

**DEFICIT REDUCTION ACT OF 2005 REPORT TO CONGRESS
FOR FISCAL YEAR 2007**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL**

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SECTION 1: INTRODUCTION

This report fulfills the Department of Health and Human Services (HHS), Office of Inspector General's (OIG), statutory requirement to report on the use and effectiveness of funds provided through section 6034 of the Deficit Reduction Act of 2005 (DRA), P.L. 109-171. Specifically, this report summarizes OIG's Medicaid-related oversight activities during fiscal year (FY) 2007. In addition, this report includes an overview of Medicaid integrity work that OIG anticipates undertaking during FY 2008.

SECTION 2: OVERVIEW OF OIG

Organization of OIG

The mission of OIG, as mandated by P.L. 95-452 (as amended), is to protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. OIG has a responsibility to report both to the Secretary and to Congress program and management problems and recommendations to correct them. OIG accomplishes its statutory responsibilities through audits; evaluations; investigations; legal services; and when appropriate, criminal and civil enforcement actions, as well as administrative sanctions. OIG is organized into five component offices to carry out these activities.

- *Office of Audit Services (OAS)*. OAS conducts financial and performance audits of departmental programs, operations, grantees, and contractors following Government Auditing Standards issued by the Government Accountability Office (GAO). Financial audits principally provide reasonable assurance about whether financial statements are presented fairly in all material respects; performance audits assess the achievement of objectives and identify the presence of systemic weaknesses giving rise to waste, fraud, or abuse. Recommendations address problems, such as improper payments and inefficient and ineffective use of resources. OAS performs audits or oversees the audit work of others through a nationwide network of auditors, information technology experts, and other professionals.
- *Office of Evaluation and Inspections (OEI)*. OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations, conducted by a nationwide staff of evaluators and other professionals, focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.
- *Office of Investigations (OI)*. OI conducts and coordinates investigations of fraud and misconduct related to the Department's programs, operations, and beneficiaries. With investigators working in all 50 States, OI leverages its

resources by actively coordinating with the Department of Justice (DOJ) and other law enforcement authorities. OI identifies systemic weaknesses that leave Department programs vulnerable to fraud and recovers damages and penalties through civil and administrative proceedings.

- *Office of Counsel to the Inspector General (OCIG)*. OCIG provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act (FCA), program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.
- *Office of Management and Policy (OMP)*. OMP provides mission support services to the Inspector General (IG) and OIG components by formulating and executing the budget, issuing grants to State Medicaid Fraud Control Units (MFCU), developing administrative policies, disseminating OIG information in the form of publications, and managing information technology and human resources. OMP also executes and maintains an internal quality assurance system, which includes quality control reviews of OMP processes and products, to ensure that OIG policies and procedures are followed effectively and function as intended.

OIG accomplishes its mission through a nationwide network of offices, including headquarters in Washington, DC, and approximately 90 regional and field offices. In total, more than 80 percent of OIG resources are deployed to regional and field offices.

OIG staff at all locations work closely with the Department, its Operating and Staff Divisions, the DOJ and other agencies in the Executive Branch, Congress, and the States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds.

OIG Budget

The funding that supports OIG's oversight activities is divided among a single discretionary budget authority and multiple mandatory authorities. OIG's discretionary funding is used for oversight of all HHS programs and offices except for Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), which are funded separately under the Health Care Fraud and Abuse Control Program (HCFAC) and the Medicaid Integrity Program (MIP). Following are summaries of the two Acts that provide OIG with funding for oversight of health care and, in particular, of the Medicaid program.

- *Health Care Fraud and Abuse Control Program*. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191 established a Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General and the Secretary of HHS, acting through the HHS Inspector General (IG). The HIPAA appropriates

monies from the Medicare Trust Fund in amounts that the Secretary of HHS and Attorney General jointly certify as necessary to finance antifraud activities, up to ceilings fixed by this legislation. Certain of these funds are, by law, set aside for OIG “activities . . . with respect to Medicare and Medicaid.”¹ The HIPAA also requires the Attorney General and the Secretary of HHS to submit a joint annual report to Congress identifying expenditures and accomplishments under the law (Social Security Act § 1817(k)(5)). These reports are available on the Web sites of both agencies at <http://oig.hhs.gov/reading/publications.html> and <http://www.usdoj.gov/dag/pubdoc.html>, respectively. Since FY 1997, the HCFAC has been the primary source of funding for health care fraud investigations and prosecutions by both OIG and DOJ.

- *Medicaid Integrity Program.* The DRA established the MIP through which OIG receives enhanced funding for fraud and abuse control “activities with respect to the Medicaid program” (42 U.S.C. § 1396(c)). This funding is to be provided annually from FY 2006 through FY 2010 in addition to OIG’s HCFAC resources and is available until expended.

Table 1 presents a summary of OIG’s recent funding history and current estimates of its future funding commitment for Medicaid oversight.

**Table 1: Summary of OIG’s Financial Expenditures
Related to Medicaid for Health Care Oversight, FY 2005 – FY 2009
(Dollars in Thousands)**

Fiscal Year	Health Care Oversight Funds Available		Estimated Funds Used for Medicaid Oversight		Estimated Total Medicaid Funding	Estimated % of Funds Used for Medicaid Oversight ²
	HCFAC	MIP	HCFAC	MIP ³		
2005	\$160,000	–	\$36,800	–	\$36,800	23
2006	\$160,000	\$25,000	\$44,800	–	\$44,800	28
2007	\$165,920	\$25,000	\$24,643	\$24,858	\$49,501	26
2008	\$169,238	\$25,000	\$30,544	\$28,283	\$57,827	30
2009	\$174,998	\$25,000	\$27,578	\$27,578	\$55,156	27

As illustrated in Table 1, a sizeable portion of OIG’s HCFAC funds has been used for Medicaid oversight in recent years. As OIG continues spending its MIP funding in FYs 2008 and 2009, it can enhance the depth and scope of its Medicaid integrity work.

¹ The Social Security Act, § 1817(k)(3)(A).

² FYs 2008 and 2009 are estimated as percentages of the combined HIPAA/HCFAC and DRA/MIP funding streams.

³ OIG began FY 2007 with \$25 million of unspent MIP funds that were appropriated during FY 2006. These funds are being used to fund OIG’s continued Medicaid oversight from FY 2007 through FY 2010.

Because there is an overlap among the activities funded by the HCFAC and MIP sources, OIG work activities relating to Medicaid may draw on funding from both sources. For investigations and subsequent prosecutions, it is particularly difficult—sometimes impossible—to accurately segregate HCFAC- and MIP-funded Medicaid enforcement activities. For example, even if OIG conducts a given investigation exclusively with MIP funds, the subsequent prosecution of that case could draw upon DOJ’s own HCFAC money, and the matter would be reportable in both the annual HCFAC and DRA reports. An overlap could also occur when an investigation involves fraud in both Medicaid and other Federal health care programs, such as Medicare, as is often the case. For these reasons, this report does not artificially divide accomplishments between the two funding sources; OIG’s successes are typically the result of the combined funding from both resources.

In addition, much of OIG’s audit, evaluation, and investigation work requires more than 1 year to yield results. As a consequence, many of the accomplishments summarized in this report reflect the results of OIG work performed over several years that culminated in FY 2007.

SECTION 3: SUMMARY OF DRA PROVISIONS THAT AFFECT OIG

Sections 6001, 6031, and 6034 of the DRA include provisions that require OIG to conduct mandatory activities, as well as annual reporting on overall Medicaid activities. These sections are summarized below.

- *Section 6001: Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions.* This section requires OIG to, by no later than June 1, 2006, (1) review the requirements for, and manner in which, average manufacturer prices (AMP) are determined under section 1927 of the Social Security Act and (2) submit to the Secretary of HHS and Congress recommendations for changes in such requirements or manner as the IG determines to be appropriate.

