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Highlights of the OIG's 2015 Work Plan

Wade Pearson Miller, Dawnmarie R. Matlock, Kimyatta E. McClary, Leanne Marek Kantner, Julia Dempewolf, and Trey Stephens*

The authors of this article explain the highlights of some of the new and notable continuing projects in the Office of Inspector General's 2015 Work Plan.

The Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") recently issued its Work Plan for Fiscal Year 2015 ("2015 Work Plan").[1] The 2015 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 2015 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 and compliance efforts for the year.

The OIG 2015 Work Plan included 19 new initiatives, likely due in part to the January 2014 release of last year's Work Plan, rather than its usual release date of late October the preceding year. As a result, many of the activities outlined in the 2014 Work Plan are repeated in the 2015 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 2015.

The 2015 Work Plan covers a broad array of projects related to CMS programs, organized by type of provider and federal reimbursement scheme. Here are highlights of some of the new and notable continuing projects in the 2015 Work Plan:

HOSPITALS

- *New inpatient admission criteria.* In Fiscal Year 2014, new Medicare

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[1] https://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf.

criteria indicated that physicians should admit beneficiaries for inpatient care if those beneficiaries are expected to need at least two nights of hospital care (known as the "two midnight policy"). Previous OIG work identified millions of dollars in overpayments to hospitals for short inpatient stays that should have been billed as outpatient stays. The OIG will determine the impact of the new inpatient admission criteria on hospital billing, Medicare payments and beneficiary copayments. This review will also determine how billing varied among hospitals in Fiscal Year 2014.

- *Medicare costs associated with defective medical devices.* The OIG will review Medicare claims to identify the costs resulting from additional use of medical services associated with defective medical devices and determine the impact of the cost on the Medicare Trust Fund. CMS has previously expressed concerns about the impact of the cost of replacement devices, including ancillary cost, on Medicare payments for inpatient and outpatient services.
- *Comparison of provider-based and freestanding clinics.* The OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact of hospitals' claiming provider-based status for such facilities on the Medicare program. Provider-based facilities often receive higher payments for some services than do freestanding clinics.
- *Outpatient evaluation and management services billed at the new-patient rate.* The OIG will review Medicare outpatient payments made to hospitals for evaluation and management ("E/M") services for clinic visits billed at the new-patient rate to determine whether such claims were appropriately coded and will recommend recovery of overpayments. The rate at which Medicare pays for E/M services requires hospitals to identify patients as either new or established, depending on previous encounters with the hospital. According to federal regulations, the meanings of "new" and "established" pertain to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past three years.
- *Review of hospital wage data used to calculate Medicare payments (new).* The OIG will review hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments. Prior OIG wage index work identified hundreds of millions of dollars in incorrectly reported wage data and caused CMS to change policies on how hospitals reported deferred compensation costs. Hospitals must accu-

rately report wage data to CMS annually to develop wage index rates.

- *Oversight of pharmaceutical compounding.* The OIG will determine the extent to which Medicare's oversight of Medicare-participating acute care hospitals addresses recommended practices for pharmaceutical compounding oversight. Pharmaceutical compounding is the creation of a prescription drug tailored to meet the needs of an individual patient. Most hospitals compound at least some pharmaceuticals onsite, and Medicare oversees the safety of pharmaceuticals compounded at Medicare-participating hospitals through the accreditation and certification process.
- *Oversight of hospital privileging.* The OIG will determine how hospitals assess medical staff candidates before granting initial privileges, including verification of credentials and review of the National Practitioner Data Bank. Hospitals that participate in Medicare must have an organized medical staff that operates under bylaws approved by a governing body.
- *Long-term care hospitals—Adverse events in post-acute care for Medicare beneficiaries (new).* The OIG will estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving care in long-term care hospitals. The OIG will also identify factors contributing to these events, determine the extent to which the events were preventable, and estimate the associated costs to Medicare.

NURSING HOMES

- *Medicare Part A billing by skilled nursing facilities.* The OIG will describe skilled nursing facility ("SNF") billing practices and the variations among SNFs in specific years. The OIG found that SNFs billed one-quarter of all 2009 claims in error, which resulted in $1.5 billion in inappropriate Medicare payments. The OIG notes that CMS has made substantial changes to how SNFs bill for Medicare Part A stays.
- *Questionable billing patterns for Part B services during nursing home stays.* The OIG will identify and review questionable billing patterns of nursing homes and Medicare providers for Part B services provided to nursing home residents during stays not paid under Part A. One specific area of examination will be foot care.
- *Hospitalizations of nursing home residents for manageable and preventable conditions.* The OIG will determine the extent to which Medicare beneficiaries residing in nursing homes are hospitalized as a result of conditions thought to be manageable or preventable in the nursing

home setting. The OIG noted that hospitalizations of nursing home residents may indicate quality-of-care problems in nursing homes.

