



Health Care ADVISORY ■

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Highlights of the OIG's 2016 *Work Plan*

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On November 2, 2015, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) issued its [Work Plan for Fiscal Year 2016](#) ("2016 Work Plan").¹ The 2016 *Work Plan* outlines the areas of special concern to the OIG and describes the enforcement and monitoring initiatives the OIG will pursue in Fiscal Year 2016 in connection with its oversight of the Centers for Medicare & Medicaid Services (CMS) and other agencies of HHS. The OIG's mission is to protect the integrity, quality and safety of HHS programs while also reducing fraud, waste and abuse of those programs through various enforcement and monitoring initiatives. Companies in the health care industry should be aware of the OIG's initiatives when planning their business strategies, internal audits and compliance efforts for the year.

The OIG 2016 *Work Plan* included several new initiatives as well as a number of revised initiatives from the previous year. Many of the activities outlined in the 2015 *Work Plan* are repeated with updates in the 2016 *Work Plan*. This indicates that the initiatives from last year's *Work Plan* remain high priorities and areas of special concern to the OIG for 2016.

The 2016 *Work Plan* covers a broad array of projects related to CMS programs, organized by type of provider and federal reimbursement scheme. Here are notable highlights of some of the new and continuing projects in the 2016 *Work Plan*:

New OIG Initiatives

Hospitals

- **Medical Device Credits for Replaced Medical Devices.** Prior OIG reviews have determined that Medicare administrative contractors have made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices. Medical devices are implanted during an inpatient or an outpatient procedure. Such devices may require replacement because of defects, recalls or mechanical complication. Federal regulations require reductions in Medicare payments for the replacement of implanted devices. The OIG will determine whether Medicare payments for replaced medical devices were made in accordance with Medicare requirements.

¹ <http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf>.

- **Medicare Payments During MS-DRG Payment Window.** The OIG will review Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays are allowable and in accordance with the inpatient prospective payment system. Certain items, supplies and services furnished to inpatients are covered under Part A and should not be billed separately to Part B. Prior OIG audits, investigations and inspections have identified this area as at risk for noncompliance with Medicare billing requirements.
- **CMS Validation of Hospital-Submitted Quality Reporting Data.** The OIG will study the extent to which CMS validated hospital inpatient quality reporting data. Section 1886(b)(3)(B)(viii)(XI) of the Social Security Act gives CMS the authority to conduct validation of its quality reporting program. CMS uses this quality data for the hospital value-based purchasing program and the hospital acquired condition reduction program. The study will also describe the actions that CMS has taken as a result of its validation.

Nursing Homes

- **Skilled Nursing Facility Prospective Payment System Requirements.** Prior OIG audits and investigations have identified areas at risk for noncompliance with skilled nursing facility (SNF) Medicare billing requirements. The OIG will review compliance with various aspects of the SNF prospective payment system, including the documentation requirements in support of the claims paid by Medicare. Prior OIG reviews have found that Medicare payments for therapy greatly exceeded SNFs' cost for therapy. The OIG also found that SNFs have increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. All documentation requirements specified in 42 CFR § 483.20 must be met to ensure that SNF care is reasonable and necessary, including a physician order at the time of admission for the resident's immediate care, a comprehensive assessment and a comprehensive plan of care prepared by an interdisciplinary team that includes the attending physician, a registered nurse and other appropriate staff.

Medical Equipment and Supplies

- **Orthotic Braces – Reasonableness of Medicare Payments Compared to Amounts Paid by Other Payers.** The OIG will determine the reasonableness of Medicare fee schedule amounts for orthotic braces by comparing Medicare payments made for orthotic braces to amounts paid by non-Medicare payers. The OIG plans to align the fee schedule for orthotic braces with those of non-Medicare payers.
- **Osteogenesis Stimulators – Lump Sum Purchase vs. Rental.** Osteogenesis stimulators, also known as bone-growth stimulators, apply an electric current or ultrasound to the spine or a long bone and are used when a fusion or fracture failed to heal or after a multilevel spinal fusion. Because osteogenesis stimulators are categorized as "inexpensive and other routinely purchased items," the beneficiary has the option of either purchasing or renting the stimulators. The OIG will assess whether potential savings can be achieved by Medicare and its beneficiaries if osteogenesis stimulators are rented over a 13-month period rather than acquired through a lump-sum purchase.
- **Orthotic Braces – Supplier Compliance with Payment Requirements.** The OIG will review Medicare Part B payments for orthotic braces to determine whether durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers' claims are medically necessary. Prior OIG analysis has indicated that some DMEPOS suppliers were billing for services that were medically unnecessary (e.g., beneficiaries received multiple braces and the referring physician did not see the beneficiary) or were not documented in accordance with Medicare requirements.

