Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Payer Focus

Active Work Plan Items

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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 organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The OIG Work Plan sets forth various projects, including OIG audits and evaluations, that are underway or planned to be addressed during the fiscal year and beyond. The Work Plan item summaries provided herein are referenced by their respective Work Plan numbers at the end of each abstract. SunHawk's report summarizes currently active Work Plan items and sorts relevant Work Plans items into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original Work Plan item summaries.

After your review, we would appreciate any feedback that would make this report more valuable to you or others. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to 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 Payments to Terminated Providers

Announced: May 2026
Estimated Completion: FY2028

Federal law requires States to terminate fraudulent or abusive providers from their Medicaid programs, including providers that have been terminated by Medicare, another State's Medicaid program, or any Children's Health Insurance Program. To identify providers that have been terminated by other programs, CMS requires States to review the data in its Data Exchange (DEX) system. This study will determine the extent to which providers listed in the DEX as revoked by Medicare or terminated by State Medicaid agencies were associated with Medicaid claims and encounters, as well as the amount of money paid for those claims and encounters.

Project Number: OEI-05-26-00230
HHS Agencies: Centers for Medicare and Medicaid Services

[NEW] Data Brief: Selected States' Medicaid Coverage of Emergency Services for Nonqualified Aliens

Announced: March 2026
Estimated Completion: FY2028

Individuals meet Medicaid eligibility criteria by satisfying certain Federal and State requirements related to income, residency, citizenship, immigration status, and documentation of citizenship. Federal Medicaid benefits are generally limited to individuals who are citizens or nationals of the United States or qualified aliens, such as lawfully permitted permanent residents, asylees, or refugees.

Many qualified noncitizens are not eligible for full Medicaid benefits until 5 years from the date they enter the United States with qualified alien status. Nonqualified aliens and qualified aliens who are subject to but have not yet met the 5-year waiting period are restricted from receiving full-scope Federal Medicaid benefits and are eligible only for emergency Medicaid services. However, States may elect to provide Medicaid coverage for nonqualified aliens using State-only funds. OIG will describe which types of services were covered as Medicaid emergency medical services for nonqualified aliens in selected States and claimed for Federal reimbursement.

Project Number: OAS-26-01-061
HHS Agencies: Centers for Medicare and Medicaid Services

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[NEW] Series: Audit of Federal Reimbursement Made to States for Certain Medicaid Services and Exclusion of Services That Should Have Been Fully Funded by States

Announced: March 2026
Estimated Completion: FY2028

Active Projects: OAS-25-09-147

To qualify for Medicaid, individuals must meet eligibility criteria that include certain Federal and State requirements for income, residency, and citizenship or immigration status. Many States offer health care programs that cover certain services similar to Medicaid (e.g., family planning services) but are funded entirely with State funds to serve individuals who do not meet Medicaid requirements. OIG refers to these programs as State-only programs. OIG's objectives will be to determine whether State Medicaid agencies: (1) complied with Federal and State requirements for claiming certain Medicaid expenditures, and (2) properly excluded State-only program expenditures when claiming Federal reimbursement.

Series Number: SRS-A-26-024
HHS Agencies: Centers for Medicare and Medicaid Services

[NEW] Select States' Use of Health Care-Related Taxes as the State Share of Medicaid Expenditures

Announced: February 2026
Estimated Completion: FY2028

States increasingly use health care-related taxes instead of State general funds to finance their share of Medicaid expenditures. Health care-related taxes allow States to grow their Medicaid programs without increasing their general fund contribution. Federal Medicaid coverage is generally limited to U.S. citizens, U.S. nationals, and qualified noncitizens. Individuals without satisfactory immigration status are not eligible for full-scope Federal Medicaid benefits, but they are eligible for emergency services funded under Medicaid. States may elect to provide health care coverage beyond emergency services (i.e., additional health care coverage) for individuals who do not qualify for Medicaid, including undocumented immigrants, using State-only funds. The OIG's data brief will provide information about selected States' use of Federal Medicaid reimbursement obtained through health care-related taxes. It will also identify State-funded health care programs that provide services, in addition to emergency services under Medicaid, to individuals who do not meet Medicaid eligibility requirements.

Project Number: OAS-26-06-019
HHS Agencies: Centers for Medicare and Medicaid Services

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[NEW] Series: Audit of State Medicaid Claimed at the 100 Percent FMAP Rate

Announced: February 2026
Estimated Completion: FY2028

Active Projects: OAS-26-01-015

Approximately 1.3 million American Indians and Alaska Natives (AI/ANs) are enrolled in State Medicaid programs. The Social Security Act indicates that States will receive 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid health services provided to eligible AI/ANs through an Indian Health Service (IHS) facility whether operated by IHS or by a Tribe or Tribal organization. OIG will determine whether the State agency claimed Medicaid AI/AN services that are eligible for reimbursement at the enhanced 100 percent FMAP rate in accordance with Federal and State requirements.

Series Number: SRS-A-26-022
HHS Agencies: Centers for Medicare and Medicaid Services

[NEW] Series: Audit of Medicaid Unenrolled Providers

Announced: January 2026
Estimated Completion: FY2028

Active Projects: OAS-25-07-097

To strengthen Medicaid provider enrollment, the 21st Century Cures Act (Cures Act) required that all providers that serve Medicaid beneficiaries enroll with their State Medicaid agency effective January 1, 2017, for Medicaid FFS and January 1, 2018, for Medicaid managed care organizations (MCOs). In addition, the Cures Act required that no Federal financial participation be paid for managed care expenditures when States have not complied with the requirement to enroll MCO network providers. States must also return to CMS the Federal share of overpayments associated with unenrolled fee-for-service (FFS) providers. OIG will determine whether the State agencies complied with these Federal requirements and prohibited payments associated with providers that were not enrolled in their Medicaid FFS and managed care programs.

