Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Payer-Focused Audits Summary

November 1, 2021 - November 30, 2024

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year. 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 two years, 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 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.

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.

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

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[NEW] Utah Generally Operated Its Medicaid Estate Recovery Program in Accordance With Requirements and in a Cost Effective Manner, but Utah Did Not Have Formal Written Procedures

- All States were required to have a Medicaid Estate Recovery Program (MERP) that sought, from the estates of deceased Medicaid enrollees who were 55 years old and older when they received medical assistance, reimbursement for certain Medicaid costs such as long-term care (e.g., nursing homes).
- As part of its oversight activities, OIG was auditing Medicaid estate recovery to determine whether States were operating their MERPs in accordance with requirements and the extent to which States' MERPs were cost effective.
- This audit examined whether: (1) Utah operated its MERP in accordance with Federal and State requirements and (2) Utah's MERP was cost effective.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Utah generally operated its MERP in accordance with Federal and State requirements in that it performed required estate recovery procedures for 85 of the 100 deceased Medicaid enrollees in OIG's stratified random sample.

- OIG's audit also identified 15 enrollee cases for which, because of an absence of supporting documentation, it could not be determined whether Utah performed any estate recovery procedures.
- OIG also identified 3 enrollee cases that Utah had opened between 12 and 14 years before the start of the audit, but for which the State had not performed any periodic monitoring.

  The deficiencies that OIG identified occurred because Utah did not have formal written policies and procedures for its estate recovery program, and because Utah's estate recovery system edits did not always work as intended.

  OIG also concluded that Utah's MERP was cost effective.

OIG recommended that Utah make three procedural improvements to its estate recovery program, including establishing formal written estate recovery policies and procedures, which should include policies and procedures regarding documentation; implementing formal procedures to periodically review open cases; and verifying that system edits are functioning properly, improving those edits as necessary, and ensuring that caseworkers perform and document all applicable estate recovery procedures. The full recommendations were in the report.

Audit #: A-07-23-03257 (11/12/2024)
Government Program: CMS

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[NEW] States Could Better Leverage Coverage and Access Requirements To Promote Maternal Health Care Access in Medicaid Managed Care

- The U.S. was experiencing a maternal health crisis, with worse outcomes there than in any other high-income country. Significant racial and geographic disparities existed in maternal deaths and complications. Access to maternal health care influenced these outcomes.

- Medicaid was the Nation's largest maternal health care payor and most pregnant enrollees were covered by managed care organizations (MCOs). States used provider coverage rules and network adequacy standards (i.e., requirements that MCOs include enough providers in their networks) to help ensure that enrollees had adequate access to care.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that states were not leveraging managed care provider coverage requirements and network adequacy standards to promote access to maternal health care. Access to maternal health care could support better health outcomes.

All States required their MCOs to cover obstetrician/gynecologist (OB/GYN) physicians and hospitals, but many States reported they did not require MCOs to cover other important types of maternal health providers and professionals, some of whose services were federally required.

Some States were not using network adequacy standards to address important dimensions of maternal health care access. For example, some States measured access to specific provider types such as OB/GYNs, but many States did not. Some States tailored their standards to maternal health care (e.g., by varying appointment wait time requirements by stage of pregnancy), while others did not.

All States reported monitoring MCOs' compliance with network adequacy standards, but they may have lacked data on the standards' impact on enrollees' access to maternal health care.

OIG recommended that CMS:
1. Take steps to confirm that all States covered required services from maternal health care providers for managed care enrollees.
2. Clarify the requirement that States had a provider-specific OB/GYN network adequacy standard.
3. Support States in tailoring their network adequacy standards to better address maternal health care needs.

Evaluation #: OEI-05-22-00330 (09/30/2024)
Government Program: CMS

[NEW] Systemic and Operational Challenges Hinder Efforts to Ensure HIV Care for Medicaid Enrollees

- People with HIV needed ongoing recommended care to improve their health outcomes, reduce HIV-related deaths, and reduce new HIV transmissions.

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- The Medicaid program played a critical role in supporting HIV care as the largest source of insurance for Americans with HIV. Previous OIG work found that one in four Medicaid enrollees with HIV may have not received at least one service critical to HIV care in 2021.
- This report built on OIG's previous work by interviewing select State Medicaid agencies (States) and comprehensive, risk-based Medicaid managed care plans (Plans) to explore challenges that contributed to gaps in HIV care and potential actions that could improve their ability to ensure that all enrollees with HIV received needed care.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that two systemic issues—unmet health-related social needs and provider shortages—impacted enrollees' abilities to maintain their care and limited States' and Plans' abilities to address resulting gaps in care. Additionally, two operational challenges—limited access to data and insufficient administrative staff—impacted States' and Plans' efforts to monitor enrollees' care needs and take action to connect enrollees to care.

OIG recommended that CMS:

1. Pursue further actions to help States share knowledge with each other and coordinate internally regarding strategies to ensure needed care for Medicaid enrollees with HIV.
2. Take additional steps to help States leverage the State Data Resource Center to access and use Medicare data for dually eligible enrollees with HIV.

Evaluation #: OEI-05-22-00242 (09/19/2024
Government Program: CMS

South Carolina Did Not Always Invoice Rebates to Manufacturers 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 had to pay rebates to the States for the drugs.
- Prior OIG audits found that States did not always invoice and collect all rebates due for drugs administered to Medicaid managed-care organizations' (MCOs') enrollees.
- This audit, one of a series of audits, determined whether South Carolina complied with Federal Medicaid requirements for invoicing manufacturers for physician-administered drugs dispensed to MCO enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that South Carolina did not always comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees. South Carolina did not invoice for, and collect from manufacturers, rebates totaling $14.2 million (Federal share).

- Of this amount, $12.1 million (Federal share) was for single-source drugs and $65,691 (Federal share) was for top-20 multiple-source drugs.
- OIG also identified rebates totaling $1.9 million (Federal share) for other multiple-source drugs for which OIG was unable to determine whether, in some cases, the State was required to invoice for rebates.

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OIG recommended that South Carolina:

1. invoice for and collect manufacturers' rebates totaling $12.2 million (Federal share) for single-source and top-20 multiple-source physician-administered drugs and refund the Federal share;

2. work with CMS to determine whether the claims for other multiple-source physician-administered drugs, totaling $1.9 million (Federal share), were eligible for rebates and, if so, determine the rebates due for these drugs and, upon receipt of the rebates, refund the Federal share of the rebates collected;

3. ensure that all physician-administered drugs eligible for rebates after OIG's audit period were processed for rebates; and

4. continue to review and strengthen its internal controls to ensure that, in line with South Carolina's existing policies, all physician-administered drugs eligible for rebates were invoiced.

Audit #: A-07-22-07010 (08/28/2024)
Government Program: CMS

Utah Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

1. In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure that most individuals were continuously enrolled for Medicaid benefits (enrollees).
2. The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees, including terminating Medicaid enrollment of ineligible individuals.
3. This audit of Utah was part of a series of audits examining whether States completed Medicaid eligibility actions during their unwinding periods in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the 193,009 enrollees who had their Medicaid eligibility renewed or coverage terminated during April 1 through September 30, 2023 (audit period), OIG sampled 140 enrollees and determined that Utah incorrectly completed Medicaid eligibility actions for 6 enrollees. On the basis of the sample results, OIG estimated that Utah incorrectly renewed eligibility or incorrectly terminated Medicaid coverage for 5,233 of the 193,009 enrollees during the audit period. OIG also estimated that Utah reported 15,269 of the 193,009 enrollees on the incorrect line of Utah's monthly unwinding data reports to CMS during the audit period.

OIG recommended that Utah redetermine Medicaid eligibility for the six sampled enrollees identified as having incorrect eligibility determinations, provide periodic training to caseworkers, identify and correct data limitations OIG identified, and strengthen policies and procedures to provide for greater accuracy in the monthly unwinding data reports. The full recommendations are in the report.

Audit #: A-07-24-07013 (08/27/2024)
Government Program: CMS

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New Mexico Did Not Ensure Attendants Were Qualified To Provide Personal Care Services, Putting Medicaid Enrollees at Risk

Prior Office of Inspector General (OIG) audits of New Mexico's Medicaid personal care services (PCS) program found that the New Mexico Human Services Department (State agency) did not always ensure that PCS were provided by an individual (attendant) qualified to provide such services in accordance with Federal and State requirements. The audits identified several deficiencies related to attendants' qualifications, including areas related to tuberculosis (TB) testing, annual training, and certifications in cardiopulmonary resuscitation (CPR) and first aid.

OIG's objective was to determine whether the State agency ensured that PCS were provided by qualified attendants in accordance with Federal and State requirements.

OIG's audit covered 2.7 million paid Medicaid PCS encounter claims (claims) and the qualifications of the attendants who provided those services during CY 2019 (audit period). OIG reviewed a stratified random sample of 300 claims to determine whether the associated services were provided by attendants whose qualifications complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Mexico did not ensure that PCS were provided by qualified attendants in accordance with Federal and State requirements. For 106 of the 300 sampled claims, the associated attendants met qualification requirements. However, for the remaining 194 claims, the associated attendants did not meet 1 or more requirements related to criminal background checks, abuse registry checks, TB testing, written competency tests, annual training, and CPR and first aid certifications.

On the basis of OIG's sample results, OIG estimated that 69 percent of attendants associated with PCS claims during the audit period did not meet qualification requirements.

OIG recommended that New Mexico work with Medicaid managed care organizations to develop procedures to monitor PCS providers' compliance with attendant qualification requirements and to educate providers about these requirements. The full recommendations are in the report.

Audit #: A-06-22-02000 (08/27/2024)
Government Program: CMS

Kansas's Implemented Electronic Visit Verification System Could Be Improved

- As required by the 21st Century Cures Act, Kansas used an Electronic Visit Verification (EVV) system to verify that a personal care services (PCS) service worker had arrived at a Medicaid enrollee's residence and assisted with Medicaid-approved tasks.
- EVV was developed to address weaknesses in the PCS program that contributed to improper payments, questionable quality of care, and notable amounts of fraud.
- This audit examined whether Kansas implemented an EVV system in accordance with Federal and State requirements and complied with Federal and State requirements when claiming in-home PCS.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Kansas implemented an EVV system, but it did not require all in-home PCS visits to be recorded and verified in that system and did not always comply with requirements when claiming in-home PCS.

Among other things, these errors occurred because Kansas did not:

- have procedures to prevent claimed visits from being submitted outside of the EVV system,
- have edits in its EVV system to verify that tasks performed and recorded on the in-home PCS claim matched with allowable tasks in the enrollee's approved service plan, and
- require providers to maintain adequate documentation.
- OIG recommended that Kansas make four improvements to its EVV system, including:
- improving its EVV system by developing and implementing procedures to verify that in-home PCS claims were recorded and verified in its EVV system,
- improving its EVV system by implementing edits to verify that tasks recorded on in-home PCS claims matched allowable tasks in the enrollees' approved service plans, and
- verifying that providers were complying with the State's established policies and procedures.

The full recommendations were in the report.

Audit #: A-07-23-03255 (08/20/2024)
Government Program: CMS

Illinois MMIS and E&E; System Had Adequate Security Controls in Place, but Some Improvements Are Needed

HHS OIG conducted 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 were protected when subjected to cyberattacks.

OIG's objectives were to determine whether (1) security controls in operation at Illinois' MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the Illinois MMIS and E&E; system or its data, and (3) Illinois' ability to detect cyberattacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of the Illinois MMIS and E&E; system from August through September 2022. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign targeting Illinois personnel. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Illinois.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Illinois MMIS and E&E; system had adequate security controls in place to prevent OIG's simulated cyberattacks from resulting in a successful compromise; however, some of those security controls could have been improved to better prevent certain cyberattacks and reduce Illinois' risk of compromise. Specifically, Illinois did not correctly implement four security controls required by the National Institute of Standards and Technology (NIST) Special Publication 800-53, Revision 4.

OIG estimated that an adversary would have needed a significant level of sophistication to compromise the Illinois MMIS and E&E; system. At this level, an adversary would have needed a significant level of expertise through advanced training and a significant level of persistence to circumvent most of the current security controls. Illinois demonstrated the ability to detect some of OIG's cyberattacks against its MMIS and E&E; system by blocking OIG's testing domain after it detected OIG's hacking attempts.

Potential reasons why Illinois did not correctly implement these security controls may have been that system developers and administrators were not aware of Government standards, due to a lack of documented enterprise flaw remediation procedures, and ineffective testing procedures when periodically assessing implementation of NIST security controls. As a result, an attacker could have potentially executed multiple types of targeted attacks against the Illinois MMIS and E&E; system.

OIG recommended that Illinois improve its security controls over its MMIS and E&E; system, including enhancing its security control assessment testing procedures and taking corrective actions when deficiencies in controls were identified. The full recommendations were in the report.

Audit #: A-18-22-09009 (08/15/2024)
Government Program: CMS

Massachusetts Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure that most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees.
- This audit was part of a series and examined whether Massachusetts completed Medicaid eligibility actions during its unwinding period in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that, of the 352,408 enrollees covered during the audit period (April through September 2023), OIG sampled 140 enrollees and determined that 3 enrollees had their Medicaid eligibility incorrectly determined. On the basis of the sample results, OIG estimated that Massachusetts incorrectly renewed Medicaid eligibility for 7,040 of the 190,043 Medicaid enrollees whose eligibility was renewed during the audit period. Additionally, OIG found that, in its reports to CMS, Massachusetts incorrectly reported on its eligibility actions for eight enrollees in the sample. OIG also estimated

that Massachusetts' reports to CMS during the audit period incorrectly reported on eligibility actions for 17,749 of 352,408 enrollees.

OIG recommended that Massachusetts redetermine eligibility for the three sampled enrollees whose eligibility was incorrectly determined and take appropriate action, provide periodic training to caseworkers, and revise its policies and procedures related to its reports to CMS. The full recommendations are in the report.

Audit #: A-02-24-01001 (08/13/2024)
Government Program: CMS

Opioid Treatment Programs in Washington State Did Not Fully Comply With Federal and State Requirements, Which May Have Put Medicaid Enrollees at Risk for Poor Treatment Outcomes

The United States currently faced a nationwide public health emergency due to the opioid crisis. In 2021 alone, there were more than 80,000 opioid-related overdose deaths in the United States. Opioid treatment programs (OTPs) provided medication coupled with counseling services for people diagnosed with an opioid use disorder. OTPs' failure to comply with Federal and State requirements for providing and documenting opioid treatment services might have led to poor treatment outcomes for individuals, including relapses, overdoses, or deaths. As part of OIG's oversight of States' efforts to combat the opioid crisis, OIG audited OTP services provided to Medicaid enrollees in Washington State.

OIG's objective was to determine whether Washington ensured that OTPs complied with Federal and State requirements.

The audit covered the Medicaid OTP services that 22 OTPs in Washington provided from January 1, 2019, through July 31, 2020. OIG excluded from the audit OTP services provided by tribally owned and operated OTPs.

OIG selected a random sample of 100 enrollee-months. An enrollee-month (which OIG referred to as a "sample item") included all OTP services that an OTP provided to an enrollee in a calendar month. OIG reviewed supporting documentation for each sample item to determine compliance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Washington did not ensure that OTPs fully complied with Federal and State requirements for OTP services they provided. Of the 100 sample items, 4 met the requirements, but 96 sample items did not meet the requirements. Among other findings, OIG found that OTPs did not adequately document enrollee admissions, treatment plans, opioid treatment services, the results of drug screens, checks of Washington's prescription drug monitoring program (PDMP) prescription data, and enrollee assessments. OIG also found that OTPs did not provide take-home medications in accordance with Federal and State requirements. These deficiencies occurred, in part, because Washington's oversight was not effective in ensuring that OTPs complied with Federal and State requirements for providing and documenting OTP services.

On the basis of OIG's sample results, OIG estimated that OTPs did not comply with Federal and State requirements for 132,002 enrollee-months, or 96 percent of the enrollee-months in the audit period. OTPs' lack of compliance with Federal and State requirements may have put enrollees at risk for poor treatment outcomes, including relapses,

overdoses, or deaths.

OIG recommended that the Washington State Health Care Authority work with its contracted managed care organizations and the Department of Health to ensure that OTPs complied with Federal and State requirements for providing and documenting OTP services, including ensuring that OTPs: (1) adequately documented enrollee admissions, treatment plans, opioid treatment services, the results of drug screens, checks of Washington PDMP prescription data, and enrollee assessments; and (2) provided take-home medications in accordance with Federal and State requirements. The report contained additional procedural recommendations.

Audit #: A-09-21-02001 (08/05/2024)
Government Program: CMS

California Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

- California paid managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee.
- 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.
- This audit assessed whether California 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

OIG found that, on the basis of OIG's sample results, OIG estimated that California incurred costs of approximately $19.9 million ($15.5 million Federal share) for August 2021 capitation payments made on behalf of enrollees who were residing and concurrently enrolled in a Medicaid managed care program in another State.

OIG found that:

- OIG's audit covered August 2021 Medicaid managed care capitation payments totaling $36.4 million made by California on behalf of 108,800 enrollees who were concurrently enrolled for Medicaid benefits in California and another State during the period of July 1 through September 30, 2021.
- Of the 100 enrollees in OIG's stratified random sample, OIG determined that 54 enrollees were residing and enrolled for Medicaid benefits in California, but 46 enrollees were residing and concurrently enrolled in Medicaid in another State.

OIG recommended that California:

1. resume and enhance procedures that were in accordance with current Federal requirements to identify and disenroll enrollees who were residing and enrolled in Medicaid managed care in another State and
2. work with CMS to consider the potential use of Transformed Medicaid Statistical Information System data to identify potential cases of concurrent enrollment.

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Audit #: A-05-23-00008 (07/24/2024)
Government Program: CMS

California Improperly Claimed $52.7 Million in Federal Medicaid Reimbursement for Capitation Payments Made on Behalf of Noncitizens With Unsatisfactory Immigration Status

States were generally prohibited from claiming Federal reimbursement for Medicaid services, other than treatment of an emergency medical condition, provided to certain noncitizens with unsatisfactory immigration status (UIS). However, California's Medicaid program extended coverage beyond limited Federal Medicaid benefits to these noncitizens and would generally need to pay for nonemergency services using State funds. California applied a proxy percentage (39.87 percent) to capitation payments made on behalf of noncitizens with UIS to identify costs of providing nonemergency services and to avoid claiming Federal reimbursement for these costs. CMS requested that OIG conduct this audit. OIG's objective was to determine whether California claimed Federal Medicaid reimbursement for capitation payments made on behalf of noncitizens with UIS in accordance with Federal requirements.

OIG's audit covered $888.8 million ($372.9 million Federal share) for managed care capitation payments made on behalf of noncitizens with UIS from October 1, 2018, through June 30, 2019. OIG first determined whether California's proxy percentage correctly accounted for the costs of providing nonemergency services by calculating a new percentage using managed care encounter data. Then, OIG applied this percentage to the capitation payments to determine the allowability of managed care claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the $372.9 million in total Federal Medicaid reimbursement for capitation payments made on behalf of noncitizens with UIS, California did not claim $52.7 million in accordance with Federal requirements. Specifically, the proxy percentage (39.87 percent) that California applied to capitation payments did not correctly account for the costs of providing nonemergency services to noncitizens with UIS. This proxy percentage was 8.49 percentage points lower than the percentage that OIG calculated (48.36 percent).

California improperly claimed $52.7 million in Federal Medicaid reimbursement because it continued to use the proxy percentage that was developed in the early 2000s without assessing whether the percentage correctly accounted for the costs of providing nonemergency services to noncitizens with UIS under managed care. In addition, California did not have any policies and procedures for assessing and periodically reassessing the proxy percentage.

OIG recommended that California:

- refund to the Federal Government the improperly claimed Federal reimbursement of $52.7 million for capitation payments made on behalf of noncitizens with UIS
- work with CMS to determine the amount of any improperly claimed Federal reimbursement for capitation payments made on behalf of noncitizens with UIS for an agreed-upon period not covered by OIG's audit.

Audit #: A-09-22-02004 (05/17/2024)
Government Program: CMS

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Medicaid Managed Care: States Do Not Consistently Define or Validate Paid Amount Data for Drug Claims

- In Medicaid managed care, consistent and accurate data on the amount pharmacies were reimbursed for filling prescriptions were critical for CMS and States to administer the program and oversee drug spending. Such data were particularly important in light of concerns that pharmacy benefit managers' (PBMs') use of spread pricing could inflate Medicaid drug costs.
- In the Transformed Medicaid Statistical Information System (T-MSIS), the Medicaid Paid Amount data elements that States reported for managed care drug claims could--in practice--represent (1) the amount that the plan or its PBM reimbursed to the pharmacy or (2) the amount that the plan paid to its PBM, which might have included PBM administrative fees, such as spread.
- If these paid amount data did not consistently and accurately reflect pharmacy reimbursement, this could have undermined States' use of these data to determine actual Medicaid drug spending; to develop plans' capitation rates; and to combat fraud, waste, and abuse in Medicaid managed care. Also, CMS had emphasized the importance of these data for Federal oversight, including financial management of Medicaid managed care.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that state requirements varied for how plans should report the paid amount for drug claims. Of the 36 States that covered outpatient prescription drugs for Medicaid through managed care in January 2022, 28 States required Medicaid managed care plans to report the paid amount for drug claims as the amount the plan or its PBM reimbursed to the pharmacy; 2 States required plans to report the amount the plan paid to its PBM; and 6 States had no reporting requirements.

For 37 of 252 managed care drug claims in OIG's review, the T-MSIS paid amount did not equal pharmacy-reported reimbursement, raising concerns about the accuracy or consistency of the paid amounts on these claims. Twenty-two non-matching claims in OIG's sample were from States where the T-MSIS paid amounts should have equaled pharmacy-reported reimbursement amounts for all claims according to States' requirements and practices.

Although all States relied on drug claim paid amounts to safeguard and administer the Medicaid program, many States did not conduct certain activities to validate these data. Most States relied on these data to develop capitation rates and identify fraud, waste, and abuse. Ten States did not validate these data by comparing them to another data source--a recommended, but not required, activity.

OIG recommended that CMS should:

- Revise the T-MSIS Data Dictionary to instruct States to report the paid amount as the amount paid to the pharmacy for all Medicaid managed care drug claims;
- Provide additional technical assistance to States to clarify what to include or exclude from the reported paid amounts to providers for Medicaid managed care drug claims; and
- Follow up with States that did not verify that paid amounts for managed care drug claims were complete.

Evaluation #: OEI-03-20-00560 (05/15/2024)
Government Program: CMS

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Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for Some Cases Identified by the State's Program Integrity Section

This audit was one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claims amounts as well as any damages (when assessed). For this audit, the focus was on Colorado's actions related to the recoveries of Medicaid overpayments. Colorado was required to report these recoveries to the Centers for Medicare & Medicaid Services (CMS) and to refund the Federal share of those recoveries to the Federal Government.

The objective was to determine whether Colorado reported and refunded the correct Federal share of Medicaid overpayments that its Program Integrity Section identified during the period October 1, 2014, through December 31, 2020.

