Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Payer-Focused Audits Summary

January 1, 2023 - December 31, 2025

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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] Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees

- Since 2016, OIG had conducted 18 audits identifying that Medicaid agencies had improperly made roughly $289 million ($202 million Federal share) in capitation payments on behalf of deceased enrollees.
- The improper payments had drawn the attention of the U.S. Senate Committee on Finance, which had found that States continued to struggle with the issue. Provisions of the recently enacted One Big Beautiful Bill Act (OBBB Act) may help minimize unallowable Medicaid payments made on behalf of deceased enrollees.
- Because of the significant issues identified in OIG's prior audits and ongoing congressional interest, OIG conducted this audit to estimate the value of Medicaid capitation payments made to managed care organizations (MCOs) on behalf of deceased enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:
- OIG estimated that Medicaid agencies made $207,501,380 ($138,645,710 Federal share) in unallowable capitation payments to MCOs for enrollees whose date of death, as recorded by the Social Security Administration's Death Master File, occurred before the monthly service periods covered by the capitation payments during the audit period (July 1, 2021, through June 30, 2022).
- This estimate was based on the results of OIG's review of 100 statistically sampled capitation payments. OIG determined that Medicaid agencies made unallowable capitation payments after enrollees' deaths for 99 of the 100 sample payments. However, for 50 of those unallowable capitation payments, OIG found that Medicaid agencies recovered the overpayments before OIG provided them with the sample capitation payments for their review. The remaining 49 capitation payments were either not recovered or recovered after OIG sent the Medicaid agencies the sample capitation payments for their review. As a result of these unallowable and not previously recovered payments, OIG estimated $207,501,380 ($138,645,710 Federal share) in unallowable capitation payments for the audit period.

OIG recommended that CMS take two actions: (1) provide the Medicaid agencies covered by OIG's audit with OIG's matched T-MSIS data so that those agencies could review the capitation payments and take appropriate action to recover any unallowable payments, and (2) explore opportunities to work with Medicaid agencies to ensure that provisions of the OBBB Act were properly implemented. This effort could have resulted in yearly estimated savings of $207,501,380 ($138,645,710 Federal share).

Audit #: A-04-23-09010 (12/22/2025)
Government Program: CMS

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[NEW] Illinois Made Unallowable Managed Care Capitation Payments on Behalf of Incarcerated Medicaid Enrollees

- Illinois 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 audits found that State Medicaid agencies made unallowable capitation payments on behalf of incarcerated Medicaid enrollees.
- OIG performed this audit to determine whether Illinois made unallowable capitation payments on behalf of incarcerated Medicaid enrollees and to identify the dollar amount of any unallowable capitation payments that were not recovered.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Illinois made unallowable capitation payments totaling $263,186 ($229,423 Federal share) on behalf of 48 of the 100 incarcerated Medicaid managed care enrollees in OIG's stratified random sample.
- On the basis of OIG's sample results, OIG estimated that during the audit period Illinois made unallowable capitation payments on behalf of incarcerated Medicaid enrollees totaling at least $9.5 million ($8.3 million Federal share).

OIG recommended that Illinois refund $8,366,521 (Federal share) for unallowable capitation payments made on behalf of incarcerated Medicaid enrollees and expand its automated process that terminated managed care enrollment to include inmates housed in a non-Illinois Department of Corrections facility.

Audit #: A-05-24-00019 (12/18/2025)
Government Program: CMS

[NEW] Oklahoma Medicaid Fraud Control Unit: 2025 Inspection

OIG administered the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertified each Unit, and oversaw the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducted periodic inspections of Units and issued public reports of its findings and observations.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the Oklahoma Unit reported 55 indictments, 49 convictions, 17 civil settlements, and $10.1 million in recoveries during OIG's review period of fiscal years 2022-2024. The Unit maintained positive working relationships with external partners; made recommendations to the State Medicaid agency to limit improper payments; and investigated fraud and patient abuse or neglect cases involving a mix of provider types. However, the Unit did not always adhere to the MFCU performance standards or comply with applicable requirements.

OIG found that:

- The Unit's policies and procedures did not address certain aspects of its operations.

- The Unit took steps to maintain an adequate volume and quality of fraud referrals from the Program Integrity Unit (PIU) and managed care organizations (MCOs), but the Unit received few fraud referrals from these sources during OIG's review period.
- Sixteen percent of cases open during OIG's review period had significant investigative delays.
- The Unit lacked a case management system capable of efficiently managing and reporting case information and performance data.
- The Unit did not consistently conduct and document periodic supervisory reviews of cases during OIG's review period.
- The Unit did not report substantial proportions of its adverse actions and convictions to Federal partners within the required timeframes.
- The Unit's memorandum of understanding (MOU) with the State Medicaid agency generally reflected current practice, policy, and legal requirements, but the MOU did not reference the *CMS Performance Standard for Referrals.*

To address the findings, OIG recommended that the Unit (1) update its policies and procedures manual to address certain aspects of its operations; (2) build upon its efforts to increase the volume and quality of fraud referrals from the PIU and MCOs; (3) take steps to mitigate investigative delays; (4) take steps to implement a case management system capable of efficiently managing and reporting case information and performance data; (5) take steps to conduct and document periodic supervisory reviews of cases in accordance with Unit policy; (6) take steps to ensure that it reported all convictions and adverse actions to Federal partners within the appropriate timeframes; and (7) revise its MOU with the State Medicaid agency to reference the *CMS Performance Standard for Referrals*.

Evaluation #: OEI-07-25-00060 (12/11/2025)
Government Program: MFCU

[NEW] Arkansas Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Arkansas, the State's Arkansas Department of Human Services conducted surveys of ICF/IIDs for compliance with Federal requirements.
- This audit was part of a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 93 deficiencies related to life safety, emergency preparedness, and infection control were identified at the 10 ICF/IIDs in Arkansas that they reviewed. These deficiencies put residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

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OIG recommended that Arkansas:
1. follow up with the 10 ICF/IIDs to verify that they had taken corrective actions on the life safety, emergency preparedness, and infection control deficiencies identified during the audit;
2. work with State surveyors to include all areas of life safety, emergency preparedness, and infection control when conducting their reviews at ICF/IIDs as required by CMS; and
3. work with CMS to develop standardized life safety, emergency preparedness, and infection control training for ICF/IID staff.

Audit #: OAS-25-06-029 (12/09/2025)
Government Program: CMS

[NEW] New Jersey Did Not Ensure Providers Complied With Federal and State Requirements at All 20 Adult Day Health Services Facilities Audited

- Adult day health services (ADHS) facilities provided preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision to meet the needs of functionally impaired adult participants.
- OIG had conducted health and safety reviews of adult day care facilities in various States. These reviews identified multiple health and safety issues that put program enrollees at risk.
- This audit assessed whether New Jersey ensured that ADHS providers that served Medicaid managed care enrollees complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- New Jersey did not ensure that ADHS providers that served Medicaid managed care enrollees complied with Federal and State requirements. All 20 ADHS providers that OIG reviewed did not comply with 1 or more health and safety and administrative requirements. OIG found a total of 348 instances of noncompliance with these requirements at the 20 providers.
- New Jersey's inspections of facilities were insufficient to ensure a continuously

OIG recommended that New Jersey ensure that providers corrected the 348 instances of noncompliance identified in this report; improved its oversight and monitoring of the providers; and worked with providers to improve their facilities, staffing, and training. The full recommendations were in the report.

Audit #: A-02-24-01009 (12/02/2025)
Government Program: CMS

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[NEW] Pennsylvania Correctly Invoiced Rebates to Manufacturers for Most 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 organization (MCO) enrollees.
- This audit, one of a series, determined whether Pennsylvania complied with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs dispensed to MCO enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Pennsylvania generally complied with applicable Federal Medicaid requirements but did not invoice all rebate eligible physician-administered drugs dispensed to MCO enrollees.
- Specifically, Pennsylvania did not invoice for rebates totaling $488,051 ($284,617 Federal share):

OIG recommended that Pennsylvania invoice for and collect from manufacturers rebates totaling $488,051 ($284,617 Federal share) for single-source and top-20 multiple-source physician-administered drugs and refund the Federal share of rebates collected. The full recommendations were in the report.

Audit #: A-03-24-00206 (11/05/2025)
Government Program: CMS

[NEW] Texas' Ambulance Services Supplemental Payment Program Did Not Comply With Federal and State Reimbursement Requirements

- As part of the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver, Texas established the Ambulance Services Supplemental Payment Program (ASSPP), which provided Medicaid payments to governmental ambulance providers. These payments were made from an uncompensated care pool to help defray the costs of charity care.
- From Federal fiscal years (FYs) 2012 through 2021, the number of ambulance providers receiving ASSPP payments increased from 7 to 80.
- For FY 2021, four ambulance providers received $24 million, or 42 percent, of all ASSPP Federal funds paid to ambulance providers in Texas.
- This audit determined whether the State agency's claim for Federal reimbursement for ASSPP payments for selected ambulance providers complied with Federal and State requirements.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Texas' claims for Federal reimbursement for ASSPP payments for three of the four selected ambulance providers did not comply with Federal and State requirements. Specifically, in the cost reports of the selected ambulance providers, OIG identified an adjustment error in one ambulance provider's ASSPP cost report. Additionally, OIG identified unallowable and potentially unallowable costs in three ambulance providers' ASSPP cost reports.