Series Number: SRS-A-26-023
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: Medicaid Eligibility Determinations and Associated Payments Based on Enrollees' Citizenship or Immigration Status

Announced: December 2025
Estimated Completion: FY2027

Active Projects: OAS-26-02-002, OAS-26-05-049, OAS-26-09-052, OAS-26-06-053

Individuals meet Medicaid eligibility criteria by satisfying certain Federal and State requirements related to income, residency, citizenship, immigration status, and documentation of citizenship. Specifically, eligibility for Medicaid coverage related to citizenship and immigration status is limited to U.S. citizens or nationals and qualified noncitizens. States must verify individuals' eligibility information, such as citizenship and immigration status, with the Social Security Administration and the Department of Homeland Security. Any discrepancy between an individual's attested citizenship or immigration status and the information verified by the State must generally be resolved within a 90-day timeframe known as the reasonable opportunity period. OIG will determine whether selected States determined Medicaid eligibility for enrollees based on citizenship or immigration status and claimed Federal Medicaid reimbursement in accordance with Federal and State requirements.

Series Number: SRS-A-26-003
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Rebates for Physician-Administered and Pharmacy Drug Claims

Announced: October 2025
Estimated Completion: FY2027

Active Projects: OAS-26-07-009, OAS-26-07-010, OAS-26-06-059, OAS-26-06-058, OAS-26-07-067

States are generally required to collect rebates on physician-administered and pharmacy drugs in order to receive Federal matching funds for those drugs. Previous OIG work identified significant concerns with States' efforts in obtaining rebates for physician-administered drug claims. OIG will follow-up with select States to determine whether States have implemented controls to ensure ongoing compliance with Federal Medicaid drug rebate requirements.

Series Number: SRS-A-26-002
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid Managed Care Behavioral Health Screening for New Adult Enrollees

Announced: October 2025
Estimated Completion: FY2027

State Medicaid programs contract with managed care organizations (MCOs) to provide health care services to enrollees. Federal regulations require MCOs to make a best effort to conduct an initial screening of each new enrollee's needs within 90 days of the effective date of enrollment. OIG will review selected State Medicaid agencies and their MCOs' efforts to screen new adult enrollees' needs for behavioral health services.

Project Number: OAS-25-02-037
HHS Agencies: Centers for Medicare and Medicaid Services

Potential Cost Savings for the Medicaid Program if States Adopted a Minimum Medical Loss Ratio and Required Remittances From Managed Care Organizations

Announced: October 2025
Estimated Completion: FY2027

Most Medicaid enrollees receive healthcare services though managed care delivery arrangements, where States pay managed care organizations (MCOs) a monthly capitation payment for each Medicaid enrollee. Centers for Medicare & Medicaid Services reviews and approves capitation rates that are actuarially sound and developed in a way that MCOs could reasonably achieve a medical loss ratio (MLR) of at least 85 percent. The MLR is a measure of the proportion of premium revenue spent on enrollee healthcare services or quality improvement activities, compared to health plan administrative costs and profits. Federal managed care regulations give States the option to set a minimum MLR of at least 85 percent and require MCOs to submit remittances to the State if a Medicaid managed care plan fails to meet the minimum MLR. However, not all States have a minimum MLR requirement or require remittances when MCOs do not meet the State-set minimum MLR. The OIG plans to identify potential cost savings for the Medicaid program in States that do not have a minimum MLR requirement or require remittances from MCOs when the State-set minimum MLR is not met.

Project Number: OAS-25-02-077
HHS Agencies: Centers for Medicare and Medicaid Services

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Using Targeted Reviews to Reduce Fraud, Waste, and Abuse in Medicaid Nonemergency Medical Transportation

Announced: October 2025
Estimated Completion: FY2027

Medicaid covers nonemergency medical transportation for eligible enrollees, allowing them to travel to doctors' offices, hospitals, or other settings where Medicaid-approved services are provided. However, transportation services can pose a significant risk of fraud, waste, and abuse in Medicaid. Past OIG work has identified significant vulnerabilities in State and Federal efforts to reduce fraud, waste, and abuse involving nonemergency medical transportation in Medicaid. This report will use key indicators of concerning billing to conduct a targeted review of nonemergency medical transportation services. It will determine the extent to which these services did not meet Medicaid requirements and will identify the amount that could be saved by using indicators to target reviews of nonemergency medical transportation services.

Project Number: OEI-02-25-00360
HHS Agencies: Centers for Medicare and Medicaid Services

Medicaid Managed Care Early and Periodic Screening, Diagnostic, and Treatment Behavioral Health Services

Announced: July 2025
Estimated Completion: FY2027

Mental health in childhood includes reaching developmental and emotional milestones and learning healthy social skills and coping skills for when problems arise. Medicaid's mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit requires that children under age 21 who are enrolled in Medicaid receive all medically necessary services, including behavioral health services, which include services for mental and substance use disorders. Many States include coverage of behavioral health services for children and youth in their Medicaid State plans and through various Medicaid managed care waivers. OIG will determine the extent to which children enrolled in Medicaid received EPSDT medical screenings and, if diagnosed with a behavioral health condition, whether behavioral health treatment services were provided. OIG will also review whether States and managed care organizations met Federal and State requirements for providing EPSDT behavioral health services.

Project Number: OAS-24-02-009
HHS Agencies: Centers for Medicare and Medicaid Services

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MLTSS Enrollees With Capitation Payments but No Long-Term Care Services Provided

Announced: July 2025
Estimated Completion: FY2027

Managed long-term service and supports (MLTSS) programs annually serve approximately 2 million Medicaid enrollees with cognitive or functional limitations, accounting for $72.5 billion of spending in 2022. It is crucial to ensure that MLTSS enrollees receive the care they need and that plans deliver value for the taxpayer dollars they receive. Prior OIG work has found that some MLTSS plans received capitation payments for enrollees who did not receive any long-term care services. This study will determine the extent to which States made capitation payments to MLTSS plans for enrollees who were not provided any long-term care services, as well as the dollar value of such capitation payments, at a national level.

Project Number: OEI-05-25-00270
HHS Agencies: Centers for Medicare and Medicaid Services

Reducing Costs and Improving Outcomes for Medicaid Managed Care Enrollees Diagnosed with Postpartum Preeclampsia

Announced: July 2025
Estimated Completion: FY2027

Postpartum preeclampsia is the highest contributor to overall maternity costs in the United States and the leading cause of maternal morbidity and mortality. Early symptom identification and diagnosis can prevent severe complications and reduce the need for costly medical services, such as emergency room visits and lengthy hospital stays. However, research indicates that many women do not attend postpartum visits, which can delay postpartum preeclampsia diagnoses. Alternative screening tools, such as telehealth, home visits, and remote patient monitoring, can help women at risk for postpartum preeclampsia identify symptoms and seek necessary care sooner. OIG will assess the use of various screening tools to identify and diagnose postpartum preeclampsia in Medicaid managed care enrollees. These findings will inform efforts to support early identification of symptoms and diagnosis through screening to help reduce Medicaid costs and improve health outcomes for enrollees.