OIG reviewed 403 cases with Medicaid overpayments totaling $28.4 million during the audit period. OIG worked with Colorado to identify what portion of the $28.4 million it reported to CMS for the period October 1, 2014, through December 31, 2020. OIG obtained documentation related to Medicaid overpayments as well as Colorado's documentation that supported its reporting of those overpayments to determine whether Colorado reported the correct Federal share.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Colorado did not report and refund the correct Federal share of Medicaid overpayments that its Program Integrity Section identified during the period October 1, 2014, through December 31, 2020. Specifically, OIG determined that Colorado did not report $385,180 ($637,686 Federal share) in Medicaid overpayments for 80 of the 403 cases reviewed. (The Federal share was greater than the total amount because there were some cases in which the State reported the entire total amount but not the entire Federal share portion that it should have reported.) In addition, Colorado did not report $12.7 million ($8.5 million Federal share) to CMS in a timely manner. Furthermore, the State did not correctly report Medicaid overpayments that either had been recovered or had not been recovered within regulatory timeframes. Although Colorado had policies and procedures for reporting Medicaid overpayments that its Program Integrity Section had identified, OIG concluded that these policies and procedures were not always adequate to ensure that Colorado reported and refunded all of the overpayments.

OIG recommended that Colorado report and refund $385,180 ($673,686 Federal share) in unreported Medicaid overpayments that were related to paid claims that had been recovered and collected. OIG also recommended that Colorado determine the value of overpayments identified after the audit period that had been recovered and collected but not reported, report them to CMS, and refund the Federal share. Additionally, OIG recommended that Colorado work with CMS to determine the amount of interest, if any, on the Federal share owed, and report that amount; and OIG made procedural recommendations for the strengthening and updating of policies and procedures to ensure that overpayments were reported correctly and in a timely manner.

Audit #: A-07-19-02816 (05/14/2024)
Government Program: CMS

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Medicare Part C

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State Agencies Could Be Obtaining Hundreds of Millions in Additional Medicaid Rebates Associated With Physician-Administered Drugs

Generally, for a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program, manufacturers had to pay rebates to the States for drugs under the Medicaid drug rebate program. OIG conducted a series of audits to examine whether Medicaid State agencies (State agencies) properly invoiced for, and collected, rebates for physician-administered drugs. This report provided the Centers for Medicare & Medicaid Services (CMS) with a summary of the results of previous OIG reports and identified potential issues that, if addressed, could bring about significant reductions in costs to the Medicaid program as a result of renewed efforts to collect rebates for physician-administered drugs.

OIG's objective was to summarize the results from previous audits of individual State agencies that determined whether the State agencies complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

OIG reviewed each of their 57 previous OIG audits of the Medicaid drug rebate program and summarized the results of those audits for this report. Their 57 previous audits covered physician-administered drug costs that the State agencies claimed for Federal reimbursement. Those audits covered audit periods that ranged from 3 months to 5 years in length, with the earliest audit period beginning on April 1, 2008, and the most recent audit period ending on December 31, 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that its 57 previous audits of individual State agencies, which were summarized for this report, determined that the State agencies generally did not comply with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs and that, in the aggregate, the State agencies could have invoiced for hundreds of millions of dollars in additional rebates. State agencies could have invoiced and obtained rebates from the manufacturers for $225.7 million (Federal share) for physician-administered drugs reimbursed on a fee-for-service basis, and should have collected additional rebates associated with $236.2 million (Federal share) for physician-administered drugs administered to Medicaid managed-care organization enrollees. Furthermore, some State agencies had opportunities to obtain additional rebates for physician-administered drugs beyond those that were required by Federal law. The State agencies generally lacked internal controls, to include policies and procedures, to provide for the collection of adequate and sufficient data to enable the State agencies to collect all rebates for eligible physician-administered drugs.

OIG recommended that CMS work with the State agencies to implement internal controls, including policies and procedures, to collect information to facilitate the collection of all rebates for eligible physician-administered drugs; issue finalized guidance to clarify and reinforce the requirement that rebates should be collected for all required physician-administered drugs; and work with and encourage the State agencies to maximize the amount of rebates that could be obtained when feasible, including invoicing for and obtaining rebates in cases when the rebates might not be required.

Audit #: A-07-23-06111 (05/09/2024)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

New Mexico Should Refund Almost $120 Million to the Federal Government for Medicaid Nursing Facility Level-of-Care Managed Care Capitated Payments

In a previous OIG audit, OIG reviewed recoveries that New Mexico received from its managed care organizations (MCOs) related to payments that New Mexico had made to its MCOs for calendar years 2014 and 2015. For that audit, OIG reported that New Mexico had not performed reconciliations of capitated payments for Community Benefit (CB) services. This audit followed up on OIG's recommendation that New Mexico perform the required reconciliations and refund the Federal share of any recoveries.

OIG's objectives were to determine whether New Mexico: (1) performed reconciliations of capitated payments for CB services as required under its contracts with MCOs and refunded the Federal share of any related recoupments to the Federal Government and (2) provided support that enrollees were eligible to receive services at the nursing facility level-of-care (NFLOC) rate.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Mexico performed reconciliations of capitated payments for CB services as required under its contracts with MCOs. However, it did not recoup from its MCOs any overpayments identified in the CB services reconciliations and did not refund any related Federal share to the Federal Government. Of the $3.8 billion in CB services capitated payments for the audit period, New Mexico did not recoup $139.2 million in overpayments for enrollees who did not use CB services within 90 calendar days of their approval for CB services. As a result, New Mexico did not return the related Federal share of $98.6 million.

Additionally, New Mexico did not provide support that the enrollees on whose behalf MCOs received $35.2 million in capitated payments at the higher NFLOC rate for the audit period were eligible for services at that rate. As a result, New Mexico claimed $29.4 million in overpayments for those enrollees and inappropriately received $20.5 million in Federal share for those overpayments.

OIG recommended that New Mexico:

(1) recoup $139.2 million in CB services capitated payments from its MCOs and refund the $98.6 million in Federal share to the Federal Government,
(2) recoup the $29.4 million in NFLOC capitated payments from its MCOs and refund the $20.5 million Federal share to the Federal Government, and
(3) establish policies and procedures to recoup the NFLOC capitated payments made to its MCOs based on settings-of-care that were removed after payment and no longer valid.

Audit #: A-06-20-09001 (05/08/2024)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

California Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure that most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees, including terminating Medicaid enrollment of ineligible individuals.
- This audit of California was part of a series of audits examining whether States completed Medicaid eligibility actions during the unwinding period in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the 1,830,923 enrollees who had their Medicaid eligibility renewed or coverage terminated during April 1 through August 31, 2023 (audit period), OIG sampled 140 enrollees and determined that California incorrectly completed Medicaid eligibility actions for 9 enrollees. On the basis of OIG's sample results, OIG estimated that California incorrectly renewed eligibility or incorrectly terminated coverage for 78,853 of the 1,830,923 enrollees during the audit period.

OIG recommended that California:

- redetermine eligibility for the sampled enrollees that OIG identified as having incorrect eligibility determinations,
- provide caseworkers additional training to reduce errors,
- revise its guidance to instruct counties to document in case files essential information to support enrollees' continuing eligibility, and
- identify and correct the system issues that caused incorrect Medicaid eligibility actions.

The full recommendations are in the report.

Audit #: A-09-24-02001 (05/07/2024)
Government Program: CMS

Medicaid Enrollees May Not Be Screened for Intimate Partner Violence Because of Challenges Reported by Primary Care Clinicians

- Intimate partner violence (IPV)--which includes physical, sexual, and psychological abuse perpetrated by a spouse or partner--was a significant health problem that affected millions of Americans.
- The U.S. Preventive Services Task Force (USPSTF) and the Women's Preventive Services Initiative (WPSI) recommended that clinicians screen certain women for IPV and provide, or refer those who screened positive to, support resources. The 41 States with Medicaid expansion programs had to cover the IPV screening and referral services recommended by USPSTF and WPSI.
- This study analyzed survey responses from 1,186 primary care clinicians who served patients enrolled in Medicaid to identify clinicians' screening and referral practices and the challenges they faced related to providing IPV screening and referral services, as well as incentives that could improve these practices. OIG's findings were based

on completed surveys from 4 percent of the clinicians who met OIG's inclusion criteria and could not be generalized to all primary care clinicians who served Medicaid enrollees.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that responding primary care clinicians who served Medicaid enrollees reported a range of challenges to IPV screening. The most frequently reported challenge was time constraints. Other barriers included concerns about patient privacy and safety, and inadequate training.

Among primary care clinicians who screened patients for IPV, there were additional challenges that hindered their ability to make referrals. These additional challenges included limitations with IPV support resources for patients who screened positive.

OIG concluded that despite the widespread impact of IPV, clinicians faced limitations in their ability to screen and refer their patients for this significant health risk. Primary care clinicians who responded to the survey reported that changes to how IPV screening and referral services were reimbursed; better resources to help patients; and additional training and guidance might have increased the likelihood that IPV screening and referral services were delivered to Medicaid enrollees. The results of this evaluation highlighted challenges that hindered some primary care clinicians' ability to perform IPV screening and make referrals as well as the incentives that might have helped them to overcome these challenges. Clinicians played a critical role in IPV screening and making referrals. Therefore, policymakers might have considered the challenges and incentives the clinicians reported to OIG to plan steps so that primary care clinicians might have more easily prioritized providing these critical services to their patients.

CPT Codes Identified in This Evaluation:

- 99202 - 99205
- 99211 - 99215
- 99385 - 99387
- 99395 - 99397
- 99401 - 99404
- 99411 - 99412
- 99415 - 99417
- 99421 - 99427
- 99441 - 99443
- 99497 - 99499

Evaluation #: OEI-03-21-00310 (04/30/2024)
Government Program: ACF, CMS

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Medicare Part C

Medicare Part D

Ohio Generally Completed Medicaid Eligibility Actions During the Unwinding Period in Accordance With Federal and State Requirements

- In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required States to ensure most individuals were continuously enrolled for Medicaid benefits (enrollees).
- The Consolidated Appropriations Act, 2023, ended the continuous enrollment condition. As a result, States had to conduct renewals, post-enrollment verifications, and redeterminations (Medicaid eligibility actions) for all enrollees, including disenrolling individuals who were no longer eligible.
- This audit was part of a series that examined whether Ohio completed Medicaid eligibility actions during its unwinding period in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the 1,211,991 enrollees covered under OIG's audit period (April 1 through August 31, 2023), OIG sampled 140 enrollees and determined that 9 enrollees had their Medicaid enrollment incorrectly determined. On the basis of OIG's sample results, OIG estimated that Ohio either incorrectly renewed or terminated Medicaid eligibility for 78,486 of the 1,211,991 Medicaid enrollees during OIG's audit period.

OIG recommended that Ohio:

1. take appropriate action with respect to the incorrect Medicaid eligibility determinations identified in OIG's sample,
2. provide periodic training to caseworkers about verifying and documenting enrollees' income during the renewal process, and
3. provide additional training to caseworkers about using current information when conducting enrollee eligibility determinations.

Audit #: A-05-23-00019 (04/09/2024)
Government Program: CMS

New York Generally Identified and Corrected Duplicate Children's Health Insurance Plan Payments Made to Managed Care Organizations

Previous OIG audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some individuals enrolled in Medicaid managed care had more than one identification number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries. An analysis of New York Children Health Insurance Program (CHIP) data indicated that New York may have made similar unallowable, duplicate CHIP payments to MCOs.

OIG's objective was to determine whether New York claimed Federal reimbursement for duplicate CHIP payments made to MCOs.

OIG limited the audit to potential CHIP payments New York may have made to MCOs for the same enrollee for the same month of coverage. Specifically, OIG identified 104 enrollee-matches with payments totaling $594,492 ($389,704 Federal share) that New York claimed for the period January 1, 2020, through December 31, 2022. For purposes of this

audit, OIG defined an enrollee-match to be an individual for whom selected personal information (i.e., identical first five characters of first name, middle name initial, last name, and date of birth) was the same for more than one claim for the same month of coverage.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York generally did not claim Federal reimbursement for duplicate CHIP payments made to MCOs. New York identified and corrected duplicate CHIP payments associated with 100 of the 104 enrollee-matches OIG reviewed. Specifically, New York (1) appropriately determined that the CHIP payments associated with sampled enrollee-matches were for two different enrollees or (2) timely identified and corrected the duplicate CHIP payments made to MCOs. However, New York did not identify and correct duplicate CHIP payments to MCOs for the remaining four enrollee-matches totaling $24,679 ($7,026 Federal share).

OIG concluded that this report did not contain any recommendations because New York generally identified and corrected duplicate CHIP payments made to MCOs, and the amounts associated with the improper payments OIG identified were immaterial. OIG provided New York with its findings for the four enrollee-matches it identified to contain duplicate CHIP payments to MCOs so that it could evaluate these claims and decide whether to recover the improper payments in accordance with New York's policies and procedures.

Audit #: A-02-23-01017 (04/01/2024)
Government Program: CMS

Alabama Claimed Federal Medicaid Reimbursement for Millions of Dollars in Targeted Case Management Services That Did Not Comply With Federal and State Requirements

Targeted Case Management (TCM) services assisted specific State-designated Medicaid groups in gaining access to medical, social, educational, and other types of services. Previous 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 Alabama claimed Federal Medicaid reimbursement for TCM services during Federal fiscal years (FYs) 2019 through 2021 in accordance with Federal and State requirements.

OIG's audit covered $123.4 million ($95.2 million Federal share) in Medicaid payments for TCM services provided and paid for in Alabama during FYs 2019 through 2021 (October 1, 2018, through September 30, 2021).

OIG reviewed documentation for a stratified random sample of 150 unique TCM grouped line items from the 5 largest target groups in the State to determine whether the services provided were allowable, case managers providing services were qualified, and enrollees 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 Alabama to applicable Federal regulations and the State plan supplements governing Alabama's TCM program.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Alabama did not always claim Federal Medicaid reimbursement for TCM services during FYs 2019 through 2021 in accordance with Federal and State requirements. Of the 150 sampled grouped line items, 24 grouped line items were at least partially unallowable because they had at least 1 error related to unallowable services, case managers lacking required qualification documentation, unsupported services, or ineligible enrollees. Alabama had policies and procedures in place for the administration of TCM services in the State but did not follow them. As a result, providers billed the State (and received payment) for some unallowable TCM services. Based on OIG's sample results, OIG estimated that Alabama claimed at least $6.4 million ($5 million Federal share) in unallowable Medicaid reimbursement for TCM services.

OIG recommended that Alabama refund to the Federal Government the more than $5 million (Federal share) in overpayments; and that it improve TCM program oversight by giving additional guidance to TCM providers regarding: billing of services, to verify that they were allowable and non-duplicative; case manager hiring practices, to verify adherence with the State plan's qualification requirements; target group eligibility screening processes, so that only eligible individuals received TCM services; and the maintenance of supporting documentation for billed services.

Audit #: A-07-22-03253 (04/01/2024)
Government Program: CMS

Alabama MMIS and E&E; System Security Controls Were Adequate, but Some Improvements Are Needed

OIG conducted 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 were protected when subjected to cyber-attacks.

OIG's objectives were to determine: (1) whether security controls in operation for Alabama MMIS and E&E; system environments were effective in preventing certain cyber-attacks, (2) the likely level of sophistication or complexity an attacker needed to compromise Alabama's MMIS and E&E; system or its data, and (3) Alabama's ability to detect cyber-attacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of the Alabama MMIS and E&E; system from November through December 2022. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that included Alabama personnel in December 2022. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Alabama.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Alabama MMIS and E&E; system had adequate security controls in place to prevent OIG's simulated cyber-attacks from resulting in a successful compromise; however, OIG found six security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4, that could be improved to better prevent certain cyber-attacks.

In addition, OIG estimated that an adversary would need a moderate level of sophistication to compromise the Alabama MMIS and E&E; system. Finally, Alabama demonstrated that it had implemented adequate controls to detect and block phishing emails sent from a known malicious IP address. However, improvements to its detection controls were needed to better identify certain web application cyber-attacks.

OIG found that Alabama did not effectively implement some security controls because, in part, its vulnerability scanning tools did not identify the flaws and vulnerabilities OIG discovered in its systems. Additionally, Alabama did not adequately follow secure coding practices during their software development lifecycle and remediate vulnerabilities before deployment to Alabama's production systems. As a result of Alabama not effectively implementing security controls or identifying vulnerabilities, an attacker could potentially launch certain cyber-attacks against the Alabama MMIS and E&E; system to remotely execute malicious code on a computer or redirect users to malicious websites. Such cyber-attacks could facilitate an attacker's ability to get initial unauthorized access to an Alabama system and potentially allow them to move deeper into the network and/or extract sensitive information such as Personal Health Information.

OIG recommended that Alabama improve its security controls over its MMIS and E&E; system, including requiring its developers to follow secure coding best practice requirements.

Audit #: A-18-22-09010 (03/28/2024)
Government Program: CMS

New Jersey Significantly Improved Its Oversight of Medicaid Adult Partial Care Services Except for Those Provided Using Telehealth During the COVID-19 Public Health Emergency

During a prior audit of Medicaid adult partial care services, OIG found that New Jersey claimed Medicaid reimbursement for services that did not comply with Federal and State requirements. OIG recommended that New Jersey refund $94.8 million in Federal Medicaid funds, issue guidance to partial care providers, and improve its monitoring of providers. OIG performed this audit to determine if New Jersey improved its program oversight and implemented OIG's prior audit recommendations. OIG included telehealth service performed during COVID-19.

OIG's objectives were to determine whether New Jersey adequately implemented the recommendations made in OIG's prior audit report and ensured Medicaid adult partial care services complied with Federal and State requirements.

OIG's audit covered $61.3 million in Federal Medicaid reimbursement for 1,378,671 adult partial care claims, that were paid from January 1, 2019, through December 31, 2020. OIG reviewed a stratified random sample of 100 claims to determine if claims for these services complied with Federal and State requirements.

For each sampled claim, OIG reviewed service documentation obtained from providers.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Jersey adequately implemented the procedural recommendations made in OIG's prior report; however, New Jersey had not refunded OIG's recommended disallowance of $94.8 million in Federal Medicaid funds.

Of the 100 claims in OIG's sample, 56 claims complied with Federal and State requirements, but 44 claims did not. Most of the deficiencies OIG identified occurred because New Jersey misapplied Federal telehealth flexibilities by issuing guidance not approved by CMS that changed the rate for telehealth services. Based on OIG's sample results, OIG estimated that New Jersey was improperly reimbursed at least $18.8 million in Federal Medicaid funds for adult partial care services that did not meet Federal and State requirements.

OIG recommended that New Jersey work with CMS to refund the recommended disallowance of $94.8 million from the prior audit, refund to the Federal Government $18.8 million associated with deficiencies identified in the current audit, and provide training or guidance to address noncompliance issues it identified during site visits to ensure Medicaid enrollees received required services with the necessary amount of care.

HCPCS Codes Identified in This Audit:

- H0035 - In-person adult partial care services
- H0035GTUC - Telehealth adult partial care services

Audit #: A-02-22-01007 (03/28/2024)
Government Program: CMS

CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements

In 2021, nearly 58 million adults in the United States experienced some form of mental illness, and an estimated 46.3 million people aged 12 or older had a substance use disorder. Individuals seeking care for mental health and substance use disorder (MH/SUD) conditions often found that treatment operated in a separate, and often very disparate, system than treatment for medical/surgical care, even under the same health insurance coverage. Federal regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 were put in place to make it easier for people with MH/SUD conditions to access treatment and services by prohibiting coverage limitations that applied more restrictively to MH/SUD benefits than to medical/surgical benefits.

OIG's objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured that selected States complied with Medicaid managed care MH/SUD parity requirements.

OIG selected eight States for review with Medicaid managed care contracts in effect on or after October 2, 2017 (the compliance date). OIG selected four States in which the State was required to conduct the parity analysis and four States in which managed care organizations (MCOs) were required to conduct the parity analysis. OIG reviewed CMS's approval of States' MCO contract provisions and its oversight of States' compliance with MH/SUD parity requirements.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS did not ensure that selected States complied with Medicaid managed care MH/SUD parity requirements. For all eight States reviewed, State contracts with Medicaid MCOs did not contain required parity provisions by the compliance date. Further, States and their MCOs did not conduct required parity analyses (five States), and States did not make documentation of compliance available to the public by the compliance date (eight States). In addition, all eight States may not have ensured that all services were delivered to MCO enrollees in compliance with MH/SUD parity requirements. Specifically, MCOs applied financial requirements (two States) and quantitative treatment limitations (six States) for MH/SUD services that were more restrictive than those for medical/surgical services in the same classifications and imposed non-quantitative treatment limitations (eight States) on MH/SUD benefits that were not comparable to, or were more stringent than, those for medical/surgical benefits in the same classifications.

OIG recommended that CMS improve its oversight of States' compliance with MH/SUD parity requirements and require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements.

Audit #: A-02-22-01016 (03/25/2024)
Government Program: CMS

Delaware Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths

Delaware paid Medicaid managed care organizations (MCOs) to make services available to Medicaid enrollees in return for a monthly fixed payment for each enrollee (capitation payment). Previous OIG audits found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased enrollees. OIG conducted a similar audit of Delaware.

OIG's objective was to determine whether Delaware made capitation payments to MCOs on behalf of deceased Medicaid enrollees.

OIG's audit covered 7,122 capitation payments totaling $8.6 million that Delaware made to MCOs and claimed for Federal reimbursement during calendar years 2019 through 2021 (audit period) on behalf of 409 enrollees whose dates of death, as recorded in one or more of the data sources OIG consulted, preceded the monthly service periods covered by the capitation payments.

OIG selected and reviewed a stratified random sample of 100 capitation payments totaling $345,093 ($224,940 Federal share) from those 7,122 capitation payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the State agency made unallowable capitation payments after enrollees' deaths. For 53 of the 100 capitation payments in OIG's sample, the State agency made unallowable capitation payments totaling $102,867 ($71,751 Federal share). For 44 of the remaining capitation payments in OIG's sample, the capitation payments were allowable, but the State agency erroneously linked the enrollees' Medicaid records to deceased enrollees. OIG could not fully confirm that the remaining 3 enrollees associated with 3 of the 100 capitation payments were deceased.

Based on OIG's sample results, OIG estimated that Delaware made unallowable capitation payments totaling at least $4.2 million (over $3.4 million Federal share) to MCOs on behalf of the 409 deceased enrollees during OIG's audit period. Additionally, linking living enrollees to deceased individuals' Social Security Numbers (SSNs) could have led to enrollees being mistakenly disenrolled, which would have caused a delay or denial of services.

OIG found that Delaware made unallowable capitation payments on behalf of deceased enrollees because it did not have adequate processes in place to enable it to identify deceased enrollees. Further, Delaware incorrectly aligned the SSNs of deceased individuals with living enrollees due to data entry errors and inadequate supervisory oversight of the data entry process.

OIG recommended that Delaware: (1) refund the Federal share (over $3.4 million) to the Federal Government; (2) identify and recover unallowable capitation payments, which OIG estimated to be at least $4.2 million, made to MCOs during the audit period on behalf of deceased enrollees; and (3) identify and recover unallowable capitation payments made on behalf of deceased enrollees in 2022 and 2023 (the years after the audit period), and repay the Federal share of amounts recovered. OIG also recommended that Delaware develop and implement quality assurance steps. The full recommendations were in the report.

Audit #: A-03-22-00205 (03/25/2024)
Government Program: CMS

Utah MMIS and E&E; System Had Adequate Security Controls In Place, but Improvements Are Needed

OIG conducted 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 were protected when subjected to cyber-attacks.

OIG's objectives were to determine whether: (1) security controls in operation at Utah's MMIS and E&E; system environments were effective in preventing certain cyber-attacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the Utah MMIS and E&E; system or its data, and (3) Utah's ability to detect cyber-attacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of the Utah MMIS and E&E; system from February to March 2021. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign targeting Utah personnel. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Utah.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Utah MMIS and E&E; system had adequate security controls in place to prevent OIG's simulated cyber-attacks from resulting in a successful compromise; however, some of those security controls could have been improved to better prevent certain cyber-attacks and reduce overall risk. Specifically, Utah did not correctly implement seven security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP)

800-53, Revision 4. OIG shared this information with Utah, which provided evidence that four of the security control findings had been remediated.