- **Increased Billing for Ventilators.** CMS has expressed concerns about the increase in billing for ventilators, specifically HCPCS Code E0464 (a pressure support ventilator with a volume control mode and a noninvasive interface). The OIG believes suppliers may be inappropriately billing for ventilators for beneficiaries with non-life-threatening conditions, which would not meet the medical necessity criteria for ventilators and might instead be more appropriately billed to codes for CPAPs or RADs. The CMS National Coverage Determination Manual §280.1 stipulates that ventilators are covered for the treatment of severe conditions associated with “neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.” Ventilators would not be considered reasonable and necessary to treat any of the conditions described in the LCDs for either CPAPs or RADs.

Other Providers and Suppliers

- **Ambulatory Surgical Centers – Quality Oversight.** The OIG will review Medicare’s quality oversight of ambulatory surgical centers (ASCs). Previous OIG work found problems with such oversight, including finding spans of five or more years between certification surveys for some ASCs, poor CMS oversight of state survey agencies and ASC accreditation organizations and little public information on ASCs’ quality of care.
- **Physicians – Referring/Ordering Medicare Services and Supplies.** The OIG will review select referrals/orders by physicians and non-physician practitioners for services, supplies and durable medical equipment (DME) to determine whether payments were made in accordance with Medicare requirements. For certain services, supplies and DME to be reimbursable by Medicare, CMS requires that the referring/ordering physician or non-physician practitioner be enrolled in Medicare and legally eligible to refer/order services, supplies and DME.
- **Anesthesia Services – Non-Covered Services.** The OIG will review Medicare Part B claims for anesthesia services to determine whether the claims were supported by a related Medicare service in accordance with Medicare requirements.
- **Physician Home Visits – Reasonableness of Services.** The OIG will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements, including the requirement that physicians document the medical necessity of a home visit in lieu of an office or outpatient visit.
- **Prolonged Services – Reasonableness of Services.** The OIG will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. The necessity of prolonged services are considered to be rare and unusual.
- **Histocompatibility Laboratories – Supplier Compliance with Payment Requirements.** The OIG will determine whether payments to histocompatibility laboratories were made in accordance with Medicare requirements. Histocompatibility laboratories are reimbursed on the basis of reasonable costs. Costs claimed by histocompatibility laboratories on cost reports must be related to the care of beneficiaries, reasonable, necessary and proper; and cost information must be accurate and sufficient in detail to support payments made for services provided.

Other Part A and Part B Program Management Issues

- **Accountable Care Organizations: Strategies and Promising Practices.** The OIG will review accountable care organizations (ACOs) that participate in the Medicare Shared Savings Program. Specifically, the OIG will look at ACOs' performance of quality measures and cost savings over the first three years of the program. Additionally, the OIG will identify strategies for and challenges to achieving quality and cost savings.
- **Medicare Payments for Beneficiaries Unlawfully Present in the United States – Mandated Review.** The OIG will review the procedures established by CMS pursuant to Section 502 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted in April 2015, to prevent and recoup Medicare payments for items and services furnished to beneficiaries unlawfully present in the United States. The OIG is required by MACRA to submit to Congress a report on the procedures established by CMS no later than 18 months after the date of its enactment (October 2016).
- **Medicare Payments for Incarcerated Beneficiaries – Mandated Review.** The OIG will review the procedures established by CMS pursuant to Section 502 of MACRA to prevent and recoup Medicare payments for items and services furnished to incarcerated beneficiaries. The OIG is required under MACRA to submit to Congress a report on the procedures established by CMS no later than 18 months after the date of its enactment (October 2016).
- **CMS Management of the ICD-10 Implementation.** The OIG will review aspects of CMS's early management of the implementation of the tenth version of the International Classification of Diseases (ICD-10) codes in Medicare Parts A and B. The OIG's assessment may include reviewing CMS's and its contractors' (e.g., MACs) assistance and guidance to hospitals and physicians and assessing how the transition to ICD-10 is affecting claims processing. The OIG may also determine how ICD-10 diagnosis codes are being applied to selected CMS payment rules and safeguards.