Project Number: OEI-04-25-00170
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: Risk Assessment Puerto Rico Medicaid Program

Announced: February 2025
Estimated Completion: FY2027

Active Projects: OAS-25-02-066, OAS-25-02-081

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

Series Number: W-00-24-31544
HHS Agencies: Centers for Medicare and Medicaid Services

Project OAS-25-06-044

Announced: January 2025
Estimated Completion: FY2027

Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. Prior OIG reviews identified significant problems with States' compliance with PCS requirements. Some reviews also showed that program safeguards intended to ensure medical necessity, patient safety, and quality, and prevent improper payments were often ineffective. OIG will determine whether improvements have been made to the oversight and monitoring of PCS and whether those improvements have reduced the number of PCS claims not in compliance with Federal and State requirements.

Project Number: OAS-25-06-044
HHS Agencies: Centers for Medicare and Medicaid Services

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Status of State Medicaid Provider Enrollment and Screening Activities

Announced: December 2024
Estimated Completion: FY2026

Provider enrollment screening is a key program integrity tool for protecting Medicaid against fraudulent and abusive providers. Federal law requires State Medicaid agencies to screen providers as part of the Medicaid enrollment process. For high-risk provider types, including durable medical equipment, prosthetics, and orthotics suppliers and home health agencies, required screening activities include site visits and fingerprint-based criminal background checks. Prior OIG work has identified issues with States' implementation of provider enrollment and screening requirements for both fee-for-service Medicaid and Medicaid managed care. During the COVID-19 public health emergency, CMS suspended certain screening requirements, which may have exacerbated the issues previously identified and presented new challenges. This study will determine the status of States' required Medicaid provider enrollment and screening and will assess States' standards and processes for screening.

Project Number: OEI-05-24-00400
HHS Agencies: Centers for Medicare and Medicaid Services

Access to Hepatitis C Treatment in Medicaid

Announced: November 2024
Estimated Completion: FY2026

Hepatitis C is a liver disease caused by the highly infectious hepatitis C virus. If untreated, hepatitis C can result in serious liver disease. In the past decade, direct-acting antiviral drugs that can cure hepatitis C within 12 weeks have revolutionized treatment. Despite their improved tolerability over previous treatments and recommended use by prominent medical associations, these hepatitis C drugs are underutilized, and the virus continues to spread. In recent years, Federal and State policymakers have attempted to improve access to hepatitis C treatment while simultaneously addressing its high cost. In Medicaid—which serves a high proportion of people with hepatitis C—some States have arranged alternative payment structures for hepatitis C drugs and removed related coverage restrictions. This study will examine the extent to which Medicaid enrollees diagnosed with chronic hepatitis C receive drug treatment in Medicaid and identify potential disparities in treatment rates.

Project Number: OEI-BL-24-00450
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid Managed Care Organizations in States With Remittance Requirements

Announced: September 2024
Estimated Completion: FY2026

CMS established medical loss ratios (MLRs) in Medicaid managed care as a tool to ensure that managed care plans spend most of their revenue on services related to the health of their enrollees, thereby limiting the amount that plans can spend on administration and keep as profit. As part of the capitation rate setting process, Federal regulations require States to set their plans' capitation rates so that plans will reasonably achieve MLRs of at least 85 percent. Further, States also have the option to require their managed care plans to pay remittances if the plan fails to meet the minimum MLR set by the State. OIG will review States and managed care plans with contract provisions that require remittances from managed care plans if a minimum MLR is not met. OIG will determine whether the remittances the MCOs reported to States were correctly calculated and whether the Federal share of remittances that States received was returned to the Federal Government.

Project Number: OAS-25-07-143
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Medicaid Managed Care Capitation Payments on Behalf of Incarcerated Enrollees

Announced: July 2024
Estimated Completion: FY2026

Active Projects: OAS-25-04-100, OAS-25-04-117, OAS-25-05-119, OAS-25-07-139, OAS-25-02-074, OAS-26-05-013, OAS-26-03-043
Projects Completed: A-05-24-00019

States contract with Medicaid managed care organizations to provide specific services to Medicaid enrollees, usually in return for a predetermined periodic payment known as a capitation payment. Section 1905 of Title XIX of the Social Security Act, 42 CFR § 435.1009, and guidance from CMS state that Federal financial participation is generally not available for services provided to adult inmates of public institutions except when the individual is not in a prison setting and becomes an inpatient in a medical institution. The OIG will determine whether select States made unallowable capitation payments to Medicaid managed care organizations on behalf of individuals incarcerated in State prisons.

Series Number: SRS-A-25-024
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: State Directed Payments in Medicaid Managed Care

Announced: July 2024
Estimated Completion: FY2026

Active Projects: A-04-24-00139, OAS-25-04-002, OAS-26-02-076

As the HHS agency overseeing Medicaid, CMS issued regulations establishing certain circumstances under which States may direct managed-care payments to providers. These payments are referred to as State directed payments. While working within Federal parameters, States determine criteria for providers to receive these directed payments. For selected State directed payments in Medicaid managed care, OIG's objective is to determine whether the State: (1) obtained CMS approval for the directed payment proposal, (2) complied with CMS-approved requirements and outcomes in the approved proposal, and (3) ensured that directed payments were made according to the approved proposal.

Series Number: SRS-A-24-001
HHS Agencies: Centers for Medicare and Medicaid Services

Use of Electronic Visit Verification Data for Medicaid Personal Care Services

Announced: June 2024
Estimated Completion: FY2026

Section 12006 of the 21st Century Cures Act (Cures Act) requires that States implement and use an Electronic Visit Verification (EVV) system to verify the delivery of Medicaid personal care services. EVV requirements were included in the Cures Act in response to longstanding fraud, waste, and abuse concerns associated with Medicaid personal care services. This evaluation will assess the availability and completeness of EVV data and examine how State Medicaid agencies and others use these data for program integrity purposes.