HOSPICES

- *Hospices in assisted living facilities.* The OIG will review the level of service provided to Medicare beneficiaries living in assisted living facilities, including the length of stay, levels of care received and common terminal illnesses. This information is necessary for CMS to reform the hospice payment system and develop quality measures for hospices pursuant to the Patient Protection and Affordable Care Act ("ACA").
- *Hospice general inpatient care.* 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 this level of hospice care is being misused.

HOME HEALTH SERVICES

- *Home health prospective payment system requirements.* The OIG will review compliance with various aspects of the home health prospective payment system ("PPS"), including the documentation required in support of the claims paid by Medicare. The OIG will determine whether home health claims were paid in accordance with federal laws and regulations. The OIG noted that a prior report found that one in four home health agencies had questionable billing.

MEDICAL EQUIPMENT AND SUPPLIES

- *Power mobility devices—Lump-sum purchase versus rental.* The OIG will determine whether potential savings can be achieved by Medicare if certain power mobility devices are rented over a 13-month period rather than acquired through a lump-sum purchase.
- *Competitive bidding for medical equipment items and services—Mandatory post-award audit.* The OIG will review the process CMS uses to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under Rounds 1 and 2 of the competitive bidding program.

OTHER PROVIDERS AND SUPPLIERS

- *Ambulance services—Portfolio report on Medicare Part B payments.* The OIG will analyze and synthesize OIG evaluations, audits, investigations and compliance guidance related to ground ambulance transport

services paid by Medicare Part B to identify vulnerabilities, inefficiencies and fraud trends and offer recommendations to improve detected vulnerabilities and minimize inappropriate payments for ambulance services. The planned portfolio will offer recommendations to address the vulnerabilities that have been identified and improve efficiency. Medicare does not pay for items or services that are not "reasonable and necessary."

- *Anesthesia services—Payments for personally performed services.* The OIG will review claims for personally performed anesthesia services to determine whether the claims were supported in accordance with Medicare requirements. The OIG will also determine whether services with the "AA" service code modifier (personally performed by the anesthesiologist) met Medicare requirements.
- *Chiropractic services—Questionable billing.* The OIG will determine and describe the extent of questionable billing for chiropractic services.
- *Selected independent clinical laboratory billing requirements (new).* The OIG will review Medicare payments to independent clinical laboratories to determine laboratories' compliance with selected billing requirements and will use the results of these reviews to identify clinical laboratories that routinely submit improper claims and recommend recovery of overpayments. The OIG will focus on independent clinical laboratories with claims that may be at risk for overpayments.

OTHER PART A AND PART B PROGRAM MANAGEMENT ISSUES

- *Risk assessment of CMS's administration of the Pioneer Accountable Care Organization Model (new).* The OIG will conduct a risk assessment of the internal controls over administration of the Pioneer Accountable Care Organization ("ACO") Model. An ACO is a group of providers and suppliers of services (e.g., hospitals and physicians and others involved in patient care) that will work together to coordinate care for the Medicare fee-for-service beneficiaries they serve. The Center for Medicare & Medicaid Innovation, which was created to test innovative care and service delivery models, administers the Pioneer ACO Model.

PART D—PRESCRIPTION DRUG PROGRAM

- *Recommendations follow-up: Oversight of conflicts of interest in Medicare prescription drug decisions (new).* The OIG will determine what steps CMS has taken to improve its oversight of Part D sponsors' Pharmacy and Therapeutics ("P&T") Committee conflict of interest procedures. Federal law and regulations require Medicare Part D P&T committees

to make prescription drug coverage decisions on the basis of scientific evidence and standards of practice. To comply with the law, Part D sponsors' P&T committees must prevent conflicts of interest from influencing members to give preference to certain drugs.

MEDICAID PRESCRIPTION DRUG REVIEWS

- *State collection of rebates for drugs dispensed to Medicaid managed care organization enrollees (new).* The OIG will determine whether the states are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid managed care organizations ("MCOs"). Drugs dispensed by Medicaid MCOs were excluded from this requirement until March 23, 2010. Section 2501(c) of the ACA expanded the rebate requirement to include drugs dispensed to MCO enrollees. Medicaid MCOs are required to report enrollees' drug utilization to the state for the purpose of collecting rebates from manufacturers.