Part C – Medicare Advantage

- **Medicare Advantage Organization Practices in Puerto Rico.** The OIG will determine whether Medicare Advantage (MA) organization provider networks in Puerto Rico were established in accordance with federal requirements. The OIG will review MA organization networks to determine whether MA beneficiaries have access to appropriate medical care. The OIG will also determine whether providers in the network complied with federal, state and local credentialing requirements. The OIG highlighted the requirement that MA organizations may select the providers that provide the benefits under the plan as long as the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner that assures continuity in the provision of benefits. The OIG noted that MA organizations must disclose to each plan enrollee the plan's service area and the number, mix and distribution of plan providers. This notice must be provided at enrollment and at least annually thereafter in a clear, accurate, standardized form.

Part D – Prescription Drug Program

- **Medicare Part D Beneficiaries' Exposure to Inappropriate Drug Pairs.** The OIG will determine whether Medicare Part D beneficiaries are being prescribed drugs that should not be prescribed in combination with other drugs. This includes drugs that cause a severe reaction when used in combination with other drugs and drugs that should not be co-prescribed with component drugs.

- **Medicare Part D Eligibility Verification Transactions.** The OIG will review E1 transactions to assess the validity of the data. An E1 transaction is a Medicare eligibility verification transaction that is submitted by the pharmacy to determine a beneficiary's eligibility in the Part D program and Part D insurance coverage information to the TrOOP (true out-of-pocket) facilitator. E1 transactions are part of the real-time process of the coordination of benefits and calculating the TrOOP balance.
- **Part D Pharmacy Enrollment.** The OIG will review CMS's ability to oversee Part D pharmacies and also determine the extent to which pharmacies that bill for Part D drugs—especially those identified as high risk—are enrolled in Medicare. Numerous OIG reports have raised concerns about the oversight of Part D and pharmacy-related fraud. In June 2015, OIG participated in the [largest national health care fraud takedown](#) in history, resulting in over 240 subjects being charged with defrauding Medicare and Medicaid. Much of this alleged fraud involved prescription drug pharmacies.²
- **Increase in Prices for Brand-Name Drugs Under Part D.** The OIG will evaluate the extent pharmacy reimbursement for brand-name drugs under Medicare Part D changed between 2010 and 2014 and compare the rate of change in pharmacy reimbursement for brand-name drugs under Medicare Part D to the rate of inflation for the same period. Prices for the most commonly used brand-name drugs increased nearly 13 percent in 2013, an increase eight times greater than the general inflation rate for the year.

Medicaid Prescription Drug Reviews

- **Specialty Drug Pricing and Reimbursement in Medicaid.** The OIG will examine how state Medicaid agencies define specialty drugs, how much states paid for specialty drugs, how states determine payment methodologies for specialty drugs and the differences in reimbursement amounts for these drugs among the states. Specialty pharmacies dispense prescription drugs that often require special handling or administration. These specialty drugs are often expensive and are used to treat rare conditions, such as Hepatitis C, HIV and certain cancers. States use CMS's national average drug acquisition cost to set Medicaid pharmacy reimbursement amounts. This average does not include the cost of drugs sold at specialty pharmacies, so states that use the national average drug acquisition cost may have difficulty determining Medicaid pharmacy reimbursement amounts for specialty drugs.