Project Number: OEI-09-24-00290
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Audits of Medicaid Select Diabetes and Weight Loss Drugs

Announced: March 2024
Estimated Completion: FY2026

Active Projects: WA-24-0036
Projects Completed: OAS-25-05-067, A-05-24-00016

Medicaid utilization of and gross spending on select diabetes and weight loss drugs have rapidly increased in recent years. The select diabetes drugs were approved to help control blood sugar levels for individuals with type 2 diabetes; however, these drugs are known to be used for weight loss. Most States cover these drugs to treat Medicaid enrollees with diabetes. Additionally, some States cover similar types of drugs that were approved for weight loss. OIG will identify national Medicaid utilization for select diabetes and weight loss drugs and select one or more States to review.

Series Number: SRS-A-26-013
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: Medicaid Managed Care Organizations' Denials

Announced: February 2024
Estimated Completion: FY2026

Active Projects: A-03-24-00204, A-09-24-02007, OAS-25-07-039
Projects Completed: A-06-24-02000

The State Medicaid agency and the Federal Government are responsible for the financial risk for the costs of Medicaid services. State Medicaid agencies contract with managed care organizations (MCOs) to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts the financial risk from the State Medicaid agency and the Federal Government to MCOs, which can create an incentive for MCOs to deny beneficiaries' access to covered services. OIG audits will determine whether Medicaid MCOs complied with Federal requirements when denying access to requested medical and dental services, behavioral health services, and associated drug prescriptions that required prior authorization.

Series Number: W-00-24-31535
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Evaluating the Accuracy of Medicaid Managed Care Provider Directories for Maternal Health Care Providers

Announced: January 2024
Estimated Completion: FY2026

Active Projects: OEI-05-24-00090, OEI-05-24-00091

Pregnant women in the United States experience worse pregnancy outcomes than women in any other high-income country. Maternal health care can improve pregnancy outcomes; however, many pregnant women in the United States lack access to maternal health care. Medicaid is the Nation's largest maternal health care payor, financing more than 40 percent of all U.S. births, and many pregnant women enrolled in Medicaid are enrolled in managed care plans. This study will review Medicaid managed care provider directories to evaluate the accuracy of information listed for maternal health care providers.

Series Number: SRS-E-26-005
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: Audits of Medicaid's Hospice Inpatient and Aggregate Cap Calculations

Announced: December 2023
Estimated Completion: FY2026

Active Projects: OAS-25-06-098, OAS-26-04-032
Projects Completed: A-06-24-09001

Under Medicare, CMS requires two annual limits to ensure that hospice care does not exceed the cost of conventional medical care at the end of life: the inpatient cap and the aggregate cap. Under Medicaid, however, CMS only requires States to calculate the hospice inpatient cap, and calculating the aggregate cap is optional for each State. If a State applies the hospice caps, any amount paid to a hospice for its claims in excess of each cap is considered an overpayment and must be repaid to Medicaid. OIG will audit selected States to determine whether the hospice caps were calculated correctly, whether cap overpayments were collected, and whether the Federal share of the collected cap overpayments was properly refunded.

Series Number: SRS-A-26-005
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Medicaid—Audit of Health and Safety Standards at Individual Supported Living Facilities

Announced: November 2023
Estimated Completion: FY2026

Active Projects: A-07-24-04137, OAS-25-01-072
Projects Completed: A-05-24-00013

State agencies operate home and community-based services programs under a 1915(c) waiver to their respective Medicaid State plans. Some of these waivers allow for providing services to individuals with developmental disabilities. Such waivers include individualized supported living habilitation services, which provide assistance and necessary support to achieve personal outcomes that enhance individuals' ability to live in and participate in their communities. To receive approval for a waiver, State agencies must ensure the health and welfare of the beneficiaries of the service. Recent media coverage throughout the United States of deaths of people with developmental disabilities involving abuse, neglect, or medical errors has led to OIG audits in several States. OIG's objective is to determine whether State agencies and providers complied with Federal and State health and safety requirements involving Medicaid beneficiaries with developmental disabilities residing in individualized supported living settings, including infection control for conditions such as coronavirus disease 2019 (COVID-19) and other infectious diseases.

Series Number: SRS-A-25-025
HHS Agencies: Centers for Medicare and Medicaid Services

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CMS Oversight of States' Preparation of the CMS-64 Report

Announced: June 2023
Estimated Completion: FY2026

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

Project Number: A-06-23-09006
HHS Agencies: Centers for Medicare and Medicaid Services

State Medicaid Agencies' Perspectives of Managed Care Plans' Referral of Fraud

Announced: June 2023
Estimated Completion: FY2026

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

Project Number: OEI-03-23-00340
HHS Agencies: Centers for Medicare and Medicaid Services

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Series: Audits of Medicaid Collections During COVID-19 Federal Medical Assistance Percentage Increase

Announced: January 2023
Estimated Completion: FY2026

Active Projects: OAS-25-04-114
Projects Completed: A-06-23-09002

The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage (FMAP), which varies depending on a State's relative per capita income. In response to the pandemic, the Families First Coronavirus Response Act provided a temporary 6.2-percentage-point increase to each qualifying State's and Territory's FMAP effective January 1, 2020. States must refund the Federal share of overpayments and other collections, which decreases the amount of Federal funding States receive for a quarter. CMS instructs States to make refunds of the Federal share at the FMAP at which the original expenditures were reimbursed. OIG will audit selected States to determine whether those States used the correct FMAP when making refunds of the Federal share.

Series Number: W-00-24-31569
HHS Agencies: Centers for Medicare and Medicaid Services

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

Announced: December 2022
Estimated Completion: FY2026

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

Project Number: OEI-03-23-00040
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Joint Work With State Agencies

Announced: December 2022
Estimated Completion: FY2026

Active Projects: OAS-24-01-003, OAS-25-05-030, OAS-25-01-110, OAS-25-04-111, OAS-25-09-151, OAS-26-04-090
Projects Completed: A-07-23-05136, A-09-23-02005, A-01-23-00004, A-09-23-02009, A-09-23-02004, A-01-23-00001

To strengthen program integrity and efficiently use audit resources, OIG will enhance its efforts to provide broader oversight of the Medicaid program by partnering with State auditors, State comptrollers general, and State inspectors general. Federal-State partnerships will provide effective methods that address improper payments in fee-for-service programs such as home health, hospice, and durable medical equipment, and in managed care. OIG will partner with States to: (1) address known vulnerabilities that it has identified in both Medicare and Medicaid to curb such vulnerabilities in Medicaid nationwide; and (2) identify new areas that put the integrity of the Medicaid program at risk.