OIG estimated that the level of sophistication needed by an adversary to compromise the Utah MMIS and E&E; system was significant. At this level, an adversary would have needed a significant level of expertise through advanced training and persistence to circumvent most of the current security controls. Finally, based on the results of OIG's simulated cyber-attacks, Utah demonstrated the ability to detect some attacks and respond appropriately. However, Utah did not detect and prevent other penetration test activities OIG performed in later phases.

Utah may not have correctly implemented security controls because system administrators were not aware of Government standards or industry best practices that required securely configured systems before deployment to production. Also, Utah's flaw remediation procedures were not consistent with the timeframe defined in the CMS ARS policy for correcting identified security-related information system flaws on production systems. Lastly, there was no requirement from CMS for more frequent penetration testing unless the system was considered a high value asset.

OIG recommended that Utah:

- Remediate the remaining three security control findings
- Revise flaw remediation procedures such that they fully implement the flaw remediation requirements defined in the CMS Acceptable Risk Safeguards.

Audit #: A-18-21-09001 (03/15/2024)
Government Program: CMS

South Carolina MMIS and E&E; System Security Controls Were Adequate, but Some Improvements Are Needed

OIG conducted a series of audits of State Medicaid Management Information Systems (MMIS) and Eligibility and Enrollment (E&E;) systems of selected States to determine how well these systems were protected when subjected to cyber-attacks.

OIG's objectives were to determine: (1) whether security controls in operation at South Carolina's MMIS and E&E; system environments were effective in preventing certain cyber-attacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the South Carolina Medicaid System or its data, and (3) South Carolina's ability to detect cyber-attacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of the South Carolina MMIS and E&E; system from April through July 2022. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign targeting South Carolina personnel. OIG contracted with XOR Security, LLC (XOR), to conduct the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and South Carolina.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the South Carolina MMIS and E&E; system had adequate security controls in place to prevent OIG's simulated cyber-attacks from resulting in a successful compromise; however, OIG identified security controls that could be further enhanced to better prevent certain cyber-attacks. Specifically, South Carolina did not correctly implement four security controls required by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 5.

OIG estimated that an adversary would need at least a moderate level of sophistication to compromise the South Carolina MMIS and E&E; system. At this level, an adversary would need a moderate level of expertise with moderate resources and opportunities to support multiple successful coordinated attacks. Additionally, although penetration testers were able to exploit an application-level vulnerability that was not blocked by network firewalls or other mechanisms, testers were not able to gain access to any systems or networks. OIG shared this information with South Carolina, who later provided OIG adequate evidence of the remediation of the security control findings related to Flaw Remediation (SI-2) and Error Handling (SI-11).

OIG recommended that South Carolina remediate the remaining two control findings (SI-10 and SC-8) in accordance with government standards and periodically test the effectiveness of these controls.

Audit #: A-18-22-09005 (03/15/2024)
Government Program: CMS

Kansas's Medicaid Estate Recovery Program Was Cost Effective, but Kansas Did Not Always Follow Its Procedures, Which Could Have Resulted in Reduced Recoveries

All States are required to have a Medicaid Estate Recovery Program (MERP) that seeks, from the estates of deceased Medicaid recipients who were 55 years old and older when they received medical assistance, reimbursement for certain Medicaid costs.

OIG's objectives were to determine whether: (1) Kansas operated its MERP in accordance with Federal and State requirements and (2) Kansas's MERP was cost effective.

The audit covered deceased Medicaid recipients whose estates were subject to estate recovery by Kansas during State fiscal years 2020 through 2022 (audit period).

OIG reviewed documentation for a stratified random sample of 128 deceased Medicaid recipients to determine whether Kansas operated its MERP in accordance with requirements. Of these, 30 recipients had estate recovery cases that resulted in asset recoveries; the cases for the other 98 sampled recipients did not result in asset recoveries.

In addition, OIG compared Medicaid claims data to the estate recoveries to identify deceased Medicaid recipients and determine whether Kansas had opened a case for all potential estate recoveries. OIG also obtained Kansas's estate recovery operating costs and subtracted that amount from the total estate recoveries to determine whether the State recovered more than it spent.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Kansas did not always operate its MERP in accordance with Federal and State requirements in that it did not always follow its estate recovery procedures. Specifically, for the 30 sampled deceased Medicaid recipients with estate recovery cases that had asset recoveries, OIG did not find any deficiencies. However, for the 98 sampled deceased Medicaid recipients with estate recovery cases that did not have asset recoveries, OIG identified 18 recipient cases with at least 1 deficiency related to probates and liens for estate recovery that were not initiated in a timely manner, the incorrect closing of a case for having no Medicaid paid claims, or the incorrect performance of other estate recovery procedures. Furthermore, OIG identified 1,095 deceased Medicaid recipients outside of the sampling frame for whom Kansas had not opened an estate recovery case. For the second objective, during the audit period Kansas's MERP collected $37 million in estate recoveries while spending $5 million to operate the program. Therefore, OIG concluded that Kansas's MERP was cost effective. The deficiencies OIG identified occurred because Kansas did not always follow its existing estate recovery procedures, the effect of which was that Kansas did not thoroughly pursue estate recovery for all deceased Medicaid recipients and consequently, may not have executed some asset recoveries.

OIG recommended that Kansas improve its estate recovery program by confirming that all deceased Medicaid recipients who were subject to estate recovery were identified and by providing information on them to the State's contractor in a timely manner. OIG also recommended that Kansas improve its oversight of the estate recovery contractor's performance by:

- verifying that the contractor filed liens and initiated probate in a timely manner,
- confirming that the contractor's current process for claims verification was accurate, and
- verifying that the contractor performed applicable estate recovery procedures for deceased Medicaid recipients.

Audit #: A-07-22-03254 (03/12/2024)
Government Program: CMS

Pennsylvania Improperly Claimed $551 Million in Medicaid Funds for Its School-Based Program

As part of its oversight activities, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) conducted a series of audits of States that claimed Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs). Pennsylvania was one of the States that received the highest amount of reimbursement for Medicaid school-based services, and it had an agreement with a contractor to conduct its RMTSs.

The objective of OIG's audit was to determine whether Pennsylvania properly claimed Federal funds through its Medicaid school-based program.

The audit covered approximately $590 million in Federal Medicaid payments for school-based services claimed from July 1, 2015, through June 30, 2019. This included $498 million for Medicaid-eligible health services and $92 million for Medicaid administrative activities. OIG reviewed a stratified random sample of random moments, each coded as a "health service" or an "administrative activity." The stratified random sample comprised 310 random moments. OIG also reviewed the methods that Pennsylvania used to allocate health services costs to Medicaid.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Pennsylvania improperly claimed Federal funds through its Medicaid school-based health services program. Specifically, Pennsylvania claimed estimated unallowable Federal funds totaling $182.5 million because it did not support that all moments used in RMTSs and coded as Medicaid-eligible were for Medicaid-eligible health services or Medicaid administrative activities. Also, Pennsylvania improperly claimed an additional $368.9 million when it used unsupported ratios to allocate costs to Medicaid. Finally, Pennsylvania's RMTSs did not include all days worked by school staff members because it did not include the first month of the school year. As a result of these deficiencies, Pennsylvania improperly claimed $551.4 million. These deficiencies occurred because Pennsylvania and its contractor developed complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance.

OIG recommended that Pennsylvania refund $182.5 million in unallowable funds for unsupported Medicaid-eligible health services and Medicaid administrative activities, and support or refund $368.9 million claimed based on its unsupported cost allocation method. OIG also made procedural recommendations to assist Pennsylvania in preparing accurate and supportable claims.

Audit #: A-02-21-01011 (03/11/2024)
Government Program: CMS

California Did Not Comply With Requirements for Documenting Psychotropic and Opioid Medications Prescribed for Children in Foster Care

The United States Food and Drug Administration issued a safety announcement stating that a review found the combined use of opioid and some psychotropic medications could result in serious side effects, including slowed or difficult breathing and death. In addition, ineffective oversight of psychotropic and opioid medications might have increased the risk of inappropriate dosing or medication combinations. To receive Federal funding for child welfare services, States were required to have a plan for the oversight of prescription medications, including psychotropic and opioid medications prescribed for children in foster care. In recent audits, OIG found that psychotropic and opioid medications prescribed for children in foster care were not accurately documented in the States' child welfare information systems.

OIG's objective was to determine whether California complied with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under Title IV-E of the Social Security Act (the Act).

OIG randomly selected 115 children who were prescribed psychotropic or opioid medications. OIG reviewed the Medicaid claim data, case records in the Child Welfare Services Case Management System (CWS/CMS), and other documentation for the children in the sample.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that California did not always comply with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under the Act. Specifically, the documentation for children in the sample contained the following deficiencies: (1) the opioid medications prescribed for 25 children in the sample were not recorded in CWS/CMS; (2) the psychotropic medications prescribed for 22 children were not recorded in CWS/CMS; and (3) for 28 children who were prescribed psychotropic medications, the court authorizations were not maintained in CWS/CMS, and California was not able to provide the court authorizations from the children's case files.

OIG recommended that California:

(1) establish procedures for county agency staff to document all medications (including opioid medications) prescribed for children in foster care in CWS/CMS, to the extent allowable under California law;
(2) coordinate with California Department of Health Care Services to modify the existing data sharing agreement to obtain access to Medicaid claim data for all medications prescribed for children under its care and supervision, to the extent allowable under California law;
(3) establish procedures for county agency staff to utilize Medicaid data match reports to verify that court authorizations for psychotropic medications prescribed for children in foster care were documented and maintained; and
(4) develop and implement procedures for county agency staff to upload the court authorizations for psychotropic medications prescribed for children in foster care into CWS/CMS.

Audit #: A-05-22-00007 (12/19/2023)
Government Program: ACF

Connecticut Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

OIG previously conducted an audit of critical incidents involving Medicaid 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.

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, 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Connecticut implemented the four recommendations from 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 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.

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

Audit #: A-01-21-00001 (12/06/2023)
Government Program: CMS

Pennsylvania Implemented Our Prior Audit Recommendations for Critical Incidents Involving Medicaid Enrollees With Developmental Disabilities but Should Continue To Take Action To Reduce Unreported Incidents

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 OIG's previous audit, it was found that Pennsylvania did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring such incidents. OIG's previous audit report contained seven recommendations.

OIG's objective was to determine whether Pennsylvania implemented the recommendations from the prior audit, (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 OIG's previous recommendations and had taken actions that satisfied the intent of those recommendations.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Pennsylvania implemented or was in the process of implementing the seven recommendations from OIG's previous audit but should have continued 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 involved a multi-year training plan for its current Incident Management Policy and a dashboard to identify unreported incidents and providers that may have had incident management processes in need of systemic improvement.

OIG recommended that Pennsylvania 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. The full recommendations are in the report.

Audit #: A-03-22-00202 (11/30/2023)
Government Program: CMS

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

HHS-OIG 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 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 were sufficiently preventing Medicaid capitation payments from being made to MCOs on behalf of deceased enrollees.

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SunHawk Summary of OIG Audit Findings and Recommendations

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

In this audit, OIG identified additional actions CMS could take to help States that continued 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 were 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.

OIG recommended that CMS take the following steps: (1) collect the outstanding unallowable payments totaling the estimated $41,003,804 previously identified, (2) ensure that States completed actions on OIG's remaining recommendations to address the internal control weaknesses 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 have developed a process to match enrollment and payment information in T-MSIS with the DMF and provided the results of that match to States to help reduce Medicaid capitation payments made to MCOs on behalf of deceased enrollees.

Audit #: A-04-21-09005 (11/24/2023)
Government Program: CMS

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

Medicaid was generally the payer of last resort. This meant that if a Medicaid enrollee had another source of health care coverage, that source should have paid its share before Medicaid paid. Federal regulations referred 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 had encountered in their efforts to meet TPL requirements to help ensure that Medicaid functioned as the payer of last resort. Some of the more recent reports suggested that many of these challenges were ongoing and that billions of dollars were at risk.

The objectives of the audit were to identify challenges States had experienced in their efforts to meet TPL requirements and actions they had taken to address those challenges. In addition, OIG was 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 had 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

OIG found that states reported they continued 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 did 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.

OIG recommended that CMS develop an action plan that addressed 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 was included in the body of the report.

Audit #: A-05-21-00013 (10/20/2023)
Government Program: CMS

South Dakota MMIS and E&E; System Security Controls Were Partially Effective and Improvements Are Needed

OIG conducted a series of audits of State Medicaid Management Information Systems (MMIS) and Eligibility and Enrollment (E&E;) systems of selected States to determine how well these systems were protected when subjected to cyberattacks.

OIG's objectives were to determine whether (1) security controls in operation at South Dakota's MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the South Dakota MMIS and E&E; system or its data, and (3) South Dakota's ability to detect cyberattacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of South Dakota's MMIS and E&E; system from November 2021 through January 2022. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that included a limited number of South Dakota personnel in February 2022. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and South Dakota.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 have been 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 have needed 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 have needed 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 have been 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 have potentially extracted sensitive data and PII, impersonated other users, and redirected users to malicious websites.

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

Audit #: A-18-21-09004 (10/18/2023)
Government Program: CMS

Mississippi Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

For a covered outpatient drug to be eligible for Federal Medicaid reimbursement under the Medicaid Drug Rebate Program, drug manufacturers had to pay rebates to the States for covered drugs. Previous Office of Inspector General (OIG) audits found that States did not always invoice and collect all rebates due for drugs administered to Medicaid managed-care organizations' (MCOs') enrollees.

OIG's objective was to determine whether Mississippi complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

OIG reviewed physician-administered drug claims totaling $192.2 million paid between January 1, 2016, and December 31, 2019 (audit period).

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 the 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.

Audit #: A-07-21-06103 (10/18/2023)
Government Program: CMS

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

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 was essential to reducing overdose deaths; however, many individuals in need experienced 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 faced barriers such as difficulty finding providers who were 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 suggested that particular demographic groups, such as adolescents or people of certain races, might have been less likely to receive MOUD. Medicaid covered 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 have been 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, OIG used Medicaid enrollment and eligibility data to examine how MOUD treatment rates differed among demographic groups.

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SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 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.

OIG's findings underscored the need for continued efforts to increase the use of MOUD in Medicaid. Accordingly, OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

- Encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may have been underserved.
- Encourage States and work with Federal partners to educate Medicaid and CHIP enrollees about access to MOUD.

ICD Codes Identified in This Evaluation:

- F11.1 - Opioid abuse
- F11.2 - Opioid dependence
- 304.0 - Opioid type dependence
- 304.7 - Combinations of opioid type drug with any other drug dependence
- 305.5 - Opioid abuse

Evaluation #: OEI-BL-22-00260 (09/25/2023)
Government Program: CMS

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 had to 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.

OIG selected four States (New York, Florida, Texas, and Minnesota) for review. These States received an additional $12.8 billion in FMAP funding during the audit period (January 1, 2020, through June 30, 2021). For each State, OIG: (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

OIG found that the four States 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 was identified, work with Minnesota to ensure that enrollees were reimbursed for any out-of-pocket expenses incurred.

Audit #: A-06-21-09002 (09/22/2023)
Government Program: CMS

Alabama 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 had to 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 Alabama complied with Federal Medicaid requirements for invoicing manufacturers for rebates for pharmacy and physician-administered drugs.

The audit covered pharmacy and physician-administered drug claims that Alabama paid between January 1, 2016, and December 31, 2019.

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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 was 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, 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 recommended 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 determined were 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. OIG also made two additional recommendations.

Audit #: A-04-21-08090 (09/21/2023)
Government Program: CMS

Key Strategies That States Used for Managing Medicaid and Marketplace Enrollment During the COVID-19 PHE

The Office of Inspector General (OIG) collected survey information between November 2021 and February 2022 from 49 of 51 State Medicaid agencies including the District of Columbia and all 18 State-based Marketplaces (hereafter "Marketplaces") that used their own enrollment platform at some point during the PHE. In these surveys, OIG asked Medicaid and Marketplace officials about their experiences with enrollment processes during the PHE, from January 2020 to the time of their survey response.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that states faced challenges in maintaining key Medicaid and Marketplace enrollment functions as a result of a rapidly changing landscape during the COVID-19 public health emergency (PHE). States could no longer rely on existing outreach and application practices because patterns of work and life shifted. Further, gaps in demographic data about applicants and enrollees limited States' ability to identify disparities and to support equitable access to enhanced coverage. At the same time, States faced a surge in demand for coverage and had to align their enrollment and program operations with new Medicaid and Marketplace requirements and eligibility options promulgated in response to COVID-19.

States used several strategies for addressing Medicaid and Marketplace enrollment challenges:

Expanded outreach efforts. States leveraged information from a variety of sources to identify potential enrollment disparities and target their outreach. They took actions to address barriers to applicants being able to access information about enrollment through outreach efforts and found different ways to connect with existing enrollees and groups of people newly eligible to enroll.

Improved applications and support. States expanded options for receiving application assistance; simplified their application processes; and updated their online application features and tools to support their applicants and enrollees.

Simplified eligibility determination processes. States streamlined their Medicaid and Marketplace eligibility determination processes while also being mindful of program integrity vulnerabilities.

Adapted program operations. States introduced new ways of managing enrollment and modified their hiring and onboarding processes. States also reflected on their experiences to help them reconsider program operations in preparation for another emergency.

OIG concluded that this brief highlighted strategies that State Medicaid agencies and State-based Marketplace--collectively, "States"--described as beneficial for their enrollment processes during the COVID-19 Public Health Emergency (PHE). Although this brief did not contain recommendations from OIG, it did provide insights that State officials might find helpful to consider for their program operations.

Evaluation #: OEI-09-20-00590 (09/18/2023)
Government Program: CMS

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

OIG identified longstanding challenges, including insufficient oversight and limited access to specialists, that may have reduced 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 were meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several news articles 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.

The 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

OIG found that 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.

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 were appropriate, (2) review CPHL's appeal process and ensure that CPHL made 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.

Audit #: A-02-21-01016 (09/18/2023)
Government Program: CMS

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

The Office of Inspector General (OIG) identified longstanding challenges, including insufficient oversight and limited access to specialists, that may have reduced 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 were meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 received 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.

Audit #: A-07-22-07007 (09/13/2023)
Government Program: CMS

Kentucky Did Not Always Invoice Manufacturers for 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 had to 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 Kentucky complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to managed-care organization (MCO) enrollees.

OIG reviewed claims for physician-administered drugs paid between January 1, 2019, and December 31, 2020.

OIG removed the physician-administered drug claims that were not eligible for rebate as part of the drug rebate program and worked with Kentucky to calculate the amounts of rebates that were associated with the remaining drugs and that were not invoiced.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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:

- 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;
- 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;
- Strengthen internal controls to ensure that all eligible physician-administered drugs were invoiced for rebate; and
- Ensure that all physician-administered drugs eligible for rebates after OIG's audit period were processed for rebates.

Audit #: A-04-22-07102 (09/12/2023)
Government Program: CMS

Texas Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

Texas paid managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee. 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 was concerned that the concurrent Medicaid enrollment identified in previous audits could be an issue that negatively impacted Texas' Medicaid program.

OIG's objective was to determine whether Texas made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

The audit covered $30.9 million in Medicaid managed care capitation payments for August 2021 made by Texas on behalf of 61,065 Texas enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2021 (audit period).

To identify the population of enrollees who had concurrent enrollment during the audit period, OIG compared CMS's

Transformed Medicaid Statistical Information System (T-MSIS) data from 48 States, the District of Columbia, and Puerto Rico. OIG then identified all associated August 2021 capitation payments that Texas made.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 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 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 were in accordance with Federal requirements and the State's unwinding process to identify and disenroll enrollees who were 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.

Audit #: A-05-22-00018 (09/11/2023)
Government Program: CMS

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 the audit period (April 1, 2018, through September 30, 2020). OIG selected a stratified random sample of 105 capitation payments totaling $70,215 ($66,484 Federal share) for review. For each of these payments, 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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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 OIG's 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.

OIG recommended that DOH: (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 did not make capitation payments on behalf of deceased enrollees.

Audit #: A-02-21-01005 (09/11/2023)
Government Program: CMS

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. OIG audited Puerto Rico because OIG previously identified factors that may have increased 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.

The 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). 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 the 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 sample results, 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 was issued more than one ID number, and (3) establish policies and procedures with ASES to ensure ASES recovered unallowable payments made on behalf of enrollees assigned more than one ID number.

Audit #: A-02-21-01004 (09/08/2023)
Government Program: CMS

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 operated under a managed care waiver in which MCOs were required to make achieved savings rebates (rebates) to Florida when pretax income exceeded 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.

The 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

OIG found that Florida calculated and received the required MCO rebates totaling $448,891,916 ($292,485,420 Federal share) for the 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).

OIG found that 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.

Audit #: A-04-22-04089 (08/31/2023)
Government Program: CMS

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

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

People diagnosed with HIV needed regular care to improve their health outcomes, reduce HIV-related deaths, and ultimately reduce new HIV transmissions. The ultimate goal of HIV care was to achieve viral suppression—meaning that the amount of HIV in the body was very low or undetectable in viral load tests. At the individual level, viral suppression allowed 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 prevented transmission of HIV because people with HIV who reached and maintained viral suppression had effectively no risk of passing HIV to others. Lack of viral suppression among people with HIV was often attributed to appropriate care not being initiated or not being regularly received. HHS recognized the importance of HIV care and developed guidelines on the clinical needs of people with HIV to achieve viral suppression.

The Medicaid program played a critical role in ensuring that people with HIV received care that could 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 were covered by Medicaid also tended to 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

OIG found that 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 have meant that they were at greater risk of negative health

impacts and HIV transmission.

OIG found that 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.

Evaluation #: OEI-05-22-00240 (08/31/2023)
Government Program: CMS

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 had to obtain drug rebates for Medicaid-covered outpatient prescription drugs that were 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 did not apply.

As of the preparation of this Data Brief, 40 States operated separate CHIPs, whether in combination with Medicaid expansion or on a stand-alone basis. Separate CHIP was a program under which a State received Federal funding to provide child health assistance to uninsured, low-income children and which met 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.

OIG used the State agencies' responses to a survey 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

OIG found that 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 contained no recommendations, CMS did not provide written comments on OIG's draft Data Brief but did furnish technical comments, which OIG addressed as appropriate.

Audit #: A-07-22-06106 (08/09/2023)
Government Program: CMS

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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) was an integrated group of procedures and computer processing operations designed to meet principal objectives, such as processing medical claims. States reported costs related to private MMIS contract services as administrative costs. Generally, the Federal Government reimbursed States 50 percent of their administrative costs; however, for certain approved MMIS costs, the Federal Government reimbursed 90 percent or 75 percent. States generally were 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. OIG reviewed Texas' APDs and related supporting documents.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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.

OIG found that 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. Additionally, Texas should ensure that sufficient details were provided on contractors' employees' timesheets, costs were allocated to Medicaid based on an approved methodology in the CAP, the Federal match was claimed at the approved rate, and it did not claim costs when it was reimbursed for those costs by other agencies.

Audit #: A-06-19-09003 (08/08/2023)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

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 existed.

The objective of 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). 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

OIG found that 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 commended 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.

OIG recommended that New York refund $19.9 million to the Federal Government. OIG also recommended 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.

