senior Health Company (A-03-19-00001)

OIG found that, with respect to the six high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 160 of the 226 sampled enrollee-years, the diagnosis codes were not supported in the medical records.

The errors occurred because the policies and procedures that Highmark had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the Hierarchical Condition Categories (diagnosis code groupings based on similarity of clinical characteristics, severity, and cost implications) for these high-risk diagnosis codes were not validated. On the basis of OIG's sample results, OIG estimated that Highmark received at least $6.2 million of net overpayments for 2015 and 2016.

OIG recommended that Highmark: (1) refund to the Federal Government the $6.2 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in the report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of 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.

[NEW] Inter Valley Health Plan, Inc. (A-05-18-00020)

OIG found that Inter Valley 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 Inter Valley Health Plan submitted were supported in the medical records and therefore validated 1,411 of the 1,553 sampled enrollees' HCCs, the remaining 142 HCCs were not validated and resulted in overpayments. These 142 unvalidated HCCs included 23 HCCs for which OIG identified 23 other, replacement HCCs for more and less severe manifestations of the diseases. Second, there were an additional 12 HCCs for which the medical records supported diagnosis codes that Inter Valley should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,553 HCCs. Rather, the risk scores should have been based on 1,446 HCCs (1,411 validated HCCs + 23 other HCCs + 12 additional HCCs). As a result, OIG estimated that Inter Valley received at least $5.3 million in net overpayments for 2015. These errors occurred because Inter Valley's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.

OIG recommended that Inter Valley refund to the Federal Government the $5.3 million of estimated net overpayments and continue to 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.

[NEW] BlueCross BlueShield of Oregon (A-09-20-03009)

OIG found that, with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Regence submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 111 of the 179 sampled enrollee-years, the diagnosis codes were not supported in the medical records and resulted in net overpayments of $248,885. As demonstrated by the errors in OIG's sample, the policies and procedures that Regence had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. On the basis of OIG's sample results, OIG estimated that Regence received at least $1.8 million of net overpayments for these high-risk diagnosis codes for 2015 and 2016.

OIG recommended that Regence: (1) refund to the Federal Government the $1.8 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 OIG's audit period and refund any resulting overpayments to the Federal Government; and (3) continue to examine its 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 of Florida (A-04-19-07084)

OIG found that, 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.

Cigna HealthSpring (A-03-18-00002)

OIG found that 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.

Cariten Health Plan (A-02-20-01009)

OIG found that, 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.

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)

OIG found that 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 recommended 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)

OIG found that 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 recommended 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.

BlueCross BlueShield of Michigan (A-02-18-01028)

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.

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

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.

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, Inc. (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. 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-07-20-01198 (February 2024); A-06-19-05002 (November 2023); A-04-19-07082 (October 2023); A-01-18-00504 (October 2023); A-09-18-03007 (September 2023); A-07-20-01197 (August 2023); A-07-20-01202 (July 2023); A-03-20-00001 (May 2023); A-05-19-00013 (April 2023); A-07-19-01192 (March 2023); A-02-20-01008 (March 2023); A-09-21-03011 (March 2023); A-07-19-01193 (December 2022); A-01-20-00500 (November 2022); A-09-19-03001 (November 2022); A-05-19-00039 (September 2022); A-07-19-01195 (September 2022); A-03-19-00001 (September 2022); A-05-18-00020 (September 2022); A-09-20-03009 (September 2022); 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-02-18-01028 (February 2021); A-07-19-01188 (November 2021); A-07-17-01173 (October 2021); A-07-19-01187 (May 2021); A-07-16-01165 (April 2021)
Government Program: Medicare Part C - Advantage

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 OIG 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 Program: Medicare Part C - Advantage

Medicare Part D - Prescription Drug Program

[NEW] The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern

Medicare enrollees continue to face challenges accessing medication to treat their opioid use disorder, with certain groups of enrollees facing even greater challenges than others. Yet, for the first time, more than 600,000 enrollees received naloxone—the opioid overdose-reversal drug—through Medicare Part D, an important step toward reducing overdose-related deaths.

Opioid-related overdose deaths remain near all-time highs. In 2022, there were an estimated 83,827 opioid-related overdose deaths in the United States. Most of these deaths involved synthetic opioids, such as illicit fentanyl. As such, the Office of Inspector General (OIG) continues to monitor access to treatment for opioid use disorder and the opioid overdose-reversal drug naloxone—both of which can save lives.