Series Number: W-00-24-40002
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Electronic Visit Verification System for Medicaid In-Home Services

Announced: October 2022
Estimated Completion: FY2026

Active Projects: A-06-24-05005, OAS-24-02-011, A-07-24-03260, OAS-26-01-060, OAS-26-07-065
Projects Completed: A-07-23-03255

All States were required to implement an electronic visit verification (EVV) system for personal care services (PCS) by January 1, 2020, and for home health services by January 1, 2023. CMS granted the vast majority of States a 1-year extension (to January 1, 2021) for meeting EVV requirements for PCS. EVV was developed to address weaknesses in PCS that contribute to improper payments, questionable quality of care, and significant fraud. OIG's objectives will be to determine whether selected States: (1) implemented an EVV system according to Federal and State requirements, and (2) complied with Federal and State requirements when claiming Medicaid in home PCS.

Series Number: W-00-24-31564
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: States' and MCOs' Compliance With Mental Health Parity Requirements

Announced: June 2022
Estimated Completion: FY2026

Active Projects: A-07-24-02842, A-02-24-01011, A-04-24-07115, OAS-24-09-002
Projects Completed: A-02-22-01016

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) promotes equal access to treatment for mental health and substance use disorder (MH/SUD) by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than medical or surgical benefits. Such limitations could include higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews, as compared to other covered medical treatments. Federal regulations require managed care organizations (MCOs) with plans that provide services to Medicaid enrollees to comply with the parity provisions of MHPAEA. Federal regulations require that States or their MCOs, as applicable, conduct analyses to demonstrate compliance with parity requirements. CMS reviews States' parity analyses as part of its review of States' MCO contracts. The OIG will audit CMS's oversight of States' compliance with Federal parity requirements, including whether States and their MCOs conducted the required parity analyses and whether States ensured that their MCOs complied with certain parity requirements for MH/SUD benefits.

Series Number: W-00-24-31565
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed With Autism

Announced: January 2022
Estimated Completion: FY2026

Active Projects: A-05-24-00005, A-03-24-00205, OAS-25-09-015, OAS-25-02-019
Projects Completed: A-09-24-02004, A-01-24-00006, A-06-23-01002, A-09-22-02002

Autism can cause significant social, communication, and behavioral challenges for children. According to the Centers for Disease Control and Prevention, research has shown that early intervention and therapy can improve social and behavioral development in children diagnosed with autism. A common therapy for autism is Applied Behavior Analysis (ABA). ABA can help an autistic child improve social interaction, learn new skills, maintain positive behaviors, and minimize negative behaviors. In the past few years, some Federal and State agencies have identified questionable billing patterns by some ABA providers as well as Federal and State payments to providers for unallowable services. OIG will audit Medicaid claims for ABA services provided to children diagnosed with autism to determine whether a State Medicaid agency's ABA payments complied with Federal and State requirements.

Series Number: SRS-A-25-029
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

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

Announced: March 2021
Estimated Completion: FY2026

Active Projects: A-02-24-01020
Projects Completed: A-02-21-01011

Several State Medicaid agencies retain consultants to assist with preparing Medicaid claims for school-based activities. Consultants often are paid a contingency fee based on the percentage of Federal funds reimbursed to the State. During a prior review, OIG found that one consultant developed unsupported time studies that it used to develop payment rates for school-based health services. Based on those rates, the State claimed unallowable Federal funds. Consultants developed time studies using a similar methodology in many other States. OIG will initiate a multiple State review with a roll-up report to CMS to determine whether consultants developed school-based Medicaid rates based on unsupported time studies and unallowable costs in these States

Series Number: W-00-24-31529
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Review of State Uncompensated Care Pools

Announced: December 2020
Estimated Completion: FY2026

Active Projects: A-07-21-07001
Projects Completed: A-04-22-04091

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

Series Number: W-00-24-31537
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Recovery of Federal Funds Through Judgments/Settlements

Announced: May 2019
Estimated Completion: FY2026

Active Projects: OAS-25-06-061, OAS-26-06-046, OAS-26-04-066
Projects Completed: A-06-24-04002, A-06-23-04004, A-07-19-02816

Any State action taken as a result of harm to a State's Medicaid program must seek to recover damages sustained by the Medicaid program as a whole, including both Federal and State shares. On October 28, 2008, CMS issued a letter (SHO #08-004) to State health officials that clarified language from Section 1903(d) of the Social Security Act, stating that the Federal Government is entitled to the Federal Medical Assistance Percentages (FMAP) proportionate share of a States entire settlement or final judgment amount. OIG will determine whether selected States reported and returned the applicable FMAP share of the settlement and judgment amounts to the Federal Government.

Series Number: W-00-24-31522
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Medicare Part C

[NEW] Utilization and Oversight of Medicare Part C Supplemental Benefits for Over-the-Counter Items

Announced: March 2026
Estimated Completion: FY2028

Medicare Advantage (MA) plans may offer supplemental benefits, such as over-the-counter (OTC) benefits, to support enrollee health. These benefits are funded through rebates and must be used on CMS-approved, health-related items. In 2024, CMS required MA organizations to report utilization and cost data for OTC benefits. However, MA organizations have varying approaches to delivering this benefit, and there is limited visibility into how funds are spent or whether all enrollees are able to access the benefit. The OIG will audit selected MA organizations to determine whether OTC benefits are being accurately reported to CMS and administered in accordance with Federal requirements.

Project Number: OAS-26-06-057
HHS Agencies: Centers for Medicare and Medicaid Services

[NEW] Trends, Patterns, and Key Comparisons Related to CMS-HCC Risk Adjustment 2020 Model (V24) and 2024 Model (V28)

Announced: January 2026
Estimated Completion: FY2028

Payments to Medicare Advantage (MA) organizations are risk-adjusted based on the health status of each enrollee (Social Security Act §§ 1853(a)). MA organizations are required to submit risk-adjustment data to CMS so CMS can determine each enrollee's health status (42 CFR § 422.310(b)). Specifically, CMS maps certain diagnosis codes to hierarchical condition categories (HCCs), which CMS then uses to increase its payments to the MA organizations. In 2024, CMS began paying MA organizations according to a new model, known as version 28 (V28). The new model significantly decreased the number of diagnosis codes that map to an HCC and increased the number of HCCs that CMS uses to increase payments. CMS anticipated that the transition to the V28 model would save over $7.6 billion in payments for 2024 alone. OIG will analyze the diagnosis codes that MA organizations submitted to CMS for 2024 to determine whether CMS was able to achieve its intended savings.