Audit #: A-02-22-01011 (07/31/2023)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Virginia Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths

Virginia paid Medicaid managed care organizations (MCOs) to make services available to Medicaid enrollees in return for a monthly fixed payment for each enrollee (capitation payment). Previous OIG audits found that State Medicaid agencies had improperly paid capitation payments on behalf of deceased enrollees. OIG conducted a similar audit of Virginia.

OIG's objective was to determine whether Virginia made capitation payments to MCOs on behalf of deceased Medicaid enrollees.

The audit covered 58,351 capitation payments totaling over $70.8 million that Virginia made to MCOs and claimed for Federal reimbursement during calendar years 2019 through 2021 (audit period) on behalf of 12,054 enrollees whose dates of death, as recorded in one or more of the data sources OIG consulted, preceded the monthly service periods covered by the capitation payments.

OIG selected and reviewed a stratified random sample of 100 capitation payments totaling $319,525 ($195,219 Federal share) from those 58,351 capitation payments.

SunHawk Summary of OIG Audit Findings and Recommendations

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

Based on the sample results, 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 the 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 estimated to be at least $21.8 million, made to MCOs during the 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. 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 were in the report.

Audit #: A-03-22-00203 (07/19/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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 continued to grow, Medicaid managed care organizations (MCOs) played an increasingly important role in ensuring that people with Medicaid had access to medically necessary, covered services. In recent years, allegations 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 was a priority for OIG. In addition, OIG received a congressional request to evaluate whether MCOs were 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

OIG found that overall, the MCOs included in the review denied one out of every eight requests for the prior authorization of services in 2019. Among the 115 MCOs in the 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 presented a limitation that could allow inappropriate denials to go undetected in Medicaid managed care.

Although the appeals process was intended to act as a potential remedy to correct inappropriate denials, several factors might have inhibited its usefulness for this purpose in Medicaid managed care. Most State Medicaid agencies reported that they did 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 were required to offer State fair hearings as an appeal option, these administrative hearings might have been 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 was more robust. For example, each year CMS reviewed the appropriateness of a sample of prior authorization denials and required health plans to report data on denials and appeals. Further, Medicare Advantage enrollees had access to automatic, external medical reviews of denials that plans upheld at the first level of appeal. These differences in oversight and access to external medical reviews between the two programs raised concerns about health equity and access to care for Medicaid managed care enrollees.

Given these findings, more action was needed to improve the oversight of denials in Medicaid managed care and the

safeguards to ensure that enrollees had access to all medically necessary and covered services.

OIG recommended 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.

Evaluation #: OEI-09-19-00350 (07/17/2023)
Government Program: CMS

Florida Did Not Comply With Requirements for Documenting Psychotropic and Opioid Medications Prescribed for Children in Foster Care

The United States Food and Drug Administration issued a safety announcement stating that a review found the combined use of opioid and some psychotropic medications could result in serious side effects, including slowed or difficult breathing and death. In addition, ineffective oversight of psychotropic and opioid medications might have increased the risk of inappropriate dosing or medication combinations. To receive Federal funding for child welfare services, States were required to have a plan for the oversight of prescription medications, including psychotropic and opioid medications prescribed for children in foster care. In recent audits, OIG found that psychotropic and opioid medications prescribed for children in foster care were not accurately documented in the States' child welfare information systems.

OIG's objective was to determine whether Florida complied with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under Title IV-E of the Social Security Act (the Act).

OIG randomly selected a sample of 115 children who were prescribed psychotropic or opioid medications. OIG reviewed the Medicaid claim data, case files in Florida's Safe Families Network (FSFN), and health care records maintained outside of FSFN for the children in the sample.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Florida did not always comply with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under the Act. Specifically, for the 85 sample children who were prescribed psychotropic drugs, OIG found: (1) the psychotropic medications prescribed for 36 children were not recorded in FSFN, (2) the medication logs for 56 children were not maintained in FSFN, and (3) the authorization for prescription of psychotropic medications for 33 children were not contained in FSFN. In addition, OIG found the opioid medications prescribed for 57 of the 60 children in the sample were not recorded in FSFN.

OIG recommended that Florida: (1) provide training to child protective investigators and caseworkers on medication management and administration that addressed requirements for updating case records in FSFN for children who were prescribed psychotropic medications (including related medication logs and authorizations) and opioid medications and (2) coordinate with the Florida Agency for Health Care Administration to obtain access to Medicaid claim data for all children under its care and supervision.

Audit #: A-05-22-00009 (07/14/2023)
Government Program: ACF

Maryland MMIS and E&E; System Security Controls Were Partially Effective and Improvements Are Needed

OIG conducted 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 were protected when subjected to cyberattacks.

OIG's objectives were to determine whether: (1) security controls in operation for Maryland MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the Maryland MMIS and E&E; system or its data, and (3) Maryland's ability to detect cyberattacks against its MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of Maryland's MMIS and E&E; system from September through November 2021. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that covered a limited number of Maryland personnel in November 2021. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Maryland.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 were 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 have needed 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.

A potential reason why Maryland did not implement these security controls correctly may have been 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 facilitated 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.

Audit #: A-18-21-09003 (05/25/2023)
Government Program: CMS

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

Medicaid telehealth referred to the services performed via a telecommunication system. A Medicaid patient at an originating site used audio and video equipment to communicate with a health professional at a distant site.

Because of the speed with which the use of telehealth expanded during the COVID-19 pandemic, opportunities existed for inefficiencies and potential abuse in the telehealth system. Rapid expansion of telehealth posed 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.

The 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

OIG found that 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 one 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 paid only telehealth claims whose procedure codes denoted the associated services as eligible to be performed via telehealth.

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Payer

Medicaid

Medicare Part C

Medicare Part D

HCPCS Codes Identified in This Audit:

- Q3014 - Telehealth originating site facility fee
- GT - Telehealth modifier

Audit #: A-07-21-03250 (05/17/2023)
Government Program: CMS

Massachusetts MMIS and E&E; System Security Controls Were Generally Effective, but Some Improvements Are Needed

OIG conducted 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 were protected when subjected to cyberattacks.

OIG's objectives were to determine whether: (1) security controls in operation for Massachusetts MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise Massachusetts' Medicaid System or its data, and (3) Massachusetts' ability to detect cyberattacks against its Medicaid MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of the Massachusetts MMIS and E&E; systems from September 2020 to October 2020. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that included a limited number of Massachusetts personnel in December 2020. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Massachusetts.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 have been 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 have needed 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 have been 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 have potentially collected 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 were assessed for risk and remediated promptly, if necessary.

Audit #: A-18-20-08003 (05/16/2023)
Government Program: CMS

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

States operated home and community-based services (HCBS) waiver programs under a waiver to their respective Medicaid State plans. States had to ensure the health and welfare of the recipients of the service. Media coverage nationwide 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

OIG found that 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.

Audit #: A-07-21-03247 (03/21/2023)
Government Program: CMS

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

Spread pricing occurred when a managed care organization (MCO) contracted with a pharmacy benefit manager (PBM) to manage its prescription drug benefits, and the PBM kept 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 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, 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

OIG found that 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 the audit period. Spread pricing may have increased the cost of Medicaid prescriptions for both the MCO and the Medicaid program and, if not correctly accounted for, inflated 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.

Audit #: A-03-20-00200 (03/16/2023)
Government Program: CMS

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) funded home and community-based services for people 65 and older and individuals with disabilities under 65 who were eligible for medical assistance and required the level of care provided in a nursing home but chose to live in the community. Georgia operated the program under a Federal waiver to its Medicaid State plan. The program funded adult day health care services for Medicaid beneficiaries who resided at home and attended adult day health care facilities (facilities). OIG 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 served vulnerable adults who received 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

OIG found that Georgia did not fully comply with Federal waiver and State requirements in overseeing providers that served 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.

OIG found that Georgia did not fully comply with Federal waiver and State requirements because its inspections of facilities were insufficient to ensure a continuously safe and nonhazardous environment.

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

Audit #: A-04-22-00134 (03/14/2023)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Georgia 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 had to 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 Georgia complied with Federal Medicaid requirements for invoicing manufacturers for rebates for pharmacy and physician-administered drugs.

The audit covered pharmacy and physician-administered drug claims that Georgia paid between April 1, 2018, and December 31, 2019.

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. Additionally, OIG determined whether the Healthcare Common Procedure Coding System codes were published in CMS's top-20 multiple-source drug listing.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 was 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, 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 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 recommended 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 determined were allowable. OIG also made three additional recommendations.

Audit #: A-04-21-08089 (03/13/2023)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Michigan MMIS and E&E; Systems Security Controls Were Generally Effective, but Some Improvements Are Needed

OIG conducted 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 were protected when subjected to cyberattacks.

OIG's objectives were to determine whether: (1) security controls in operation at Michigan MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the Michigan Medicaid System or its data, and (3) Michigan's ability to detect cyberattacks against its Medicaid MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of Michigan's MMIS and E&E; system from October through December 2020. The penetration test focused on the MMIS and E&E; system's public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that included a limited number of Michigan personnel in December 2020. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Michigan.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 have been 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.

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 have needed 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 have been 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 could 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 had changed.

Audit #: A-18-20-08004 (03/09/2023)
Government Program: CMS

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.

The 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

OIG found that 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 had the burden to document the allowability and allocability of its claims for Federal Financial Participation, and this burden was 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 transferred to cover the State share of Medicaid expenditures, emphasizing that the State was required to maintain records that adequately identified the source and application of funds for federally funded activities.

Audit #: A-06-17-09004 (03/08/2023)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

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

OIG reviewed claims for physician-administered drugs paid between January 1, 2019, and December 31, 2019.

OIG used the Centers for Medicare & Medicaid Services's (CMS's) Medicare Part B crosswalk and 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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 was 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 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 recommended 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 are eligible for rebates.

Audit #: A-04-21-07098 (03/03/2023)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

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 assisted 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 provided 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.

The 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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 set 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, OIG found that 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 was determined to be unallowable. OIG also made procedural recommendations regarding the monitoring of PCA providers and the State's establishment of and adherence to policies and procedures.

Audit #: A-07-20-03243 (02/23/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State

Florida paid managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee. Previous OIG audits found that State Medicaid agencies had improperly made capitation payments on behalf of enrollees who were residing and enrolled in Medicaid in another State. OIG was concerned that the concurrent Medicaid enrollment identified in previous audits could be an issue that negatively impacted Florida's Medicaid program.

The objective was to determine whether Florida made capitation payments on behalf of Medicaid enrollees who were concurrently enrolled in a Medicaid managed care program in another State.

The audit covered $15.8 million in Medicaid managed care capitation payments for August 2020 made by Florida on behalf of 55,164 Florida enrollees who were concurrently enrolled in a managed care program in another State during the period of July 1 through September 30, 2020 (audit period).

To identify the population of enrollees who had concurrent enrollment during the audit period, OIG compared CMS's Transformed Medicaid Statistical Information System (T-MSIS) data from 47 States, the District of Columbia, and Puerto Rico. OIG then identified all associated August 2020 capitation payments that Florida made.

SunHawk Summary of OIG Audit Findings and Recommendations

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

Audit #: A-05-21-00028 (02/16/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Michigan Did Not Comply With Requirements for Documenting Psychotropic and Opioid Medications Prescribed for Children in Foster Care

The United States Food and Drug Administration issued a safety announcement stating that a review found the combined use of opioid and some psychotropic medications could result in serious side effects, including slowed or difficult breathing and death. In addition, ineffective oversight of psychotropic and opioid medications might have increased the risk of inappropriate dosing or medication combinations. To receive Federal funding for child welfare services, States were required to have a plan for the oversight of prescription medications, including psychotropic and opioid medications prescribed for children in foster care. In recent audits, OIG found that psychotropic and opioid medications prescribed for children in foster care were not accurately documented in the States' child welfare information systems.

OIG's objective was to determine whether Michigan complied with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under Title IV-E of the Social Security Act (the Act).

OIG randomly selected a sample of 115 children who were prescribed psychotropic or opioid medications. OIG reviewed the electronic case records in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) and the Medicaid claim data for the children in the sample.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Michigan did not always comply with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under the Act. Specifically, OIG found:
(1) the electronic case records for 18 of the 115 children in the sample who were prescribed psychotropic or opioid medications did not contain the required medical information;
(2) the electronic case records for 14 of the 85 children in the sample who were prescribed psychotropic medications did not include consent forms for psychotropic medications; and
(3) opioid medications prescribed for 60 children in the sample were not recorded in MiSACWIS.

OIG recommended that Michigan ensure that electronic case records for children in foster care were maintained in accordance with requirements by:
(1) modifying procedures for the monitoring of caseworkers to ensure the required medical information was maintained in MiSACWIS;
(2) implementing policies to document when consent forms were not required in non-emergency situations, monitoring Medicaid claim data to ensure consent forms were obtained and documented, and implementing procedures to monitor other medications prescribed for children, including opioids, for potential medication interaction and adverse side effects for children who were prescribed psychotropic medications; and
(3) implementing procedures to monitor Medicaid claim data for opioid medications prescribed for children and providing training for documenting the opioid medications prescribed for children due to medical procedures or emergency treatment. The detailed recommendations were in the report.

Audit #: A-05-21-00030 (02/08/2023)
Government Program: ACF

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

For a covered outpatient drug to be eligible for Federal reimbursement under the Medicaid program's drug rebate requirements, manufacturers had to pay rebates to the States for the drugs. However, prior Office of Inspector General 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 North Carolina complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

OIG reviewed claims for physician-administered drugs paid between January 2016 and December 2019.

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 was 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 recommended 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 determined that the drug claims were 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 were invoiced.

Audit #: A-07-21-07002 (02/07/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

Medicaid telehealth referred to the services provided via a telecommunication system. A Medicaid patient at an originating site used 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 could be performed via telecommunication systems. OIG also contacted providers and reviewed medical records for 230 payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 the 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.

HCPCS Codes Identified in This Audit:

- Q3014 - originating site fee
- Q3014 - originating site fee

Audit #: A-05-21-00035 (12/21/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

OIG identified longstanding challenges, including insufficient oversight and limited access to specialists, that may have reduced 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 were meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles 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 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 prior authorization to determine whether they complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 did not receive information about their right to request a State fair hearing, they may not have had 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:

- update Keystone First's administrative process to require that medical directors assess whether overnight care requests met the medical necessity requirement, even if some documentation was missing;
- review all pediatric skilled nursing service requests for which overnight care was completely denied and determine whether overnight care requests met the medical necessity requirement; and
- implement a revised initial denial notice to explain that a beneficiary had the right to request a State fair hearing after exhausting the MCO's appeals process.

  OIG also recommended that Pennsylvania revise its denial notice template. The full recommendations were in the report.

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Payer

Medicaid

Medicare Part C

Medicare Part D

Audit #: A-03-20-00201 (12/20/2022)
Government Program: CMS

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

Lead toxicity was an environmental health concern that could have lasting effects on the lives of children. Although there was no safe level of lead exposure for young children, exposure was preventable. Children's exposure to lead could 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 followup testing and treatment services.

An Office of Inspector General (OIG) 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 expanded on that work.

The Centers for Medicare & Medicaid Services' (CMS's) Medicaid program offered comprehensive preventive medical screening services for millions of children annually through the EPSDT benefit. This benefit also included 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 did not receive timely followup 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 followup 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 asked medical reviewers to consider the respective State medical management guidance. Finally, OIG interviewed stakeholders regarding followup testing and treatment services for children exposed to lead.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 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 was 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 have been a matter of confusion about appropriate diagnosis codes. Nonetheless, the lack of documentation in the medical records to confirm children's lead toxicity diagnoses raised concerns regarding the accuracy of using Medicaid claims data, solely, to identify children being treated for lead toxicity. It might also have had implications for States' annual EPSDT reporting to CMS regarding treatment services.

Because there was no safe lead level for children, even very low blood lead levels might have indicated 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 'g/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 followup testing and treatment services during the 6-month review period. Similarly, without accurate data, CMS might have been unable to accurately measure EPSDT performance and ensure that Medicaid-enrolled children with lead toxicity were given the best possible health care.

For this review, medical reviewers determined appropriate services for lead toxicity using their professional judgment, with reference to followup 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 followup 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.

Evaluation #: OEI-07-18-00370 (12/14/2022)
Government Program: CMS

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) was responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds were 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 was 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.

The 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

OIG found that 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 was not able to determine whether the remaining 40 payment review determinations were correct because the payment reviews were not documented and therefore may have been 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.

OIG found that 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 concluded that CMS took action to address the deficiencies 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.

Audit #: A-04-21-09003 (12/08/2022)
Government Program: CMS

Puerto Rico MMIS and E&E; Systems Security Controls Were Generally Effective, but Some Improvements Are Needed

OIG was 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 were protected when subjected to cyberattacks.

OIG's objectives were to determine whether: (1) security controls in operation at Puerto Rico MMIS and E&E; system environments were effective in preventing certain cyberattacks, (2) the likely level of sophistication or complexity an attacker needed to compromise the Puerto Rico Medicaid System or its data, and (3) Puerto Rico's ability to detect cyberattacks against its Medicaid MMIS and E&E; system and respond appropriately.

OIG conducted a penetration test of Puerto Rico's MMIS and E&E; systems from November to December 2020. The penetration test focused on the MMIS and E&E; systems' public IP addresses and web application URLs. OIG also conducted a simulated phishing campaign that included a limited number of Puerto Rico personnel in December 2020. OIG contracted with XOR Security, LLC (XOR), to assist in conducting the penetration test. OIG closely oversaw the work performed by XOR, and the assessment was performed in accordance with agreed upon Rules of Engagement among OIG, XOR, and Puerto Rico.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 have been 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 have needed 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 have been 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 could 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 had changed.

Audit #: A-18-20-08005 (11/18/2022)
Government Program: CMS

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) was responsible for overseeing States' design and operation of their Medicaid programs and ensuring that Federal funds were 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 was the second 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 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

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

Audit #: A-04-21-00132 (11/17/2022)
Government Program: CMS

Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents

OIG performed this audit 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 after nationwide media coverage on deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In OIG's previous audit in Iowa, it was 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 followup audit to determine whether Iowa implemented these recommendations.

OIG's objectives were to determine whether Iowa: (1) implemented the recommendations from the prior audit and (2) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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.

Audit #: A-07-21-06105 (11/09/2022)
Government Program: CMS

Mississippi 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 had to pay rebates to the States for the drugs. However, prior Office of Inspector General (OIG) audits found that States did not always invoice and collect all rebates due for drugs administered by physicians.

OIG's objective was to determine whether Mississippi complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

OIG reviewed physician-administered drug claims totaling $88.5 million paid between January 1, 2016, and December 31, 2019 (audit period).

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 was 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 determined that the drug claims were allowable; (4) strengthen internal controls for non-crossover claims to ensure that all eligible physician-administered drugs were invoiced; and (5) consider revising its payment methodology going forward regarding payments for crossover claims.

Audit #: A-07-21-06101 (10/27/2022)
Government Program: CMS

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).

The 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. OIG selected and reviewed a stratified random sample of 100 of these beneficiary matches.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that California made unallowable capitation payments on behalf of beneficiaries with multiple CINs. Of the 100 beneficiary matches in the 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, 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 was 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 was issued multiple CINs.

Audit #: A-04-21-07097 (10/25/2022)
Government Program: CMS

UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, But Challenges Remain

Unified Program Integrity Contractors (UPICs) were CMS's only program integrity contractors that safeguarded both the Medicare fee-for-service (FFS) and the Medicaid programs from fraud, waste, and abuse. Combined, Medicare and Medicaid provided health care coverage to 139 million people at a cost of $1.5 trillion in 2020. Given the cost and scope of these Federal health care programs, it was essential that UPICs successfully detected and deterred fraud, waste, and abuse.

OIG requested and analyzed workload data related to program integrity activities for each of the five UPICs in 2019. In addition, OIG sent a survey to each UPIC to ask about the challenges it faced in performing these activities. From CMS, OIG requested and reviewed certain deliverables that UPICs submitted related to their program integrity activities conducted in 2019. OIG also sent CMS a questionnaire asking about the effects of the unification of Medicare and Medicaid program integrity activities; how CMS measures the effectiveness of UPICs; and any challenges UPICs faced in conducting their work. OIG also asked both UPICs and CMS about the effects of the COVID-19 pandemic on UPICs' work.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that in 2016, CMS began consolidating its Medicare and Medicaid program integrity activities to enhance its ability to detect and deter fraud, waste, and abuse across both programs. UPICs conducted substantially more Medicare FFS program integrity work in 2019 compared to that for Medicaid. The UPICs also conducted only minimal activities related to Medicaid managed care, even though most Medicaid enrollees received services through managed care. UPICs reported no data analysis projects completed or vulnerabilities identified related to Medicaid managed care in 2019. Further, they reported only a single Medicaid managed care fraud referral. Overall, UPICs conducted disproportionately fewer Medicaid activities compared to the levels of funding they received from CMS for Medicaid program integrity activities.

UPICs faced several challenges that could have contributed to the lower levels of program integrity activities in Medicaid. These challenges included problems with Medicaid data availability and quality, and differences across States' Medicaid policies and regulations.

OIG found wide unexplained disparities in program integrity activities across UPICs, even after adjusting for the size of their respective oversight responsibilities. Further, strategies that unify Medicare and Medicaid data to improve program integrity had not yet produced significant results.

At the same time, CMS and UPICs had laid a foundation for improvements. The development of collaborative processes, analytical tools, and new technologies across the UPICs-including the Unified Case Management (UCM) system and Major Case Coordination (MCC) initiative-helped to achieve the benefits of unifying program integrity activities. Lastly, despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and continue program integrity activities with some limitations.

OIG recommended that CMS (1) implement a plan to increase UPICs' Medicaid program integrity activities, particularly related to managed care; (2) make improvements to the UCM system; (3) implement a plan to help ensure the success of the MCC for Medicaid referrals; and (4) identify the reasons for the unexplained variation in program integrity activities across UPICs.

Evaluation #: OEI-03-20-00330 (09/29/2022)
Government Program: CMS

Texas Claimed or May Have Claimed More Than $30 Million of $9.89 Billion in Federal Funds for Medicaid Uncompensated Care Payments That Did Not Meet Federal and State Requirements

In 2011, the Centers for Medicare & Medicaid Services (CMS) approved the Texas Healthcare Transformation and Quality Improvement Program demonstration waiver (the waiver). As a part of the waiver, Texas established uncompensated care (UC) payments to offset eligible UC costs hospitals and other providers incurred. UC payments helped defray uncompensated costs of care provided to Medicaid-eligible and uninsured individuals. The waiver established a maximum amount, $17.58 billion, that would be paid under the UC program during the first 5 demonstration years (DYs). UC payments had a significant financial impact on Texas health care providers. Further, a previous OIG audit identified substantial unallowable payments Florida made under a similar type of program.

OIG's objective was to determine whether Texas claimed UC payments in accordance with applicable Federal and State requirements.

OIG reviewed $16.95 billion ($9.89 billion Federal share) in UC payments distributed for UC costs incurred from December 12, 2011, through September 30, 2016 (DYs 1 through 5).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas claimed $16.90 billion ($9.86 billion Federal share) in UC payments in accordance with applicable Federal and State requirements. However, Texas incorrectly claimed $18.90 million ($11.05 million Federal share). Specifically, Texas claimed (1) $12.91 million ($7.51 million Federal share) because it did not refund the full Federal share of overpayments and (2) $5.99 million ($3.54 million Federal share) because it did not collect overpayments it identified.

Additionally, the State agency may have incorrectly claimed $33.78 million ($19.66 million Federal share) because it did not reduce hospitals' actual UC costs by Medicare payments the hospitals received.