This data brief is a part of a series, released annually by OIG since 2017, that monitors indicators of the opioid epidemic in Medicare. It provides the most updated information on the number of enrollees experiencing opioid overdoses and the number receiving medication for opioid use disorder and overdose-reversal medications. It also monitors the use of prescription opioids and questionable prescribing in Part D.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that about 52,000 people enrolled in Medicare experienced an opioid overdose during 2022. The exact number is likely higher, as additional enrollees may have overdosed who did not receive medical care billed to Medicare. Further, of the about 1.1 million enrollees who have opioid use disorder, just 18 percent received medication to treat their disorder. This low percentage highlights that enrollees are continuing to face challenges accessing treatment. In some States, the percentage of enrollees receiving treatment for their opioid use disorder was far lower than that for the Nation, with just 6 percent receiving medication in Florida. In addition, certain groups of enrollees—including those without the low-income subsidy-were less likely than others to receive medication. There are also notable disparities by race and ethnicity in those receiving medication.

On the other hand, the number of Part D enrollees receiving the opioid overdose-reversal drug naloxone grew to more than 600,000-an all-time high. Although reaching this high number is an important step toward reducing overdose-related deaths, there is also new concern. In 2023, Narcan—a brand-name naloxone—became available over-the-counter. Because of Narcan's change from prescription to over-the-counter status, manufacturers of generic equivalents of Narcan—i.e., 4 mg naloxone nasal sprays—must also now change their products to over-the-counter status. As a result, Narcan and its generic equivalents will no longer be covered by Medicare Part D. Without Part D coverage, enrollees will likely face higher out-of-pocket costs, which may create access barriers.

In addition, OIG found that key indicators of misuse or diversion of prescription opioids in Part D continue to decline. The number of Medicare enrollees who received high amounts of prescription opioids decreased from prior years, as did the number who received extreme amounts of opioids or who appear to be doctor shopping. Further, the number of prescribers

with questionable prescribing remained about 100, similar to that for the prior 2 years. As the opioid epidemic continues to take tens of thousands of lives each year, it is essential that the Centers for Medicare & Medicaid Services (CMS) and the Department continue to work to ensure access to medication to treat opioid use disorder and opioid overdose-reversal drugs. CMS and the Department have taken a number of actions to increase access to medication for opioid use disorder. However, the low percentage of enrollees receiving medication to treat their opioid use disorder calls for additional action.

OIG has made several recommendations to CMS in previous studies related to treatment. Notably, to encourage providers to treat more Part D enrollees who have opioid use disorder, OIG recommended that CMS inform providers about the use of buprenorphine—a common medication to treat opioid use disorder—and the low risk of diversion of this medication in Medicare. CMS should continue its efforts to implement these and other recommendations and to identify additional ways to improve access to medication to treat opioid use disorder for all Medicare enrollees who need it. Further, as part of this data brief, OIG recommends that CMS educate enrollees and providers about options for access to overdose-reversal medications, as Narcan and its generic equivalents will no longer be covered by Part D. Depending on the enrollee's circumstances, these options may include receiving coverage of over-the-counter naloxone through certain States' Medicaid programs (if dually eligible).

Work Plan #: OEI-02-23-00250 (December 2023)
Government Program: Medicare Part D - Prescription Drug Program

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[NEW] The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder in Medicare Part D Continues to Appear Low: 2022

Opioid-related overdose deaths in the United States remain a concern, with an estimated 82,310 deaths in 2021. As the country continues to struggle with the opioid crisis, it is essential to ensure access to buprenorphine to treat individuals with opioid use disorder. Buprenorphine has been shown to decrease illicit opioid use and opioid-related overdose deaths. However, there are concerns about access to this potentially life-saving medication. Previous Office of Inspector General (OIG) work has shown a need to increase the number of Medicare enrollees receiving treatment for opioid use disorder. OIG has found that just 18 percent of Medicare enrollees with a diagnosis of opioid use disorder received medication to treat their opioid use disorder. Furthermore, Black, Hispanic, and Asian/Pacific Islander Medicare enrollees are less likely to receive medication to treat their opioid use disorder than are White enrollees.

The first evaluation in this series examines use of buprenorphine in Medicare Part D in 2021 and found that buprenorphine's risk of misuse and diversion appeared to be low. The second data brief provides updated information—based on prescription drug event data from 2022—on the use of buprenorphine in Medicare Part D and its risk for diversion.