Other Medicaid Services, Equipment and Supplies

- **Express Lane Eligibility.** The OIG will assess the extent to which selected states made inaccurate eligibility determinations using the Express Lane option for Medicaid and the Children's Health Insurance Program (CHIP). The Express Lane option permits states to rely on eligibility findings made by other programs, such as Head Start and Temporary Assistance to Needy Families. The OIG will also assess whether and how the selected states addressed issues that contributed to inaccurate determinations. The OIG will calculate an eligibility error rate and determine the amount of payments associated with beneficiaries who received incorrect eligibility determinations for Medicaid and CHIP beneficiaries under the Express Lane option. In its review, the OIG will assess states' use of the different Express Lane Eligibility (ELE) models, the reported benefits of such use and the efforts and barriers to employing and extending ELE to renewal and adult applications.

² <http://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712>.

- **State Agency Verification of Deficiency Corrections.** The OIG will determine whether state survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys. A [prior OIG review](#) found that Washington State's survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with federal requirements.³ Federal regulations require nursing homes to submit correction plans to the state survey agency or CMS for deficiencies identified during surveys. (42 CFR § 488.402(d)) CMS requires state survey agencies to verify the correction of identified deficiencies through onsite reviews or by obtaining other evidence of correction.

Medicaid Managed Care

- **Medical Loss Ratio – Recoveries of MCO Rebates from Profit-Limiting Arrangements.** The OIG will review states and managed care plans with contract provisions that require rebates from managed care plans if a minimum percentage of total costs to be expended for medical services (medical loss ratio) is not met to ensure that the federal share of recoveries of managed care organization (MCO) payments that states received through profit-limiting methodologies is returned to the federal government. Pursuant to Section 1903(a)(1) of the Social Security Act, CMS reimburses each state at the federal medical assistance percentage (FMAP) for the quarter in which the expenditure was made. In accordance with Section 1903(d)(2) of the Act, the CMS State Medicaid Manual Section 2500.6(B) requires that when a state recovers a prior expenditure, it refunds the federal share by reporting the recovery on the CMS-64 report at the FMAP used to calculate the amount it originally had received.
- **Review of States' Methodologies for Assigning MCO Payments to Different Medicaid FMAPs.** The OIG will review methodologies for assigning MCO payments to different Medicaid FMAPs. According to Section 1905(b) of the Social Security Act, the federal government pays its share of a state's FMAP, which varies depending on the state's relative per capita income. The FMAPs under the Medicaid program are varied, and the actual services provided are less transparent under a managed care model. The burden is on states to create accurate and reasonable methodologies to assign managed care payments to those FMAPs.
- **Managed Long-Term Care Reimbursements.** The OIG will review states' reimbursements made to managed long-term care (MLTC) plans to determine whether those reimbursements complied with certain federal and state requirements. Medicaid managed care plans are subject to federal requirements (42 CFR Part 438). State contracts with MCOs include terms for eligibility and enrollment of beneficiaries. In addition, federal financial participation (FFP) is available in expenditures for payments under an MCO contract only for the periods during which the contract is in effect (42 CFR § 438.802(b)).

Other HHS-Related Issues

- **Office for Civil Rights' Oversight of the Security of Electronic Protected Health Information.** The OIG will determine the adequacy of the Office for Civil Rights' (OCR) oversight over the security of electronic protected health information (ePHI). Prior OIG audits reported that the OCR had not assessed the risks, established priorities or implemented controls for its HITECH Act requirement to provide for periodic audits of covered entities and business associates to ensure compliance with HITECH Act and HIPAA Rule requirements and, therefore, had limited assurance that covered entities and business associates adequately protected ePHI. Prior audits have also summarized numerous vulnerabilities in the systems and controls to protect ePHI at selected covered entities.

³ <http://oig.hhs.gov/oas/reports/region9/91302039.pdf>.