Project Number: OAS-26-03-004
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Recommendation Followup: Ensuring that MAOs Submit Rendering Provider Identifiers for Applicable Encounter Records

Announced: November 2025
Estimated Completion: FY2027

A rendering provider National Provider Identifier (NPI) is a critical data element on Medicare Advantage (MA) encounter records that: (1) identifies the individual who performed a health care service and (2) enables oversight entities and MA organizations (MAOs) to identify individuals who may pose a risk to Federal funds and enrollee safety. CMS stated that it requires MAOs to submit the rendering provider NPI when it differs from the billing provider NPI. A 2018 OIG report found that rendering provider NPIs were missing on 13 percent of 2014 MA encounter records for outpatient evaluation and management services in which the billing provider was an organization (e.g., a clinic or a provider group). OIG continues to be concerned that the omission of rendering provider NPIs may impede oversight and program integrity activities. This new evaluation will review 2024 encounter data to determine whether MAOs are submitting rendering provider NPIs.

Project Number: OEI-03-25-00440
HHS Agencies: Centers for Medicare and Medicaid Services

Identifying 340B Units to Recoup Inflation Rebates for Part B Drugs in Medicare Advantage

Announced: October 2025
Estimated Completion: FY2027

To help address rising costs, the Inflation Reduction Act requires drug manufacturers to pay rebates when the price of an eligible Part B drug rises faster than inflation. While CMS began implementing this program in Medicare Fee-for-Service, it has not done so in Medicare Advantage (MA), citing "operational considerations". Such considerations may include difficulties with using the MA encounter data to identify which units of Part B drugs were purchased at a 340B discount price. Cost savings from inflation rebates for Part B drugs furnished in MA could be significant, especially considering that MA accounts for the majority of Medicare enrollment. This evaluation will determine the extent to which MA companies collect, store, and report 340B information on Part B drugs furnished in MA. Further, the OIG will estimate the potential cost savings of recouping inflation rebates on eligible Part B drugs furnished in MA.

Project Number: OEI-03-25-00420
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicare Advantage Enrollment Manipulation Schemes

Announced: September 2025
Estimated Completion: FY2027

The Medicare Advantage program is vulnerable to schemes designed to increase Medicare Advantage organization (MAO) profits by improperly influencing enrollment. Known examples of such schemes include enrolling people into MA plans without their consent, structuring incentive payments to agents to minimize enrollment of people with disabilities, and paying kickbacks to providers in exchange for enrollments. These schemes put taxpayer dollars and Medicare enrollees' wellbeing at risk. To date, enrollment manipulation schemes have primarily been identified through whistleblowers, with minimal visibility into schemes that go unreported. To address this gap, OIG will conduct a large-scale analysis of enrollment and disenrollment data to identify aberrant patterns that may signal improper MAO actions to influence enrollment.

Project Number: OEI-BL-25-00380
HHS Agencies: Centers for Medicare and Medicaid Services

Audit of Diagnosis Codes That MA Organizations Submitted to CMS for Use in the Medicare Part C Risk-Adjustment Program

Announced: August 2025
Estimated Completion: FY2027

Payments to Medicare Advantage organizations (MAOs) are risk-adjusted based on the health status of each enrollee (Social Security Act §§ 1853(a)). MAOs are required to submit risk-adjustment data to CMS according to CMS instructions (42 CFR § 422.310(b)). Inaccurate diagnoses may cause CMS to pay improper amounts to MAOs. For this audit, OIG will focus on diagnoses that are at high risk for not being supported by medical records for a face-to-face encounter with an acceptable provider type and resulted in increased risk-adjusted payments from CMS to MAOs. OIG will determine whether MAOs' submission of these diagnosis codes to CMS, for use in CMS's risk-adjustment program, complied with Federal requirements.

Project Number: OAS-25-02-025
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicare Part C

Medicare Part D

Misleading Marketing Practices in Medicare Advantage

Announced: July 2025
Estimated Completion: FY2027

In recent years, concerns about aggressive and deceptive marketing practices in Medicare Advantage have become more pressing. These concerns have focused on agents and brokers used by Medicare Advantage plans who target and mislead seniors, at times enrolling them in plans without their knowledge or directing them to plans that substantially increase their out-of-pocket costs. This study will examine Medicare Advantage marketing practices and the harms they cause to individuals. It will focus on the complaints individuals reported to CMS from 2020 to 2024 about Medicare Advantage marketing practices. The OIG will also look at the actions taken by agents and brokers that led to the complaints and the incentive structures that encourage brokers to change individuals' enrollments.

Project Number: OEI-02-25-00340
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Utilization and Oversight of Medicare Part C In-Home Support Services

Announced: July 2025
Estimated Completion: FY2027

Active Projects: OAS-25-06-087, OAS-25-06-153, OAS-26-06-011

Medicare Advantage (MA) plans may offer supplemental benefits not covered under Original Medicare to its enrollees. MA organizations must design the supplemental benefits to improve enrollees' health, allow enrollees to manage their chronic conditions, or support enrollees' access to care. During the past 5 years, CMS has expanded the flexibility of the types of supplemental benefits that can be provided, including in-home support services (IHSS). Given the new CMS reporting requirements, there is a need to assess whether MA organizations are accurately capturing and reporting IHSS utilization data. In addition, because CMS does not require MA organizations to conduct background checks on non-health care professionals, OIG will also determine what kind of background checks, if any, that MA organizations conducted. Without effective oversight, there is a risk that services are not being delivered as intended, leading to discrepancies in encounter data, potential gaps in care, and financial inefficiencies. For this series of audits, OIG will determine whether MA organizations complied with Federal requirements for IHSS being used by their enrollees.