On May 30, 2006, OIG issued a report entitled “Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005” (A-06-06-00063), which fulfilled this statutory requirement. In this report, OIG found that some AMP requirements were unclear and that manufacturers’ methods of calculating AMPs were inconsistent. OIG recommended that the Secretary direct the Centers for Medicare and Medicaid Services (CMS), in promulgating the AMP regulation, to clarify requirements in regard to the definition of retail class of trade and the treatment of pharmacy benefit manager rebates and Medicaid sales, and to consider addressing issues raised by industry groups. OIG also recommended that the Secretary direct CMS to issue guidance that specifically addresses the implementation of the AMP-related reimbursement provisions of the DRA and to encourage States to analyze the relationship between AMP and pharmacy acquisition cost before using AMP for their reimbursement methodology. During FY 2007, OIG continued to address topics related to the Federal upper payment limit for multiple source drugs and other drug payment provisions by issuing an evaluation report in June 2007 entitled “Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program” (OEI-03-06-00400).

- *Section 6031: Encouraging the Enactment of State False Claims Acts (FCA).* Effective January 1, 2007, this section provides a financial incentive for States to enact FCAs that establish liability to the State for the submission of false or fraudulent claims to the State's Medicaid program. If a State's FCA is determined to meet certain enumerated requirements, the Federal share of Medicaid recoveries under the State FCA will be reduced by 10 percentage points.

Specifically, for a State to be eligible for the 10-percentage point increase in its share of false claims recoveries, the State law relating to false and fraudulent claims must be determined by OIG, in consultation with the Attorney General, to meet the following criteria: (1) establish liability to the State for false or fraudulent claims described in the FCA with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA, (3) contain a requirement for filing an action under seal for 60 days with review by the State Attorney General, and (4) contain a civil penalty that is not less than the amount authorized by the FCA.

On August 21, 2006, OIG published in the Federal Register (71 FR 48552) its guidelines for evaluating State FCAs under the requirements of section 6031 of the DRA. This notice was developed in consultation with DOJ's Civil Division. In the notice, OIG invited the States to request review of their FCAs. Since the publication of the Federal Register notice, OIG has received requests from 20 States to review both existing and proposed State laws.

As of February 2008, OIG had provided written responses to 13 States and approved 8 of the State laws—those passed by Massachusetts, Illinois, Tennessee, Virginia, Hawaii, Texas, Nevada, and New York—for the DRA incentive. OIG made these determinations in consultation with DOJ's Civil Division. The response letters are published on OIG's Web site at <http://www.oig.hhs.gov>.

- *Section 6034: Medicaid Integrity Program.* This section establishes the MIP and requires the Secretary to enhance the capacity of CMS to conduct oversight of Medicaid expenditures. The program's activities include: review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, audit of claims for payment for items or services furnished or for administrative services rendered, and education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care. The section further establishes that, from FY 2006 through FY 2010, \$25 million shall be appropriated to OIG for the Medicaid activities of OIG in addition to any other amounts appropriated or made available for Medicaid oversight. Such funds shall remain available until expended. This section of the DRA also requires OIG to submit to Congress a report that identifies the use and effectiveness of the use of such funds no later than 180 days after the end of each fiscal year.

SECTION 4: OIG OVERSIGHT OF THE MEDICAID PROGRAM DURING FY 2007

This section of the report includes information on the Medicaid oversight activities conducted by OIG during FY 2007. Many of the Medicaid enforcement actions and collections cited in this report will also be included in the total figures set forth in OIG’s annual MFCU report, as well as the OIG Semiannual and the joint OIG-DOJ annual HCFAC reports. These documents are available on OIG’s Web site at <http://www.oig.hhs.gov/publications.html>.

Audit and Evaluation Reports

During FY 2007, OIG issued 48 audits and 14 evaluations that were related specifically to Medicaid. Table 2 provides a summary of the health care sectors that these audits and evaluations addressed.

Table 2: OIG’s Medicaid Audit and Evaluation Reports Issued in FY 2007

Health Care Sectors	Reports Issued
Medicaid Administration	18
Medicaid Services (i.e., not otherwise listed)	11
Medicaid Information Systems Controls	8
Medicaid Long-Term and Community Care	6
Medicaid Hospitals	6
Medicaid/SCHIP	5
Medicaid Prescription Drugs	5
Medicaid Hurricane Response	2
Medicaid Mental Health Services	1
Total	62

As a result of these audits and evaluations of the Medicaid program in FY 2007, OIG questioned \$460 million in costs and identified \$630 million in funds that could be put to better use. Furthermore, management action on OIG recommendations resulted in audit disallowances of \$1.2 billion.

A list of OIG’s audit and evaluation reports issued in FY 2007 is contained in Appendix A of this document. The complete text of all reports, excluding the Medicaid Information Systems controls reports, which are considered sensitive, can be accessed through the “Reports” section of OIG’s Web site at <http://www.oig.hhs.gov/reports>. Below are highlights of the findings contained in several of these Medicaid reports.

- *Medicaid Eligibility.* OIG determined that from January 1 through June 30, 2005, two States (New York and California) made Medicaid payments on behalf of beneficiaries who did not

meet Federal or State eligibility requirements or did not adequately document all eligibility determinations. OIG estimated that New York made more than 4.2 million payments totaling \$230.4 million (Federal share) on behalf of ineligible beneficiaries and did not adequately document eligibility determinations for an additional 15.3 million payments totaling \$2.8 billion (Federal share). OIG estimated that California made 4.7 million payments totaling \$133 million (Federal share) on behalf of ineligible beneficiaries and did not adequately document eligibility determinations for an additional 2.5 million payments totaling \$117 million (Federal share). OIG did not recommend recoveries because a disallowance may occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program. However, OIG recommended that New York and California review these report results to help ensure compliance with Federal and State Medicaid eligibility requirements. (A-02-05-01028; A-09-06-00028; A-04-06-00020)

- *Medicaid Disproportionate Share Hospital Payments.* The Social Security Act requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionately large numbers of low-income patients. The Omnibus Budget Reconciliation Act of 1993 (OBRA) limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. OIG found that two States, New Hampshire and New Jersey, claimed a total of \$45.3 million in unallowable Federal payments. Of the \$194.1 million that New Hampshire claimed in DSH payments for FY 2004, \$70.6 million (\$35.3 million Federal share) was unallowable. OIG review of DSH payments to two New Jersey hospitals also identified unallowable payments. DSH payments to one hospital from July 1995 through June 2001 exceeded the hospital-specific limits by \$20 million (\$10 million Federal share) because a consultant used by the State erroneously included costs that were not DSH eligible in its calculations, and the State claimed some duplicate DSH expenditures. DSH payments to the other hospital exceeded the hospital-specific limits by \$2.2 million (\$1.1 million Federal share) from November 1996 through June 2001 because the consultant improperly included costs applicable to patients with private insurance coverage. (A-01-05-00001; A-02-04-01024; A-02-05-01007)
- *Medicaid Community Mental Health Center Provider Services in Indiana.* OIG estimated that Indiana overpaid community mental health center providers at least \$33.4 million (\$21.3 million Federal share) in reimbursement for Medicaid Rehabilitation Option (MRO) services provided during FY 2003. Under the MRO services program, clinical mental health services are provided to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness. OIG recommended that Indiana refund the Federal share of the overpayment and strengthen its internal controls over the monitoring of MRO services. (A-05-05-00057)
- *Medicaid Reimbursement Rate for School-Based Health Services in Maryland.* OIG found that Maryland had not complied with reimbursement provisions specified in its CMS-approved State Medicaid plan for school-based health services resulting in overpayments totaling \$65.5 million (\$32.8 million Federal share) between State FYs 2002 and 2004. Medicaid covers the costs of school-based health services, such as physical therapy, speech pathology/therapy services, and psychological counseling that are provided to children under

the Individuals with Disabilities Education Act. OIG recommended that the State refund the Federal share of unallowable costs, determine the unallowable costs for State FY 2005, make the appropriate refund, and continue to work with CMS to develop more accurate school-based health service rates. (A-03-05-00206)

- *Use of Health Information Technology in State Medicaid Programs.* OIG found that 12 State Medicaid agencies have implemented a total of 16 health information technology (HIT) initiatives for Medicaid beneficiaries and participating providers, including claims-based electronic health records initiatives, electronic prescribing initiatives, remote disease-monitoring initiatives, and personal health records initiatives. OIG also found that 25 State Medicaid agencies are currently involved in planning and developing statewide health information exchange (HIE) networks. Lastly, OIG found that 13 State Medicaid agencies are incorporating the Medicaid Information Technology Architecture (MITA) into their HIT and HIE planning. The MITA is a framework developed by CMS to help States modernize their Medicaid information systems.