OIG recommended that Texas (1) work with CMS to determine whether the $33.78 million in UC payments hospitals retained because costs were not reduced by the Medicare payments they received should be recouped and, if so, either refund the related Federal share of $19.66 million to the Federal Government or redistribute the recouped funds to hospitals that had unmet UC costs; (2) refund $11.05 million to the Federal Government for the underreported UC overpayments; (3) follow the CMS-approved methodology for calculating actual UC costs when reconciling initial UC payments with providers' actual UC costs, including reducing UC costs by Medicare payments providers received; and (4) establish review procedures for overpayments to ensure that they were accurately entered into the State agency's accounting system and returned to the Federal Government.

Audit #: A-06-19-09002 (09/29/2022)
Government Program: CMS

Indiana Did Not Comply With Requirements for Documenting Psychotropic and Opioid Medications Prescribed for Children in Foster Care

To receive Federal funding for child welfare services, States were required to have a plan for overseeing and coordinating health care services for any child in foster care placement, including medications prescribed for the child. Psychotropic and opioid medications were among those that might have been prescribed for children in foster care. Medications could have had serious side effects, and ineffective monitoring might have increased the risk for inappropriate dosing, frequent medication changes, or the use of inappropriate medication combinations. In a recent audit, OIG found that psychotropic and opioid medications prescribed for children in foster care were not accurately documented in the State's child welfare information system.

OIG's objective was to determine whether Indiana complied with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under Title IV-E of the Social Security Act (the Act).

OIG randomly selected a sample of 115 children who were prescribed psychotropic or opioid medications. OIG reviewed the Medicaid claim data, health care records in Management Gateway for Indiana's Kids system (MaGIK), and records maintained outside of MaGIK for the children in the sample.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Indiana did not always comply with State requirements related to the psychotropic and opioid medications prescribed for children in foster care who were eligible for assistance under Title IV-E of the Act. Specifically, OIG found: (1) the health care records for 109 of the 115 children in the sample did not contain medical passports; (2) the psychotropic or opioid medications prescribed for 76 of the 115 children were not recorded in MaGIK; (3) the health care records for 49 of the 85 children in the sample who were prescribed psychotropic medications did not include authorizations for those medications; and (4) the health care records for 13 of the 21 children residing in residential facilities and prescribed psychotropic medications did not contain the required written reports and medical reviews from the prescribing health care providers.

OIG recommended that Indiana: (1) ensure that health care records for the children under its care and supervision were maintained in accordance with State requirements by providing training, technical assistance, and implementing additional controls and procedures; (2) obtain the psychotropic medication authorizations for the children in the sample who were currently in foster care and did not have the authorizations documented; and (3) continue efforts with the Indiana Family and Social Services Administration to obtain access to Medicaid claim history. The detailed recommendations were in the report.

OIG commended Indiana for the actions it had taken and planned to take to address OIG's recommendations.

Audit #: A-05-21-00020 (09/27/2022)
Government Program: ACF

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 was 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.

The 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

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

Audit #: A-02-20-01028 (09/20/2022)
Government Program: CMS

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 paid 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 was concerned that the concurrent Medicaid enrollment identified in previous audits could be an issue that negatively impacted 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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.

OIG found that CMS did not actively monitor beneficiaries' concurrent Medicaid managed care enrollments; instead, it relied on the individual States to identify concurrent enrollments and potential erroneous payments. CMS did 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 did 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 identified 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.

Audit #: A-05-20-00025 (09/19/2022)
Government Program: CMS

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 were 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 was critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care.

Managed care had replaced fee for service as the predominant payment model in Medicaid. Federal MLR requirements were established to ensure that Medicaid managed care plans spent most of their revenue on services related to the health of their enrollees, thereby limiting the amount that plans could spend on administration and keep as profit.

The Federal MLR was 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 had to 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 had to take into account plans' calculated MLRs as part of the process for setting plans' future capitation rates. States had to set capitation rates so that plans would "reasonably achieve" the Federal MLR standard of

at least 85 percent.

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.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that states reported most Medicaid managed care plans submitted MLR reports as required. However, 49 percent of the 495 MLR reports reviewed were incomplete. These incomplete MLR reports were missing at least one of seven numeric data elements 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 might have reduced transparency on managed care spending and limited states' ability to ensure that plans were 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 reviewed MLR reports for completeness, but few states identified issues. In addition, although 26 states reported that they reviewed 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 were using Federal dollars for patient care—CMS:

- design an annual MLR reporting template for States to provide to their Medicaid managed care plans;
- clarify that States should verify the completeness of their plans' MLR reports;
- clarify that States should review their plans' MLR reports to verify the accuracy of reported data elements; and
- provide additional guidance to States regarding plans' reporting of non-claims costs in MLR reports.

Evaluation #: OEI-03-20-00231 (09/19/2022)
Government Program: CMS

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Tennessee Did Not Always Invoice Rebates to Manufacturers 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 to Medicaid managed-care organizations' (MCOs') enrollees.

OIG's objective was to determine whether Tennessee complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

OIG reviewed physician-administered drug claims totaling $359.9 million that were paid by the MCOs between January 1, 2016, and December 31, 2019 (audit period).

OIG removed the physician-administered drug claims that were not eligible for rebate as part of the drug rebate program and worked with Tennessee to calculate the amounts of rebates that were associated with the remaining drugs and that were not invoiced.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 were invoiced for rebate; and (4) consider revising its methodology going forward regarding payments for crossover claims.

Audit #: A-07-21-06096 (09/14/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

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

OIG found that 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 sample results, 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 recommended that New York 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.

Audit #: A-02-21-01001 (09/12/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

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 assisted 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

OIG found that 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 made procedural recommendations that Montana always follow 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 made procedural recommendations that Montana require TCM providers to comply with established policies and procedures.

Audit #: A-07-21-03246 (08/26/2022)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

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

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

OIG's objective was to determine whether South Carolina complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

OIG reviewed claims for physician-administered drugs paid between January 2016 and December 2019.

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

OIG recommended that South Carolina refund to the Federal Government $14.3 million (Federal share) for claims for single-source physician-administered drugs and $242,000 (Federal share) for claims for top-20 multiple-source physician-administered drugs. OIG also recommended 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 determined that the drug claims were 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 were invoiced.

Audit #: A-07-21-07003 (08/10/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

More Than 90 Percent of the New Hampshire Managed Care Organization and Fee-for-Service Claims for Opioid Treatment Program Services Did Not Comply With Medicaid Requirements

The Medicaid program paid for opioid treatment program (OTP) services. Prior Office of Inspector General (OIG) audit reports had identified OTP services as vulnerable to fraud, waste, and abuse.

OIG's objective was to determine whether New Hampshire claimed Medicaid reimbursement for OTP services in accordance with Federal and State requirements.

OIG reviewed New Hampshire's monitoring and oversight of the OTP providers (providers), including compliance with Federal and State requirements, to determine whether: (1) counseling hour and toxicology testing requirements were met, (2) initial treatment plans were prepared, (3) treatment plans were reviewed as required, and (4) the OTP service was provided. OIG reviewed 100 randomly sampled claim lines of service from the 1,458,896 lines of service between July 1, 2016, to June 30, 2019, for which New Hampshire paid $16.2 million.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Hampshire claimed Medicaid reimbursement for OTP services that did not comply with Federal and State requirements. Of the 100 OTP services OIG sampled, 6 complied with Federal and State requirements, but 94 did not meet applicable Federal and State requirements. These deficiencies occurred because New Hampshire did not have the resources to oversee providers and enforce the OTP requirements. Providers said high personnel turnover, difficulty attracting and retaining personnel, and difficulty keeping patients engaged in counseling services contributed to the lack of adherence to State requirements. Furthermore, New Hampshire did not always provide guidance regarding State OTP requirements.

On the basis of OIG's sample results, OIG estimated that New Hampshire improperly claimed at least $7.9 million in Federal Medicaid reimbursement for OTP services during the audit period.

OIG recommended that the New Hampshire Department of Health and Human Services:

- refund $7.9 million to the Federal Government,
- take steps to ensure that providers complied with Federal and State requirements for providing and claiming Medicaid reimbursement for OTP services, and
- improve communication with providers regarding the State requirements for opioid use disorder treatment and provide written confirmation about whether offsite counseling might be included as a required counseling service.

Audit #: A-01-20-00006 (06/23/2022)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Maine Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings and found that Maine did not comply with Federal and State requirements for reporting and monitoring critical incidents. The report contained seven recommendations.

OIG's objectives were to determine whether Maine implemented the recommendations from OIG's prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

OIG reviewed the system that Maine had in place during the audit period (calendar year 2019) for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities. To determine whether the seven recommendations from the prior OIG report were implemented, OIG reviewed correspondence between Centers for Medicare & Medicaid Services (CMS) and Maine and supporting documentation provided by Maine. To determine whether Maine's corrective actions addressed OIG's previous findings, OIG reviewed 123 emergency room claims with service dates from October 2019 to December 2019 for 89 beneficiaries who were diagnosed with conditions that OIG determined to be indicative of high risk for suspected abuse or neglect.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Maine implemented the seven 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. In addition, the corrective actions implemented in response to five of the seven recommendations were effective in addressing the related findings. However, Maine's corrective actions for two recommendations were not fully implemented by the conclusion of OIG's current audit period and, therefore, were only partially effective in addressing two of OIG's previous findings. OIG concluded that the corrective actions were not fully effective in addressing these findings because Maine did not ensure that all followup reports were completed by community-based providers within 30 days of each incident and that the Mortality Review Committee conducted a trend analysis based on completed Mortality Review Form aggregate data. As a result, Maine did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Waiver along with the State requirements incorporated under the waiver.

OIG recommended that Maine: (1) continue to work with CMS to fully implement the prior recommendation to ensure that followup reports were submitted by community-based providers appropriately and (2) ensure that the Mortality Review Committee reviewed Mortality Review Form aggregate data to identify patterns and trends and to make recommendations to improve care.

Audit #: A-01-20-00007 (06/06/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

Washington State Did Not Comply With Federal and State Requirements for Claiming Enhanced Federal Reimbursement for Medicaid Managed-Care Health Home Service Expenditures

A health home is a designated provider or a team of health care providers that coordinated health care services for Medicaid beneficiaries with chronic medical conditions at a reasonable cost. States were authorized to receive Federal reimbursement at an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent (enhanced FMAP) for health home service payments they made to providers during the first eight quarters their programs were in effect.

OIG's objective was to determine whether Washington State complied with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP.

The audit covered the $1,957,622 ($1,770,860 Federal share) that Washington claimed as managed-care health home expenditures at the enhanced FMAP from April 1, 2017, through March 31, 2019. OIG reviewed the journal vouchers that Washington used to assign the enhanced FMAP to its managed-care health home expenditures, the managed-care encounter data that it used to support the claimed amount, and its capitation rate documentation that identified the portion of the managed-care capitation payments that was attributable to health home services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Washington did not comply with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP. Specifically, Washington improperly used fee-for-service health home reimbursement rates instead of the portion of the managed-care capitation payments that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement for its managed-care health home expenditures, totaling $1,770,860. In addition, of the $1,770,860 that Washington claimed, $374,579 was not supported by encounter data, and $29,161 was claimed for encounters that exceeded the number of encounters that managed-care organizations were allowed to report for a beneficiary. These issues occurred because Washington did not follow its State plan or Federal guidance and lacked adequate procedures and Medicaid Management Information System (MMIS) edits.

OIG recommended that Washington:

- refund to the Federal Government $374,579 for the encounters that were no longer supported and the $29,161 that exceeded the number of allowable encounters;
- determine the portion of the remaining $1,367,120 that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services and refund any unallowable amounts;
- review all managed-care health home encounters from July 1, 2013, through March 31, 2017, to determine the amount that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services;
- implement a procedure to identify whether encounters used to support journal vouchers had been removed from the encounter data; and
- strengthen its MMIS edits to ensure that encounters complied with State reporting requirements.

The full text of OIG's recommendations is shown in the report.

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Medicare Part C

Medicare Part D

HCPCS Codes Identified in This Audit:

- G9148 - Initial engagement and health action plan completion
- G9149 - Intensive level of care coordination
- G9150 - Low level of care coordination

Audit #: A-09-20-02008 (05/13/2022)
Government Program: CMS

Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes and found that Massachusetts did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. The report contained five recommendations.

OIG's objectives were to determine whether Massachusetts implemented the recommendations from OIG's prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Massachusetts implemented the five recommendations from OIG's prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes. However, the corrective actions for one recommendation in OIG's prior audit were not effective in addressing one of OIG's previous findings. Specifically, Massachusetts did not ensure all reasonable suspicions of abuse or neglect were reported to the Disabled Persons Protection Commission (DPPC). One possible reason that this issue occurred was 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 were 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.

CPT Codes Identified in This Audit:

- 0450 - Emergency Room – General Classification

Audit #: A-01-20-00003 (04/25/2022)
Government Program: CMS

California Improperly Claimed at Least $23 Million of $260 Million in Total Medicaid Reimbursement for Opioid Treatment Program Services

The United States currently faced a nationwide public health emergency due to the opioid crisis. Opioid treatment programs (OTPs) provided medication coupled with counseling services (referred to in this report as "OTP services") for people diagnosed with an opioid use disorder. This audit was part of OIG's oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis. Based on OIG's prior audit of a selected OTP in California, OIG identified that there was a risk of improper Medicaid reimbursement for OTP services. Therefore, OIG performed this statewide audit of OTP services in California for calendar years 2018 and 2019.

OIG's objective was to determine whether California claimed Medicaid reimbursement for OTP services that met Federal and State requirements.

The audit covered Medicaid claims for OTP services provided from January 2018 through December 2019 (audit period), with Medicaid reimbursement totaling $371.6 million ($259.8 million Federal share).

OIG reviewed a stratified random sample of 130 beneficiary-months to determine compliance with Federal and State requirements. A beneficiary-month (which OIG referred to as a "sample item") included all claims for OTP services provided to a beneficiary in a month.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that California claimed Medicaid reimbursement for some OTP services that did not meet Federal and State requirements. Of the 130 sample items, 88 had services that were all allowable, but 42 had services that were unallowable.

On the basis of OIG's sample results, OIG estimated that California claimed at least $23.1 million in unallowable Federal Medicaid reimbursement for OTP services during the audit period. In addition, OIG identified deficiencies in three areas that did not result in unallowable services but could impact the quality of care provided to beneficiaries receiving OTP services.

OIG recommended that California refund $23.1 million to the Federal Government and take specific actions to address the deficiencies that were identified. In addition, OIG recommended that California take actions to ensure that OTPs comply with Federal and State requirements for providing and claiming reimbursement for OTP services. (The full text of OIG's recommendations is shown in the report.)

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Medicaid

Medicare Part C

Medicare Part D

Audit #: A-09-20-02009 (04/20/2022)
Government Program: CMS

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

OIG performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

OIG's objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that South Carolina did not 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 were listed in the body of the report.

OIG recommended that South Carolina work with the Department of Disabilities and Special Needs (DDSN) to:

- ensure that providers followed the reporting requirements for critical events,
- provide training to providers on recognizing and reporting critical incidents according to reporting requirements,
- perform analytical procedures such as data matches on Medicaid claims data to identify any unreported critical incidents and investigate as needed, and
- ensure that providers submitted all incident reports to DDSN through the Incident Management System within 24 hours of an incident or the next business day.

The detailed recommendations were listed in the body of the report.

Audit #: A-04-18-07078 (04/01/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

New York Verified That Medicaid Assisted Living Program Providers Met Life Safety and Emergency Planning Requirements But Did Not Always Ensure That Assisted Living Program Services Met Federal and State Requirements

OIG conducted site visits at five ALP providers to review New York's monitoring and oversight of ALP providers' compliance with life safety and emergency planning requirements. OIG's audit covered 195,373 beneficiary-months of ALP services with Federal Medicaid payments totaling $244 million for calendar years 2017 through 2018 (audit period). OIG audited a random sample of 100 beneficiary-months of ALP services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York verified that life safety and emergency planning requirements were met at the five judgmentally selected ALP providers OIG visited. However, it claimed reimbursement for some unallowable ALP services during OIG's random sample of 100 beneficiary-months. Specifically, New York properly claimed Medicaid reimbursement for all ALP services during 91 beneficiary-months and claimed reimbursement for unallowable ALP services during the remaining 9 beneficiary-months. These deficiencies occurred because New York's monitoring was not sufficient to ensure that ALP providers complied with certain Federal and State requirements for providing, documenting, and billing services. Despite New York's efforts, some ALP providers did not comply with requirements for (1) documenting beneficiary assessments and care plans and (2) claiming reimbursement only for services in accordance with Medicaid billing requirements and beneficiary care plans.

On the basis of OIG's sample results, OIG estimated that New York improperly claimed at least $1.9 million in Federal Medicaid reimbursement for ALP services during OIG's audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their assessments and care plans were not valid or were missing, and some nurse's aides' qualifications were not documented. As a result, beneficiaries may have (1) not received ALP services that they were entitled to, (2) received services that were not needed, or (3) received services from some nurse's aides that were not qualified to perform the services furnished.

OIG recommended that New York refund $1.9 million to the Federal Government. OIG also made a series of recommendations for New York to strengthen its oversight and monitoring of its ALP to ensure that providers complied with Federal and State requirements.

Audit #: A-02-19-01017 (03/15/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

New Mexico Did Not Claim $12.4 Million of $222.6 Million in Medicaid Payments for Services Provided by Indian Health Service Facilities in Accordance With Federal and State Requirements

While conducting a previous audit in New Mexico, OIG noted that it had not conducted reconciliations of Indian Health Service (IHS) payments it made to its managed care organizations (MCOs) with actual payments those MCOs made for services provided by IHS facilities. During the exit conference for that audit, New Mexico said that it had completed the IHS reconciliations, but OIG did not have an opportunity to review them.

OIG's objective was to determine whether New Mexico claimed IHS expenditures in accordance with Federal and State requirements.

OIG's audit covered $222.6 million in claimed IHS expenditures for the period July 1, 2012, through December 31, 2016 (audit period). OIG reviewed New Mexico's reconciliations of claimed and initial IHS expenditures with paid IHS encounter data, verified the accuracy of the IHS encounter data, and conducted a reconciliation of claimed IHS expenditures with paid IHS encounter data for services provided under New Mexico's Salud! and CoLTS waivers (its older waivers).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Mexico claimed $209.4 million of $222.6 million in IHS expenditures in accordance with Federal and State requirements. However, New Mexico claimed $12.4 million in IHS expenditures that did not meet Federal and State requirements. Specifically, New Mexico claimed (1) $6.2 million in unsupported expenditures under its older waivers, which New Mexico did not identify because it did not reconcile initial expenditures with IHS encounter data; (2) $3.6 million in unsupported expenditures under its current waiver because its reconciliations did not account for encounter data adjustments; and (3) $2.6 million in expenditures for encounter data MCOs submitted beyond the 2-year limit outlined in the MCO contracts.

Additionally, New Mexico may have claimed $750,811 for inpatient encounter data with dates-of-service spans that did not support the number of paid inpatient days.

OIG recommended that New Mexico (1) refund $12.4 million to the Federal Government, (2) work with the Centers for Medicare & Medicaid Services to determine the appropriate amount of the additional $750,811 that it should have claimed and refund the Federal share difference, (3) establish policies and procedures to account for adjustments MCOs made to IHS encounter data after reconciliations were completed, and (4) use the entered date to determine whether the MCO submitted an encounter within the 2-year limit. See the audit report for additional recommendations.

Audit #: A-06-19-09005 (03/14/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

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 had 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 was seeking to use the Process Guide to claim additional Medicaid reimbursement for school-based costs for prior periods if CMS approved a related proposal by New Jersey to amend its Medicaid State plan. OIG initiated this audit because New Jersey had not corrected the deficiencies identified in the November 2019 report and sought to use the Process Guide to claim additional funds for prior periods.

The objective of the audit was to determine whether New Jersey's CMS-approved Process Guide complied with Federal requirements.

To achieve their 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, did not comply with Federal requirements. Specifically, the Process Guide's methodology for conducting random moment time studies (RMTSs) (1) did not meet Federal requirements for statistical sampling, (2) defined one Medicaid administrative activity code as including activities not necessary for the administration of the Medicaid State plan, and (3) did not ensure that RMTS responses and Medicaid cost allocation ratios were 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 did not work with New Jersey to address the deficiencies identified in this report, Medicaid claims submitted for reimbursement by New Jersey school districts would 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 complied with Federal requirements. The detailed recommendations were listed in the body of the report.

Audit #: A-02-20-01012 (03/08/2022)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

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 had 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 found that CMS's eligibility review contractor correctly determined Medicaid eligibility for the beneficiaries associated with all 100 sampled claims. Based on the sample results, OIG 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 contained no recommendations.

Audit #: A-02-20-01006 (03/02/2022)
Government Program: CMS

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

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

The objective of this audit was to summarize the results of prior audits in order to assist the Centers for Medicare &

Medicaid Services (CMS) in achieving greater efficiencies in its operation of the Medicaid program.

OIG's prior audits covered Federal Medicaid payments totaling $33.6 billion on behalf of almost 17.5 million beneficiaries. Using statistical sampling, OIG reviewed the four States' Medicaid eligibility determinations.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that previous audits of 4 States' Medicaid eligibility determinations revealed 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 remained 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.

Audit #: A-02-20-01018 (02/01/2022)
Government Program: CMS

Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents 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.

Federal waivers permitted States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they might live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services required States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

OIG's objective was to determine whether Arkansas complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

OIG compared Medicaid emergency room claims with reported critical incidents to determine whether any critical incidents were unreported. OIG also analyzed data on critical incidents that occurred during the audit period to determine whether critical incidents were reported and followed up on in a timely manner.

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

ICD Codes Identified in This Audit:

- 81200 - Closed fracture of unspecified part of upper end of humerus
- 81209 - Other closed fracture of upper end of humerus
- 82380 - Closed fracture of unspecified part of tibia alone
- 8248 - Unspecified fracture of ankle, closed
- 83104 - Closed dislocation of acromioclavicular (joint)
- 83500 - Closed dislocation of hip, unspecified site
- 8363 - Dislocation of patella, closed
- 8820 - 8821
- 8830 - Open wound of finger(s), without mention of complication
- 8910 - Open wound of knee, leg (except thigh), and ankle, without mention of complication
- 8920 - Open wound of foot except toe(s) alone, without mention of complication
- 8930 - Open wound of toe(s), without mention of complication
- 9221 - Contusion of chest wall
- 92311 - Contusion of elbow
- 92320 - Contusion of hand(s)
- 92401 - Contusion of hip
- 92421 - Contusion of ankle
- 9243 - Contusion of toe

- 9245 - Contusion of unspecified part of lower limb
- 9331 - Foreign body in larynx
- 94526 - Blisters, epidermal loss (second degree) of thigh (any part)
- 9623 - Poisoning by insulins and antidiabetic agents
- 87342 - 87344
- 87349 - Open wound of other and multiple sites of face, without mention of complication
- 95901 - Head injury, unspecified

Audit #: A-06-17-01003 (12/22/2021)
Government Program: CMS

Kentucky Made Almost $2 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Medicaid ID Numbers

Previous Office of Inspector General audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some beneficiaries enrolled in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid payments for these beneficiaries.

OIG's objective was to determine whether the Kentucky Cabinet for Health and Family Services (Kentucky) made unallowable capitation payments on behalf of beneficiaries with multiple Medicaid ID numbers.