Affordable Care Act Reviews

Health Insurance Marketplaces, Financial Assistance Payments and Premium Stabilization Payments

- **Consumer Operated and Oriented Plan Loan Program – CO-OP Compliance with Requirements and CMS Monitoring Activities.** The OIG will follow up on prior work that examined the loan award selection process, financial condition and other factors that could impair the effectiveness of the Consumer Operated and Oriented Plan (CO-OP) loan program. The OIG will determine whether CO-OPs were in compliance with federal regulations and program requirements in managing the federal funds. The OIG will also reassess the CO-OPs' financial condition to determine whether any improvements were made in 2015 and identify actions CMS has taken to effectively oversee the loan program and monitor underperforming CO-OPs.
- **Allowability of Contract Expenditures.** The OIG will review the allowability of expenditures for contractor services claimed for federal reimbursement by selected health insurance marketplace grantees under the ACA Marketplace Establishment Grants. HHS award recipients often contract with organizations to provide services necessary to meet the performance requirements of the grant. Contractors that provide services specified in the grant award to beneficiaries are subject to the same requirements and cost principles as the grantee.
- **Rollup of State-Based Marketplace Eligibility Determination Audits and CMS Oversight.** The OIG will summarize the results of its reviews of seven state-based marketplaces (SBMs), which determined whether SBM internal controls were effective in ensuring that individuals were enrolled in qualified health plans (QHPs) according to federal requirements. The OIG will also review CMS's oversight of eligibility determinations at the seven SBMs. In support of those objectives, the OIG will assess CMS's efforts to address the deficiencies identified in the OIG's audit reports and contact the seven SBMs to understand how they worked with CMS to establish internal controls over eligibility determinations. Section 1321 of the ACA directs the secretary of HHS to issue regulations that set standards for meeting the requirements under Title I of the ACA, which includes procedures for determining eligibility for enrollment in QHPs and for insurance affordability programs.

Medicaid and Managed Care Reforms

- **Physicians—Referring/Ordering Medicare Services and Supplies.** The OIG will review select Medicare services, supplies and DME referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements.
- **Accountable Care Organizations: Strategies and Promising Practices.** The OIG will review ACOs that participate in the Medicare Shared Savings Program. It will: (1) describe their performance on the quality measures and cost savings over the first three years of the program, identifying the characteristics of the ACOs that performed well on measures and achieved savings; and (2) identify ACOs' strategies for and challenges to achieving quality and cost savings.
- **CMS Validation of Hospital-Submitted Quality Reporting Data.** Section 1886(b)(3)(B)(viii)(XI) of the Social Security Act gives CMS authority to conduct validation of its quality reporting program. Because CMS uses these quality data for the hospital value-based purchasing program and the hospital acquired condition reduction program, their accuracy and completeness are important. Thus, the OIG will determine the extent to which CMS validated hospital inpatient quality reporting data.

Revised OIG Initiatives

The following initiatives are repeated from the 2015 *Work Plan*, with revisions.

Hospitals

- **Medicare Oversight of Provider-Based Status.** The OIG will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. The OIG will also determine the extent to which provider-based facilities meet the requirements described in 42 CFR § 412.65 and CMS Transmittal A-03-030, and whether there were any challenges associated with the provider-based attestation review process. The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about the financial incentives presented by provider-based status.

Hospices

- **Hospice General Inpatient Care.** The OIG will review the use of the general inpatient care level of the Medicare hospice benefit. Pursuant to its review, the OIG will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. The OIG will also review hospice medical records to address concerns that the general inpatient level of hospice care is being billed when that level of service is not medically necessary. The OIG will review beneficiaries' plans of care and determine whether they meet key requirements. In addition, the OIG will determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Prescription Drugs

- **Part B Payments for Drugs Purchased Under the 340B Program.** The 340B Drug Pricing Program enables eligible health care providers (generally those that serve a disproportionate share of needy patients) to purchase prescription drugs at discounted prices while charging paying patients and insurers full price for the drugs. The OIG will determine the financial impact of three different shared savings arrangements upon 340B-covered entities, the Medicare program and Medicaid beneficiaries. These shared savings arrangements would enable Medicare and its beneficiaries to share in the cost savings resulting from 340B discounts. The OIG will also calculate the amount by which average sales price (ASP)-based payments exceed 340B prices.
- **Covered Uses for Medicare Part B Drugs.** The OIG will review the oversight actions that CMS and its claims processing contractors take to ensure that payments for Part B drugs meet the appropriate coverage criteria. It will also identify challenges contractors face when making coverage decisions for drugs.