In recent years, both the President and the Secretary of HHS have promoted the goal of developing the HIT and the HIE initiatives. OIG recommended that CMS continue to support the goals of the MITA to help facilitate future State Medicaid HIT and HIE initiatives, assist State Medicaid agencies with developing privacy and security policies regarding the use of Medicaid health care information in HIT and HIE initiatives, and continue to work with the Office of the National Coordinator for HIT to ensure that State Medicaid initiatives are consistent with national goals. CMS concurred with all OIG recommendations. (OEI-02-06-00270)

- *Preadmission Screening and Resident Review for Younger Nursing Facility Residents With Serious Mental Illness and Mental Retardation.* In two separate reviews, OIG examined the extent to which Preadmission Screening and Resident Review (PASRR) requirements were addressed for Medicaid facility residents aged 22 to 64 with (1) serious mental illness and (2) mental retardation. All individuals who apply to or reside in Medicaid nursing facilities are required to receive a Level I PASRR screen to identify suspected serious mental illness or mental retardation. Those identified must receive a Level II PASRR to confirm their mental illness or retardation, to determine whether they require nursing facility services, and to determine whether they require specialized services.

With regard to residents with serious mental illness, OIG found that almost all sampled residents had Level I screens that met all Federal requirements. Two-thirds had evidence of Level II PASRRs, but only 5 percent of the Level II PASRRs met all Federal requirements. For those residents who received Level II PASRRs, 85 percent received mental health service recommendations, and 33 percent had all the recommended services in their nursing facility care plans. Only two of five selected States' Level II PASRR evaluation forms prompted evaluators to consider community-based placements, and, although all selected States monitored aspects of the PASRR process, CMS provided only limited oversight. With regard to residents with mental retardation, OIG found that, while Level I screens were present in 88 percent of cases, one-fourth of these were completed late. Fifty-two percent of selected files contained neither a Level II evaluation nor a Level II determination. Twenty-

two percent of sampled Level II evaluations did not contain evidence that the evaluator assessed whether the individual's total needs could be met in a community setting. CMS and the survey and certification agencies conducted only limited oversight. OIG recommended in both reviews that CMS hold State Medicaid agencies accountable for ensuring compliance with Federal requirements, hold States accountable for considering community placements during the Level II PASRR process, and revise survey and certification requirements to ensure systematic oversight of the PASRR. CMS agreed with all our recommendations. (OEI-05-05-00220; OEI-07-05-00230)

- *States' Requirements for Medicaid-Funded Personal Care Service Attendants.* OIG found in its review of all 50 States and the District of Columbia that States have established multiple sets of attendant requirements that often vary among programs and by delivery models within programs, resulting in 300 sets of attendant requirements nationwide. The "Medicaid State Manual" requires States to develop qualifications for attendants who provide care to Medicaid beneficiaries; it does not list specific qualifications but offers examples of requirements that States may establish to ensure that attendants provide high quality personal care.

Because States had established different requirements for various programs and/or delivery models, attendants may need to meet different requirements depending on the programs and delivery models through which they are serving beneficiaries. Only seven States applied uniform requirements to all the programs within them, and there were five programs nationwide using the consumer-directed delivery model that had no requirements. Those States that defined requirements did so differently and used them in different combinations. We concluded that most States were monitoring compliance with these attendant requirements on two levels. First, States delegated responsibility for ensuring that attendants met requirements to another entity (e.g., home health or personal care service agency, beneficiary, case manager). Second, States retained direct responsibility by ensuring that the entities with primary responsibility fulfilled their oversight duties. This report did not include recommendations. (OEI-07-05-00250)

- *Suspected Medicaid Fraud Referrals.* OIG found that MFCUs reported receiving a total of 13,733 suspected fraud referrals over the 3-year period from July 2002 through June 2005, of which 29 percent came from State Medicaid agencies. Eighty-four percent of MFCUs that provided information reported receiving less than half of all suspected fraud referrals from their respective State Medicaid agencies. MFCU-accepted referrals are matters that each MFCU retains for further investigation. Overall, MFCU-accepted referrals from State Medicaid agencies increased in number but their percentage of total referrals remained constant over the 3-year period reviewed. Within individual States these trends varied widely. Fifty-nine percent of MFCUs reported accepting fewer referrals from their respective State Medicaid agencies in the last year of our review compared to the average number of referrals over all 3 years. One State Medicaid agency contributed to 67 percent of the increase in the number of MFCU-accepted referrals over the 3-year study period. OIG recommended that CMS establish fraud referral performance standards for State Medicaid agencies. CMS concurred. (OEI-07-04-00181)

- *Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program.* Pursuant to the DRA and effective January 2007, Medicaid Federal upper limits are to be based on 250 percent of AMP rather than 150 percent of the lowest price published in the national compendia. This report, which assessed the expected impact of this new provision, found that Federal upper limit amounts are likely to decrease substantially under the new calculation method. Under the previous calculation method, Federal upper limit amounts were more than double pharmacy acquisition costs for 23 of 25 selected high-expenditure Medicaid drugs in the second quarter of 2006. However, if the new calculation had been in effect during that time period, pharmacies on average would have been able to purchase only 6 of the 25 selected high-expenditure drugs for less than the new Federal upper limit amounts. Furthermore, the AMP used to set a new Federal upper limit amount may be substantially lower than other AMPs associated with a drug.

OIG recommended that CMS take steps to identify when a new Federal upper limit amount may not be representative of a drug's acquisition cost to pharmacies and, in those situations, determine the proper course of action. CMS did not agree with our findings. In July 2007, CMS published final rule 72 FR 39142-39245 (July 17, 2007), which implements section 6001 of the DRA and incorporates provisions that ensure that a drug is for sale nationally.⁴ (OEI-03-06-00400)

Investigations and Legal Services

In addition to conducting audits and evaluations, OIG investigates allegations of criminal and civil wrongdoing in conjunction with DOJ, conducts administrative enforcement and litigation, and provides technical support. As a result of these activities, OIG reported over \$2 billion in monetary receivables to both Federal and non-Federal government entities in FY 2007. Of that amount, over \$391 million was specifically identified as restitutions or recoveries to be returned to Federal and State Medicaid programs.

OIG's enforcement work and industry guidance are often designed to have broad impact on Federal health care programs. In large part, OIG's industry outreach and enforcement efforts affect other health care programs, not just Medicaid. Table 3 presents a summary of OIG's investigative, enforcement, and industry outreach activities during FY 2007 related to Medicaid.

⁴ In December 2007, the US District Court for the District of Columbia preliminarily enjoined the implementation of this regulation.

Table 3: OIG’s Medicaid-Related Investigations and Legal Services in FY 2007

OIG Activity Area ⁵	Number
Enforcement	
Medicaid Cases Worked	1201
Joint Investigations Worked With State MFCUs	724
Total Medicaid Cases Opened	490
Criminal Convictions	145
Civil Actions	90
Program Exclusions – Imposed	3,308
Program Exclusions – Appeal Proceedings	90
Civil Monetary Penalty Actions	20
Emergency Medical Treatment and Labor Act –“Patient Dumping”	9
CIAs– New	76
CIAs– Monitored ⁶	469
Outreach	
Advisory Opinions	18

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicaid and other Federal health care programs involves filing false claims for reimbursement. The filing of false claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the civil FCA.

The successful resolution of such civil FCA matters often involves the combined investigative efforts and resources of OIG, State MFCUs, and a variety of other law enforcement agencies. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter into integrity agreements with OIG to avoid exclusions and to be permitted to continue participating in Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require providers to enhance existing compliance programs or establish new ones. Providers that settle these cases generally deny that they were liable or that they committed the alleged conduct.