The audit covered approximately $6.97 million ($4.94 million Federal share) in Medicaid capitation payments Kentucky made to MCOs from July 1, 2015, through June 30, 2019, for the 1,634 beneficiary matches that OIG identified. OIG selected and reviewed a stratified random sample of 100 of these beneficiary matches.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Kentucky made unallowable capitation payments on behalf of beneficiaries with multiple Medicaid ID numbers. Of the 100 beneficiary matches in the sample, Kentucky correctly made capitation payments on behalf of 3. However, it incorrectly made capitation payments that totaled $455,296 ($323,126 Federal share) on behalf of the remaining 97.

The unallowable capitation payments occurred because the beneficiaries had multiple Medicaid ID numbers. According to Kentucky, the beneficiaries had multiple ID numbers because either the beneficiaries themselves or the caseworkers entered demographic data incorrectly during the application process.

On the basis of OIG's sample results, OIG estimated that Kentucky made unallowable capitation payments totaling at approximately $2.7 million ($1.9 million Federal share) on behalf of beneficiaries with multiple Medicaid ID numbers during the audit period.

OIG recommended that Kentucky:

- refund to the Federal Government approximately $1.9 million (Federal share) in unallowable payments,
- review capitation payments that fell outside of OIG's audit period and refund any unallowable payments, and

- enhance or establish new controls to ensure that no beneficiary was issued multiple Medicaid ID numbers.

Audit #: A-04-20-07094 (12/02/2021)
Government Program: CMS

Missouri Properly Converted Provisionally Enrolled Medicaid Providers to Permanent Providers

In response to the COVID-19 pandemic, the Secretary of Health and Human Services temporarily waived certain Medicaid provider enrollment requirements.

Loosening of provider screening requirements increased Medicaid vulnerability to fraud by moderate and high-risk providers. Because of the speed with which established provider enrollment requirements had been waived or modified, OIG believed that the opportunity for abuse of the Medicaid system could result in unallowable billing, duplication of services, breach of confidentiality, identity theft, and ineffective or unsafe care.

OIG's objectives were to determine whether Missouri: (1) followed up with provisionally enrolled Medicaid providers to ensure that all documentation was obtained according to applicable provider screening and enrollment requirements after regular enrollment practices resumed and (2) had effective controls over the provisional enrollment process during the public health emergency for the period of March 1, 2020, through May 15, 2020.

OIG selected a stratified random sample of 100 provisionally enrolled providers (of the 1,036 during the audit period) and reviewed their documentation to determine whether they were properly converted to permanent providers or terminated by May 15, 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

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

Audit #: A-07-21-03248 (11/17/2021)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Part C

[NEW] Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions

- Medicare Advantage (MA) companies received higher risk-adjusted payments from the Centers for Medicare & Medicaid Services (CMS) for enrollees who were sicker, which helped to ensure that plans received sufficient payment to cover more costly care and enrollees had continued access to MA plans. However, taxpayers funded billions of dollars in overpayments to MA companies each year based on unsupported diagnoses for MA enrollees. Unsupported diagnoses inflated risk-adjusted payments and drove improper payments in the MA program.
- Using 2016 MA encounter data, prior OIG work identified two sources of enrollee diagnoses--health risk assessments (HRAs) and chart reviews--as vulnerable to misuse by MA companies. This evaluation updated that work and determined whether vulnerabilities persisted regarding the appropriateness of resulting risk-adjusted payments and the quality of care for enrollees with diagnoses reported only on HRAs and on no other records of services (i.e., service records) in the 2022 MA encounter data. This evaluation also newly examined the extent to which MA companies used chart reviews of information gathered as part of HRAs to add diagnoses that increased their risk-adjusted payment (HRA-linked chart reviews).

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that diagnoses reported only on enrollees' HRAs and HRA-linked chart reviews, and not on any other 2022 service records, resulted in an estimated $7.5 billion in MA risk-adjusted payments for 2023. The lack of any other followup visits, procedures, tests, or supplies for these diagnoses in the MA encounter data for 1.7 million MA enrollees raised concerns that either: (1) the diagnoses were inaccurate and thus the payments were improper or (2) enrollees did not receive needed care for serious conditions reported only on HRAs or HRA-linked chart reviews.

In-home HRAs and HRA-linked chart reviews generated almost two-thirds of the estimated $7.5 billion in risk-adjusted payments. In-home HRAs and HRA-linked chart reviews might have been more vulnerable to misuse because these tools were often administered by MA companies or their third-party vendors and not enrollees' own providers. Diagnoses reported only on these types of records heightened concerns about the validity of the diagnoses or the coordination of care for MA enrollees.

Just 20 MA companies drove 80 percent of the estimated $7.5 billion in payments. Also, these MA companies generated a substantially greater share of payments resulting from HRAs or HRA-linked chart reviews for certain health conditions, including serious and chronic illnesses, such as diabetes and congestive heart failure.

OIG recommended that in addition to implementing prior OIG recommendations, CMS should:

1. Impose additional restrictions on the use of diagnoses reported only on in-home HRAs or chart reviews that were linked to in-home HRAs for risk-adjusted payments.
   2. Conduct audits to validate diagnoses reported only on in-home HRAs and HRA-linked chart reviews.
2. Determine whether select health conditions that drove payments from in-home HRAs and HRA-linked chart reviews might have been more susceptible to misuse among MA companies.

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Payer

Medicaid

Medicare Part C

Medicare Part D

CPT Codes Identified in This Evaluation:

- 99341-99345 - Evaluation and management home visits, new patient
- 99347-99350 - Evaluation and management home visits, established patient

HCPCS Codes Identified in This Evaluation:

- G0438 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), initial visit
- G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit
- G0402 - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Evaluation #: OEI-03-23-00380 (10/21/2024)
Government Program: CMS

[NEW] Medicare Advantage Compliance Audit of Diagnosis Codes That EmblemHealth (Contract H3330) Submitted to CMS

Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then mapped certain diagnosis codes into Hierarchical Condition Categories (HCCs) based on similar clinical characteristics and severity and cost implications. CMS made higher payments for enrollees who received diagnoses that mapped to HCCs.

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

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. EmblemHealth provided medical records as support for 1,220 HCCs associated with 199 of the 200 enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that EmblemHealth 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 EmblemHealth submitted were supported in the medical records and therefore validated 860 of the 1,220 sampled enrollees' HCCs, the remaining 362 HCCs were not validated and resulted in overpayments.

These 362 unvalidated HCCs included 54 HCCs for which OIG identified 54 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 65 HCCs for which the medical records supported diagnosis codes that EmblemHealth should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,222 HCCs. Rather, the risk scores should have been based on 979 HCCs (860 validated HCCs plus 54 other HCCs plus 65 additional HCCs) and resulted in $551,917 in net overpayments. On the basis of OIG's sample results, OIG estimated that EmblemHealth received at least $130 million in net overpayments for 2015. Because of Federal regulations that limit the use of extrapolation in RADV audits for recovery purposes to payment year 2018 and forward, OIG reported the overall estimated net overpayment amount but recommended a refund of $551,917 in net overpayments. As demonstrated by the errors found in OIG's sample, EmblemHealth'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 EmblemHealth refund to the Federal Government $551,917 of net overpayments and continue to ensure that its policies and procedures had been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that were used to calculate risk-adjusted payments.

ICD Codes Identified in This Audit:

- Asymptomatic Human Immunodeficiency Virus (HIV) Infection Status - This diagnosis code maps to and validates both the Version 12 model HCC for HIV/AIDS and the Version 22 model HCC also named HIV/AIDS

Audit #: A-06-18-02001 (09/24/2024)
Government Program: CMS

[NEW] Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HealthAssurance, Pennsylvania, Inc. (Contract R5826) Submitted to CMS

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

To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, HealthAssurance Pennsylvania, Inc. (HealthAssurance), and focused on nine groups of high-risk diagnosis codes.

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

OIG selected a stratified random sample of 269 unique enrollee-years with the high-risk diagnosis codes for which HealthAssurance (administered by Aetna, a CVS Health company) received higher payments for 2018 and 2019. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $966,561.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by OIG's audit, most of the selected diagnosis codes that HealthAssurance submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 222 of the 269 sampled enrollee-years, the medical records that HealthAssurance provided did not support the diagnosis codes and resulted in $657,744 in overpayments.

As demonstrated by the errors found in OIG's sample, HealthAssurance's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could have been improved. On the basis of OIG's sample results, OIG estimated that HealthAssurance received at least $4.2 million in overpayments for 2018 and 2019.

OIG recommended that CVS Health: (1) refund to the Federal Government the $4.2 million in overpayments; (2) identify, for the high-risk diagnoses included in the 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 its examination of its existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Audit #: A-05-22-00020 (09/23/2024)
Government Program: CMS

[NEW] Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Humana Health Plan, Inc. (Contract H2649) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Humana Health Plan, Inc. (Humana), and focused on eight groups of high-risk diagnosis codes (high-risk groups). OIG's objective was to determine whether Humana's submission of selected diagnosis codes to CMS, for use in CMS's risk adjustment program, complied with Federal

requirements.

OIG selected a stratified random sample of 240 unique enrollee years with the high-risk diagnosis codes for which Humana received higher payments for 2017 through 2018. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $642,816.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for the eight high-risk groups covered by OIG's audit, most of Humana's submissions of the selected diagnosis codes to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 202 of the 240 sampled enrollee-years, the diagnosis codes that Humana submitted to CMS were not supported by the medical records and resulted in $497,225 in overpayments. As demonstrated by the errors found in OIG's sample, Humana's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could have been improved. On the basis of OIG's sample results, OIG estimated that Humana received at least $13.1 million in 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 reported the overall estimated overpayment amount but recommended a refund of $6.8 million ($274,151 for the sampled enrollee-years from 2017 and an estimated $6,503,234 for 2018).

OIG recommended that Humana (1) refund to the Federal Government the $6.8 million of estimated 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 examine its existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-02-22-01001 (09/23/2024)
Government Program: CMS

Medicare Advantage Compliance Audit of Diagnosis Codes That MMM Healthcare, LLC, (Contract H4003) Submitted to CMS

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

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

For this audit, OIG reviewed the contract that MMM Healthcare, LLC, had with CMS with respect to the diagnosis codes that MMM submitted to CMS. The objective was to determine whether MMM submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2017. MMM provided medical records as support for 688 HCCs associated with these enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that MMM did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. Although 580 of the 688 sampled enrollees' HCCs were supported in the medical records and therefore validated, the remaining 108 HCCs were not validated, which resulted in overpayments. These 108 unvalidated HCCs included 11 HCCs for which OIG identified other HCCs for less severe manifestations of the diseases. In addition, there were 11 HCCs for which the medical records supported diagnosis codes that MMM should have submitted to CMS but did not.

Thus, the risk scores for the 200 sampled enrollees should not have been based on the 688 HCCs. Rather, the risk scores should have been based on 602 HCCs (580 validated HCCs plus 11 other HCCs plus 11 additional HCCs). As a result, MMM received $165,312 in net overpayments. On the basis of OIG's sample results, OIG estimated that MMM

received approximately $59 million in net overpayments for 2017. Because of Federal regulations that limited the use of extrapolation in RADV audits for recovery purposes to payment years 2018 and forward, OIG only recommended a refund of $165,312 in net overpayments for the sampled enrollees. These errors occurred because MMM's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved.

OIG recommended that MMM refund to the Federal Government the $165,312 of net overpayments and continue to improve its policies and procedures to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that were used to calculate risk-adjusted payments.

After reviewing MMM's comments and the additional information provided, OIG reduced the number of HCCs in error and adjusted OIG's calculation of net overpayments. OIG also reduced the recommended refund in OIG's first recommendation to $165,312. OIG maintained that OIG's second recommendation remained valid.

Audit #: A-04-20-07090 (08/13/2024)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Independent Health Association, Inc. (Contract H3362) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Independent Health Association, Inc. (IHA), and focused on eight groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that IHA submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 247 unique enrollee-years with the high-risk diagnosis codes for which IHA received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $744,772.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the eight high-risk groups covered by the audit, most of the selected diagnosis codes that IHA submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. Specifically, for 230 of the 247 sampled enrollee-years, the medical records that IHA provided did not support the diagnosis codes and resulted in $646,217 in overpayments. As demonstrated by the errors found in the sample, IHA's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could have been improved. On the basis of the sample results, OIG estimated that IHA received at least $7.0 million in overpayments for 2016 and 2017. 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 reported the overall estimated overpayment amount but recommended a refund of only the overpayments for the sampled enrollee-years.

OIG recommended that IHA: (1) refund to the Federal Government the $646,217 of overpayments; (2) identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before and after the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 444.1 - Embolism and thrombosis of thoracic aorta
- 441.4 - Abdominal aneurysm without mention of rupture
- 441.01 - Dissection of aorta, thoracic
- 414.01 - Coronary atherosclerosis of native coronary artery
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 441.00 - Dissection of aorta, unspecified site
- 414.00 - Coronary atherosclerosis of unspecified type of vessel, native or graft
- 205.00 - Acute myeloblastic leukemia, not having achieved remission
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 227.4 - Benign neoplasm of pineal gland
- 272.4 - Other and unspecified hyperlipidemia
- 205.01 - Acute myeloid leukemia, in remission
- 250.01 - 200.02
- 200.62 - Anaplastic large cell lymphoma, intrathoracic lymph nodes
- 250.62 - Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
- 250.10 - Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
- 205.10 - Chronic myeloid leukemia, without mention of having achieved remission
- 254.9 - Unspecified disease of thymus gland
- 245.9 - Thyroiditis, unspecified
- 402.10 - Benign hypertensive heart disease without heart failure
- 518.81 - Acute respiratory failure
- 581.81 - Nephrotic syndrome in diseases classified elsewhere
- C78.5 - Secondary malignant neoplasm of large intestine and rectum
- E78.5 - Hyperlipidemia, unspecified
- 714.9 - Unspecified inflammatory polyarthropathy
- 174.9 - Malignant neoplasm of breast (Female), unspecified
- 433.10 - Occlusion and stenosis of carotid artery without mention of cerebral infarction

Audit #: A-07-19-01194 (06/26/2024)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MediGold (Contract H3668) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, MediGold, and focused on seven groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that MediGold submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG selected a stratified random sample of 210 unique enrollee-years with the high-risk diagnosis codes for which MediGold received higher payments for 2017 through 2018. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $567,570.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the seven high-risk groups covered by the 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 the sample, MediGold's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could have been improved. On the basis of the 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 reported the overall estimated overpayment amount but recommended 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-07-20-01198 (02/16/2024)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That SelectCare of Texas, Inc. (Contract H4506), Submitted to CMS

Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, SelectCare of Texas, Inc. (SelectCare), and focused on 10 groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that SelectCare submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 285 unique enrollee-years with the high-risk diagnosis codes for which SelectCare received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $689,604.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the audit period and refund any resulting overpayments to the Federal Government; and (3) review its existing compliance procedures to identify areas where improvements could be made to ensure diagnosis codes that were at high risk for being miscoded complied 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.

ICD Codes Identified in This Audit:

- 482.0 - Pneumonia Due to Klebsiella Pneumoniae
- 428.0 - Congestive Heart Failure, Unspecified
- 174.0 - Malignant Neoplasm of Nipple and Areola of Female Breast
- 714.0 - Rheumatoid Arthritis
- 174.9 - Malignant Neoplasm of Breast, Unspecified
- 205.00 - Acute Myeloid Leukemia

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

- 250.00 - Diabetes Mellitus Without Complications
- 249.10 - Secondary Diabetes Mellitus With Ketoacidosis
- 294.10 - Dementia Without Behavior Disturbance
- 250.10 - Diabetes With Ketoacidosis, Type II Or Unspecified Type
- 433.01 - Occlusion and Stenosis of Basilar Artery With Cerebral Infarction
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 493.20 - Chronic Obstructive Asthma, Unspecified
- 493.02 - Extrinsic Asthma With Exacerbation
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 402.01 - Malignant Hypertensive Heart Disease With Heart Failure
- 402.10 - Benign Hypertensive Heart Disease Without Heart Failure
- 296.20 - Major Depressive Disorder
- C61 - Prostate Cancer
- 443.9 - Peripheral Vascular Disease
- 197.0 - Metastatic Pulmonary Disease
- 311 - Depression, NEC
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 493.20 - Chronic Obstructive Asthma, Unspecified
- 493.02 - Extrinsic Asthma With Exacerbation
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 174.9 - Malignant Neoplasm of Breast, Unspecified
- 250.00 - Diabetes Mellitus Without Complications
- 205.00 - Acute Myeloid Leukemia
- 249.10 - Secondary Diabetes Mellitus With Ketoacidosis
- 294.10 - Dementia Without Behavior Disturbance
- 250.10 - Diabetes With Ketoacidosis, Type II Or Unspecified Type
- 433.01 - Occlusion and Stenosis of Basilar Artery With Cerebral Infarction
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 493.20 - Chronic Obstructive Asthma, Unspecified
- 493.02 - Extrinsic Asthma With Exacerbation
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 402.01 - Malignant Hypertensive Heart Disease With Heart Failure
- 402.10 - Benign Hypertensive Heart Disease Without Heart Failure
- 296.20 - Major Depressive Disorder
- C61 - Prostate Cancer
- 443.9 - Peripheral Vascular Disease
- 197.0 - Metastatic Pulmonary Disease
- 311 - Depression, NEC

Audit #: A-06-19-05002 (11/27/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Diagnosis Codes That CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on each enrollee's health status. MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then mapped certain diagnosis codes into Hierarchical Condition Categories (HCCs), based on similar clinical characteristics and severity and cost implications. CMS made higher payments for enrollees who received diagnoses that mapped to HCCs.

For this audit, OIG reviewed one of the contracts that CarePlus Health Plans, Inc., had with CMS with respect to the diagnosis codes that CarePlus submitted. The objective was to determine whether CarePlus submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. CarePlus provided medical records as support for 1,656 HCCs associated with these enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

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 had been adequately designed and implemented to prevent, detect, and correct noncompliance with Federal requirements for diagnosis codes that were used to calculate risk-adjusted payments.

After reviewing CarePlus's comments and the additional information provided, OIG revised its findings and the associated net overpayment amount in its first recommendation. After OIG had issued its draft report, CMS updated regulations for audits in its risk adjustment program to specify that extrapolated overpayments could only be recouped

beginning with payment year 2018. OIG changed the amount of the recommended refund to include only the net overpayments of $641,467. OIG made no changes to its second recommendation.

Audit #: A-04-19-07082 (10/26/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Aetna, Inc. (Contract H5521) Submitted to CMS

Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS. For this audit, OIG reviewed one MA organization, Aetna, Inc. (Aetna), and focused on seven groups of high-risk diagnosis codes.

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

OIG sampled 210 unique enrollee-years with the high-risk diagnosis codes for which Aetna received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $856,818.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the seven high-risk groups covered by the 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 the 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 the 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 supported 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 the audit period and refund any resulting overpayments to the Federal Government; and (4) continue to examine and improve its compliance procedures.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

ICD Codes Identified in This Audit:

- 443.9 - Peripheral vascular disease, unspecified
- 250.70 - Diabetes mellitus with peripheral circulatory complications
- 443.81 - Peripheral angiopathy
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 482.0 - Pneumonia due to klebsiella pneumoniae
- 428.0 - Congestive heart failure, unspecified
- 714.9 - Unspecified inflammatory polyarthropathy
- 174.9 - Malignant neoplasm of breast (female), unspecified
- 200.00 - Reticulosarcoma, unspecified site, extranodal and solid organ sites
- 250.02 - Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
- 996.56 - Mechanical complication due to peritoneal dialysis catheter
- 996.65 - Infection and inflammatory reaction due to other genitourinary device, implant, and graft
- 200.62 - Anaplastic large cell lymphoma, intrathoracic lymph nodes
- 205.80 - Other myeloid leukemia, without mention of having achieved remission
- 250.80 - Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
- 482.42 - Methicillin resistant pneumonia due to Staphylococcus aureus
- 428.42 - Chronic combined systolic and diastolic heart failure
- 518.81 - Acute respiratory failure
- 581.81 - Nephrotic syndrome in diseases classified elsewhere
- 200.60 - Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites
- 714.4 - Chronic postrheumatic arthropathy
- 174.4 - Malignant neoplasm of upper-outer quadrant of female breast
- 434.91 - Cerebral artery occlusion; unspecified with cerebral infarction
- 416.2 - Chronic pulmonary embolism

Audit #: A-01-18-00504 (10/02/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Diagnosis Codes That Health Net of California, Inc. (Contract H0562) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then mapped certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, to Hierarchical Condition Categories (HCCs). Thus, CMS made higher

payments for enrollees who received diagnoses that mapped to HCCs.

For this audit, OIG reviewed the contract that Health Net of California, Inc., had with CMS with respect to the diagnosis codes that Health Net submitted to CMS. OIG's objective was to determine whether Health Net submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. Health Net provided medical records as support for 1,325 HCCs associated with 195 of the 200 enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

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.

ICD Codes Identified in This Audit:

- ICD-9-CM 041.49 - Escherichia coli, identified as the organism causing urosepsis
- ICD-9-CM 995.91 - Sepsis due to UTI, coded with the specific infection code and the sepsis code
- ICD-9-CM 250.40 - Diabetes mellitus type II with chronic kidney disease, stage 3
- ICD-9-CM 270.4 - Homocystenemia, an endocrine and metabolic disorder
- ICD-9-CM 296.80 - Bipolar disorder, a lifelong condition with significant underlying depression
- ICD-9-CM 453.40 - Chronic DVT on Coumadin, noted in the Chief Complaint under the major problem (MP) section

Audit #: A-09-18-03007 (09/22/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Presbyterian Health Plan, Inc. (Contract H3204) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Presbyterian Health Plan, Inc. (PHP), and focused on seven groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that PHP submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 211 unique enrollee-years with the high-risk diagnosis codes for which PHP received higher payments for 2017 through 2018. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $496,911.

SunHawk Summary of OIG Audit Findings and Recommendations

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's 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 reported the overall estimated overpayment amount but recommended 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Audit #: A-07-20-01197 (08/03/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Excellus Health Plan, Inc. (Contract H3351) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Excellus Health Plan, Inc. (Excellus), and focused on seven groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that Excellus submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 210 unique enrollee-years with the high-risk diagnosis codes for which Excellus received higher payments for 2017 through 2018. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $515,090.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the seven high-risk groups covered by the 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 the sample, Excellus's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could have been improved. On the basis of the 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 limited the use of extrapolation in Risk Adjustment Data Validation audits for recovery purposes to payment years 2018 and forward, OIG reported the overall estimated overpayment amount but recommended 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-07-20-01202 (07/10/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Keystone Health Plan East, Inc. (Contract H3952) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes were at a higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Keystone Health Plan East. The objective was to determine whether selected diagnosis codes that Keystone submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 270 unique enrollee condition and payment years (enrollee-years) with the high-risk diagnosis codes for which Keystone received higher payments for 2016 and 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $746,012.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the 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 could be made to ensure diagnosis codes that were at high risk for being miscoded complied 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 collected, for audits of risk adjustment data, medical records that complied with CMS requirements.

Audit #: A-03-20-00001 (05/31/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities

Medicare paid practitioners for physician services separately from the payments it made to inpatient facilities, such as skilled nursing facilities (SNFs) and hospitals. Practitioners reported a two-digit place-of-service code on a Medicare claim line that generally reflected where the practitioner furnished the service. Medicare used the place-of-service code to determine the payment to the practitioner. OIG conducted this audit because their analysis of claims indicated that practitioners might not always follow the Centers for Medicare & Medicaid (CMS) regulations and guidance when reporting the place-of-service code on a claim line, thereby increasing the risk of Medicare making an overpayment for physician services furnished to inpatients of a SNF or hospital.

OIG's objective was to determine whether Medicare paid the proper rate for physician services furnished to enrollees while they were inpatients of a SNF or hospital.