Series Number: SRS-A-25-035
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Medicare Advantage: D-SNP Compliance with Care Coordination Requirements

Announced: June 2025
Estimated Completion: FY2027

In Medicare Advantage (MA), Dual Eligible Special Needs Plans (D-SNPs) are designed to better manage and coordinate care for high-need patients who are dually eligible for both Medicare and Medicaid. For most health conditions, D-SNPs receive potentially higher MA payments than most other types of plans to care for their high-need patients. In addition, D-SNPs must fulfill certain care coordination requirements that do not apply to non-SNP MA plans, including the requirement to maintain procedures for care coordination activities following enrollee health risk assessments (HRAs). Despite these higher payments and additional requirements, OIG and other researchers have raised concerns about MA plans' use of HRAs to generate payments without also coordinating followup care, as required for all D-SNPs. This evaluation will assess the extent to which select D-SNPs complied with certain care coordination requirements. OIG also will identify the strategies that select D-SNPs use to ensure care coordination for their enrollees. NOTE: This is a spin-off report from Medicare Advantage: Questionable Use of Health Risk Assessments Among Dual Eligible Special Needs Plans (OEI-03-25-00210).

Project Number: OEI-03-25-00211
HHS Agencies: Centers for Medicare and Medicaid Services

Medicare Advantage: Questionable Use of Health Risk Assessments Among Dual Eligible Special Needs Plans

Announced: June 2025
Estimated Completion: FY2027

In Medicare Advantage (MA), Dual Eligible Special Needs Plans (D-SNPs) are designed to better manage and coordinate care for high-need patients who are dually eligible for both Medicare and Medicaid. For most health conditions, D-SNPs receive potentially higher MA payments than most other types of plans to care for their high-need patients. In addition, D-SNPs must fulfill certain care coordination requirements that do not apply to non-SNP MA plans, including the requirement to maintain procedures for care coordination activities following enrollee health risk assessments (HRAs). Despite these higher payments and additional requirements, OIG and other researchers have raised concerns about MA plans' use of HRAs to generate payments without also coordinating followup care, as required for all D-SNPs. This evaluation will determine the extent to which D-SNPs received 2025 risk-adjusted payments for diagnoses reported only on HRAs (or added to HRAs by chart reviews) and no other records of service in the MA or Medicaid data.

Project Number: OEI-03-25-00210
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Medicare Advantage Health Risk Assessments – Continuity of Care

Announced: November 2024
Estimated Completion: FY2026

Active Projects: OAS-24-07-015, OAS-25-07-125, OAS-25-07-126

CMS makes monthly risk-adjusted payments to Medicare Advantage (MA) organizations based in part on the health characteristics of the enrollees being covered (Social Security Act § 1853(a)). Federal regulations at 42 CFR § 422.310(b) require that MA organizations submit risk adjustment data, which includes diagnosis codes, to CMS in accordance with CMS instructions. Inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. MA organizations use health risk assessments (HRAs) to gather information, including diagnoses, about enrollees. MA organizations can use HRAs for early identification of health risks to improve enrollees' care and health outcomes. However, prior OIG work found that MA organizations may have inappropriately leveraged HRAs to maximize risk-adjusted payments. These audits focused on enrollees whose diagnoses, reported first on HRAs, mapped to hierarchical condition categories and resulted in increased risk-adjusted payments from CMS to MA organizations. OIG will determine whether MA organizations complied with Federal requirements when: (1) submitting diagnoses reported on HRAs to CMS for use in CMS's risk-adjustment program and (2) taking any needed steps to ensure continuity of care and integration of services for enrollees who had received HRAs.

Series Number: SRS-A-25-019
HHS Agencies: Centers for Medicare and Medicaid Services

Audit to Determine Whether CMS Oversight of Its Preclusion List Ensured That Certain Revoked Providers Did Not Receive Payment for Medicare Part C and Part D Services

Announced: June 2024
Estimated Completion: FY2026

CMS contracts with Medicare Advantage plans and private prescription drug plans (collectively known as sponsors) to offer Part C and Part D managed care benefits to eligible enrollees. CMS maintains a list known as the Preclusion List that includes excluded providers and other providers who have been or could have been revoked from the Medicare program for conduct that CMS determines is detrimental to the best interest of the Medicare program. Federal regulations prohibit sponsors from making payments for services provided or prescriptions written by providers on the Preclusion List. OIG will analyze CMS data to identify any revoked providers not included on the Preclusion List; report on why they were not included, as determined by CMS; and point out potential vulnerabilities in not including revoked providers on the Preclusion List.

Project Number: A-02-24-01013
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Audits of Medicare Part C Supplemental Benefits

Announced: June 2024
Estimated Completion: FY2026

Active Projects: A-06-24-06001

Under the Medicare Advantage (MA) program, an MA organization can offer supplemental benefits, which are items or services that are not covered by traditional Medicare, to its enrollees. MA organizations must design the supplemental benefits to improve enrollees' health, allow enrollees to manage their chronic conditions, or support enrollees' access to care. Over the past 5 years, the types of supplemental benefits—and payments for them—have grown considerably, and per-person payments from CMS to MA organizations for these benefits have more than doubled. For this series of audits, OIG will determine whether MA organizations complied with Federal requirements for the supplemental benefits offered to their enrollees.

Series Number: SRS-A-25-022
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care

Announced: June 2024
Estimated Completion: FY2026

Active Projects: OEI-09-24-00330, OEI-09-24-00331, OEI-09-24-00332

Medicare Advantage plans must cover at least the same services as original Medicare, but Medicare Advantage Organizations (MAOs) may impose additional administrative requirements, such as requiring prior authorization before certain services can be provided. Prior OIG work found that MAOs sometimes denied prior authorization requests for post-acute care after a qualifying hospital stay even though the requests met Medicare coverage rules. OIG will review the extent to which selected MAOs denied requests for post-acute care in long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities, and the extent to which denied requests were appealed and overturned. OIG will also conduct medical record reviews for a sample of cases to determine the extent to which MAOs denied requests for post-acute care admissions that met Medicare coverage rules.