In FY 2007, OIG opened 490 Medicaid-related cases for investigation of criminal or civil wrongdoing and participated in 145 successful criminal convictions and 90 civil actions. In addition, the Government’s enforcement efforts, including FCA cases, resulted in over \$1.4 billion in investigative receivables related to Medicaid and other Federal health care programs. Some successful enforcement actions are described below.

⁵ Matters listed here are not necessarily Medicaid specific. Many also involve fraud against other health care programs.

⁶ This number includes 14 quality-of-care CIAs representing more than 1,250 facilities funded primarily by Medicaid.

Criminal Enforcement

- *Ohio.* Jorge Martinez, a pain management physician convicted in a jury trial, was sentenced to life in prison and ordered to pay over \$14.3 million in restitution, including over \$1.6 million to Medicaid, for health care fraud resulting in death. Martinez was additionally sentenced to 20 years in jail for illegal drug distribution, mail fraud, wire fraud, and health care fraud. The investigation revealed that Martinez conducted unnecessary and painful procedures on patients as a pretext for writing prescriptions for narcotic drugs. The physician then submitted claims to health care benefit programs, falsely indicating that he performed multiple complex procedures, such as nerve block or epidural injections. Many of the patients endured painful treatments because they were addicted to drugs, while other patients, who initially had legitimate injuries, fell victim to the physician's scheme and became addicted. Two of his patients died of drug overdoses in 2001. Martinez is subject to supervised release and deportation if his life sentence is overturned.
- *New York.* Phillip Frank, a dentist, was sentenced to 18 months in jail and ordered to forfeit \$5 million in assets as a result of being found guilty of defrauding the Medicaid program. Frank had been excluded from participating in the Medicaid program in 1995. However, he devised a scheme to maintain his practice which was comprised of 95-percent Medicaid patients. To continue treating his Medicaid patients, Frank hired junior dentists with valid Medicaid provider numbers to perform basic procedures and paid them on a per diem basis. The excluded dentist provided the more complex procedures and billed Medicaid for all the services performed in the practice under the provider numbers of the junior dentists. In an attempt to cover up his scheme, Frank created management companies enabling him to deposit the Medicaid funds received in the names of the junior dentists.
- *Virginia.* Rebecca Conyer, the owner of a home health agency, and Donna Bates, her office manager, were sentenced in Virginia for defrauding the Medicaid program. Conyer was sentenced to 30 months' incarceration and ordered to pay \$923,000 in restitution. Bates received a 24-month prison sentence and was held responsible for paying \$713,000, a portion of the total restitution amount. The investigation revealed that personal care services billed to the Medicaid program were not performed at all, were not performed according to Medicaid standards, or were performed by personal care aides who were not adequately trained.
- *Ohio.* Kevin Dennis, the former owner of a home health company, was sentenced to 13 years incarceration and ordered to pay \$564,000 in restitution for health care fraud, money laundering, and drug and weapons charges. The investigation revealed that Dennis solicited a population of an immigrant community to provide unnecessary medical services and billed Medicaid for those services. To facilitate the fraud, doctors signed plans of care to indicate that patients were in need of skilled nursing and home health aid services. In reality, patients had not been seen by the doctors. In addition, reimbursements from claims submitted to Medicaid were diverted to support Dennis's drug habit and to fund personal business ventures.

Civil Enforcement

- *Virginia.* As part of a global criminal, civil, and administrative settlement agreement, the Purdue Frederick Company, Inc., and Purdue Pharma L.P. (collectively, the Purdue Companies), and three top executives agreed to pay almost \$635 million to resolve a variety of Federal, State, and private claims for fraudulently marketing OxyContin, a controlled-release formulation of Oxycodone, a powerful pain medication. The investigation revealed that from December 1995 through June 2001, Purdue Frederick effectively undertook a fraudulent and deceptive marketing campaign aimed at convincing doctors nationwide that OxyContin, because of its time-release formula, was less prone to abuse and that it was less likely to cause addiction or to produce other narcotic side effects than competing immediate release opioids. Purdue Frederick, along with its former president, Michael Friedman; Chief Legal Officer, Howard Udell; and former Chief Medical Officer, Paul Goldenheim, were sentenced for criminal violations of the Federal Food, Drug, and Cosmetic Act for the misbranding of the drug OxyContin.

Each executive was sentenced to 3 years of probation, ordered to perform 400 hours of community service in a drug abuse or drug treatment program, and ordered to pay a \$5,000 fine. Purdue Frederick was sentenced to 5 years of probation. Pursuant to their plea agreements, the executives will pay a total of \$34.5 million in penalties. The Purdue Companies will pay a total of almost \$600 million in settlement and restitution costs and pay a maximum statutory fine of \$500,000. Of the total global settlement, HHS received over \$95 million in Medicaid restitution (Federal and State shares) and over \$3 million in the recovery of improperly calculated Medicaid rebates involving OxyContin (Federal and State shares). Purdue Frederick will be subject to a 25-year exclusion; Purdue Pharma L.P. agreed to enter a 5-year CIA with OIG.

- *District of Columbia.* Maximus, Inc., a revenue maximization consultant, entered into a \$42.7 million settlement agreement with the United States to resolve the company's liability under the FCA. Maximus allegedly filed false claims for Medicaid-funded targeted case management services. Such services assist foster children in obtaining needed medical, social, educational, and other services. Maximus submitted 26,683 claims for Medicaid reimbursement that were not supported by documentation. The Federal Government contended that these services were never rendered. As part of the global resolution of the case, Maximus also entered into a 5-year CIA with OIG, as well as a 24-month deferred prosecution agreement with the U.S. Attorney's Office. In a novel provision, the CIA requires that OIG's OAS perform the claims and contract reviews that are ordinarily performed by an Independent Review Organization.
- *Maryland.* Pediatrix Medical Group, Inc., agreed to pay the Government \$25 million, including approximately \$10.8 million to Medicaid, and enter into a 5-year CIA to resolve its liability under the FCA for improperly billing Medicaid, TRICARE, and the Federal Employees Health Benefits Program for neonatal services provided by its doctors. Through its network of affiliated physician groups, Pediatrix provides neonatal services at various hospital neonatal intensive care units in 32 States and Puerto Rico.

Pediatrix allegedly used improper billing codes for neonatal services provided at several of these units. The Government alleged that from January 1996 to December 1999, Pediatrix billed critical care services for infants when, in fact, many of the infants were not critically ill. The settlement also resolved a Colorado case being investigated for the same misconduct.

- *Idaho.* Alan D. Kohal, Kohal Pharmacy, Inc., and Kohal Pharmacy and Medical Supply (collectively, “Kohal”), agreed to pay \$214,000 to resolve their false claims act liability. The settlement resolved allegations that Kohal billed Medicaid for more than its usual and customary charge to the general public, failed to credit Medicaid for prescriptions returned unused, billed Medicaid for prior authorizations before prescriptions were eligible to be refilled, and billed Medicaid for doses of prescription drugs not distributed to beneficiaries. The State of Idaho was also a party to the settlement. Kohal also agreed to enter into a comprehensive 5-year CIA. Alan D. Kohal and any entity in which he has an ownership interest will be bound by the terms of the CIA during the five reporting periods.

Administrative Sanctions

Program Exclusions

Through the legal authorities contained in sections 1128 and 1156 of the Social Security Act, OIG established a program to exclude individuals and entities from participation in Medicaid, Medicare, and other Federal health care programs. OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities from Federal Health Care Programs. The bases for exclusion include convictions for program-related fraud, patient abuse, State licensing board actions, default on Health Education Assistance Loans, and violation of existing CIAs. Many of these are acts committed against the Medicaid program or its beneficiaries.

During FY 2007, OIG excluded 3,308 individuals and entities from participating in Medicaid, Medicare, and other health care programs. These exclusions can have the effect of reducing potential fraud that may be committed by the excluded entities against similar Federal health care programs. The following are examples of program exclusions imposed in FY 2007.