For calendar years 2019 and 2020, OIG identified 2.1 million physician service claim lines at risk of overpayment because of non-compliance with the place-of-service policy. OIG conducted claims analysis and calculated the overpayments and potential overpayments. OIG also discussed coding with CMS and practitioners and reviewed a sample of medical records.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare sometimes paid higher nonfacility rates rather than lower facility rates for physician services while enrollees were Part A SNF or hospital inpatients. During the 2-year audit period, Medicare made overpayments totaling $22,463,193 for 1,130,182 claim lines by paying the nonfacility rate for services coded as furnished in a nursing facility or SNF setting without Part A coverage while enrollees were Part A SNF inpatients. CMS did not have Common Working File (CWF) system edits to detect these coding errors. Similarly, while enrollees were Part A SNF or hospital inpatients, Medicare paid an additional $22,142,489 for 1,012,203 physician service claim lines coded as furnished in a nonfacility setting. CMS had expressed reluctance to take enforcement action for these claim lines because neither statute nor CMS's regulation specifically addressed situations in which a SNF or hospital inpatient left to receive a physician service in a nonfacility setting.

OIG recommended that CMS 1) direct its Medicare contractors to recover the $22.5 million in overpayments identified in the audit; 2) notify the appropriate practitioners so that they could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; 3) establish and apply CWF edits to detect instances in which practitioners incorrectly used the nonfacility place-of-service code for a SNF while an enrollee was a Part A SNF inpatient; 4) take the necessary steps, including seeking legislative authority, if necessary, to revise its regulations, to ensure that Medicare appropriately paid for the physician services, which could have resulted in the Medicare program paying up to $22.1 million less; 5) consider developing a mechanism for facilities to indicate when an inpatient left a facility and returned the same day; and 6) provide additional education to practitioners on the appropriate use of place-of-service codes.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

CPT Codes Identified in This Audit:

- 11043 - Removal of skin and/or muscle, first 20 square centimeters or less
- 11720 - Removal of tissue from 1 to 5 fingernails or toenails (nail debridement)
- 90791 - Psychiatric diagnostic evaluation
- 92004 - Eye and medical examination for diagnosis and treatment, new patient, 1 or more visits
- 99214 - Established patient office or other outpatient, visit typically 25 minutes

Audit #: A-04-21-04084 (05/30/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract H6609) Submitted to CMS

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

To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, HumanaChoice (administered by Humana, Inc.), and focused on seven groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that HumanaChoice submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 210 unique enrollee-years with the high-risk diagnosis codes for which HumanaChoice received higher payments for 2015 and 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $694,939.

SunHawk Summary of OIG Audit Findings and Recommendations

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 have been 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 the audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 493.20 - Chronic obstructive asthma, unspecified
- 493.02 - Extrinsic asthma with (acute) exacerbation
- 200.00 - Reticulosarcoma, unspecified site, extranodal and solid organ sites
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 205.02 - Acute myeloid leukemia, in relapse
- 250.02 - Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
- 205.80 - Other myeloid leukemia, without mention of having achieved remission
- 250.80 - Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
- 402.01 - Malignant hypertensive heart disease with heart failure
- 402.10 - Benign hypertensive heart disease without heart failure
- 433.01 - Occlusion and stenosis of basilar artery with cerebral infarction
- 433.10 - Occlusion and stenosis of carotid artery without mention of cerebral infarction
- 707.01 - Pressure ulcer, elbow
- 707.10 - Ulcer of lower limb, unspecified
- 707.21 - Pressure ulcer, stage I
- 707.12 - Ulcer of calf
- 174.9 - Malignant neoplasm of breast (female), unspecified
- 714.9 - Unspecified inflammatory polyarthritis
- 802.5 - Open fracture of malar and maxillary bones
- 805.2 - Closed fracture of dorsal [thoracic] vertebra without mention of spinal cord injury
- I24.8 - Other forms of acute ischemic heart disease
- I42.8 - Other cardiomyopathies
- 482.0 - Pneumonia due to Klebsiella pneumoniae
- 428.0 - Congestive heart failure, unspecified
- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 441.00 - Dissection of aorta, unspecified site
- 414.00 - 441.01
- E32.9 - Disease of thymus, unspecified
- F32.9 - Major depressive disorder, single episode, unspecified
- 249.20 - Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 294.20 - Dementia, unspecified, without behavioral disturbance
- I24.9 - Acute ischemic heart disease, unspecified
- I42.9 - Cardiomyopathy, unspecified

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Audit #: A-05-19-00013 (04/04/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cigna-HealthSpring Life & Health Insurance Company, Inc. (Contract H4513) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Cigna-HealthSpring Life & Health Insurance Company, Inc. (Cigna), and focused on nine groups of high-risk diagnosis codes. OIG's objective was to determine whether selected diagnosis codes that Cigna submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 300 unique enrollee-years with the high-risk diagnosis codes for which Cigna received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $720,395.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by the 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 the sample, Cigna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of the 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-07-19-01192 (03/28/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MCS Advantage, Inc. (Contract H5577) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS. For this audit, OIG reviewed one MA organization, MCS Advantage, Inc., and focused on nine groups of high-risk diagnosis codes.

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

OIG sampled 280 unique enrollee-years with the high-risk diagnosis codes for which MCS received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $402,073.

SunHawk Summary of OIG Audit Findings and Recommendations

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 million 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-02-20-01008 (03/24/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Geisinger Health Plan (Contract H3954) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Geisinger Health Plan (Geisinger), and focused on nine groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that Geisinger submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 270 unique enrollee-years with the high-risk diagnosis codes for which Geisinger received higher payments for 2016 and 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $706,678.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by the 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 the sample, Geisinger's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements could be improved. On the basis of the 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 the audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-09-21-03011 (03/16/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

This issue brief summarized results from OIG's evaluation of MA encounter data and examined whether the lack of an indicator to identify payment denials in the data hindered efforts to combat fraud, waste, and abuse. (In this issue brief, OIG used the term "denied claim" to refer to a record that contained a service for which the payer denied payment to the provider.) Detailed data about the services provided to enrollees were essential for combating fraud and abuse in Medicare and Medicaid. The oversight entities tasked with safeguarding these programs relied 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) did not require MAOs to include an indicator that identified denied claims in their MA encounter data. Instead, MAOs had to submit claim adjustment reason codes (hereafter adjustment codes) when MAOs did not pay the actual amount billed by the provider (e.g., the MAO paid a lesser amount). Adjustment codes explained 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 did 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 have contained 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 affected their work, OIG interviewed and/or administered questionnaires to staff from oversight entities tasked with safeguarding MA program integrity. These oversight entities included 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 did 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 were not a definitive method for identifying denied claims in the MA encounter data. The descriptions for some adjustment codes were 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") did not specify whether payment was denied. The descriptions for other adjustment codes seemed 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 was 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 could 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 had to make separate requests to MAOs asking them to identify denied claims in a subset of their data, which added time and burden to investigations. The lack of an indicator limited the scope of efforts to determine the full impact of potential fraud activities in MA. For example, without an indicator, it was 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 denied payments to their providers; and
- examine suspected providers' billing activities across many plans.

However, for Medicare fee-for-service and Medicaid, oversight entities could 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 were not required to submit a denied-claim indicator in MA because the MA payment group did 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 covered most MA enrollees also had contracts for Medicaid managed care--where CMS required a denied-claim indicator on encounter records--and thus had demonstrated their ability to make accommodations in their systems and report these indicators. Once any initial challenges of modifying MAOs' systems were addressed, the inclusion of a denied-claim indicator in the MA encounter data might reduce the burden on MAOs of providing denied-claim information to oversight entities for fraud analyses. Finally, CMS might eventually need a denied-claim indicator to determine MA payments if it transitioned to using the MA encounter data to estimate costs and set MA payments, as it had previously stated that it would 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 had denied payment for a service on a claim.

Evaluation #: OEI-03-21-00380 (02/27/2023)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cigna-HealthSpring of Tennessee, Inc. (Contract H4454) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Cigna-HealthSpring of Tennessee, Inc. (Cigna), and focused on 10 groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that Cigna

submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 279 unique enrollee-years with the high-risk diagnosis codes for which Cigna received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $759,529.

SunHawk Summary of OIG Audit Findings and Recommendations

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 have been 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Audit #: A-07-19-01193 (12/22/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BCBS of Rhode Island (Contract H4152) Submitted to CMS

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

To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.

For this audit, OIG reviewed one MA organization, Blue Cross & Blue Shield of Rhode Island (BCBS RI) and focused on nine groups of high-risk diagnosis codes for payment years 2016 and 2017.

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

OIG sampled 270 unique enrollee-years with the high-risk diagnosis codes for which BCBS RI received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $732,418.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 182.4x - Acute deep vein thrombosis

Audit #: A-01-20-00500 (11/16/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That California Physicians' Service, Inc. (Contract H0504) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, California Physicians' Service, Inc. (CPS), and focused on seven

groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that CPS submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 196 unique enrollee-years with the high-risk diagnosis codes for which CPS received higher payments for 2015 and 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $523,340.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 174.0 - Malignant neoplasm of nipple and areola of female breast
- 714.0 - Rheumatoid arthritis
- 205.80 - Other myeloid leukemia, without mention of having achieved remission
- 250.80 - Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
- 205.90 - Unspecified myeloid leukemia, without mention of having achieved remission
- 250.90 - Diabetes with unspecified complications type II or unspecified type, not stated as uncontrolled
- 402.01 - Malignant hypertensive heart disease with heart failure
- 402.10 - Benign hypertensive heart disease without heart failure
- 250.10 - Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
- 205.10 - Chronic myeloid leukemia, without mention of having achieved remission
- 493.20 - Chronic obstructive asthma, unspecified
- 493.02 - Extrinsic asthma with (acute) exacerbation
- 441.00 - Dissection of aorta, unspecified site
- 414.00 - Coronary atherosclerosis of unspecified type of vessel, native or graft
- 174.9 - Malignant neoplasm of breast (female), unspecified
- 714.9 - Unspecified inflammatory polyarthropathy
- I24.9 - Acute ischemic heart disease, unspecified

- I42.9 - Cardiomyopathy, unspecified
- 434.91 - Cerebral artery occlusion, unspecified with cerebral infarction.

Audit #: A-09-19-03001 (11/10/2022)
Government Program: CMS

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) contracted 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 relied on Part C and Part D sponsors to ensure that excluded, precluded, deactivated, and deceased providers (ineligible providers) did 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. The 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. OIG 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 did 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 recommended that CMS direct Part C and Part D sponsors to ensure that only eligible providers received 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 were listed in the body of the report.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Audit #: A-02-20-01027 (10/25/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That HumanaChoice (Contract R5826) Submitted to CMS

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

To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, HumanaChoice (administered by Humana, Inc.), and focused on nine groups of high-risk diagnosis codes.

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

OIG sampled 270 unique enrollee-years with the high-risk diagnosis codes for which HumanaChoice received higher payments for 2016 and 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $744,438.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by the 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 the 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 the audit period and refund any resulting overpayments to the Federal Government; and (3) examine its existing compliance procedures to identify areas where improvements could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Audit #: A-05-19-00039 (09/30/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Highmark Senior Health Company (Contract H3916) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes were at higher risk for being miscoded, which might have resulted in overpayments from CMS. For this audit, OIG reviewed one MA organization, Highmark Senior Health Company.

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

OIG sampled 226 unique enrollee condition and payment years (enrollee-years) with the high-risk diagnosis codes for which Highmark received higher payments for 2015 and 2016. OIG limited the review to the portion of the payments that were associated with these high-risk diagnosis codes, which totaled $801,166.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the 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 could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

ICD Codes Identified in This Audit:

- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 250.00 - Diabetes mellitus without mention of complications, type II or unspecified type
- 441.00 - Dissection of aorta, unspecified site
- 414.00 - 441.01
- E32.9 - Disease of thymus, unspecified
- F32.9 - Major depressive disorder, single episode
- 433.10 - Occlusion and stenosis of carotid artery without mention of cerebral infarction
- 714.9 - Unspecified inflammatory polyarthropathy
- 174.9 - Malignant neoplasm of breast (female), unspecified
- 850.2 - Concussion with moderate loss of consciousness
- 805.2 - Closed fracture of thoracic vertebra without mention of spinal cord injury
- 250.10 - Other specified diabetes mellitus with ketoacidosis without coma
- 205.10 - Chronic myeloid leukemia, without mention of having achieved remission
- 402.10 - Benign hypertensive heart disease without heart failure
- 205.02 - Acute myeloid leukemia, in relapse
- 250.02 - Diabetes mellitus without mention of complication, type II or unspecified, uncontrolled
- 249.20 - Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 294.20 - Dementia, unspecified, without behavioral disturbance
- 441.2 - Thoracic aneurysm without mention of rupture
- 414.2 - 710.3
- 996.56 - Mechanical complication due to peritoneal dialysis catheter
- 996.65 - Infection and inflammatory reaction due to other genitourinary device, implant, and graft.

Audit #: A-03-19-00001 (09/29/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That BlueCross BlueShield of Tennessee, Inc. (Contract H7917) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, BlueCross BlueShield of Tennessee, Inc. (BCBST), and focused on nine groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that BCBST

submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 270 unique enrollee-years with the high-risk diagnosis codes for which BCBST received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $683,651.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by the 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 the 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 the 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

Audit #: A-07-19-01195 (09/29/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Diagnosis Codes That Inter Valley Health Plan, Inc. (Contract H0545), Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then mapped certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). Thus, CMS made higher payments for enrollees who received diagnoses that mapped to HCCs.

For this audit, OIG reviewed the contract that Inter Valley Health Plan, Inc., had with CMS with respect to the diagnosis codes that Inter Valley submitted to CMS. OIG's objective was to determine whether Inter Valley submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. Inter Valley provided medical records as support for 1,553 HCCs associated with the 200 enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

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.

Audit #: A-05-18-00020 (09/26/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Regence BlueCross BlueShield of Oregon (Contract H3817) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Regence BlueCross BlueShield of Oregon (Regence), and focused on seven groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that Regence submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

OIG sampled 179 unique enrollee-years with the high-risk diagnosis codes for which Regence received higher payments for 2015 and 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $462,043.

SunHawk Summary of OIG Audit Findings and Recommendations

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 have been 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 433.01 - Occlusion and stenosis of basilar artery with cerebral infarction
- 433.10 - Occlusion and stenosis of carotid artery without mention of cerebral infarction
- 441.01 - Dissection of thoracic aorta
- 414.01 - Coronary atherosclerosis of native coronary artery
- E32.9 - Disease of thymus, unspecified
- F32.9 - Major depressive disorder, single episode, unspecified
- 249.20 - Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 294.20 - 249.21

Audit #: A-09-20-03009 (09/13/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That WellCare of Florida, Inc., (Contract H1032) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their

providers and submit these codes to CMS.

For this audit, OIG reviewed one MA organization, WellCare of Florida, Inc. (WellCare), and focused on seven groups of high-risk diagnosis codes.

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

OIG sampled 250 unique enrollee-years with the high-risk diagnosis codes for which WellCare received higher payments for 2015 through 2016, respectively. OIG limited the audit to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $689,234.

SunHawk Summary of OIG Audit Findings and Recommendations

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 OIG's 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 the 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 could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- E32.9 - Disease of Thymus, Unspecified
- F32.9 - Major Depressive Disorder, Single Episode, Unspecified
- I24.9 - Acute Ischemic Heart Disease, Unspecified
- I42.9 - Cardiomyopathy, Unspecified
- E10.21 - Type 1 Diabetes Mellitus With Diabetic Nephropathy
- F10.21 - Alcohol Dependence, in Remission
- E20.9 - Hypoparathyroidism, Unspecified
- F20.9 - Schizophrenia, Unspecified

Audit #: A-04-19-07084 (08/29/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Diagnosis Codes That Cigna HealthSpring of Florida, Inc. (Contract H5410) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Based on similar clinical characteristics and severity and cost implications, CMS then mapped certain diagnosis codes into Hierarchical Condition Categories (HCCs). CMS made higher payments for enrollees who received diagnoses that mapped to HCCs. For this audit, OIG reviewed one CMS contract with Cigna HealthSpring of Florida, Inc.

OIG's objective was to determine whether Cigna HealthSpring submitted diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG sampled 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. Cigna HealthSpring provided medical records as support for 1,470 HCCs associated with these enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

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 OIG's 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 were used to calculate risk-adjusted payments.

ICD Codes Identified in This Audit:

- V10.51 - History of bladder cancer
- 995.9x - Sepsis codes

Audit #: A-03-18-00002 (08/19/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Cariten Health Plan, Inc., (Contract H4461) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Cariten Health Plan, Inc. (Cariten), and focused on nine groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that Cariten submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 270 unique enrollee-years with the high-risk diagnosis codes for which Cariten received higher payments for 2016 through 2017. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $750,508.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the nine high-risk groups covered by OIG's 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 OIG's 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 could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

Audit #: A-02-20-01009 (07/18/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities

The disparate impacts of the COVID-19 pandemic on various racial and ethnic groups brought health disparities to the forefront. Health disparities were differences in health that adversely affected certain groups. People of color were found to experience disparities in areas such as access to care and quality of care. Such disparities had profound implications for the health and well-being of these individuals.

Medicare was an essential part of the Nation's health care system, with 66 million beneficiaries enrolled. CMS made advancing health equity a top priority. Ensuring that Medicare was able to assess disparities was key to this goal. The ability to assess health disparities hinged on the quality of the underlying race and ethnicity data.

OIG analyzed the race and ethnicity data in Medicare's enrollment database, the only source of this information for all enrolled beneficiaries. These race and ethnicity data were derived from source data from the Social Security Administration and the results of an algorithm that CMS applied to the source data. OIG assessed the accuracy of Medicare's enrollment race and ethnicity data for different groups by comparing them to self-reported data for a subset of beneficiaries who resided in nursing homes. Race and ethnicity data that were self-reported were considered the most accurate. OIG also assessed the adequacy of Medicare's data using the Federal standards for collecting race and ethnicity data as a benchmark.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Medicare's enrollment race and ethnicity data were less accurate for some groups, particularly for beneficiaries identified as American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic. Data that were not accurate limited the ability to assess health disparities. Limited race and ethnicity categories and missing information contributed to inaccuracies in the enrollment data. Although the use of an algorithm improved the existing data to some extent, it fell short of self-reported data. Finally, Medicare's enrollment data on race and ethnicity were inconsistent with Federal data collection standards, which inhibited the work of identifying and improving health disparities within the Medicare population.

Advancing health equity was a priority for CMS and the Department. Race and ethnicity data were foundational to identifying and understanding health disparities among Medicare beneficiaries and to assessing the effectiveness of efforts to reduce such disparities. It was critical that these data were accurate, complete, and comprehensive. Therefore, CMS had to improve its race and ethnicity data; though a significant undertaking, the need for better data was pressing. Accordingly, OIG recommended that CMS:

- develop its own source of race and ethnicity data,
- use self-reported race and ethnicity information to improve data for current beneficiaries,
- develop a process to ensure that the data were as standardized as possible, and
- educate beneficiaries about CMS's efforts to improve the race and ethnicity information.

Evaluation #: OEI-02-21-00100 (06/03/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare and Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.

For this audit, OIG reviewed one MA organization, Peoples Health Network (Peoples Health), and focused on seven groups of high-risk diagnosis codes.

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

OIG sampled 242 unique enrollee-years with the high-risk diagnosis codes for which Peoples Health received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $712,200.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 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 OIG's 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 the audit period and refund any resulting overpayments to the Federal Government; and (3) enhance its existing compliance procedures to identify areas where improvements could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

ICD Codes Identified in This Audit:

- 482.0 - Pneumonia Due to Klebsiella Pneumoniae
- 428.0 - Congestive Heart Failure, Unspecified
- 205.00 - Acute Myeloblastic Leukemia, Not Having Achieved Remission
- 250.00 - 482.1
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 518.81 - Acute Respiratory Failure
- 581.81 - Nephrotic Syndrome in Diseases Classified Elsewhere
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 174.9 - Malignant Neoplasm of Breast (Female), Unspecified

Audit #: A-06-18-05002 (05/25/2022)
Government Program: CMS

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 was 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 approved the vast majority of requests for services and payment, they issued millions of denials each year, and CMS annual audits of MAOs had highlighted widespread and persistent problems related to inappropriate denials of services and payment. As Medicare Advantage enrollment continued to grow, MAOs played an increasingly critical role in ensuring that Medicare beneficiaries had access to medically necessary covered services and that providers were 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 Evaluation Findings and Recommendations

OIG found 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 met Medicare coverage rules may have prevented or delayed beneficiaries from receiving medically necessary care and could have burdened providers. Although some of the denials that OIG reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps created friction in the program and may have created 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 were 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 OIG's physician reviewers determined were medically necessary. Although OIG's review determined that the requests in these cases did meet Medicare coverage rules, CMS guidance was not sufficiently detailed to determine whether MAOs may deny authorization based on internal MAO clinical criteria that went beyond Medicare coverage rules.

Second, MAOs indicated that some prior authorization requests did not have enough documentation to support approval, yet OIG's 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 OIG's 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 recommended that CMS:

- issue 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 could lead to manual review errors and system errors.

Evaluation #: OEI-09-18-00260 (04/27/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare and Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their

providers and submit these codes to CMS.

For this audit, OIG reviewed one MA organization, Tufts Health Plan, Inc. (Tufts), and focused on seven groups of high-risk diagnosis codes.

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

OIG sampled 212 unique enrollee-years with the high-risk diagnosis codes for which Tufts received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $746,427.

SunHawk Summary of OIG Audit Findings and Recommendations

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 OIG's 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 could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 200.60 - Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites
- 250.60 - Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
- 482.42 - Methicillin resistant pneumonia due to Staphylococcus aureus
- 428.42 - Chronic combined systolic and diastolic heart failure
- 820.8 - Closed fracture of unspecified part of neck of femur
- 802.8 - Closed fracture of other facial bones
- 433.01 - Occlusion and stenosis of basilar artery with cerebral infarction
- 433.10 - Occlusion and stenosis of carotid artery without mention of cerebral infarction
- 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 205.00 - Acute myeloid leukemia, without mention of having achieved remission
- 428.41 - Acute combined systolic and diastolic heart failure
- 482.41 - Methicillin susceptible pneumonia due to staphylococcus aureus
- 200.00 - Reticulosarcoma, unspecified site, extranodal and solid organ sites
- 441.02 - Dissection of aorta, abdominal

- 414.02 - Coronary atherosclerosis of autologous vein bypass graft
- 482.32 - Pneumonia due to streptococcus, group B
- 428.0 - 441.01
- 714.9 - Unspecified inflammatory polyarthropathy
- 174.9 - Malignant neoplasm of breast (female), unspecified
- I24.9 - Acute ischemic heart disease, unspecified
- I42.9 - Cardiomyopathy, unspecified
- 205.02 - Acute myeloid leukemia, in relapse
- 250.02 - Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
- 249.20 - Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 294.20 - Dementia, unspecified, without behavioral disturbance
- 250.10 - Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
- 205.10 - Chronic myeloid leukemia, without mention of having achieved remission
- E32.9 - Disease of thymus, unspecified
- F32.9 - Major depressive disorder, single episode, unspecified
- 227.4 - Benign neoplasm of pineal gland
- 272.4 - Other and unspecified hyperlipidemia
- 205.20 - Subacute myeloid leukemia, without mention of having achieved remission
- 250.20 - Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled
- 482.30 - Pneumonia due to streptococcus, unspecified
- 428.30 - Diastolic heart failure, unspecified
- F20.81 - Schizophreniform disorder
- F02.81 - Dementia in other diseases classified elsewhere with behavioral disturbance

Audit #: A-01-19-00500 (02/14/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. CMS then mapped certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs). CMS made higher payments for enrollees who received diagnoses that mapped to HCCs.