SunHawk Summary of OIG Evaluation Findings and Recommendations

May 2023 Evaluation (OEI-02-22-00160)

OIG found that almost all Medicare Part D enrollees who received buprenorphine to treat their opioid use disorder received the recommended amounts. Most enrollees received buprenorphine-naloxone combination products, which have a reduced risk of misuse or diversion; however, 16 percent of enrollees received buprenorphine monoproducts. Only a small number of enrollees received very high amounts of buprenorphine or received buprenorphine at the same time as they received

high amounts of opioids indicated for pain. Most prescribers ordered buprenorphine for only a limited number of enrollees, which could provide an opportunity to increase access. Further, very few prescribers had patterns that raise concern. Only 35 prescribers ordered buprenorphine for multiple Part D enrollees who either received very high levels of buprenorphine or received buprenorphine at the same time as they received high amounts of opioids.

Together, these findings suggest that the risk of misuse and diversion of buprenorphine in Medicare Part D is low. These findings further support the recent repeal of the DATA waiver, which was in place, in part, to limit diversion of buprenorphine. The repeal of the waiver is a significant step towards increasing access to treatment. Further, the data in this report provide baseline information about buprenorphine utilization and prescribing that can assist CMS, the Department, and others as they implement changes related to the repeal and take other steps to improve access to buprenorphine, while also ensuring that the risk of misuse and diversion remains low.

Accordingly, OIG recommended that CMS (1) monitor the use of buprenorphine and share information, as appropriate, with Departmental partners; (2) inform providers about buprenorphine use and the low risk of diversion to encourage providers to treat more Part D enrollees who have opioid use disorder; (3) take steps to inform providers about the availability of buprenorphine combination products in Part D, which can minimize the risk of misuse and diversion; and (4) follow up on the prescribers with concerning patterns identified in this report.

November 2023 Evaluation (OEI-02-24-00130)

The OIG found that:

- As in 2021, almost all Medicare Part D enrollees who received buprenorphine for the treatment of opioid use disorder received the recommended amounts in 2022.
- Most enrollees received buprenorphine-naloxone combination products which are generally recommended to minimize the risk of misuse or diversion.
- Enrollees rarely received either very high amounts of buprenorphine or received buprenorphine at the same time as they received high amounts of other opioids.
- The findings from 2022 are similar to the findings from 2021. Together, they suggest that the risk of misuse and diversion of buprenorphine in Medicare Part D continues to be low.
- These updated data provide important information about buprenorphine utilization that can assist the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, and others as they continue to take steps to improve access to buprenorphine, while also ensuring that the risk of misuse and diversion remains low.

Work Plan #: OEI-02-24-00130 (November 2023), OEI-02-22-00160 (May 2023)
Government Program: Medicare Part D - Prescription Drug Program

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Part D Plans Generally Include Drugs Commonly Used by Dual-Eligible Enrollees: 2023

This data snapshot fulfills for 2023 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 drugs commonly used by full benefit dual eligible enrollees (i.e., individuals who are eligible for both Medicare and full Medicaid benefits). 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 thirteenth study that OIG has produced to meet this mandate.

For this data snapshot, OIG determined whether the 445 unique formularies used by the 5,619 Part D plans operating in 2023 cover the 200 drugs most commonly used by dual-eligible enrollees. To create the list of the 200 drugs most commonly used by dual-eligible enrollees, OIG used the 2020 Medicare Current Beneficiary Survey—the most recent data available at the time of OIG's study. Of the top 200 drugs, 195 are eligible for Part D prescription drug coverage, while 4 are excluded from coverage. One additional drug is eligible for Part D coverage, but OIG did not include it in the analysis because OIG could not confidently project the use of this drug to the entire dual-eligible enrollee population.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that dual-eligible enrollees—that is, individuals who are covered by both Medicare and Medicaid-have access to the majority of commonly used drugs in 2023 via their Part D plans, consistent with OIG's findings from previous years. A majority of the 445 Part D plan formularies covered almost all (at least 97 percent) of the drugs most commonly used by dual-eligible enrollees. Similar to all formularies, a majority of formularies used by Part D plans with premiums below the regional benchmark (92 of 130) covered at least 97 percent of the drugs commonly used by dual-eligible enrollees. Dual-eligible enrollees have several options if their plans do not cover specific drugs; however, these options may be burdensome and do not guarantee access to the drugs.