- *Georgia.* Martin Bradley, III, owner of a pharmaceutical wholesale distributing company, was excluded for a minimum period of 70 years based on his conviction related to a racketeering scheme involving prescription drugs that were unlawfully obtained and diverted from 1996 to 2003. He was sentenced to 20 years of incarceration and ordered to pay over \$27.8 million in restitution, including over \$10.1 million in restitution to the Florida Medicaid program and over \$2.7 million to CMS.
- *Texas.* Doris Blake, owner of a billing company, was excluded for a minimum period of 50 years based on her conviction related to a Medicaid fraud scheme. She billed the Medicaid program from September 2001 to December 2003 for chemical dependency counseling services that were never rendered. She was sentenced to 50 years of incarceration and ordered to pay over \$1 million in restitution.

- *Florida.* Thomas Merrill, an osteopath, was excluded for a minimum period of 50 years based on his conviction for wire fraud, health care fraud resulting in death, and unlawful dispensing of numerous controlled substances. From about January 2000 to May 2004, the osteopath submitted claims for medical services and procedures that were not provided or medically necessary. In addition, he wrote prescriptions for controlled substances outside the usual course of professional practice, resulting in patient deaths. He was sentenced to life in prison and ordered to pay approximately \$115,000 in restitution to Blue Cross Blue Shield, Medicaid, TRICARE, and a private insurer.

Civil Monetary Penalties Under the Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) (42 U.S.C. § 1395dd) requires of all hospitals that receive Federal funding through Medicaid and other Federal health care programs that “if any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility.” This statute is designed to ensure patient access to appropriate emergency medical services regardless of the patient’s health insurance coverage status.

In FY 2007, OIG collected \$265,000 in civil monetary penalties, representing collections from nine hospitals and one physician under the EMTALA. The following are examples of settlements involving alleged violations of that statute.

- *Wheaton Franciscan Healthcare St. Joseph, Inc f/k/a St. Joseph Regional Medical Center (St. Joseph), Wisconsin.* The center agreed to pay \$40,000 to resolve its liability for civil monetary penalties under the EMTALA. OIG alleged that St. Joseph failed to provide an appropriate medical screening examination and stabilizing treatment to a woman that presented to St. Joseph’s emergency department (ED) complaining of severe upper quadrant abdominal, hip, and thigh pain, following a motor vehicle accident. The ED physician diagnosed the patient as having a right hip and thigh contusion and did not conduct any lab work, any x-rays, or a CT scan. The patient was given an anti-inflammatory and discharged. The patient protested leaving the ED and informed a nurse that she was in extreme pain and could not walk. Hospital staff told the patient to leave the hospital and threatened to call the police. The patient was then placed in a wheelchair and hospital security escorted to her relative’s car. The patient presented to another hospital’s ED, where an x-ray revealed that she had a dislocated right hip, and a CT scan of the hip revealed an acetabular fracture that prevented relocation of the hip without surgery.
- *St. Mary’s Medical Center, Indiana.* The center agreed to pay \$40,000 to resolve allegations that it engaged in patient dumping. A 46-year-old uninsured man came to the hospital’s emergency department by ambulance and in an unresponsive state. The on-call neurosurgeon was at the hospital but did not treat the patient. Instead, he directed the emergency department physician to transfer the patient over 180 miles away. The

transfer was performed without stabilizing treatment, and the patient arrived at the second hospital “brain dead.”

- *Medical Center of Arlington (MCA), Texas.* The center agreed to pay \$30,000 to resolve its liability for civil monetary penalties under the EMTALA. OIG alleged that MCA violated the screening, stabilization, and transfer provisions of the patient dumping statute when a female in her 39th week of pregnancy presented to MCA’s labor and delivery department with contractions. After approximately 35 minutes of observation, an on-duty obstetrician ordered that the patient be discharged with instructions to go, by private automobile, to another hospital that was nearly 21 miles away. Based on clinical indicators upon the patient’s arrival at the alternative hospital, the order by MCA was alleged to have created an unreasonable level of risk for the patient and her child.

Medicaid Fraud Control Units

In addition to conducting audits, evaluations and investigations and providing legal services, OIG is responsible for oversight of Federal grants to State MFCUs. In FY 2007, OIG oversaw the distribution of \$169 million to MFCUs in 49 States and the District of Columbia. Section 1902(a)(61) of the Social Security Act, as amended by section 13625 of the OBRA, required OIG to develop performance standards for assessing MFCUs. The standards are to assess the effectiveness and efficiency of MFCUs and enable OIG to determine whether the MFCUs are carrying out their duties and responsibilities in an effective manner and in accordance with applicable laws. These standards were created in consultation with the MFCU community and made effective on September 26, 1994. In FY 2007, OIG conducted 12 onsite reviews of MFCUs.

During this same time period, OIG participated in 724 joint investigations with MFCUs and opened 490 investigations into potential fraud involving the Medicaid program.

Outreach

In FY 2007, OIG undertook a diverse array of other activities to enhance its capacity to fight fraud, waste, and abuse in Medicaid and develop the capacity of its Federal and State partners in conducting their Medicaid oversight and enforcement responsibilities. More specifically, OIG conducted outreach activities such as hosting training conferences, participating in roundtable discussions, and issuing advisory opinions. The following subsections describe OIG’s FY 2007 outreach activities.

Advisory Opinions to Outside Parties

In accordance with section 205 of the HIPAA, OIG, in consultation with DOJ, issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. This authority allows OIG to provide case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse authorities. In FY 2007, OIG issued 18 advisory opinions related to Medicaid. The following are examples:

- In Advisory Opinion 07-07, OIG considered a proposed cash donation to a retirement community by a charitable foundation affiliated with a health system. The retirement community provides a residential alternative to nursing homes for certain patients with special needs, including Medicaid beneficiaries. It is in a position to purchase federally financed paid items and services from the health system. The retirement community, the foundation, and the health system are all located in a medically underserved area, and the three entities have overlapping directors. OIG determined that, although the proposed donation could implicate the anti-kickback statute, OIG would not impose sanctions for a combination of reasons. First, the donation would be unrestricted, made as part of broad solicitation of funding, in proportion with contributions of other businesses in the area, and would constitute only a small percentage of the overall funding. Second, the donation would represent a one-time-only, fixed in-advance payment that would not be determined in a manner related to the volume or value of any business generated for the health system. Third, the retirement community would not be required to purchase items or services from the health system and would have an incentive to act as a prudent purchaser. Finally, the retirement community would implement certain safeguards against improper influence by the health care system.
- In Advisory Opinion 07-12, OIG addressed a State's proposal to accept low- or no-cost bids for therapy services to be provided at State-run veterans' homes. The winning bidder would bill Medicare, Medicaid, or other third-party payers for services provided to insured patients and would bill the veterans for any cost-sharing amounts on behalf of these patients. Services to uninsured patients would be provided by the bidder at low or no cost. OIG determined that, although the proposals could implicate the anti-kickback statute, OIG would not impose sanctions based on several factors. The bid and the services to be provided would be part of a comprehensive regulatory scheme to care for the State's veterans, including some beneficiaries of the Medicaid program. The risk of overutilization would be low, because the veterans would have an incentive to monitor utilization to control costs for which they would be responsible. In addition, there would be no adverse effect on competition because the bids would be pursuant to open, competitive invitations for bids in accordance with State law. Finally, the payment of cost-sharing amounts on behalf of residents who are Medicare or Medicaid beneficiaries would not be an improper inducement, because the State would thereby fulfill its statutory responsibility under State law to provide for the care and assistance of its veterans.

Resource for Health Care Boards of Directors

In September 2007, OIG issued a resource guide for health care boards of directors. The guide is the third in a series of documents co-sponsored by OIG and the American Health Lawyers Association (AHLA). It seeks to assist directors of health care organizations in carrying out their important oversight responsibilities in the current challenging health care environment. The guide is designed to help directors ask knowledgeable and appropriate questions related to health care quality requirements, measurement tools, and reporting requirements to establish, and affirmatively demonstrate, that they have followed a reasonable quality oversight process. The comments and perspectives shared in this educational resource are intended to assist boards in exercising their duty of care as it relates to health care quality effectively, efficiently, and in a manner that will help improve the nation's health care system. The guide is available on OIG's Web site at

<http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>.