OIG recommended that Texas (1) require training for all individuals that certify ASSPP cost reports on how to review for accuracy and (2) revise its policies and procedures to require ambulance providers to submit sufficient documentation that allowed the State agency to determine whether costs claimed on ASSPP cost reports were related to the provision of contracted patient care.

Audit #: A-06-23-01003 (11/03/2025)
Government Program: CMS

[NEW] South Carolina Did Not Comply With Federal Waiver and State Requirements at 19 of 20 Adult Day Care Facilities

- OIG had conducted health and safety audits of adult day care and foster care homes in various States. Those audits identified multiple health and safety issues that put children and adults at risk.
- This audit examined whether adults participating in South Carolina's Home and Community-Based Services waiver program were at risk.
- This audit determined whether South Carolina complied with Federal waiver and State requirements in overseeing adult day care facilities that served adults who received services through the program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that South Carolina did not fully comply with Federal waiver and State requirements in overseeing providers that served adults receiving adult day care services because of insufficient inspections that did not ensure a continuously safe and nonhazardous environment. As a result, adults were at risk in numerous instances.

- OIG found 204 instances of noncompliance with health, safety, and administrative requirements among 19 of the 20 providers reviewed.
- Of the 20 providers, 17 did not comply with 1 or more health and safety requirements and 18 did not comply with 1 or more administrative requirements.

OIG recommended that the South Carolina Department of Health and Human Services:

- work with the South Carolina Department of Public Health to ensure that providers corrected the 204 instances of provider noncompliance identified in this report;
- improve its oversight and monitoring of providers; and
- work with providers to improve their facilities, staffing, and training.

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Audit #: A-04-24-00137 (10/29/2025)
Government Program: CMS

[NEW] Connecticut Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Connecticut, the State's Department of Public Health (State agency) conducted surveys of ICF/IIDs for compliance with Federal requirements.
- This audit was part of a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that there were 80 deficiencies related to life safety, emergency preparedness, and infection control at the 15 ICF/IIDs that they reviewed in Connecticut. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency, or in the event of an infectious disease outbreak.

OIG recommended that Connecticut:
1. Follow up with the 15 ICF/IIDs reviewed to verify that they had taken corrective actions on the life safety, emergency preparedness, and infection control deficiencies identified during the audit.
2. Work with CMS to develop standardized life safety training for ICF/IID staff.

Audit #: OAS-25-01-040 (10/21/2025)
Government Program: CMS

[NEW] Summary Report of Prior Office of Inspector General Penetration Tests of 10 State MMIS and E&E; Systems

- In the health care sector, State Medicaid Management Information Systems (MMIS) and Eligibility & Enrollment (E&E;) systems were increasingly targeted by cybercriminals because of the valuable sensitive information they contained. There had been a noticeable increase in ransomware, phishing, and denial-of-service attacks that posed significant risks to critical health care systems and the data they managed.
- Between 2020 and 2022, OIG conducted penetration tests on 10 State MMIS and E&E; systems. These tests were designed to simulate cyberattacks to evaluate how effectively these systems were protected against such threats.

SunHawk Summary of OIG Audit Findings and Recommendations

Overall, OIG found that:

- the 10 States implemented generally effective information technology security controls for their web-facing MMIS and E&E; systems to prevent unsophisticated or limited cyberattacks, but they needed to continue to improve these controls to prevent more sophisticated and persistent cyberattacks;
- cyber attackers would likely have needed a moderate to significant level of sophistication or complexity to compromise the State systems OIG audited; and
- the 10 States effectively detected and responded to some of OIG's simulated cyberattacks but they needed to improve their detection and response to other types of cyberattacks.

OIG concluded that this summary report contained no recommendations to the Centers for Medicare & Medicaid Services (CMS); however, it did provide an overview of the recommendations previously made to the 10 States.

Audit #: A-18-24-00002 (10/10/2025)
Government Program: CMS

[NEW] Indiana Did Not Fully Comply With Federal Waiver and State Health, Safety, and Administrative Requirements at 30 Residential Settings

- OIG conducted health and safety audits of supported living services, adult day care, foster care homes, and regulated child care facilities.
- Previous audits identified multiple health and safety issues that put children and people with special health care needs at risk.
- This audit examined whether Indiana provided oversight of Home and Community-Based Services (HCBS) residential providers serving Medicaid enrollees with developmental disabilities to ensure they complied with Federal and State health and safety requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Indiana did not fully comply with Federal waiver and State requirements in overseeing residential providers that served individuals with developmental disabilities who received supported living services through the HCBS program.
- Of the 20 residential providers and 30 residential settings OIG reviewed, OIG found 246 instances of provider noncompliance with administrative, health, safety, and residential records requirements. Specifically, OIG identified:
  • 15 residential providers that did not comply with 1 or more administrative requirements, resulting in 46 instances of provider noncompliance, and
  • 29 residential settings that were not in compliance with 1 or more health, safety, and residential records requirements, resulting in 200 instances of provider noncompliance.

OIG recommended that Indiana work with residential providers to correct the 246 instances of provider noncompliance OIG identified; improve its oversight and monitoring of residential providers; and work with the residential providers to improve internal controls for health and safety, maintenance of records, and training.

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Audit #: A-05-24-00013 (10/09/2025)
Government Program: CMS

[NEW] Vermont Medicaid Fraud Control Unit: 2024 Inspection

OIG administered the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertified each Unit, and oversaw the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducted periodic inspections of Units and issued public reports of its findings.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the Vermont MFCU reported 32 indictments, 28 convictions, 10 civil settlements, and nearly $1.3 million in recoveries during OIG's review period of fiscal years 2022-2024. In addition to the findings below, OIG observed that the Unit undertook several efforts to build strong relationships with other agencies, increase awareness of its mission in the community, and improve its operations. OIG identified the following four findings:

- Despite the Unit taking steps to encourage fraud referrals, the State's Accountable Care Organization did not submit any fraud referrals to the Department of Vermont Health Access Special Investigations Unit or the MFCU during OIG's review period or at any time prior to OIG's review period.
- The Unit lacked a central repository for case information, making access to case data and pertinent case documents inefficient.
- The Unit maintained positive working relationships with Federal law enforcement partners but lacked established practices on how to coordinate with these partners.
- The Unit did not report two of its four adverse actions to the National Practitioner Data Bank within the appropriate timeframes during OIG's review period.

To address the findings, OIG recommended that the Unit (1) build upon its efforts to increase fraud referrals from relevant partners; (2) implement a comprehensive case management system that allowed the Unit to efficiently access, maintain, and report case information and performance data; (3) develop and implement a plan to improve communication and coordination with OIG and other Federal partners; and (4) take steps to report all adverse actions to Federal partners within the appropriate timeframes.

Evaluation #: OEI-07-24-00340 (10/02/2025)
Government Program: MFCU

New Jersey Did Not Ensure That Some Medicaid Personal Care Assistant Services Provided Under the Personal Preference Program Met Federal and State Requirements

- New Jersey's Medicaid Personal Preference Program (PPP) allowed Medicaid participants to self-direct their personal care assistant (PCA) services and remain in their home and active in their community without requiring the use of a home health care agency.
- New Jersey paid managed care organizations (MCOs) fixed monthly payments to make PCA services available under the PPP. MCOs had to assess participant eligibility using a PCA assessment and provide a monthly budget

amount to be used for services. New Jersey contracted with a fiscal intermediary to provide a range of services for participants. The fiscal intermediary assisted in establishing a cash plan for the participant and verified that caregivers were eligible to provide services.

- This audit examined whether New Jersey ensured that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Jersey did not ensure that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants. Specifically:

- MCOs did not meet PCA assessment and monthly budget amount requirements for 24 of the 150 sampled participant-months.
- The fiscal intermediary did not meet cash plan and caretaker verification requirements for 55 of the 150 sampled participant-months.
- On the basis of OIG's sample results, OIG estimated that, for 41 percent of participant-months during the audit period, MCOs paid caregivers $197 million through the fiscal intermediary for PCA services provided under the PPP that did not comply with Federal and State requirements.

OIG recommended that New Jersey improve its oversight and monitoring of its Medicaid PPP. The full recommendations were in the report.

Audit #: A-02-22-01024 (09/17/2025)
Government Program: CMS

Puerto Rico Medicaid Fraud Control Unit: 2024 Onsite Review

OIG administered the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertified each Unit, and oversaw the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducted periodic reviews of Units and issued public reports of its findings. This was the first onsite inspection of the Puerto Rico MFCU since it was certified to operate in FY 2019.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the Puerto Rico MFCU reported 24 indictments; 11 convictions; 9 civil settlements and judgments; and nearly $4.6 million in recoveries during OIG's review period of FYs 2021-2023. The MFCU undertook several efforts to build strong relationships with Federal partners and other agencies; increase awareness of its mission in the community; and improve its operations. However, the Unit did not always adhere to the MFCU performance standards or comply with applicable requirements.

- The Unit made several efforts to increase fraud referrals from managed care organizations (MCOs), including conducting outreach with partner agencies and requesting updates to the MCO contract, yet it received few MCO referrals during OIG's review period.
- Despite the Unit implementing an electronic case management system in FY 2023, limitations of the system hindered efficient access to case information and case outcome data, causing the Unit to rely on other case repositories.