Series Number: SRS-E-26-004
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Medicare Part C Audits of Documentation Supporting Specific Diagnosis Codes

Announced: October 2023
Estimated Completion: FY2026

Active Projects: A-07-24-01214, A-07-24-01215, A-06-24-05002, A-05-24-00010, A-02-24-01019

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

Series Number: SRS-A-25-017
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Audits of Medicare Part C Unlinked Chart Review Diagnosis Codes

Announced: August 2023
Estimated Completion: FY2026

Active Projects: A-01-23-00503, OAS-25-02-054, OAS-25-04-101, OAS-25-04-107, OAS-25-02-144

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

Series Number: SRS-A-25-018
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes

Announced: July 2023
Estimated Completion: FY2026

Active Projects: A-02-23-01020, OAS-25-04-152

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

Series Number: SRS-A-25-021
HHS Agencies: Centers for Medicare and Medicaid Services

Project A-07-23-01210

Announced: February 2023
Estimated Completion: FY2026

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

Project Number: A-07-23-01210
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Series: Audits of Medicare Part C Health Risk Assessment Diagnosis Codes

Announced: February 2023
Estimated Completion: FY2026

Active Projects: A-07-23-01212, OAS-25-05-093, OAS-25-04-103, OAS-25-09-129, OAS-25-09-130

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

Series Number: SRS-A-25-020
HHS Agencies: Centers for Medicare and Medicaid Services

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Medicaid

Medicare Part C

Medicare Part D

Medicare Part D

[NEW] Ensuring Dual-Eligible Enrollees' Access to Drugs Under Part D: Mandatory Review

Announced: February 2026
Estimated Completion: FY2028

Dual-eligible enrollees are enrolled in both Medicaid and Medicare and receive prescription drug coverage under Medicare Part D. As long as Part D plans meet certain limitations outlined in 42 CFR § 423.120, Part D sponsors have discretion to include different Part D drugs in their formularies. As required under section 3313 of the Patient Protection and Affordable Care Act, OIG will conduct an annual study of the extent to which formularies used by Medicare Part D plans include drugs commonly used by dual-eligible enrollees. This study will focus on Part D Plans' 2026 formularies.

Project Number: OEI-05-26-00150
HHS Agencies: Centers for Medicare and Medicaid Services

[NEW] Reducing Pharmacy Fraud in Medicare Part D

Announced: January 2026
Estimated Completion: FY2028

OIG has longstanding concerns about fraud committed by bad-actor pharmacies. This fraud puts the Part D program and millions of taxpayer dollars at risk every year. Key tools that CMS uses to safeguard other parts of Medicare from fraud, such as revocation, preclusion, and payment suspension, may not be effective at deterring fraud by pharmacies that bill Part D plan sponsors. This review will determine the extent to which pharmacies that have been identified as bad actors by CMS or Part D plan sponsors continue to bill and receive payment for drugs under Part D. This review will seek to describe and identify opportunities for CMS and Part D plan sponsors to improve their ability to detect and reduce potential fraud by pharmacies in the Part D program.

Project Number: OEI-02-25-00410
HHS Agencies: Centers for Medicare and Medicaid Services

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Payer

Medicaid

Medicare Part C

Medicare Part D

Audit of Medicare Part D Over-The-Counter Drugs

Announced: October 2024
Estimated Completion: FY2026

Over-the-counter (OTC) drugs may be purchased without a prescription. Medicare Part D does not cover OTC drugs under their basic prescription drug benefit or as a supplemental benefit under enhanced alternative coverage. Subject to approval by the Food and Drug Administration (FDA), companies may convert a brand-name prescription-only (Rx-only) drug to an OTC drug. After FDA approves a brand-name drug's conversion to OTC status, which includes requiring changes to its labeling, the drug is no longer considered an Rx-only drug. Because the labeling of brand-name drugs and generic equivalents must be identical, makers of the generic equivalents must make corresponding revisions to their labeling or cease marketing their generic equivalents. OIG will conduct a nationwide audit of Medicare Part D prescription drug event data to identify payments for OTC drugs sold under obsolete Rx-only labeling. OIG will determine whether CMS oversight of Medicare Part D sponsors ensured compliance with Federal requirements for preventing payments for OTC drugs.

Project Number: OAS-24-02-004
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Audit of Vertically Integrated Medicare Part D Sponsors

Announced: April 2024
Estimated Completion: FY2026

Active Projects: A-03-24-00004, A-03-24-00006, A-03-24-00005

CMS oversees prescription drug coverage for Medicare Part D enrollees. CMS contracts with health insurers, known as plan sponsors, who are responsible for delivering the benefit through a network of pharmacy providers. Under Part D, sponsors often contract with pharmacy benefit managers (PBMs) to manage or administer the drug benefit on a sponsor's behalf. PBM services may include contracting with pharmacies to establish pharmacy networks and negotiate pharmacy reimbursement rates.

In recent years, the pharmaceutical market has experienced a wave of vertical integration between PBMs, health insurers, and pharmacies. Concern has been raised about the vertically integrated model. One such concern is that, by owning many links in the chain, a vertically integrated Medicare Part D sponsor may inflate drug prices. OIG will determine the impact of related entity transactions within select vertically integrated entities on the prices for covered Part D drugs.

Series Number: W-00-24-35912
HHS Agencies: Centers for Medicare and Medicaid Services

SUNHAWK CONSULTING

Payer

Medicaid

Medicare Part C

Medicare Part D

Series: Audits of Diabetes Drugs Under Medicare Part D

Announced: March 2024
Estimated Completion: FY2026

Active Projects: WA-24-0035, OAS-26-05-003
Projects Completed: A-05-24-00015

In 2022, six type 2 diabetes drugs accounted for more than half of all Medicare Part D payments for diabetes drugs. Diabetes drugs are meant to lower blood sugar levels and often result in weight loss. Part D spending for one of these six drugs, Ozempic, more than tripled between 2020 and 2022, with expenditures jumping from $1.5 billion to $4.6 billion. Other diabetes drugs are experiencing similar growth and could overshadow Ozempic. Part D payments for a type 2 diabetes drug, such as Ozempic, for a use that Medicare does not cover as a medically accepted indication is not in compliance with Medicare requirements and presents an opportunity for fraudulent, excessive, or unnecessary Part D payments. Furthermore, drugs that are used for weight loss are specifically excluded from Medicare Part D coverage. OIG will obtain Part D data for prescribed diabetes drugs and any related Part B service claims. OIG will determine whether they were billed according to Medicare requirements.

Series Number: SRS-A-26-010
HHS Agencies: Centers for Medicare and Medicaid Services

Series: Audits of Pharmacy Support for Prescription Drug Event Data

Announced: December 2023
Estimated Completion: FY2026

Active Projects: WA-24-0014

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

Series Number: SRS-A-26-014
HHS Agencies: Centers for Medicare and Medicaid Services