Long-Term Care Quality-of-Care Roundtable

On December 6, 2007, OIG and the Health Care Compliance Association (HCCA) cosponsored a Government-industry roundtable called "Driving for Quality in Long-Term Care: A Board of Directors Dashboard." One of the goals of the roundtable was to specify items that could be included on a "Quality of Care Dashboard" to be offered as a tool for boards of directors of long-term care organizations. Over 35 long-term care professionals and 10 Government representatives attended the day-long event. The day consisted primarily of breakout discussion groups designed around three perspectives on the oversight of quality of care: (1) organizational commitment to quality, (2) processes related to monitoring and improving quality, and (3) outcome measures related to quality. In addition to these three substantive areas, a fourth discussion group considered the benefits of, and challenges to, developing a "Quality-of-Care Dashboard." A report of the roundtable is available on the OIG Web site at

<http://www.oig.hhs.gov/fraud/docs/complianceguidance/Roundtable013007.pdf>.

OIG-Sponsored Medicaid Integrity Program Conferences

During FY 2007, OIG hosted six MIP conferences and set in motion working relationships and future collaboration among OIG, Federal and State investigators, auditors, attorneys and analysts from 26 States and the District of Columbia. Table 4 presents a list of the completed conferences.

Table 4: OIG 2007 MIP Conferences

Region	Location	Dates	Attendance
New York	Cape May, NJ	March 5–7, 2007	90
Boston	Boston, MA	May 9–10, 2007	90
Dallas	Dallas, TX	June 5–7, 2007	100
Chicago	Indianapolis, IN	July 10–11, 2007	120
Atlanta	Atlanta, GA	August 21–22, 2007	110
Baton Rouge	Baton Rouge, LA	September 11–13, 2007	140

Organizing and holding the MIP conferences has enabled OIG to involve each of the following agencies in a strategic planning process to collaboratively address Medicaid fraud and abuse: CMS, Medicaid Integrity Group (CMS/MIG); District Attorneys' Offices; Federal Bureau of Investigation; independent/nonprofit health insurance associations (e.g., National Insurance Crime Bureau); MFCUs; CMS Program Safeguard Contractors; State agencies (e.g., State Health and Human Services Departments; Division of Medical Assistance and Human Services; Office of the State Comptroller); State Attorneys' General Offices; State Medicaid Inspector General Offices; United States Attorneys' Offices; and OIG.

Holding multiple conferences across the country provided OIG the opportunity to address program integrity issues and vulnerabilities that differ substantially across State lines and within various regions. Each agenda was tailored to address specific needs unique to the States residing within the hosting OIG region. Breakout sessions helped further achieve these goals by focusing on specific areas with the highest risk for fraud.

Collaboration with CMS's Medicaid Integrity Group

OIG's Medicaid integrity workgroup collaborates with CMS/MIG to coordinate and maximize our respective activities to protect the integrity of Medicaid. OIG has provided feedback and technical assistance to CMS/MIG on a number of products, including the statement of work, task orders, and audit protocols for its Medicaid integrity contactors and letters to State Medicaid Directors. OIG has also offered input into the curriculum for CMS/MIG's training programs for its newly hired staff and for State Medicaid program integrity staff. In addition, OIG and CMS/MIG jointly developed procedures for CMS/MIG's Medicaid integrity contactors to refer cases of potential fraud to OIG. Finally, in followup to OIG's report on suspected fraud referrals from State Medicaid programs to MFCUs, OIG is assisting CMS/MIG in implementing its recommendation to develop fraud referral performance standards for State Medicaid agencies.

Seminars for Federal Agents and Attorneys

OIG cosponsored a conference with DOJ's Office of Legal Education on Medicaid fraud enforcement entitled "HHS Seminar on Strengthening OIG Response to Medicaid Fraud – Developing Successful Investigations." The conference was designed for Federal agents and attorneys with backgrounds in health care fraud and included 130 attendees and speakers from OIG, GAO, MFCUs, State Attorneys General, U.S. Attorneys' Offices, and DOJ. We specifically addressed the following subjects.

- Medicaid Vulnerabilities – The GAO Perspective
- Federal and State False Claims Acts
- Investigative Tools
- Drug Diversion
- Kickbacks
- Case Resolution
- Challenges to Collaboration: A Panel Discussion
- Nursing Home Fraud: Financial Fraud and Failure of Care

- Trying a Fraud Case: Lessons Learned; Home Health Care Fraud
- Medical Transportation Fraud
- Hospital Medicaid Fraud
- Pharmaceutical Cases

Biannual MFCU Conference

To assist MFCUs in meeting their training needs, OIG conducted its biannual administrative training conference in Chicago, Illinois, from July 30 through August 2, 2007. The purpose of the conference was to provide guidance on issues and concerns that relate directly to the oversight responsibilities of OIG.

Congressional Hearing

On July 18, 2007, Assistant Inspector General for Legal Affairs, Gregory Demske, testified before the Senate Special Committee on Aging regarding OIG's work related to identifying and preventing the abuse of the elderly. The testimony described the spectrum of activities, enforcement actions, and initiatives that OIG has undertaken to identify cases of elder abuse, ensure that those who would harm the elderly are prosecuted to the fullest extent of the law and/or prevented from continuing to participate in Federal health care programs, identify where programs and systems involved in the oversight of quality of care may be strengthened, and promote practices that will help prevent elder abuse.

SECTION 5: MEDICAID OVERSIGHT IN FY 2008 AND BEYOND

At the beginning of each fiscal year, OIG publishes its Work Plan to highlight the areas in which it expects to conduct oversight work during the coming year. In addition to being a planning document, the Work Plan serves as a method for focusing public attention on the areas deemed important and identified as particularly vulnerable to fraud, waste, and abuse.

Throughout the course of each fiscal year, the OIG work undertaken may change for a number of reasons. Some activities announced in the Work Plan may shift from higher to lower priority or may be postponed until future years as a result of the changing focus of Congress, the Secretary, OIG, or an intervening emergency or in response to trends identified in other related work. As such, OIG's work planning is an evolving process that enables OIG to remain adaptable to the changing priorities of its stakeholders.

Appendix A of this report lists OIG reports issued in FY 2007, and Appendix B identifies more than 70 Medicaid Work Plan items that OIG anticipates undertaking during FY 2008. Although most Work Plan items will be initiated in FY 2008, many will not be completed within the fiscal year. Some of these reviews increase the scope and depth of prior OIG work by conducting follow-up activities and others expand into new and emerging areas of interest. OIG will also continue its investigative and enforcement activities and its outreach and guidance to the health care industry. Detailed summaries of OIG's anticipated work activities for FY 2008 can be

found in the OIG Work Plan, which is located in the “Publications” section of the OIG Web site at <http://www.oig.hhs.gov/publications>.

In addition to the activities described in the FY 2008 Work Plan, we are planning other activities to enhance Medicaid enforcement and fraud prevention. For example, we expect to continue working with CMS, State MFCUs, and the National Association for Medicaid Program Integrity to improve State Medicaid agencies’ capacity to make proper referrals based on a shared understanding of the elements of successful investigations. We plan to host seven MIP conferences during FY 2008. These conferences will involve 24 States thus completing OIG’s national MIP outreach effort.

OIG is also in the process of revising and updating its compliance program guidance for nursing facilities. OIG develops compliance program guidance in its effort to engage the private health care industry in addressing and combating fraud and abuse. Over the past several years, OIG has developed and issued compliance program guidance directed at various segments of the health care industry, including nursing homes. Risk areas for the nursing home industry include the submission of false claims, as well as quality of care concerns, kickbacks, and accurate reporting of data to Medicare and Medicaid. Since OIG first published a compliance program guidance in this area (65 FR 14289; March 16, 2000), the nursing home industry has experienced a number of changes. Additionally, the subsequent years of enforcement and compliance activity in the nursing home industry has allowed OIG to address more fully the various risk areas in nursing home compliance. On January 24, 2008, OIG published a Solicitation of Information and Recommendations for Revising the Compliance Program Guidance for Nursing Facilities (73 Fed. Reg., 16).