- Half of the Unit's case files lacked documentation of any supervisory reviews, and the Unit's policies and procedures manual did not specify a frequency for conducting and documenting such reviews.
- The Unit did not submit its convictions to OIG within the required timeframe due to delays in translating court documents from Spanish to English, and, during part of OIG's review period, it was not registered with the National Practitioner Data Bank.

To address the findings, OIG recommended that the MFCU:
1. Build upon its efforts to increase referrals from MCOs;
2. Update its electronic case management system to address the system's limitations and provide further training on the system to Unit staff;
3. Implement a process to ensure that periodic supervisory case file reviews were conducted and documented on a consistent basis; and
4. Take steps to ensure that it reported all convictions and adverse actions to Federal partners within the appropriate timeframes.

Evaluation #: OEI-06-24-00300 (09/08/2025)
Government Program: MFCU

Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases

- This audit was one of a series of audits to determine whether States had recovered, and returned the correct Federal share of, improper provider claim amounts. For this audit, OIG focused on Mississippi's Medicaid Fraud Control Unit (MFCU) actions related to the recoveries of Medicaid overpayments through legal judgments and settlements that Mississippi had pursued under relevant Medicaid fraud statutes. These recoveries also included court-ordered awards. OIG referred to these recoveries as "MFCU-determined Medicaid overpayments."
- This audit examined whether Mississippi reported and returned the correct Federal share of MFCU-determined Medicaid overpayments identified during Federal fiscal years 2021, 2022, and 2023.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Mississippi should have reported MFCU-determined Medicaid overpayments totaling $4.5 million ($3.7 million Federal share) for the 20 cases during the period that OIG reviewed.

- Mississippi did not report and return MFCU-determined Medicaid overpayments related to paid claim amounts for six cases, totaling $4.2 million ($3.5 million Federal share), on the Form CMS-64;
- Mississippi did not report and return MFCU-determined Medicaid overpayments related to court-ordered awards that MFCU collected for 4 cases totaling $7,217 ($6,077 Federal share) on the Form CMS-64; and
- Mississippi reported and returned MFCU-determined Medicaid overpayments for 12 cases, totaling $290,584 ($241,948 Federal share), on the Form CMS-64.

OIG recommended that Mississippi return the Federal share of $3.5 million for the unreported cases that related to paid claims and $6,077 for the unreported cases that related to court-ordered awards. The full recommendations were in the report.

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Audit #: A-06-24-04002 (09/08/2025)
Government Program: CMS, MFCU

Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care

- Suicide was the second leading cause of death for children in the United States. In 2023, nearly 225,000 children aged 10-17 who were enrolled in Medicaid were hospitalized or visited the emergency department (ED) for suicidal thoughts or behaviors.
- Providing timely followup care after children experienced suicidal thoughts or behaviors was critical to decreasing the likelihood of re-hospitalization and preventing suicide. OIG interviewed experts who told them that a followup visit should occur anywhere from 24 hours to 1 week after a child's discharge from the hospital or ED.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that in half of cases (i.e., hospitalizations or ED visits for suicidal thoughts or behaviors), children did not receive a followup visit in the week after their discharge—a critical time for intervention. When children did receive followup visits, most visits occurred with behavioral health providers such as counselors, social workers, and psychiatrists. Subject matter experts whom OIG interviewed attributed the lack of timely followup visits to provider shortages and difficulties connecting children to care. The experts also shared that brief interventions from any type of provider could support children while they awaited more comprehensive care from a behavioral health professional (e.g., telephone contacts and safety planning).

OIG recommended that CMS should have assisted low-performing States to better ensure that children at risk of suicide received timely follow-up care.

Evaluation #: OEI-07-23-00510 (09/04/2025)
Government Program: CMS

Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud

- Fraud, waste, and abuse in the Medicaid program depleted critical resources and may have caused physical, emotional, and financial harm to enrollees.
- Medicaid managed care plans were required to identify and refer potential fraud, waste, or abuse--including provider fraud--to the State and/or Medicaid Fraud Control Unit (MFCU) for further investigation and enforcement.
- CMS and HHS-OIG had cited concerns about plans' efforts to combat fraud, including a lack of fraud referrals and few incentives to produce them.

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SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that ten percent of plans reported that they did not make any referrals of potential provider fraud, waste, or abuse in 2022. Combined, these plans covered 1.6 million enrollees and received $8 billion in payments from 13 States. Of the plans that reported making provider referrals in 2022, more than half made 2 or fewer referrals per 10,000 enrollees. Plans that received training from the State or MFCU on the fraud referral process made more provider referrals. However, only half of plans reported that they received such training. Plans with fraud referral staff dedicated solely to that Medicaid plan made more provider referrals than plans with staff working across programs. However, 78 percent of plans reported that their fraud referral staff shared program integrity responsibilities across programs (e.g., another health care line of business).

OIG recommended that CMS should (1) follow up with States that had Medicaid managed care plans with no referrals of potential provider fraud, waste, or abuse in 2022, and (2) encourage States to increase the number of Medicaid managed care plans that have received State-led training on the fraud referral process.

Evaluation #: OEI-03-22-00410 (08/28/2025)
Government Program: CMS

Analysis of Selected Nursing Facilities' Use of Medicaid Reimbursement for Direct Care Compensation

- Nursing facility spending on direct patient care, and the quality of that care, were of critical importance for residents of these facilities, their family members, and the Medicaid program itself.
- OIG's objectives were to analyze spending for 26 selected nursing facilities in 2018 and in 2021 to determine: (1) the percentage of funds received through Medicaid reimbursement that the facilities spent on direct care compensation, (2) whether the percentage used for direct care compensation at each facility changed between OIG's 2018 and 2021 data snapshots, and (3) whether that change was a result of new ownership.
- OIG provided this data brief to CMS for its information and review. Information in this data brief might also have been of interest to other stakeholders, including other policymakers, State Medicaid agencies, and nursing facilities.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- OIG determined that 17 of the 26 selected nursing facilities increased the percentage of funds received through Medicaid reimbursement that they spent on direct care compensation between 2018 and 2021. In addition, OIG determined that 9 of the 26 selected nursing facilities decreased the percentage of funds received through Medicaid reimbursement that they spent on direct care compensation between 2018 and 2021.
- Between 2018 and 2021, the percentage of Medicaid reimbursement spent on direct care compensation increased for 17 of the 26 selected nursing facilities. Of these 17 nursing facilities, 12 had decreases in their nursing hours per resident day.
- For OIG's third objective, OIG identified 2 nursing facilities (of the 26 that were selected) that changed ownership between OIG's 2018 and 2021 data snapshots. OIG noted, though, that as CMS had pointed out, complex ownership structures made it difficult to identify nursing facilities' owners.
- This data brief is for informational purposes and made no recommendations.

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Medicaid

Medicare Part C

Medicare Part D

Audit #: A-07-23-04134 (07/30/2025)
Government Program: CMS

North Carolina Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Infection Control

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to life safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In North Carolina, the State's Department of Health and Human Services (State agency) conducted surveys of ICF/IIDs for compliance with federal requirements.
- This audit was part of a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 14 deficiencies related to life safety and infection control were identified at the 3 ICF/IIDs operated by North Carolina. OIG did not identify any deficiencies related to emergency preparedness. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

OIG recommended that North Carolina:
1. verify that the three ICF/IIDs inspected had taken corrective actions on the life safety and infection control deficiencies identified during the audit,
2. work with the applicable ICF/IID to determine whether mold existed, and
3. work with CMS to develop standardized life safety training for staff at ICF/IIDs.

Audit #: A-04-24-02504 (07/23/2025)
Government Program: CMS

Pennsylvania Made More Than $8.7 Million in Unallowable Capitation Payments for Enrollees With Multiple Medicaid Identification Numbers

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 100 enrollee-matches in OIG's sample, the State agency correctly made capitation payments on behalf of individuals associated with 2 enrollee-matches; however, the State agency incorrectly made capitation

payments--totaling $1,068,308 ($559,087 Federal share)--on behalf of individuals associated with the remaining 98 enrollee-matches.
- The unallowable capitation payments occurred because the State agency's controls were insufficient to detect or prevent multiple Medicaid ID numbers from being assigned to the same enrollee.
- On the basis of OIG's sample results, OIG estimated that the State agency made unallowable capitation payments totaling at least $8,784,549 ($4,596,390 Federal share) on behalf of enrollees with multiple Medicaid ID numbers during OIG's audit period.

OIG recommended that Pennsylvania refund an estimated $4.6 million to the Federal Government. The full recommendations were in the report.

Audit #: A-04-24-07110 (07/21/2025)
Government Program: CMS

Wisconsin Made at Least $18.5 Million in Improper Fee-For-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnoses With Autism

- Early treatment for autism is important because proper care can reduce children's difficulties while helping them build on their strengths and learn new skills. Although there are other treatments, applied behavior analysis (ABA) is a commonly used therapy for managing autism symptoms.
- Wisconsin's fee-for-service (FFS) Medicaid payments for ABA in 2018 totaled $39.9 million, and by 2022, these payments had increased to $53.7 million.
- This audit examined whether Wisconsin's FFS Medicaid payments for ABA for 2021 and 2022 complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Wisconsin's payments for ABA did not fully comply with Federal and State requirements. All 100 sampled enrollee-months included payments for one or more claim lines that were improper or potentially improper.