Part C – Medicare Advantage

- **Medicare Advantage Encounter Data – CMS Oversight of Data Integrity.** The OIG will review CMS's oversight of MA encounter data validation and assess the extent to which CMS's Integrated Data Repository contains timely, valid and complete MA encounter data. In 2012, CMS began collecting a more comprehensive set of encounter data from MA organizations that reflected the items and services provided to MA plan enrollees. Prior CMS and OIG audits have indicated vulnerabilities in the accuracy of data reporting by MA organizations.

Part D – Prescription Drug Program

- **Review of Financial Interests Reported Under the Open Payments Program.** The OIG will determine the number and nature of financial interests that were reported to CMS under the Open Payments Program. The OIG will also determine the extent to which CMS oversees manufacturers' and group purchasing organizations' (GPOs) compliance with data reporting requirements and whether the required data for physician and teaching hospital payments are valid. Section 6002 of the Affordable Care Act requires that manufacturers disclose to CMS payments made to physicians and teaching hospitals. Manufacturers and GPOs must also report ownership and investment interests held by physicians. The Open Payments Program provides public transparency about provider-industry relationships; it is important that the information be complete and accurate to serve the needs of consumers making educated decisions about their health care choices.

Medicaid Prescription Drug Reviews

- **States' Actions Based on Medicaid Drug Utilization Reviews.** The OIG will review the education and enforcement actions that the states have taken based upon information generated by their drug utilization review (DUR) programs regarding the inappropriate dispensing of—and potential abuse of—prescription drugs, including opiates. It will also review state oversight of, and coordination with, MCOs' DUR programs and any resulting actions related to the inappropriate dispensing of opiates.

State Management of Medicaid

- **State and CMS Oversight of Provider Ownership Information.** The OIG will determine the extent to which states collect required ownership information for provider entities enrolled in Medicare and Medicaid and will describe the extent to which they verify the information collected. In addition, it will determine whether states and CMS checked exclusions databases for enrolling and enrolled providers (as required). Finally, it will compare the ownership information that selected providers gave to states to enroll in Medicaid, and that providers gave to CMS to enroll in Medicare, to the ownership information that the same providers gave to the OIG for purposes of this study.
- **States' Experiences with Enhanced Provider Screening.** The OIG will review the extent to which states are conducting enhanced screenings that assess the risk of fraud, waste and abuse for moderate- and high-risk enrolling and revalidating Medicaid providers and suppliers.
- **Provider Payment Suspensions During Pending Investigations of Credible Fraud Allegations.** The OIG will review payments to providers with allegations of fraud deemed credible by states, and will also review states' use of payment suspensions.

Medicaid Information System Controls and Security

- **National Correct Coding Initiative Edits and CMS Oversight.** The National Correct Coding Initiative (NCCI) consists of coding policies and automatic computer edits. Its original purpose was to promote correct coding of health care services provided to Medicare beneficiaries and to prevent payment for improperly coded services. The OIG will review selected states' implementation of NCCI edits for Medicaid claims and will describe CMS's oversight of those edits.

- **CMS Oversight of States' Medicaid Information Systems Security Controls.** CMS is responsible for ensuring that proper security controls for Medicaid information systems are implemented. Prior OIG audits reported that the states lacked sufficient security features, potentially exposing protected health information to unauthorized access. The OIG will determine the adequacy of CMS's oversight of the states' Medicaid systems and information security controls, including the policies, technical assistance, security and operational guidance provided.

Financial Reviews

- **Compliance with Reporting Requirements for Improper Payments.** The OIG will review certain aspects of HHS's compliance with the Improper Payments Information Act of 2002 regarding the reporting of improper payments. It will also assess HHS's compliance with the Improper Payments Elimination and Recovery Act of 2010, the Improper Payments Elimination and Recovery Act of 2012 and the data presented in HHS's Agency Financial Report. The OIG will then provide recommendations for modifying the reporting and addressing the goals of the reporting requirements as needed.

Automated Information Systems

- **HHS Compliance with the Federal Information Security Modernization Act of 2014.** The OIG will review various HHS operating divisions' compliance with the Federal Information Security Modernization Act (FISMA), which along with OMB Circular A-130 requires that agencies and their contractors maintain programs that provide adequate security for all information collected, processed, transmitted, stored or disseminated in general support systems and major applications.

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