For this audit, OIG reviewed one of the contracts that SCAN Health Plan (SCAN) had with CMS with respect to the diagnosis codes that SCAN submitted to CMS. OIG's objective was to determine whether SCAN submitted diagnosis

codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

OIG selected a sample of 200 enrollees with at least 1 diagnosis code that mapped to an HCC for 2015. SCAN provided medical records as support for 1,577 HCCs associated with the 200 enrollees. OIG used an independent medical review contractor to determine whether the diagnosis codes complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

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.

ICD Codes Identified in This Audit:

- ICD-9-CM 515 - Post-Inflammatory Pulmonary Fibrosis

Audit #: A-07-17-01169 (02/03/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, Healthfirst Health Plan, Inc. (Healthfirst), and focused on seven

groups of high-risk diagnosis codes. OIG's objective was to determine whether selected diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 240 unique enrollee-years with the high-risk diagnosis codes for which Healthfirst received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $787,928.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that with respect to the seven high-risk groups covered by OIG's audit, most of the selected diagnosis codes that Healthfirst submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 155 of the 240 enrollee-years, the diagnosis codes that Healthfirst submitted to CMS were not supported in the medical records and resulted in net overpayments of $516,509.

These errors occurred because the policies and procedures that Healthfirst 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's sample results, OIG estimated that Healthfirst received at least $5.2 million in net overpayments for these high-risk diagnosis codes in 2015 and 2016.

OIG recommended that Healthfirst: refund to the Federal Government the $5.2 million of net overpayments; identify, for the diagnosis codes described 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 continue its examination of existing compliance procedures to identify areas where improvements could be made to ensure diagnosis codes that were at high risk for being miscoded complied with Federal requirements and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 493.20 - Chronic Obstructive Asthma, Unspecified
- 493.02 - Extrinsic Asthma With (Acute) Exacerbation
- 402.01 - Malignant Hypertensive Heart Disease With Heart Failure
- 402.10 - Benign Hypertensive Heart Disease Without Heart Failure
- 205.02 - Acute Myeloid Leukemia, in Relapse
- 250.02 - Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Uncontrolled
- 433.01 - Occlusion and Stenosis of Basilar Artery With Cerebral Infarction
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 249.20 - Secondary Diabetes Mellitus With Hyperosmolarity, Not Stated as Uncontrolled
- 294.20 - Dementia, Unspecified, Without Behavioral Disturbance
- 482.1 - Pneumonia Due to Pseudomonas
- 428.1 - Left Heart Failure
- 250.00 - Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled
- 205.00 - Acute Myeloid Leukemia, Without Mention of Having Achieved Remission
- 209.21 - Malignant Carcinoid Tumor of the Bronchus and Lung
- 250.90 - Diabetes With Unspecified Complication, Type II or Unspecified Type, Not Stated as Uncontrolled
- 482.0 - Pneumonia Due to Klebsiella Pneumoniae

- 428.0 - Congestive Heart Failure, Unspecified
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 174.9 - Malignant Neoplasm of Breast (Female), Unspecified
- 200.00 - Reticulosarcoma, Unspecified Site, Extranodal and Solid Organ Sites
- 205.90 - Unspecified Myeloid Leukemia, Without Mention of Having Achieved Remission
- 290.21 - Senile Dementia With Depressive Features
- E32.9 - Disease of Thymus, Unspecified
- F32.9 - Major Depressive Disorder, Single Episode, Unspecified
- 441.01 - Dissection of Aorta, Thoracic
- 414.01 - Coronary Atherosclerosis of Native Coronary Artery
- 441.00 - Dissection of Aorta, Unspecified Site
- 414.00 - Coronary Atherosclerosis of Unspecified Type of Vessel, Native or Graft

Audit #: A-02-18-01029 (01/05/2022)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) made monthly payments to MA organizations according to a system of risk adjustment that depended on the health status of each enrollee. Accordingly, MA organizations were 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 relied on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.

For this audit, OIG reviewed one MA organization, UPMC Health Plan, Inc. (UPMC), and focused on 10 groups of high-risk diagnosis codes. The objective was to determine whether selected diagnosis codes that UPMC submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

OIG sampled 280 unique enrollee-years with the high-risk diagnosis codes for which UPMC received higher payments for 2015 through 2016. OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $975,223.

SunHawk Summary of OIG Audit Findings and Recommendations

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 the audit period and refund any resulting overpayments to the Federal Government; and continue its examination of existing compliance procedures to identify areas where improvements could be made to ensure that diagnosis codes that were at high risk for being miscoded complied with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

ICD Codes Identified in This Audit:

- 205.00 - Acute Myeloblastic Leukemia, Not Having Achieved Remission
- 250.00 - Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled
- 482.0 - Pneumonia Due to Klebsiella Pneumoniae
- 428.0 - Congestive Heart Failure, Unspecified
- E32.9 - Disease of Thymus, Unspecified
- F32.9 - Major Depressive Disorder, Single Episode, Unspecified
- 205.01 - Acute Myeloid Leukemia, in Remission
- 250.01 - Diabetes Mellitus Without Mention of Complication, Type 1, Not Stated as Uncontrolled
- 433.01 - Occlusion and Stenosis of Basilar Artery With Cerebral Infarction
- 433.10 - Occlusion and Stenosis of Carotid Artery Without Mention of Cerebral Infarction
- 441.01 - Dissection of Aorta, Thoracic
- 414.01 - Coronary Atherosclerosis of Native Coronary Artery
- 200.00 - Reticulosarcoma, Unspecified Site, Extranodal and Solid Organ Sites
- 205.80 - Other Myeloid Leukemia, Without Mention of Having Achieved Remission
- 250.80 - Diabetes With Other Specified Manifestations, Type II or Unspecified Type, Not Stated as Controlled
- 174.9 - Malignant Neoplasm of Breast (Female), Unspecified
- 714.9 - Unspecified Inflammatory Polyarthropathy
- 441.00 - Dissection of Aorta, Unspecified Site
- 414.00 - Coronary Atherosclerosis of Unspecified Type of Vessel, Native or Graft
- 447.6 - 446.7
- I24.9 - Acute Ischemic Heart Disease, Unspecified
- I42.9 - Cardiomyopathy, Unspecified

Audit #: A-07-19-01188 (11/05/2021)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Part D

[NEW] Medicare Part D Paid Millions for Drugs for Which Payment Was Available Under the Medicare Part A Skilled Nursing Facility Benefit

- An OIG evaluation in 2009 found that Part D paid for drugs for enrollees during Part A skilled nursing facility (SNF) stays, and OIG audits in 2012 and 2019 found that Part D paid for drugs for enrollees receiving Part A hospice care. Part D does not cover drugs for which payment is available under Part A.
- Because the SNF evaluation report was issued almost 15 years ago and the hospice audits showed there was a continuing problem with improper Part D payments, OIG reviewed Part D plan sponsors' prescription drug event (PDE) data to determine whether Part D paid for drugs for which payment was available under the Part A SNF benefit.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for all 215 sample items, Part D improperly allowed PDEs for drugs that were dispensed to or on behalf of Part D enrollees during their Part A SNF stays.

- For 89 of the 215 sample items, SNFs' medical records confirmed that the drugs were administered to the Part D enrollees during their Part A SNF stays.
- For 136 of the 215 sample items, there was no documentation to determine whether drugs from the pharmacies listed on the PDEs were administered during Part D enrollees' Part A SNF stays.

  On the basis of OIG's sample results, for 2018 through 2020, OIG estimated that up to the entire Part D total cost of $465.1 million was improperly paid for drugs for which payment was available under the Part A SNF benefit. Of that amount, OIG estimated that approximately $245.4 million was for drugs that the medical records showed were administered to Part D enrollees during their Part A SNF stays.

OIG made five recommendations, including that CMS work with its plan sponsors to adjust or delete PDEs, as necessary, and determine the impact to the Federal Government related to the Part D total costs of $953,370 for drugs associated with OIG's sample items for which payment was available under the Part A SNF benefit; work with its plan sponsors to identify similar instances of noncompliance that occurred during OIG's audit period and determine the impact to the Federal Government, which could have amounted up to an estimated $465.1 million in Part D total cost; and provide plan sponsors with timely and accurate information, such as dates of covered Part A SNF stays, to reduce instances of inappropriate Part D payment for drugs for which payment was available under the Part A SNF benefit. The full recommendations were in the report.

Audit #: A-09-21-03008 (10/18/2024)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare and Some Enrollees Paid Substantially More When Stelara Was Covered Under Part D Versus Part B

Stelara was a high-cost prescription biologic approved to treat certain autoimmune diseases. Subcutaneous (under-the-skin) versions of Stelara were typically self-injected and covered under Medicare Part D. Prior to 2023, Part B also covered subcutaneous versions of Stelara when the injection was administered by a physician; however, Medicare Administrative Contractors (MACs) then excluded Stelara injections under a policy designed to omit self-administered drugs from Part B coverage. The period during which Stelara was covered under Parts B and D provided a unique opportunity to examine how coverage determinations affected payments made by the Medicare program and costs for its enrollees.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Medicare and some enrollees paid substantially more when Stelara injections were covered under Part D (i.e., self-administered) versus under Part B (i.e., administered by a physician). Specifically, in 2021, the annual cost per enrollee for Stelara was 80 percent more under Part D than under Part B. Moreover, the average Part B cost for a Stelara injection remained steady while the average Part D cost increased by 84 percent between 2016 and 2023. However, given recent coverage changes, enrollees who once opted to receive Stelara injections in their doctors' offices (i.e., through Part B) must now obtain Stelara through a pharmacy (i.e., through Part D), where they will potentially face much higher out-of-pocket costs.

OIG concluded that over the past several years, Medicare expenditures for Stelara increased almost tenfold, from $300 million in 2016 to almost $3 billion in 2023. OIG's findings illustrated how differences in the methods used to set drug payment amounts under Part B (i.e., manufacturers' sales prices) versus under Part D (i.e., negotiations between plan sponsors, manufacturers, pharmacy benefit managers, and pharmacies) resulted in widely different payment amounts for the same drugs. As such, Part B and Part D programmatic features--such as payment amounts and available payment supports (e.g., Medigap or LIS)--could have had a major effect on expenditures for Medicare and out-of-pocket costs for enrollees, and could also have impacted where patients chose to obtain the drug.

CPT Codes Identified in This Evaluation:

- 96372 - Administration of subcutaneous injection
- 99211 - Office visit for an established patient, typically 5 minutes
- 99215 - Office visit for an established patient, typically 40 minutes

Evaluation #: OEI-BL-19-00500 (08/06/2024)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Part D Plans Generally Include Drugs Commonly Used by Dual-Eligible Enrollees: 2024

This data snapshot fulfilled for 2024 the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA). The ACA required OIG to conduct a study of the extent to which formularies used by Medicare Part D plans included drugs commonly used by full benefit dual eligible enrollees (i.e., individuals who were eligible for both Medicare and full Medicaid benefits). These individuals generally got drug coverage through Medicare Part D. Pursuant to the ACA, OIG had to annually issue a study with recommendations as appropriate. This was the thirteenth study that OIG produced to meet this mandate.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that dual-eligible enrollees--that is, people enrolled in both Medicare and Medicaid--had access to the majority of commonly used drugs in 2024 via their Part D plans, consistent with OIG's findings from previous years. A majority of the 416 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 (95 of 130) covered at least 97 percent of the drugs commonly used by dual-eligible enrollees. Dual-eligible enrollees had several options if their plans did not cover specific drugs; however, these options might have been burdensome and did not guarantee access to the drugs.

OIG concluded that it had no recommendations at that time.

Evaluation #: OEI-05-24-00210 (06/26/2024)
Government Program: CMS

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

Opioid-related overdose deaths remained 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) continued 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 was a part of a series, released annually by OIG since 2017, that monitored indicators of the opioid epidemic in Medicare. It provided 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 monitored 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 was 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 had opioid use disorder, just 18 percent received medication to treat their disorder. This low percentage highlighted that enrollees were 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 were 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 was an important step toward reducing overdose-related deaths, there was 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 would no longer be covered by Medicare Part D. Without Part D coverage, enrollees would 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 continued 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 appeared to be doctor shopping. Further, the number of prescribers with questionable prescribing remained about 100, similar to that for the prior 2 years.

OIG concluded that as the opioid epidemic continued to take tens of thousands of lives each year, it was essential that the Centers for Medicare & Medicaid Services (CMS) and the Department continued to work to ensure access to medication to treat opioid use disorder and opioid overdose-reversal drugs. CMS and the Department had 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 called for additional action.

OIG had made several recommendations to CMS in previous studies related to treatment. Notably, to encourage providers to treat more Part D enrollees who had 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 needed it.

Further, as part of this data brief, OIG recommended that CMS educate enrollees and providers about options for access to overdose-reversal medications, as Narcan and its generic equivalents would no longer be covered by Part D. Depending on the enrollee's circumstances, these options might include receiving coverage of over-the-counter naloxone through certain States' Medicaid programs (if dually eligible).

ICD Codes Identified in This Evaluation:

- F11.1 - Opioid abuse
- F11.2 - Opioid dependence

Evaluation #: OEI-02-23-00250 (12/11/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

- Ensuring access to buprenorphine to treat individuals with opioid use disorder was a critical step in addressing the Nation's opioid crisis.
- Buprenorphine--the most common medication used to treat opioid use disorder--had been shown to decrease illicit opioid use and opioid-related overdose deaths. Yet, due to concerns that buprenorphine had the potential for misuse and was at risk for diversion, access to this medication had historically been restricted.
- The Office of Inspector General recently conducted an evaluation examining the use of buprenorphine in Medicare Part D in 2021 and found that buprenorphine's risk of misuse and diversion appeared to be low.
- This data brief provided 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

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.

OIG concluded that:

- The findings from 2022 were similar to the findings from 2021. Together, they suggested that the risk of misuse and diversion of buprenorphine in Medicare Part D continued to be low.
- These updated data provided important information about buprenorphine utilization that could assist the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, and others as they continued to take steps to improve access to buprenorphine, while also ensuring that the risk of misuse and diversion remained low.

Evaluation #: OEI-02-24-00130 (11/22/2023)
Government Program: CMS

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

This data snapshot fulfilled for 2023 the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA). The ACA required OIG to conduct a study of the extent to which formularies used by Medicare Part D plans included drugs commonly used by full benefit dual-eligible enrollees (i.e., individuals who were eligible for both Medicare and full Medicaid benefits). These individuals generally got drug coverage through Medicare Part D. Pursuant to the ACA, OIG had to annually issue a study with recommendations as appropriate. This was the thirteenth study that OIG had 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 covered 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 the study. Of the top 200 drugs, 195 were eligible for Part D prescription drug coverage, while 4 were excluded from coverage. One additional drug was eligible for Part D coverage, but OIG did not include it in the analysis because they 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 were covered by both Medicare and Medicaid—had 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 had several options if their plans did not cover specific drugs; however, these options might have been burdensome and did not guarantee access to the drugs.

OIG concluded that it had no recommendations at that time.

Evaluation #: OEI-05-23-00130 (06/30/2023)
Government Program: CMS

The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder Appears to Be Low in Medicare Part D

Opioid-related overdose deaths in the United States remained a concern, with an estimated 82,310 deaths in 2021. As the country continued to struggle with the opioid crisis, it was essential to ensure access to buprenorphine to treat individuals with opioid use disorder.

Buprenorphine had been shown to decrease illicit opioid use and opioid-related overdose deaths. However, there were concerns about access to this potentially life-saving medication. Previous Office of Inspector General (OIG) work had shown a need to increase the number of Medicare enrollees receiving treatment for opioid use disorder. OIG had 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 were less likely to receive medication to treat their opioid use disorder than were White enrollees.

At the same time, buprenorphine for the treatment of opioid use disorder--hereafter referred to as buprenorphine--had the potential for misuse and was at risk for diversion. To address this risk, providers were required to obtain a waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe or administer buprenorphine in office-based settings and were limited in the number of patients they could treat. This waiver was commonly referred to as the "DATA waiver" after the Drug Addiction Treatment Act (DATA) of 2000 that established the waiver program. In December 2022, the Consolidated Appropriations Act, 2023, repealed the waiver requirement and the corresponding patient limits. This change came alongside a wider effort by the Administration to expand access to treatment, in part, by eliminating barriers.

This data brief provided information related to the risk of misuse and diversion of buprenorphine in Medicare Part D in 2021--prior to the repeal of the DATA waiver. Prescribing of buprenorphine had been limited, in part, due to concerns related to misuse and diversion. Yet, up until now, there had been little information available on the extent to which buprenorphine might be misused or diverted in Medicare. This data brief described the use of buprenorphine and looked at several measures to assess the risk of misuse and diversion of buprenorphine in Medicare.

OIG focused this review on Medicare Part D claims for buprenorphine indicated for the treatment of opioid use disorder in 2021--prior to the repeal of the DATA waiver. OIG did not include claims for buprenorphine indicated for pain. Buprenorphine covered by Medicare Part D was generally prescribed in office-based settings and filled at retail pharmacies.

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

OIG concluded that together, these findings suggested that the risk of misuse and diversion of buprenorphine in Medicare Part D was low. These findings further supported the recent repeal of the DATA waiver which was in place, in part, to limit diversion of buprenorphine. The repeal of the waiver was a significant step towards increasing access to treatment.

Further, the data in this report provided baseline information about buprenorphine utilization and prescribing that could assist CMS, the Department, and others as they implemented changes related to the repeal and took other steps to improve access to buprenorphine, while also ensuring that the risk of misuse and diversion remained low.

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 had opioid use disorder; (3) take steps to inform providers about the availability of buprenorphine combination products in Part D, which could minimize the risk of misuse and diversion; and (4) follow up on the prescribers with concerning patterns identified in this report.

Evaluation #: OEI-02-22-00160 (05/16/2023)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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 had been tracking opioid use in Medicare during the opioid crisis and had identified providers with questionable prescribing practices and beneficiaries at serious risk of misuse or overdose of opioids. Transmucosal immediate-release fentanyl (TIRF) drugs were high-potency, prescription opioid pain relievers that were approved solely to manage breakthrough cancer pain. Because of known improper off-label use of TIRF drugs that could impact the health and safety of beneficiaries, for this audit OIG 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.

The 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 OIG 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 contained three other recommendations.

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Payer

Medicaid

Medicare Part C

Medicare Part D

Audit #: A-09-20-03033 (02/28/2023)
Government Program: CMS

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

As the nation continued to grapple with the effects of the COVID-19 pandemic, the opioid epidemic continued to surge. In 2021, there were an estimated 81,502 opioid-related overdose deaths in the United States—an all-time high. Accordingly, it was 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 provided important information on these topics for beneficiaries in Medicare Part D in 2021. It built on a series of data briefs released by OIG.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that about 50,400 Part D beneficiaries experienced an opioid overdose—from prescription opioids, illicit opioids, or both—during 2021. This number was 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.

OIG concluded that there was clearly still cause for concern and vigilance, even as some positive trends emerged. Monitoring opioid use and access to medications for the treatment of opioid use disorder as well as to naloxone were 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. OIG continued to call attention to the importance of implementing these recommendations and to ensuring access to treatment for opioid use disorder for Medicare beneficiaries. OIG was also committed to continuing its work on opioid use and access to treatment.

ICD Codes Identified in This Evaluation:

- F11.1 - Opioid abuse
- F11.2 - Opioid dependence

Evaluation #: OEI-02-22-00390 (09/13/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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 have been 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 had 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 aligned with experts' suggestions that certain programmatic factors, such as manufacturer rebates, may have been 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.

Evaluation #: OEI-BL-21-00200 (08/09/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2022

This data snapshot fulfilled for 2022 the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA). The ACA required OIG to conduct a study of the extent to which formularies used by Medicare Part D plans included prescription drugs commonly used by dual eligible individuals (i.e., individuals who were covered by both Medicare and Medicaid). These individuals generally got drug coverage through Medicare Part D. Pursuant to the ACA, OIG had to annually issue a study with recommendations as appropriate. This was the twelfth study that OIG had 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 covered 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 the study. Of the top 200 drugs, OIG analyzed 195 drugs. Three drugs were not eligible for Part D coverage, and OIG excluded two additional drugs from the 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 had 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 was important because when dual eligibles did not select their own Part D plans, CMS randomly assigned them to plans with premiums below the regional benchmark without considering their specific prescription drug needs. If dual eligibles' plans did not cover specific drugs, they had several options (switching plans, using an exceptions and appeals process, finding an alternative drug, or paying out of pocket), but these options required beneficiaries to take administrative actions and did not guarantee access to the drugs.

OIG concluded that, in general, dual eligibles had 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 were largely unchanged from OIG's findings reported from 2011 through 2021. As mandated by the ACA, OIG would continue to monitor and produce annual reports on the extent to which Part D plan formularies covered drugs that dual eligibles commonly used. OIG had no recommendations at that time.

Evaluation #: OEI-05-22-00230 (06/28/2022)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

Biologics--usually large, complex molecules produced in a living system--were some of the most expensive drugs available, and spending for biologics grew in Medicare Part D because they treated diseases common among Medicare beneficiaries. Biologics were estimated to cost Part D upwards of $12 billion annually.

A biosimilar was a lower cost biologic that was 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 were currently available for Part D covered reference products, multiple biosimilars for Humira--the best selling prescription drug in the world--were 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 had steadily increased. However, they were 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 were modest in the context of overall Part D spending, far greater spending reductions would be possible as additional biosimilars become available.

OIG found that biosimilars had the potential to significantly reduce costs for Part D and beneficiaries if their use became 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 became available. To help ensure that Part D and beneficiaries could 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.

Evaluation #: OEI-05-20-00480 (03/29/2022)
Government Program: CMS

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

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

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

OIG conducted an audit of the PDE amounts the Sponsor reported in its 2017 bid submission. The audit covered drug ingredient costs the Sponsor reported for its pharmacies in its PDE records for 2015. OIG obtained an understanding of the methodology the Sponsor used to calculate the ingredient cost and dispensing fees. From information provided by the Sponsor, OIG determined the cost of the drugs dispensed to beneficiaries during 2015 to identify the differences between the costs to the Sponsor and the amounts reported to CMS.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Sponsor complied with CMS's PDE reporting requirements. However, OIG also found that CMS's PDE reporting guidance did not adequately address a sponsor service delivery model in which a sponsor owned the pharmacy it used and did not have a negotiated contract with the pharmacy. CMS clarified that it did not consider pharmacy margin to be sponsor margin, and CMS's current guidance allowed pharmacy margin but not sponsor margin to be included in the PDE record. However, in this type of integrated service delivery model, the margin included in the ingredient costs in the PDE record for wholly owned pharmacies went to the sponsor. Any sponsor margin included in the PDE record could not be identified and separated from pharmacy costs. Ingredient costs in the PDE records were the basis for drug costs reported in the Part D bidding process. Ingredient costs in the PDE record for any one year impacted the Part D bidding process in a future year. In sponsors' Part D bid submissions, sponsor margin was reported separately from ingredient costs. Any sponsor margin included in PDE records might not have been evaluated during the bid review.

Because of the lack of clarity surrounding margin in the PDE records for sponsors with an integrated service delivery model, the inclusion of margin in ingredient costs prevented CMS from being able to readily identify and evaluate all margin that accrued to such sponsors in future years' Part D bids. Therefore, CMS could not readily determine whether the amounts included in those Part D bids were reasonable.

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

Audit #: A-03-17-00001 (11/22/2021)
Government Program: CMS