OIG recommended that Wisconsin take the following actions:

- Refund $12.2 million to the Federal Government.
- Provide additional guidance to ABA facilities for documenting ABA.
- Periodically perform a statewide post payment review of Medicaid ABA payments to educate providers on requirements. The full recommendations were in the report.

CPT Codes Identified in This Audit:

- 97153 - Applied Behavior Analysis (ABA) treatment provided by a technician, billed in 15-minute increments
- 97155 - Services for which a licensed supervisor or treatment therapist resolves issues with, or makes changes to, the existing treatment protocol
- 97156 - Face-to-face instruction to guardians or caregivers, focusing on identifying problem behaviors and deficits
- 97151 - Clinical assessment activities used to identify target behaviors and to develop a Plan of Care

Audit #: A-06-23-01002 (07/10/2025)
Government Program: CMS

California Medicaid Fraud Control Unit: 2023 Inspection

OIG administered the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertified each MFCU, and oversaw the MFCUs' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducted periodic inspections of MFCUs and issued public reports of its findings and observations.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the California MFCU reported 180 indictments; 221 convictions; 65 civil settlements and judgments; and $544 million in recoveries during the review period of FYs 2021-2023. The MFCU maintained strong working relationships with external partners; implemented a new team approach for its investigations; and worked fraud and patient abuse or neglect cases involving a mix of provider types. However, the Unit did not always adhere to the MFCU performance standards or comply with applicable requirements.

OIG found that:

- The MFCU experienced challenges maintaining adequate staffing levels for its investigators and auditors and had begun efforts to address its recruitment and retention issues.
- The Unit's written policies and procedures manual contained inconsistent policies during OIG's review period.
- Despite the Unit's efforts to increase fraud referrals from the State Medicaid agency's program integrity unit and managed care organizations, it received few fraud referrals from such sources during OIG's review period.
- The Unit took steps to maintain a continuous case flow but encountered issues with the State Medicaid data that limited its ability to investigate and identify allegations of provider fraud.
- The MFCU did not consistently report convictions and adverse actions to its Federal partners within the appropriate timeframes but had improved since the last OIG inspection.
- The MFCU claimed more than $37,000 in unsupported costs and $1.3 million in unapproved costs; made excess purchases; maintained an outdated and inaccurate inventory; and improperly claimed some of its indirect costs.

To address the findings, OIG recommended that the MFCU (1) build upon its efforts to recruit and retain qualified staff; (2) develop a process to ensure that its policies and procedures manual was current; (3) build upon its efforts to increase fraud referrals from the Department of Health Care Services' program integrity unit and the managed care organizations; (4) work to improve the Unit's access to quality Medicaid claims data; (5) report all convictions and adverse actions to Federal partners within the appropriate timeframes; (6) refund the Federal grant for the unsupported costs, excess purchases, and improperly claimed indirect costs; and (7) strengthen its fiscal controls.

Evaluation #: OEI-06-23-00450 (05/28/2025)
Government Program: MFCU

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Medicaid

Medicare Part C

Medicare Part D

Maryland Did Not Comply With Federal Waiver and State Requirements at 20 Adult Day Care Facilities Audited

- OIG had conducted health and safety audits of adult day care and foster care homes in various States. Those audits identified multiple health and safety issues that put children and adults at risk.
- This audit examined whether adults participating in Maryland's Home and Community-Based Services waiver program were at risk.
- This audit determined whether Maryland complied with Federal waiver and State requirements in overseeing adult day care facilities that served adults who received services through the program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Maryland did not fully comply with Federal waiver and State requirements in overseeing providers that served adults receiving adult day care services through the program. Of the 20 facilities OIG visited:

- 18 did not comply with 1 or more health and safety requirements, and
- all 20 failed to meet 1 or more administrative requirements.

In total, OIG found 253 instances of noncompliance with these requirements. Maryland did not detect instances of noncompliance because Maryland's inspections of facilities were insufficient to ensure a continuously safe and nonhazardous environment.

OIG recommended that the State agency ensure that providers corrected 253 instances of provider noncompliance identified in this report; improve its oversight and monitoring of providers; and collaborate with providers to enhance their facilities, staffing, and training. The full recommendations were in the report.

Audit #: A-03-24-00201 (05/15/2025)
Government Program: CMS

CMS Is Not Systematically Tracking Whether States Return Federal Shares of Medicaid Managed Care Remittances

- States could require Medicaid managed care plans (plans) to spend at least a certain percentage of their payments on enrollees' health care--known as a minimum medical loss ratio (MLR). States could also require plans to refund money when plans failed to meet this minimum MLR--called an MLR remittance.
- When a State received an MLR remittance from a plan, the State had to return some of it to the Federal government. This Federal share was based on the rate at which the Federal government matched the State's payment for Medicaid services. These amounts owed to CMS could total hundreds of millions of dollars.
- However, OIG identified concerns that CMS could not readily determine whether and when States returned the Federal share of MLR remittances to CMS, so OIG looked further into CMS's processes for this.

Payer

Medicaid

Medicare Part C

Medicare Part D

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that CMS could not readily or systematically track whether States returned to CMS the required Federal shares of MLR remittances. To respond to OIG's request for MLR remittance information, CMS needed to reach out to States to determine whether they had returned hundreds of millions of dollars owed. Three factors contributed to these gaps in MLR oversight:

- CMS's financial reporting system did not contain dedicated data fields for MLR remittance information that CMS could use to determine whether States returned the Federal shares of MLR remittances.
- CMS staff did not routinely share information with each other about the MLR remittance amounts reported or returned.
- CMS lacked procedures to track when to expect the Federal share from each State that owed an MLR remittance--which hindered oversight of timely returns.

OIG recommended that:
1. OIG obtain the Federal shares of MLR remittances from States that failed to return these amounts.
2. OIG develop the capacity to systematically track and readily determine the amounts of the Federal shares of MLR remittances that States returned to CMS.
3. OIG improve internal communication to confirm that States returned the Federal shares of the MLR remittance amounts reported annually to CMS.
4. OIG routinely confirm that States returned the Federal shares of State-reported MLR remittance amounts.
5. OIG develop procedures to track (a) when each State was expected to return the required Federal shares of MLR remittances owed and (b) whether States had returned the Federal shares timely.

Evaluation #: OEI-03-23-00041 (05/13/2025)
Government Program: CMS

Ohio Did Not Comply With Federal Waiver and State Requirements at 18 of 19 Adult Day Care Facilities Audited

- Under the Ohio Home and Community-Based Services Waiver program (the program), Ohio funded Adult Day Services (ADS) which were regularly scheduled services provided at an adult day center in a non-institutional, community-based setting and consisted of activities authorized in an individual's person-centered services plan.
- The Office of Inspector General (OIG) had conducted health and safety reviews of adult day care and foster care homes and regulated childcare facilities. Those reviews identified multiple health and safety issues that put children and adults at risk.
- This audit determined whether Ohio complied with Federal waiver and State requirements in overseeing adult day service facilities that served adults who received services through the program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Ohio Department of Medicaid (ODM) did not fully comply with Federal waiver and State requirements in overseeing providers that served adults receiving ADS through the program because its inspections of facilities were insufficient to ensure a continuously safe and nonhazardous environment. As a result, adults were at risk in numerous instances.

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Medicare Part C

Medicare Part D

- Of the 19 providers that OIG reviewed, 18 did not comply with 1 or more health and safety requirements, and 9 did not comply with 1 or more administrative requirements.
- OIG found 117 instances of provider noncompliance with health, safety, and administrative requirements.
- Providers of ADS did not always meet the needs of program participants or maintain compliance with State requirements.

OIG recommended that ODM ensure that providers corrected the 117 instances of provider noncompliance identified in this report; improve its oversight and monitoring of all providers; and work with providers to improve their facilities, staffing, and training. The full recommendations were in the report.

Audit #: A-05-23-00006 (04/10/2025)
Government Program: CMS

Texas Did Not Fully Comply With Federal Waiver and State Health, Safety, and Administrative Requirements at All 20 Adult Day Activity Health and Service Facilities Audited

- The OIG had conducted health and safety audits of adult day care and foster care homes and regulated childcare facilities.
- Previous audits identified multiple health and safety issues that put children and people with special health care needs at risk.
- This audit examined whether the Texas Health and Human Services Commission (Texas) complied with Federal waiver and State requirements in overseeing Day Activity and Health Services (DAHS) facilities that served people with special health care needs who received services through the program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Texas did not fully comply with Federal waiver and State requirements in overseeing providers that served people with special health care needs receiving DAHS services through the program.
- Of the 20 providers that OIG audited, 19 did not comply with 1 or more health and safety requirements, and 19 did not comply with 1 or more administrative requirements.
- In total, OIG found 253 instances of provider noncompliance with health, safety, and administrative requirements at the 20 providers that OIG audited.

OIG recommended that Texas:
ensure that providers correct the 253 instances of provider noncompliance identified in this report;
improve its oversight and monitoring of providers; and
work with providers to improve their facilities, staffing, and training.