SECTION 6: CONCLUSION

In conclusion, OIG’s varied and far-reaching activities help position the Federal Government and its partners to better monitor the integrity of funds appropriated to HHS to operate Medicaid and more than 300 other programs. In so doing, OIG serves Congress, HHS, and the American public by improving the solvency of Government-sponsored health and human services programs.

APPENDIX A: OIG'S MEDICAID-RELATED AUDIT AND EVALUATION REPORTS ISSUED IN FY 2007

This appendix contains selected report titles and reference numbers for OIG's Medicaid-related audit and evaluation reports issued during FY 2007. The full text for the reports listed below is available on the OIG Web site at <http://www.oig.hhs.gov>.

Medicaid Hospitals

Medicaid Hospital Outlier Payments in Virginia for State Fiscal Years 2001 Through 2003
(A-03-04-00212)

Review of Medicaid Disproportionate Share Hospital Payments to University Behavioral Healthcare Center, University of Medicine and Dentistry of New Jersey: July 1, 1995, Through June 30, 2001 (A-02-04-01024)

Review of Medicaid Disproportionate Share Hospital Payments to Runnells Specialized Hospital: November 1, 1996, Through June 30, 2001 (A-02-05-01007)

Review of Medicaid Reimbursement of Graduate Medical Education in Missouri
(A-07-04-03058)

Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004 (A-01-05-00001)

Virginia Rebase Process Used To Calculate Medicaid Rates for State Fiscal Years 2001 Through 2003 (A-03-05-00205)

Medicaid Long-Term and Community Care

Contracting Practices for Tennessee Home- and Community-Based Services for Mentally Retarded Persons (A-04-03-03025)

Preadmission Screening and Resident Review for Younger Nursing Facility Residents With Mental Retardation (OEI-07-05-00230)

Preadmission Screening and Resident Review for Younger Nursing Facility Residents With Serious Mental Illness (OEI-05-05-00220)

Review of Additional Reimbursement for Distinct-Part Nursing Facilities of Public Hospitals in California (A-09-05-00050)

States' Requirements for Medicaid-Funded Personal Care Service Attendants
(OEI-07-05-00250)

Tennessee Home- and Community-Based Mental Retardation Services for July 1, 2002, Through June 30, 2003 (A-04-03-03026)

Medicaid Mental Health Services

Review of Medicaid Community Mental Health Center Provider Services in Indiana (A-05-05-00057)

Medicaid/State Children's Health Insurance Program

Fraud and Abuse Safeguards in Separate State Children's Health Insurance Programs (OEI-06-04-00380)

Review of Premium Payments for Iowa's Separate State Children's Health Insurance Program for the Period July 1, 2000, Through June 30, 2002 (A-07-03-02011)

Review of State Children's Health Insurance Program Eligibility in California (A-09-06-00022)

Review of State Children's Health Insurance Program Eligibility in Florida (A-04-06-00021)

Review of State Children's Health Insurance Program Eligibility in New York State (A-02-06-01003)

Medicaid Prescription Drugs

Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Payment Limits (OEI-03-06-00400)

Examining Fluctuations in Average Manufacturer Prices (OEI-03-06-00350)

Review of Medicaid Outpatient Drug Expenditures in Iowa for the Period October 1, 2002, Through September 30, 2004 (A-07-06-04062)

Review of Medicaid Outpatient Drug Expenditures in Nebraska for the Period October 1, 1997, Through September 30, 2004 (A-07-05-04056)

States' Use of New Drug Pricing Data in the Medicaid Program (OEI-03-06-00490)

Other Medicaid Services

Improper Payment for Medicaid Pediatric Dental Services (OEI-04-04-00210)

Medicaid Provider Enrollment Standards: Medical Equipment Providers (OEI-04-05-00180)

Review of Abortion-Related Laboratory Claims Billed as Family Planning Under the New York State Medicaid Program (A-02-05-01009)

Review of Medicaid Reimbursement Rate for School-Based Health Services in Maryland
(A-03-05-00206)

Review of Nevada's Medicaid School-Based Administrative Expenditures for Calendar Years
2003 and 2004 (A-09-05-00054)

Review of Pharmacy Claims Billed as Family Planning Under New Jersey's Medicaid Program
(A-02-05-01019)

Review of Pharmacy Claims Billed as Family Planning Under the New York State Medicaid
Program (A-02-05-01018)

Review of Retroactive School Health Claims – New York City Department of Education
(A-02-03-01029)

Review of Retroactive School Health Claims – Rest of State (A-02-04-01021)

Review of State Claims for the Costs of Family Planning Services Provided Through Medicaid
Managed Care Programs (A-03-06-00200)

Medicaid Administration

Arkansas Physician Supplemental Payment Program (A-06-06-00064)

Audit of California's Section 1115 Medicaid Demonstration Project Extension for Los Angeles
County (A-09-04-00038)

Medicaid Payments for Skilled Professional Medical Personnel to Missouri School Districts
(A-07-06-03075)

Medicaid Enhanced Payments for Illinois State-Employed Physicians for April 1, 2002, Through
June 30, 2004 (A-05-06-00042)

Review of Allegheny County's Medicaid Administrative Case Management Costs Claimed by
Pennsylvania Between January 2002 and June 2003 (A-03-05-00201)

Review of California's Controls Over Reporting of County Medicaid Administrative
Expenditures (A-09-05-00057)

Review of Medicaid Credit Balances at Baystate Franklin Medical Center for the Period Ending
June 30, 2006 (A-01-07-00002)

Review of Medicaid Credit Balances at Baystate Mary Lane Hospital for the Period Ending
June 30, 2006 (A-01-06-00010)

Review of Medicaid Credit Balances at Baystate Medical Center for the Period Ending June 30, 2006 (A-01-07-00004)

Review of Medicaid Eligibility in California for the Period January 1 Through June 30, 2005 (A-09-06-00028)

Review of Medicaid Eligibility in Florida (A-04-06-00020)

Review of Medicaid Eligibility in New York State (A-02-05-01028)

Review of the Medicaid Program's Use of Consultants on a Contingency Fee Basis (A-04-05-00015)

Review of Missouri Provider Tax (A-07-06-01029)

Review of Montgomery County's Medicaid Administrative Health Services Costs Claimed by Maryland Between October 2003 and September 2004 (A-03-05-00208)

Review of Non-Risk Managed Care Contract Administration Fees in Utah (A-07-06-01020)

Review of Social Security Act Section 1915(c) Waiver Payments for Home and Community-Based Services at Trinity Services, Inc., July 1, 2004, through June 30, 2005 (A-05-07-00056)

Suspected Medicaid Fraud Referrals (OEI-07-04-00181)

Medicaid Information Systems Controls

Use of Health Information Technology in State Medicaid Programs (OEI-02-06-00270)

Medicaid Hurricane Response

Medicaid Payments and Services Related to Hurricanes Katrina and Rita (OEI-05-07-00300, primary report, and OEI-05-06-00140, data compendium)

APPENDIX B: MEDICAID WORK INCLUDED IN OIG'S FY 2008 WORK PLAN

This appendix lists Medicaid-related audit and evaluation work included in OIG's FY 2008 Work Plan. Summaries of the objectives of each project are provided in the work plan, located in the "Publications" section of the OIG Web site at <http://www.oig.hhs.gov>.