In general, dual-eligible enrollees have access to nearly all of the most commonly used drugs via their Part D plan formularies in 2023. 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 2022. 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-eligible enrollees commonly use. OIG has no recommendations at this time.

Work Plan #: OEI-05-23-00130 (June 2023)
Government Program: Medicare Part D - Prescription Drug Program

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Medicare Part D Plan Sponsors and CMS Did Not Ensure That Transmucosal Immediate-Release Fentanyl Drugs Were Dispensed Only to Beneficiaries Who Had a Cancer Diagnosis

OIG has been tracking opioid use in Medicare during the opioid crisis and has identified providers with questionable prescribing practices and beneficiaries at serious risk of misuse or overdose of opioids. Transmucosal immediate-release fentanyl (TIRF) drugs are high-potency, prescription opioid pain relievers that are approved solely to manage breakthrough cancer pain. Because of known improper off-label use of TIRF drugs that can impact the health and safety of beneficiaries, for this audit we reviewed Medicare Part D plan sponsors' (plan sponsors') prescription drug event (PDE) data to determine whether these drugs were dispensed in compliance with Medicare requirements. OIG's objective was to determine whether plan sponsors and the Centers for Medicare & Medicaid Services (CMS) ensured that TIRF drugs were dispensed in accordance with Medicare requirements.

OIG's audit covered 45,776 PDEs for TIRF drugs dispensed to 5,034 beneficiaries from July 2015 through December 2019, for which the Medicare Part D total cost was $513.9 million. OIG analyzed Medicare claims data to determine whether beneficiaries who received TIRF drugs had a cancer diagnosis. OIG selected a judgmental sample of 51 beneficiaries who did not have a cancer diagnosis in their Medicare claims history and reviewed plan sponsor documentation to determine why TIRF drugs were approved.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that plan sponsors and CMS did not ensure that all TIRF drugs were dispensed in accordance with Medicare requirements. Medicare requires that TIRF drugs be dispensed only for the medically accepted indication of breakthrough cancer pain. For 7,552 PDEs, plan sponsors approved TIRF drugs dispensed to 810 beneficiaries who did not have a cancer diagnosis in their Medicare claims history to support a medically accepted indication for the use of these drugs. As a result, plan sponsors paid $86.2 million in unallowable Medicare Part D total costs. Plan sponsors also approved 2,023 PDEs totaling $19.7 million for TIRF drugs for 176 beneficiaries whose most recent cancer diagnosis in their Medicare claims history was more than 1 year before the drugs were dispensed. Although we did not determine these PDEs to be unallowable, they were at high risk of being unallowable. In addition, for 65 of the 810 beneficiaries, plan sponsors continued to approve TIRF drugs after the beneficiaries' PDEs had been determined to be unallowable during CMS's assessments of medically accepted indications.

For another 409 beneficiaries included in the CMS assessments, CMS determined PDEs to be allowable for 333 beneficiaries and was inconsistent in its determinations of whether 76 beneficiaries had medically accepted indications for TIRF drugs even though these beneficiaries did not have a cancer diagnosis in their Medicare claims history.

OIG recommended that CMS work with its plan sponsors to: (1) delete the PDEs related to the $86.2 million of unallowable Medicare Part D total costs and determine after reconciliation the impact to the Federal Government; and (2) identify and delete any unallowable PDEs related to the $19.7 million of Medicare Part D total costs for beneficiaries whose most recent Medicare claim with a cancer diagnosis was for services provided more than 1 year before the TIRF drugs were dispensed, and determine the impact to the Federal Government. The report contains three other recommendations.

Work Plan #: A-09-20-03033 (February 2023)
Government Program: Medicare Part D - Prescription Drug Program

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] CMS Generally Ensured That Medicare Part C and Part D Sponsors Did Not Pay Ineligible Providers for Services to Medicare Beneficiaries

The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare Advantage (MA) organizations and private prescription drug plan sponsors (collectively known as "sponsors") to offer Part C and Part D managed care benefits to eligible Medicare beneficiaries. CMS relies on Part C and Part D sponsors to ensure that excluded, precluded, deactivated, and deceased providers (ineligible providers) do not receive payments for Medicare services.