Audit #: A-06-23-05000 (03/07/2025)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

Medicare and Medicaid Payments to Providers Are at Risk of Diversion Through Electronic Funds Transfer Fraud Schemes

- OIG identified a fraud scheme in which fraudsters diverted Federal and State payments intended for providers. Specifically, individuals purporting to be hospital providers targeted the Medicare and Medicaid programs by submitting fraudulent electronic funds transfer authorization requests or other schemes to divert payments for providers to fraudsters.
- There was a potential for large losses associated with electronic funds transfer fraud, given how widely electronic funds transfer transactions were used within the health care industry. Recently, fraudsters who were able to gain unauthorized access to email accounts targeted the HHS grant Payment Management System, leading to millions of dollars in losses in 2023.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- Two-thirds of surveyed entities that processed payments for Medicare and Medicaid (i.e., payors) reported that they were aware of being targeted by electronic funds transfer fraud schemes, some of which were frequent or recurring.
- Medicare and Medicaid payors most frequently reported using verified communication channels or knowledge-based methods to confirm electronic funds transfer changes.
- Some Medicare and Medicaid payors described employing security measures that aligned with recommendations from expert groups.
- CMS took some steps to mitigate threats from electronic funds transfer fraud schemes in Medicare.
- Nearly three-fifths of surveyed Medicare and Medicaid payors expressed interest in implementing additional measures to mitigate electronic funds transfer fraud threats, but some reported challenges or barriers to implementation.

OIG recommended that CMS:
1. Engage Medicare Administrative Contractors on improving security measures.
2. Share information with State Medicaid agencies to help improve security measures.
3. Support periodic information sharing to mitigate evolving threats of electronic funds transfer fraud schemes.

Evaluation #: OEI-07-23-00180 (03/03/2025)
Government Program: CMS

North Carolina's Medicaid Control Environment, Risk Management Practices, and Governing Processes Were Assessed as Moderate Risk

- The OIG identified improving outcomes in Medicaid as a top management and performance challenge facing the Department of HHS.
- States' management of Medicaid impacted the ability of HHS to effectively manage risk.
- The OIG had previously conducted numerous audits of the North Carolina Medicaid program and reported significant findings in several areas.
- Using an enterprise risk management approach, OIG assessed North Carolina's control environment, risk management practices, and processes governing its Medicaid program.

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Medicare Part C

Medicare Part D

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that North Carolina's control environment, risk management practices, and processes governing its Medicaid program were assessed as moderate risk. North Carolina designed and implemented numerous internal controls and risk management practices to administer its Medicaid program. However, for the six risk areas OIG assessed, they rated three as moderate risk and three as high risk. For the 25 sub-risk areas OIG assessed, they rated 2 as low risk, 15 as moderate risk, 8 as high risk, and 0 as critical risk.

OIG recommended that North Carolina develop mitigating controls and strategies to lower risk within the high- and moderate-rated risk areas OIG identified. OIG also identified 22 best practices for North Carolina's consideration in taking actions to mitigate risk within high and moderate risk areas.

Audit #: A-04-21-00127 (03/03/2025)
Government Program: CMS

Colorado Made Capitation Payments to Managed Care Organizations After Enrollees' Deaths

- Colorado paid Medicaid managed care organizations (MCOs) for health care services provided to Medicaid enrollees; in return, MCOs received a monthly fixed payment for each enrollee (capitation payment).
- Previous OIG audits found that other States had improperly paid capitation payments on behalf of deceased enrollees.
- This audit of Colorado was one of a series that examined whether States made capitation payments to MCOs on behalf of deceased enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Colorado made unallowable capitation payments to MCOs on behalf of deceased enrollees, whose dates of death preceded the service periods covered by the monthly capitation payments. Specifically:

- Of the 120 capitation payments in OIG's stratified random sample, 109 payments were made on behalf of deceased enrollees whose dates of death preceded the service period covered by the monthly capitation payment.
- OIG also identified almost 39,000 unallowable capitation payments that Colorado made on behalf of deceased enrollees even though their dates of death were accurately recorded in the State's eligibility system.

  Accordingly, OIG estimated that Colorado made at least $3.8 million (Federal share) in unallowable capitation payments to MCOs on behalf of deceased enrollees. In addition, Colorado incorrectly reported other Medicaid expenditures to CMS totaling over $2.2 million (Federal share).

OIG recommended that Colorado refund an estimated $6.0 million to the Federal Government. The full recommendations were in the report.

Audit #: A-07-21-05132 (02/14/2025)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

West Virginia 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.
- Prior OIG audits found that States did not always invoice and collect all rebates due for drugs administered by physicians.
- This audit was one of a series of audits in which OIG reviewed compliance with Federal Medicaid requirements for invoicing manufacturers for rebates for physician-administered drugs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- West Virginia did not invoice for, and collect from manufacturers, rebates totaling $2.2 million (Federal share). Of this amount, $2.2 million (Federal share) was for single-source drugs and $14,514 (Federal share) was for top-20 multiple-source drugs.
- OIG also identified rebates totaling $488,185 (Federal share) for other multiple-source drugs for which OIG was unable to determine whether, in some cases, West Virginia was required to invoice for rebates.
- In addition, West Virginia did not invoice for, and collect from manufacturers, $65 million (Federal share) in rebates for physician-administered drugs invoiced on crossover claims, for which enrollees are eligible for both Medicare and Medicaid services.

OIG recommended that West Virginia take the following actions:
1. refund to the Federal Government the $2.2 million (Federal share) for single-source drugs;
2. refund to the Federal Government the $14,514 (Federal share) for top-20 multiple-source drugs;
3. work with CMS to determine and refund the unallowable portion of the $488,185 (Federal share) for other multiple-source physician-administered drugs that may have been ineligible for Federal reimbursement and consider invoicing drug manufacturers for rebates for those drugs;
4. strengthen internal controls for non-crossover claims going forward, to better use collected data to invoice manufacturers and collect rebates; and
5. consider revising West Virginia's payment methodology going forward for crossover claims. The full recommendations were in the report.

Audit #: A-07-23-06109 (02/04/2025)
Government Program: CMS

Wisconsin Medicaid Fraud Control Unit: 2024 Inspection

OIG administered the Medicaid Fraud Control Unit (MFCU or Unit) grant awards, annually recertified each Unit, and oversaw the Units' performance in accordance with the requirements of the grant. As part of this oversight, OIG conducted periodic reviews of Units and issued public reports of its findings.

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Medicare Part D

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the Unit shared supervision of its special agent positions with another division in the Wisconsin Department of Justice, but lacked a memorandum of understanding (MOU) to ensure that these positions were supervised in compliance with Federal requirements. The Unit's electronic case management system did not allow the Unit to efficiently access and maintain case information and performance data. The Unit lacked adequate policies and procedures for effectively maintaining case files. The Unit did not consistently document periodic supervisory reviews or supervisory approvals to open cases in its case files during the review period. The Unit maintained positive working relationships with Federal law enforcement partners but lacked policies for deconflicting cases with these partners. The Unit did not report four convictions and one adverse action to Federal partners during the review period, as required. The Unit's MOU with the State Medicaid agency did not reflect several legal requirements.

OIG recommended that:
1. Establishing an MOU with the Division of Criminal Investigations to ensure that special agents were supervised in accordance with Federal requirements.
2. Implementing a comprehensive case management system that allowed the Unit to efficiently access and maintain case information and performance data.
3. Establishing policies and procedures to help ensure that case files were maintained effectively.
4. Ensuring that supervisory reviews and supervisory approvals to open cases were consistently documented in accordance with Unit policy.
5. Establishing written policies for deconflicting cases with Federal partners.
6. Taking steps to report all convictions and adverse actions to Federal partners within the appropriate timeframes.
7. Revising its MOU with the State Medicaid agency to reflect applicable legal requirements.

Evaluation #: OEI-07-24-00220 (01/30/2025)
Government Program: MFCU

Florida Did Not Comply With Federal Waiver and State Requirements at 18 of 20 Adult Day Care Facilities Reviewed

- The Florida Home and Community-Based Services Waiver program (the program) funded home and community-based services for people 65 and older, or 18 or older and eligible for Florida Medicaid by reason of a disability, who required the level of care provided in a nursing home but chose to live in the community.
- Florida operated the program under a Federal waiver to its Medicaid State plan. The program funded adult day care services for Medicaid beneficiaries who resided at home and attended adult day care facilities (facilities).
- OIG conducted various health and safety reviews nationwide and wanted to determine whether adults participating in this program were at risk.
- This audit determined whether Florida complied with Federal waiver and State requirements in overseeing adult day care facilities that served adults who received services through the program.

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Medicaid

Medicare Part C

Medicare Part D

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Florida did not fully comply with Federal waiver and State requirements in overseeing providers that served adults receiving adult day care services through the program.
- Of the 20 providers OIG reviewed, 13 did not comply with 1 or more health and safety requirements, and 17 did not comply with 1 or more administrative requirements.
- OIG found 120 instances of provider noncompliance including 39 instances of noncompliance with health and safety requirements. The remaining 81 instances related to administrative requirements, some of which could significantly affect the health and safety of recipients.
- Florida 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 Florida:

1. ensure that providers correct the 120 instances of provider noncompliance identified in this report;
2. improve its oversight and monitoring of providers; and
3. work with providers to improve their facilities, staffing, and training.