OTHER MEDICAID SERVICES, EQUIPMENT AND SUPPLIES

- *Community First Choice state plan option under the Affordable Care Act (new).* The OIG will review Community First Choice ("CFC") payments to determine whether the payments are proper and allowable. Section 2401 of the ACA added Section 1915(k) to the Social Security Act, a new Medicaid state plan option that allows states to provide statewide home and community-based attendant services and support to individuals who would otherwise require an institutional level of care. States taking up the option will receive a six percent increase in their federal medical assistance percentages ("FMAP") for CFC services. To be eligible for CFC services, beneficiaries must otherwise require an institutional level of care and meet financial eligibility criteria.
- *Payments to states under the Balancing Incentive Program (new).* The OIG will review expenditures that states claimed under the Balancing Incentive Program ("BIP") to ensure that they were for eligible Medicaid long-term services and support ("LTSS"). Under the BIP, eligible states can receive either a two percent or five percent increase in their FMAP for eligible Medicaid LTSS expenditures. To receive payments, participating states agree to make structural changes to increase access to non-institutional LTSS. The OIG will determine whether states used the additional enhanced federal match in accordance with Section 10202 of the ACA.
- *Medicaid beneficiary transfers from group homes and nursing facilities to hospital emergency rooms (new).* The OIG will review the rate of and

reasons for transfer from group homes or nursing facilities to hospital emergency departments under the premise that high occurrences of emergency transfers could indicate poor quality. The OIG noted that there is congressional interest in this area.

MEDICAID MANAGED CARE

- *MCO payments for services after beneficiaries' deaths (new).* The OIG will identify Medicaid managed care payments made on behalf of deceased beneficiaries and identify trends in Medicaid claims with service dates after beneficiaries' dates of death.
- *MCO payments for ineligible beneficiaries (new).* The OIG will identify Medicaid managed care payments made on behalf of beneficiaries who were not eligible for Medicaid and identify trends in Medicaid claims within this population.

HEALTH RESOURCES AND SERVICES ADMINISTRATION ("HRSA")

- *Community health centers' compliance with grant requirements of the ACA (new).* The OIG will determine whether community health centers that received funds pursuant to the ACA are complying with federal laws and regulations. The review will include determining the allowability of expenditures and the adequacy of accounting systems that assess and account for program income.
- *Duplicate discounts for 340B purchased drugs (new).* The OIG will assess the risk of duplicate discounts for 340B purchased drugs paid through MCOs and describe states' efforts to prevent them.
- *Oversight of vulnerable Health Center Program grantees (new).* The OIG will determine the extent to which HRSA awards grant money to Health Center Program grantees that have documented compliance or performance issues.

OTHER PUBLIC HEALTH RELATED REVIEWS

- *Audits of Hurricane Sandy disaster relief (new).* The OIG will perform audits of grantees who have received Disaster Relief Act (P.L. No. 113-2) grant funding through the Administration for Children and Families, the National Institutes of Health and the Substance Abuse and Mental Health Services Administration.
- *Hospitals' electronic health record system contingency plans (new).* The OIG will determine the extent to which hospitals comply with contingency planning requirements of the Health Insurance Portability and Accountability Act ("HIPAA").

ADMINISTRATION FOR CHILDREN AND FAMILIES

- *Hurricane Sandy—Emergency preparedness and response plans for child care facilities (new).* The OIG will determine the extent to which states develop and/or update emergency preparedness and response plans specific to child care services and programs. The OIG will also describe emergency responses and experiences of states and child care providers during and after recent disasters.
- *Head Start—Implementation of Head Start grant competition (new).* The OIG will determine the extent to which Head Start grant competition resulted in new entities' competing for and winning Head Start grants in 2013 and 2014. The Improving Head Start for School Readiness Act of 2007 required that grantees be awarded five-year (rather than indefinite) grants. The OIG will also describe the characteristics of grantees that were not deemed "high quality" by the Head Start Designation Renewal System in 2013 and 2014.

OTHER HHS-RELATED ISSUES

- *Prevent grant awards to individuals and entities that were suspended and/or debarred (new).* The OIG will determine whether HHS operating divisions are taking adequate precautions to ensure that individuals and entities suspended or debarred are not awarded federal grants or contracts.