OIG conducted a nationwide audit of Medicare Part C encounter data and Part D prescription drug event (PDE) data to identify ineligible providers associated with the data submitted to CMS by Part C and Part D sponsors. OIG's objective was to determine whether CMS oversight of Medicare Part C and Part D sponsors ensured compliance with Federal requirements for preventing payments for Medicare services to ineligible providers. OIG analyzed 1.46 billion encounters with $438 billion in total allowed charges submitted by 770 Part C plans and 3 billion PDEs with $234 billion in total drug plan payments submitted by 811 Part D plans for all services billed or rendered and prescriptions written for Medicare beneficiaries in calendar years 2018 and 2019.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS generally ensured that sponsors complied with Federal requirements for preventing payments for Medicare services to ineligible providers. However, some sponsors submitted to CMS encounter and PDE data indicating that ineligible providers rendered services and wrote prescriptions for Medicare beneficiaries. We identified 136 Part C sponsors and 62 Part D sponsors that may have paid claims for health care services associated with ineligible providers. Specifically, these sponsors submitted data for 384,000 encounters with $51.8 million in allowed charges and 24,000 PDEs with $1.14 million in payments associated with ineligible providers.

The ineligible providers were able to submit these claims to plan sponsors because some sponsors may not have had effective compliance programs in place to prevent, detect, and correct noncompliance with CMS's program requirements. Also, CMS may not have adequately monitored the sponsors to ensure that their compliance programs were effective. In addition, although Part D regulations expressly require sponsors and their pharmacy benefit managers to reject pharmacy claims unless they contain active and valid provider identification numbers, CMS does not have similar requirements for claims submitted to Part C sponsors. Additionally, CMS system edits did not properly work to identify all ineligible providers after sponsors submitted their encounter and PDE data to CMS. As a result, CMS used data from services associated with ineligible providers in its risk adjustment of capitation payments to the sponsors.

OIG made a series of recommendations for CMS to direct Part C and Part D sponsors to ensure that only eligible providers receive payments for Medicare services. OIG also recommended that CMS strengthen its oversight of sponsors and provider identifiers to prevent deactivated and deceased providers from receiving payments for Medicare services. The detailed recommendations are listed in the body of the report.

Work Plan #: A-02-20-01027 (October 2022)
Government Program: Medicare Part D - Prescription Drug Program

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C - Advantage

Medicare Part D – Prescription Drug Program

[NEW] Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries

As the nation continues to grapple with the effects of the COVID-19 pandemic, the opioid epidemic continues to surge. In 2021, there were an estimated 81,502 opioid-related overdose deaths in the United States-an all-time high. Accordingly, it is critical to monitor opioid use and access to treatment for beneficiaries with opioid use disorder as well as access to the opioid overdose-reversal drug naloxone. This data brief provides important information on these topics for beneficiaries in Medicare Part D in 2021. It builds on a series of data briefs released by OIG.

About 50,400 Part D beneficiaries experienced an opioid overdose-from prescription opioids, illicit opioids, or both-during 2021. This number is likely higher in that additional beneficiaries could have overdosed but not received medical care that was billed to Medicare, or their claims might have not yet been submitted to Medicare. At the same time, the number of Medicare Part D beneficiaries who received opioids in 2021 decreased to almost a quarter of beneficiaries, extending a downward trend from prior years. Further, fewer Part D beneficiaries were identified as receiving high amounts of opioids or at serious risk. The number of prescribers ordering opioids for large numbers of beneficiaries at serious risk was steady. Still, over 1 million Medicare beneficiaries had a diagnosis of opioid use disorder in 2021, and fewer than 1 in 5 of them received medication to treat their disorder. At the same time, the number of Part D beneficiaries receiving naloxone increased.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that there is clearly still cause for concern and vigilance, even as some positive trends emerge. Monitoring opioid use and access to medications for the treatment of opioid use disorder as well as to naloxone are critical to addressing the opioid crisis. A December 2021 OIG report recommended that CMS take steps to improve access to medications for the treatment of opioid use disorder and other support services. We continue to call attention to the importance of implementing these recommendations and to ensuring access to treatment for opioid use disorder for Medicare beneficiaries. OIG is also committed to continuing work on opioid use and access to treatment.

Work Plan #: OEI-02-22-00390 (September 2022)
Government Program: Medicare Part D - Prescription Drug Program

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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 Evaluation 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 Program: Medicare Part D - Prescription Drug Program

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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 Evaluation 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

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 Evaluation Findings and Recommendations

OIG found that 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