Audit #: A-04-23-00135 (12/26/2024)
Government Program: CMS

Medicaid Gross Spending on 10 Selected Diabetes and 2 Selected Weight Loss Drugs Totaled More Than $9 Billion in 2023, an Increase of 540 Percent From 2019

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that there had been a substantial increase in the use of certain diabetes and weight loss drugs in recent years. Certain diabetes drugs initially approved by the Food and Drug Administration (FDA) to help control blood sugar levels for individuals with type 2 diabetes were known to be highly effective weight loss agents. Similar drugs were later approved by FDA specifically for weight loss. Most State Medicaid agencies covered the diabetes drugs to treat diabetes in Medicaid enrollees, but most States did not cover the weight loss drugs or the diabetes drugs if prescribed for weight loss.

This data brief presented information about trends in national Medicaid gross spending on and utilization of 10 selected diabetes and 2 selected weight loss drugs. For this data brief, OIG identified that Medicaid gross spending on these 12 selected drugs increased by 540 percent from 2019 to 2023, totaling $9.4 billion in 2023. During this same time period, utilization of the 12 drugs increased by 350 percent, totaling 11 million claims in 2023. OIG estimated that Medicaid gross spending on the 12 selected drugs accounted for approximately 9 percent of Medicaid spending on covered outpatient prescription drugs in 2023. OIG also estimated that Medicaid gross spending on the 12 selected drugs could potentially amount to over $29 billion in 2026.

This substantial increase could have had a financial impact on the Medicaid program. Information in this data brief might have been beneficial to the Centers for Medicare & Medicaid Services (CMS) and State Medicaid agencies when developing future program guidance related to these drugs.

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-05-24-00016 (12/16/2024)
Government Program: CMS

Twelve Selected States Did Not Accurately Calculate the Federal Share of Medicaid Collections Subject to the Increased COVID-19 Federal Medical Assistance Percentages

- Collections of Medicaid expenditures, such as overpayments recovered, refunds, and similar receipts, decreased the amount of Federal funding States received for the quarter. CMS instructed States to make refunds of the Federal share at the Federal Medical Assistance Percentage (FMAP) at which the original expenditures were reimbursed.
- In response to the COVID-19 pandemic, Congress temporarily increased States' FMAPs by 6.2 percentage points.
- In a previous audit, OIG determined that States retained the difference between the Federal share of collections calculated at the increased FMAP authorized by the American Recovery and Reinvestment Act and the Federal share calculated at the regular FMAP and recommended that CMS recoup $25 million in overpayments.
- This audit examined whether 13 selected States accurately calculated the Federal share of collections subject to the increased FMAP.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Twelve of the 13 selected States underreported the Federal share of collections by a net $61.8 million because they did not use the correct FMAP or made calculation errors.

OIG recommended that CMS improve how States calculated and reported Medicaid collections, including States correcting their reporting to return the net $61.8 million in Federal share. The full recommendations were in the report.

Audit #: A-06-23-09002 (12/16/2024)
Government Program: CMS

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Medicaid

Medicare Part C

Medicare Part D

Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism

- Early treatment for autism was important because proper care could reduce children's difficulties while helping them build on their strengths and learn new skills. Although there were other treatments, applied behavior analysis (ABA) was a commonly used therapy for managing autism symptoms.
- In the past several years, Federal and State agencies had identified questionable billing patterns by some ABA providers and payments to providers for unallowable ABA services.
- Indiana's fee-for-service (FFS) Medicaid payments for ABA in 2017 were $14.4 million, and by 2020 these payments had increased to $101.8 million--the second highest in the Nation.
- This audit examined whether Indiana's FFS Medicaid payments for ABA for 2019 and 2020 complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Indiana's payments for ABA did not fully comply with Federal and State requirements. All 100 sampled enrollee-months included payments for one or more claim lines that were improper or potentially improper.

OIG recommended that Indiana refund $39.4 million to the Federal Government, provide additional guidance to ABA facilities for documenting ABA, and periodically perform a statewide postpayment review of Medicaid ABA payments to educate providers on requirements. The full recommendations were in the report.

CPT Codes Identified in This Audit:

- 97153 - This code is generally billed by an ABA facility for an RBT's time providing one-to-one treatment typically performed with an individual child
- 97155 - This code is generally billed by an ABA facility for a BCBA's time providing one-to-one treatment that includes a protocol modification
- 97156 - Describes BCBA-provided guidance to parents to implement treatment protocols

Audit #: A-09-22-02002 (12/16/2024)
Government Program: CMS

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

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

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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

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.
- 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.

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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.

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

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Utah 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 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

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.

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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.

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.

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

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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.

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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.

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

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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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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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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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Medicaid

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.

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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Medicare Part D

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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Medicare Part D

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.

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.

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.

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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.

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

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

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

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.

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.

Payer

Medicaid

Medicare Part C

Medicare Part D

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.

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

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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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Medicaid

Medicare Part C

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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

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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

Medicare Part C

[NEW] Medicare Advantage Compliance Audit of Specific Diagnosis Codes Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS

- Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations based in part on the health status of the enrollees being covered.
- To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from its providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.
- This audit of Humana Health Benefit of Louisiana (Humana) was part of a series of audits in which OIG reviewed high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that most of the selected diagnosis codes that Humana submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

- For 218 of the 240 sampled enrollee-years, medical records did not support the diagnosis codes and resulted in $553,049 in overpayments.
- On the basis of OIG's sample results, OIG estimated that Humana received at least $10.5 million in overpayments for 2017 and 2018.

  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 be improved. Due to Federal regulations that limited the use of extrapolation for recovery purposes to 2018 and forward, OIG limited the recommended recovery to $5.5 million.

OIG recommended that Humana refund to the Federal Government the $5.5 million of estimated overpayments, identify similar instances of noncompliance that occurred after OIG's audit period and refund any resulting overpayments, and continue to examine its compliance procedures to identify areas where improvements could be made to ensure that diagnoses 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-06-21-02001 (12/08/2025)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

[NEW] Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements

- Medicare did not generally cover routine foot care (RFC) services unless the enrollee had systemic medical conditions that increased the risk of infection or injury if the services were not performed by a medical nonprofessional (e.g., a podiatrist). Medicare assumed that the enrollee or a caretaker would perform these services.
- A 2002 OIG report found that Medicare inappropriately paid podiatrists for RFC services that were medically unnecessary and insufficiently documented. Because OIG had not reviewed podiatry services since that report, OIG conducted this audit to determine whether these compliance issues continued to exist in 2019 and 2020 (audit period).
- This audit examined whether podiatrists' claims for RFC services related to a systemic condition complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 100 sampled claims, 49 podiatrists' claims for RFC services related to a systemic condition did not comply with Medicare requirements.
- During the audit period, CMS's oversight may not have been sufficient to prevent improper payments.
- On the basis of the sample results, OIG estimated that of the $18.2 million paid by Medicare for the audit period, approximately $4.4 million did not comply with Medicare requirements.

OIG recommended that CMS work with the Medicare Administrative Contractors to determine whether additional oversight was necessary to prevent payments for RFC services that did not comply with Medicare requirements, which amounted to an estimated $4.4 million for OIG's audit period.

CPT Codes Identified in This Audit:

- 11055 - Paring or cutting skin lesion (e.g., corn or callus)
- 11056 - Paring or cutting 2 to 4 skin lesions
- 11057 - Paring or cutting more than 4 skin lesions
- 11719 - Trimming of non-dystrophic nails, any number
- 11720 - Debridement of 1 to 5 nail(s) by any method(s)
- 11721 - Debridement of 6 or more nails by any method(s)

HCPCS Codes Identified in This Audit:

- G0127 - Trimming of dystrophic nails (e.g., deformed, thickened, discolored, brittle), any number

Audit #: A-09-22-03011 (12/04/2025)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required

- Under Medicare's global surgery policy, CMS bundled into a single payment those services normally furnished by a practitioner before, during, and after a procedure, such as postoperative visits.
- To determine the payment (i.e., the global surgery fee), one element CMS considered was the number of postoperative visits for a typical patient. As part of the Medicare Access and CHIP Reauthorization Act of 2015, Congress mandated that CMS gather information to assist in improving the accuracy of global surgery valuation (i.e., the fees). CMS began to collect this claim information from practitioners, and OIG audited a sample of the global surgeries. The results of that audit were reported in audit report A-05-20-00021.
- This audit looked at global surgeries without any reported postoperative visits, that were not covered by the congressionally mandated audit. It assessed whether the medical record indicated there were postoperative visits and whether the global surgery fee valuation was accurate.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that although practitioners were not required to provide Medicare patients the number of postoperative visits that CMS considered in valuing the global surgery fee, fewer visits were provided than were considered in the valuation. Based on OIG's sample results, it was estimated that Medicare paid $7.8 million more and that Medicare patients paid $4.8 million more than would have been paid if global surgery fees reflected actual utilization of postoperative visits.

Postoperative visit data gathered by CMS for 9 of 105 sampled global surgeries were inaccurate and could not assist in improving global surgery valuation as Congress intended. For 98 of 105 sampled global surgeries, OIG identified that the fees did not reflect the number of postoperative visits provided. Based on these results, improving global surgery valuation was still needed.

OIG recommended that CMS confirm it was receiving Medicare postoperative visit data from practitioners that it expected would be reporting postoperative visits and notify any practitioners if no postoperative visits were reported.