Medicaid Hospitals

Hospital Eligibility for Disproportionate Share Hospital Payments (OAS W-00-05-31084)

Hospital Outlier Payments (OAS W-00-04-31069; OAS W-00-05-31069)

Medicaid Disproportionate Share Hospital Payment Distribution (OAS W-00-08-31302)

Provider Eligibility for Medicaid Reimbursement (OAS W-00-08-31301)

States' Use of Disproportionate Share Hospital Payments (OAS W-00-08-31300)

Medicaid Long Term and Community Care

Assisted Living Facilities (OAS W-00-04-31076; OAS W-00-05-31076)

Billing for Medicaid Nursing Home Patients Transferred to Hospitals (OAS W-00-07-31201)

Community Residence Rehabilitation Services (OAS W-00-07-31087)

Inappropriate Medicaid Payments for Personal Care Services During Periods of Institutionalization (OEI 07-06-00620)

Medicaid Adult Day Health Service Payments for Ineligible and Absent Beneficiaries (OEI 09-07-00500)

Medicaid Home Health Agency Claims (OAS W-00-08-31304)

Medicaid Payments for Medicare-Covered Home Health Services (OEI 07-06-00640; OEI 07-06-00641; OAS W-00-07-31305)

Medicaid Payments for Personal Care Services (OAS W-00-05-31035)

States' Use of Civil Monetary Penalty Funds (OEI 00-00-00000; OAS W-00-08-31303)

Targeted Case Management (OAS W-00-05-31082; OAS W-00-06-31082)

Medicaid Mental Health Services

Early and Periodic Screening, Diagnosis, and Treatment of Mental Health in Medicaid Managed Care Plans (OEI 00-00-00000)

Medicaid Supplemental Mental Health Payments to Prepaid Inpatient Health Plans (OAS W-00-06-31098; OAS A-07-06-04067)

Medicaid/State Children's Health Insurance Program

Assessing Medicaid Eligibility for Children Enrolled in Separate State Children's Insurance Programs (OEI 06-07-00310)

Medicaid Prescription Drugs

Additional Rebates of Brand-Name Drugs (OAS W-00-08-31306; OAS A-06-08-00000)

Assessing the Accuracy of Drug Type Classification in the Medicaid Drug Rebate Initiative File (OEI 00-00-00000)

Calculation of Average Manufacturer Prices (OAS W-00-07-31202)

Disputes Within the Medicaid Prescription Drug Rebate Program (OEI 00-00-00000)

Manufacturers' Submission of Outliers Average Manufacturer Price (OEI 03-07-00740)

Pharmacies' Ability To Purchase Drugs at the Average Manufacturer Price (OAS W-00-07-31204; OEI 00-00-00000)

Post Implementation Review of the Federal Upper Limit Program (OEI 00-00-00000)

States' Accountability Over Medicaid Drug Rebate Programs (OAS W-00-07-31205)

States' Medicaid Drug Claims (OAS W-00-07-31203)

States' Use of the Average Manufacturer Price To Establish Medicaid Pharmacy Reimbursement (OEI 00-00-00000)

Zero Dollar Unit Rebate Amounts (OAS W-00-07-31106)

Other Medicaid Services

Adult Rehabilitative Services (OAS W-00-03-31028)

Family Planning Services (OAS W-00-04-31078; OAS W-00-05-31078; OAS W-00-06-31078)

Freestanding Inpatient Alcoholism and Substance Abuse Providers (OAS W-00-06-31107)

Improper Medicaid Payments for Laboratory Services for Dual-Eligible Beneficiaries (OEI 04-07-00340)

Medicaid Laboratory Tests (OAS W-00-07-31206)

Medicaid Payments for Transportation Services (OAS W-00-06-31121)

Medicaid Physical and Occupational Therapy Services: Appropriateness of Payments (OEI 00-00-00000)

Medicaid Safeguards Over Payments for Nonemergency Transportation Services (OEI 06-07-00320)

Medicaid's Use of an All-Inclusive Rate for Reimbursing the Indian Health Service and Tribes for Prescription Drugs (OEI 09-08-00160)

Medical Equipment (OAS W-00-08-31307)

Medical Services for Undocumented Aliens (OAS W-00-06-31108)

Outpatient Alcoholism and Substance Abuse Services (OAS W-00-07-31079)

Reimbursement Rates for Services Provided by Indian Health Service Facilities (OAS W-00-07-31221)

Medicaid Administration

Additional Medicaid Payments to High-Volume Providers (OAS W-00-07-31214)

Appropriateness of Level of Care Determinations for Home- and Community-Based Services Waiver Recipients (OEI 00-00-00000)

Contingency Fee Payment Arrangements (OAS W-00-04-31045; OAS W-00-05-31045; OAS W-00-06-31045)

External Quality Review Organizations' Compliance With Federal Requirements (OEI 01-06-00510)

Medicaid and State Children's Health Insurance Program Payment Error Rate Measurement (OAS W-00-08-31314)

Medicaid Administrative Costs (OAS W-00-06-39044; OAS W-00-06-31123)

Medicaid Asset Transfers and Estate Recovery Provision for Nursing Home Care
(OAS W-00-06-31113)

Medicaid Claims at Enhanced Federal Financial Participation Rates (OAS W-00-08-31310)

Medicaid Eligibility in Multiple States (OAS W-00-06-31114)

Medicaid Enrollment of Working Disabled (OEI 00-00-00000)

Medicaid Managed Care Encounter Data: Reporting and Utilization (OEI 07-06-00540)

Medicaid Management Information System Costs (OAS W-00-08-31312)

Medicaid Payments for Services Provided Under Section 1115 Demonstration Projects
(OAS W-00-07-31208)

Medicaid Payments for Services Provided Under Section 1915(b) Managed Care/Freedom of
Choice Waivers (OAS W-00-08-31125)

Medicaid Payments for Services Provided Under Section 1915(c) Home- and Community-Based
Service Waivers (OAS W-00-06-39045; OAS W-00-06-31124)

Medicaid Payments Made for Ineligible Managed Care Members (OAS W-00-07-31212)

Medicaid Provider Tax Issues (OAS W-00-08-31094)

Medicaid Statistical Information System Data Reporting (OEI 04-07-00240)

Medicaid Upper Payment Limits (OAS W-00-08-31313)

Medicaid Waiver Safety Net Care Pools (OAS W-00-08-31308)

Medicare/Medicaid Credit Balances (OAS W-00-08-31311)

Physician Assistant Reimbursement (OAS W-00-07-31089)

Provider Enrollment Controls for Medicaid Home- and Community-Based Services Waiver
Providers (OEI 00-00-00000)

Sections 1915(b) and (c) Concurrent Waivers (OAS W-00-08-31309)

State and Federal Oversight of Home- and Community-Based Services (OEI 02-08-00170)

State Medicaid Third Party Liability (OEI 00-00-00000; OAS W-00-07-31213)

Upper Payment Limits—Flow of Funds (OAS W-00-07-31207)

Information Systems Controls

Claims-Processing Controls To Prevent Duplicate Payments for Medicaid Services
(OAS W-00-08-41040)

Health Information Technology in Medicare and Medicaid—Security Issues
(OAS W-00-08-41021)

Medicaid Management Information Systems—Business Associate Agreements
(OAS W-00-08-41028)

Oversight of System Conversions, Redesigns, and Transitions of State Medicaid Management
Information Systems (OAS W-00-08-41077)

State-Based Controls Over Medicaid Payments and Program Eligibility (OAS W-00-08-40019)

Medicaid-Related Gulf Coast Hurricane Response

Duplicate Medicaid Payments to Providers (OAS W-00-06-31117)

Medicaid Payments for Evacuees (OAS W-00-07-31216)

Uncompensated Care Costs (OAS W-00-07-31219)

APPENDIX C: ACRONYMS AND ABBREVIATIONS

The following is a list of acronyms and abbreviations used in this publication.

AMP	average manufacturer price
CIA	corporate integrity agreement
CMP	Civil monetary penalty
CMS	Centers for Medicare & Medicaid Services
CMS/MIG	CMS, Medicaid Integrity Group
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	disproportionate share hospital
ED	emergency department
EMTALA	Emergency Medical Treatment and Labor Act
FCA	False Claims Act
FR	Federal Register
FY	fiscal year
GAO	Government Accountability Office
HCCA	Health Care Compliance Association
HCFA	Health Care Fraud and Abuse Control Program
HHS	Department of Health and Human Services
HIE	health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	health information technology
IG	Inspector General

IT	information technology
MCA	Medical Center of Arlington
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MIP	Medicaid Integrity Program
MITA	Medicaid Information Technology Architecture
MRO	Medicaid Rehabilitation Option
OAS	Office of Audit Services
OBRA	Omnibus Budget Reconciliation Act of 1993
OCIG	Office of Counsel to the Inspector General
OEI	Office of Evaluation and Inspections
OI	Office of Investigations
OIG	Office of Inspector General
OMP	Office of Management and Policy
PASRR	Preadmission Screening and Resident Review
P.L.	Public Law
SCHIP	State Children's Health Insurance Program