CPT Codes Identified in This Audit:

- 99024 - Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was provided during a postoperative period
- 43644 - Gastric bypass surgery, which includes a total of seven E/M visits considered in valuing its fee
- 99212 - Office visit
- 99213 - Office visit
- 99214 - Office visit
- 99231 - Hospital care
- 99232 - Hospital care
- 99238 - Hospital discharge

Audit #: A-05-20-00027 (08/26/2025)
Government Program: CMS

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Billing for Remote Patient Monitoring in Medicare

- Remote patient monitoring was a technology-based health care service designed to allow for better management of health conditions, especially chronic conditions.
- Remote patient monitoring allowed a patient to collect their own health data (e.g., their blood pressure or weight) using a connected medical device that automatically transmitted these data to their provider. The provider then used these data to treat or manage the patient's condition.
- OIG previously found that the use of these services in Medicare had the potential to greatly expand in the future and that additional oversight of remote patient monitoring was needed.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- The use of remote patient monitoring continued to grow in 2024, with Medicare payments exceeding $500 million.
- Monitoring billing could help safeguard the Medicare program and prevent fraud, waste, and abuse.
- OIG developed several measures to monitor billing for remote patient monitoring including:
  1. billing for a high proportion of enrollees who had no prior history with the medical practice; and
  2. billing for multiple monitoring devices a month for an enrollee.
- These measures could identify medical practices with billing for remote patient monitoring that warranted further scrutiny.
- Analyzing billing could help CMS, Medicare Advantage Organizations, and other entities ensure that enrollees received the benefit of remote patient monitoring while, at the same time, minimizing program integrity risks.

CPT Codes Identified in This Evaluation:

- 99091 - Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable), requiring a minimum of 30 minutes of time, each 30 days
- 99453 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- 99454 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- 99457 - Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
- 99458 - Each additional 20 minutes of remote physiologic monitoring treatment management services.

Evaluation #: OEI-02-23-00261 (08/25/2025)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health and Life Insurance Company (Contract H1608) 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.
- This audit examined whether Coventry Health and Life Insurance Company's submission of selected diagnosis codes to CMS, for use in CMS's risk adjustment program, complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for the 10 high-risk groups covered by OIG's audit, most of Coventry's submissions of the selected diagnosis codes to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

- For 249 of 300 sampled enrollee-years, the diagnosis codes that Coventry submitted to CMS were not supported by medical records and resulted in $752,587 in net overpayments. On the basis of OIG's sample results, OIG estimated that Coventry received at least $6.9 million in net overpayments for 2018 and 2019.
- As demonstrated by the errors OIG identified, Coventry'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 Coventry refund to the Federal Government the $6.9 million of estimated net overpayments, identify similar instances of noncompliance after OIG's audit period and refund any resulting overpayments to the Federal Government, and continue to examine its existing compliance procedures to identify areas for improving compliance with Federal requirements. The full recommendations are in the report.

Audit #: A-02-22-01020 (06/03/2025)
Government Program: CMS

Medicare Paid Claims That Were Not in Accordance With the Over-the- Counter COVID-19 Test Kits Demonstration Quantity Limitation

- CMS launched the Over-the-Counter COVID-19 Test Demonstration (the Demonstration) to cover and pay for up to eight over-the-counter (OTC) COVID-19 tests per calendar month for Medicare enrollees (monthly quantity limit). The Demonstration period ran from April 4, 2022, through May 11, 2023. Medicare no longer covered or paid for OTC COVID-19 tests.

- Media outlets reported that some Medicare enrollees complained of having received Medicare-covered OTC COVID-19 tests that they did not order, need, or want--a signal that individuals may have been using enrollees' Medicare information to improperly bill the Federal Government. OIG performed an initial analysis of Medicare claims data and determined that some enrollees received more OTC COVID-19 tests than the quantity limit allowed under the Demonstration.
- This audit assessed whether Medicare paid claims for OTC COVID-19 tests in accordance with the Demonstration quantity limit.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare may have paid up to $454 million in potentially improper payments to providers for 38.7 million OTC COVID-19 tests furnished to nearly 3.2 million enrollees that exceeded the monthly quantity limit. These potentially improper payments primarily occurred because CMS did not implement nationwide system edits to prevent multiple Medicare Administrative Contractors from paying providers for claims for OTC COVID-19 tests that exceeded the quantity limit. As such, this systemic vulnerability allowed providers to improperly bill Medicare for excessive OTC COVID-19 tests. In addition, OIG identified 95,955 Medicare enrollees (less than 1 percent of all enrollees) who collectively received 4.4 million OTC COVID-19 tests more than the 112-quantity limit for the duration of the Demonstration period.

OIG recommended that, for items or services for which the Medicare program established a quantity limit, CMS use the results of this audit to research and determine the best method(s) (e.g., nationwide system edits) to detect and prevent improper payments to providers.

HCPCS Codes Identified in This Audit:

- K1034 - Used for billing Medicare for a single over-the-counter (OTC) COVID-19 test

Audit #: A-06-23-06000 (02/19/2025)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UCare Minnesota (Contract H2459) Submitted to CMS

- Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations based in part on the health status of the enrollees being covered.
- To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from its providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.
- This audit of UCare Minnesota (UCare) was part of a series of audits in which OIG reviewed high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that most of the selected diagnosis codes that UCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.

- For 254 of the 294 sampled enrollee-years, the medical records that UCare provided did not support the diagnosis codes and resulted in $869,498 in net overpayments.
- On the basis of OIG's sample results, it was estimated that UCare received at least $4.7 million in net overpayments for 2018 and 2019.

  As demonstrated by the errors found in OIG's sample, UCare'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 UCare:
1. refund to the Federal Government the $4.7 million of estimated net overpayments;
2. identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; and
3. continue its examination of its existing compliance procedures to identify areas where improvements could be made to ensure that diagnoses 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-07-22-01209 (12/23/2024)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes Blue Care Network of Michigan (Contract H5883) Submitted to CMS

- Under the Medicare Advantage (MA) program, CMS made monthly payments to MA organizations based in part on the health status of the enrollees being covered.
- To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from its providers and submit these codes to CMS. Some diagnoses were at higher risk for being miscoded, which might have resulted in overpayments from CMS.
- This audit was part of a series of audits in which OIG reviewed high-risk diagnosis codes that MA organizations submitted to CMS for use in its risk adjustment program.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Blue Care Network of Michigan (BCN) did not submit most of the selected high-risk diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements.

- For 192 of the 210 sampled enrollee-years, either the medical records that BCN provided did not support the diagnosis codes, or BCN could not locate the medical records to support the diagnosis codes, which resulted in $542,164 in overpayments.
- On the basis of OIG's sample results, OIG estimated that BCN received at least $6.4 million in overpayments for 2017 and 2018.

As demonstrated by the errors found in OIG's sample, BCN's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. Due to Federal regulations that limited the use of extrapolation for recovery purposes to 2018 and forward, OIG limited the recommended recovery to $3.4 million.

OIG recommended that BCN:

1. refund to the Federal Government the $3.4 million of estimated overpayments;
2. identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after OIG's audit period and refund any resulting overpayments to the Federal Government; and
3. continue to examine its 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-06-20-02000 (12/20/2024)
Government Program: CMS

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Triple-S Advantage, Inc., (Contract H5774) 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.
- To determine the health status of enrollees, CMS relied on MA organizations to collect diagnosis codes from its providers and submit these codes to CMS. Some diagnoses were at a higher risk for being miscoded, which might have resulted in overpayments from CMS.
- For this audit, OIG reviewed one MA organization, Triple-S Advantage, Inc. (Triple-S), and focused on nine groups of high-risk diagnosis codes. OIG's objective was to determine whether selected diagnosis codes that Triple-S submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Most of the selected diagnosis codes that were submitted by Triple-S to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 204 of the 281 sampled enrollee-years, the diagnosis codes that Triple-S submitted to CMS were not supported by the medical records and resulted in $296,758 in overpayments.
- As demonstrated by the errors in OIG's sample, Triple-S's policies and procedures did not prevent, detect, and correct noncompliance with CMS program requirements as mandated by Federal regulations.

OIG recommended that Triple-S:
1. refund to the Federal Government the $296,758 in net overpayments;
2. identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or

after OIG's audit period and refund any resulting overpayments to the Federal Government; and
3. 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.

Audit #: A-04-21-07095 (12/19/2024)
Government Program: CMS

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.
3. 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.

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

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

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

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

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

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

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
- 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.

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

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 CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

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

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

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

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.

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

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.

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Payer

Medicaid

Medicare Part C

Medicare Part D

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

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

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

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

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Payer

Medicaid

Medicare Part C

Medicare Part D

Medicare Part D

[NEW] Essence Healthcare, Inc., Did Not Comply With Federal Requirement for Reporting Direct and Indirect Remunerations for Contract Years 2017 Through 2020

- CMS contracted with private entities called sponsors that acted as payers and insurers to provide prescription drug benefits under Medicare Part D.
- For drugs dispensed to Part D enrollees, Part D prescription drug plan sponsors could receive direct and indirect remuneration (DIR), which consisted of rebates, subsidies, or other price concessions that generally decreased the costs that a sponsor incurred for a Part D drug. The higher the DIR, the lower the cost of covered drugs.
- This report was part of a series of OIG reports examining Medicare sponsor compliance with requirements related to DIR.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Essence, a Part D sponsor, incorrectly reported to CMS amounts paid to primary care physician contractors as DIR for contract years 2017 through 2020. Essence incorrectly reported as DIR risk-share payments that were not attributable to Part D drug costs.

- For calendar years 2017 through 2020, Essence incorrectly reported as DIR incentive payments totaling [REDACTED] that were not attributable to Part D drug cost.
- Another category of risk-share payments, called guarantee payments, also included amounts that were incorrectly reported as DIR. However, OIG could not determine the amount that should not have been reported as DIR.

  By including amounts that were not attributable to drug costs in its reported DIR, Essence lowered its overall DIR, overstated its drug costs, and may have received a higher payment amount from CMS than it should have received.

OIG made three recommendations, including that Essence request that CMS reopen its 2017 through 2019 DIR reports and refile its 2020 DIR report with the correct amounts. The full recommendations were in the report.

Audit #: A-03-22-00002 (12/17/2025)
Government Program: CMS

[NEW] Trends in Dual-Eligible Enrollees' Access to Drugs Under Part D, 2011-2025

- For dual-eligible enrollees--that is, people enrolled in both Medicare and Medicaid--access to prescription drugs was particularly important. Overall, they had very low incomes and--because they were more likely to be in poorer health than other people enrolled in Medicare--tended to use more Medicare services.
- After prescription drug coverage for dual-eligible enrollees shifted from Medicaid to Medicare Part D, Congress mandated that OIG study whether Part D formularies covered prescription drugs commonly used by dual-eligible enrollees. OIG produced an annual report pursuant to this mandate for the last 15 years (from 2011 to 2025).

- In this data snapshot, OIG presented trends across their annual analyses of Part D formulary coverage of the top 200 drugs used by dual eligibles to summarize their findings for Congress and the public.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- Most Part D plan formularies had covered almost all of the drugs that dual-eligible enrollees commonly used since 2011, and **coverage had been consistently high over the last decade**.
- **The number of commonly used drugs covered by all formularies had steadily increased since 2011, and only a small number of commonly used drugs were not covered by most formularies**.

OIG concluded that, in general, over the last 15 years, dual-eligible enrollees had—and continued to have—access to the drugs they most commonly use, regardless of the Part D plan in which they enrolled.

Evaluation #: OEI-05-25-00350 (12/12/2025)
Government Program: CMS

Part D Plans Generally Include Drugs Commonly Used by Dual-Eligible Enrollees: 2025

- For dual-eligible enrollees--that is, people enrolled in both Medicare and Medicaid--access to prescription drugs was particularly important. Overall, they had very low incomes and--because they were more likely to be in poorer health than other people enrolled in Medicare--tended to use more Medicare services.
- Because Medicare prescription drug coverage was an important tool for ensuring access to prescription drugs, Congress mandated that OIG study whether Part D formularies covered prescription drugs commonly used by dual-eligibles enrollees.
- For this report, OIG determined whether the 378 unique formularies used by the 5,178 Part D plans operating in 2025 covered 194 of the 200 drugs most commonly used by dual-eligible enrollees. See the methodology for more information about how OIG determined the most commonly used drugs.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- A majority of 2025 Part D plan formularies covered almost all commonly used drugs, and only a small number of commonly used drugs were not covered by most formularies. This was consistent with OIG's annual findings since 2011.

OIG concluded that dual-eligible enrollees could expect to have had access to most drugs in 2025, regardless of the Part D plan in which they were enrolled.

Evaluation #: OEI-05-25-00120 (06/18/2025)
Government Program: CMS

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Payer

Medicaid

Medicare Part C

Medicare Part D

Most Medicare Part D Plans' Formularies Included Humira Biosimilars for 2025

- Humira, a biologic drug used to treat autoimmune conditions such as rheumatoid arthritis, was one of the best-selling prescription drugs in the world. In the United States, it had an annual list price of approximately $90,000. In 2022, it cost the Part D program and enrollees $5.4 billion before accounting for rebates and other price concessions.
- The launch of Humira biosimilars (which were highly similar to Humira, with no clinically meaningful differences) had been anticipated as an opportunity to lower biologic drug costs through competition. However, if Part D plans' formularies restricted access to Humira biosimilars, competitive pressure--and its potential effects on lowering drug costs--might have been limited.
- Previous OIG work found that many Part D formularies did not cover biosimilars available for other expensive biologic drugs. OIG also found that this lack of formulary coverage could limit wider biosimilar use and any potential savings for Medicare Part D.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Part D plans' formulary coverage of Humira biosimilars increased substantially between 2024 and 2025. Nearly all Part D Prescription Drug Plans (PDPs) (96 percent), and 88 percent of Medicare Advantage Prescription Drug (MAPD) plans, covered at least 1 of the 10 available Humira biosimilars on their 2025 formulary--including some plans that covered Humira biosimilars only and not Humira. This represented substantial growth in formulary coverage from 2024, when only 65 percent of PDPs and 52 percent of MAPD plans covered at least one of Humira's biosimilars. However, 1 percent of PDP enrollees and 10 percent of MAPD enrollees were in plans that covered Humira only in 2025, which in effect prevented these enrollees' use of Humira biosimilars.

Almost none of the formularies that covered Humira and its biosimilars used preferential tier placement to encourage biosimilar use. Ninety-nine percent of these formularies placed Humira and its biosimilars on the same cost sharing tier. Likewise, these formularies either applied or did not apply utilization management requirements (i.e., prior authorization or step therapy) to both Humira and covered biosimilars. This meant that the formularies did not use such tools to encourage the use of biosimilars, nor to discourage their use.

OIG concluded that most--but not all--Part D plans covered Humira biosimilars in 2025. This increase in coverage was a positive trend, as both the Medicare Payment Advisory Commission and the Federal Trade Commission had raised concerns about the anticompetitive effects of limited biosimilar formulary coverage. OIG previously recommended that CMS monitor biosimilar coverage on formularies to identify any concerning trends, such as exclusion of biosimilars from formularies or preferential treatment for reference products like Humira. OIG encouraged CMS to continue this formulary monitoring.

Evaluation #: OEI-05-23-00520 (05/02/2025)
Government Program: CMS

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Medicare Part C

Medicare Part D

Medicare Part D Spending for 10 Selected Diabetes Drugs Totaled $35.8 Billion in 2023, an Increase of 364 Percent From 2019

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that there has been a substantial increase in the use of certain diabetes drugs in recent years. Certain diabetes drugs initially approved by the Food and Drug Administration (FDA) to help control blood sugar levels for individuals with type 2 diabetes were known to be effective weight loss agents. Medicare Part D covered diabetes drugs for FDA-approved indications, such as type 2 diabetes, but it did not cover drugs prescribed for weight loss.

This data brief presented information about trends in national Medicare spending on and utilization of 10 selected diabetes drugs. For this data brief, OIG identified that Medicare Part D spending on these 10 selected diabetes drugs increased by 364 percent, from $7.7 billion in 2019 to $35.8 billion in 2023. During the same time, there was an increase in prescriptions and prescribers who worked in a broad range of specialties. Meanwhile, the number of Medicare Part D enrollees increased 12 percent, from 44.9 million to 50.5 million. OIG estimated that Medicare spending for the 10 selected diabetes drugs could reach $102 billion by 2026.

This substantial increase could have had a financial impact on the Medicare program. Information in this data brief might have been beneficial to the Centers for Medicare & Medicaid Services (CMS) and other policymakers when developing future program guidance related to these drugs.

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-05-24-00015 (02/21/2025)
Government Program: CMS

Providers Used Medicare Part D Eligibility Verification Transactions for Permissible Purposes

- Providers had to use Part D eligibility verification transactions (E1 transactions) for the purposes of billing for a prescription or determining drug coverage billing order.
- An OIG audit of E1 transactions processed during calendar years 2013 through 2015 found that selected providers used E1 transactions for potentially impermissible purposes. In response to the prior audit, CMS officials implemented controls to monitor and help ensure the permissible use of E1 transactions.
- This audit of E1 transactions processed during calendar year 2019 determined whether providers used E1 transactions for the permissible purposes of billing for a prescription or determining drug coverage billing order.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that providers used E1 transactions for the permissible purposes of billing for a claim or determining drug coverage billing order during OIG's calendar year 2019 audit period. Of the more than 18.8 million E1 transactions covered by OIG's audit, almost 13.5 million matched a prescription drug event (PDE) record. This match gave OIG reasonable assurance that the providers submitted the transactions for the permissible purpose of obtaining drug

coverage information. For the remaining 5.3 million E1 transactions that providers submitted during OIG's audit period but that did not directly match PDE records, OIG reviewed a statistical sample of 543 E1 transactions submitted by 24 randomly selected providers and determined that providers submitted the transactions for permissible purposes.

OIG concluded that based on the results of this audit and the effectiveness of steps CMS and the Facilitator took during and after OIG's prior audit of E1 transactions to improve provider compliance, any impermissible use of E1 transactions was not widespread. As a result, this audit report did not include any recommendations.

Audit #: A-05-22-00022 (12/19/2024)
Government Program: CMS

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.

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Medicare Part C

Medicare Part D

Audit #: A-09-21-03008 (10/18/2024)
Government Program: CMS

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

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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

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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.

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Medicare Part C

Medicare Part D

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

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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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Medicare Part C

Medicare Part D

Audit #: A-09-20-03033 (02/28/2023)
Government Program: CMS