HFMA WEBINAR


Date: Thursday, November 12, 2015
Time: 2:00 – 3:30 p.m. Central (12:00 – 1:30 pm Pacific/1:00 – 2:30 pm Mountain/3:00 – 4:30 pm Eastern)

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An Overview of the Office of Inspector General’s 2016 Work Plan

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(12:00 – 1:30 pm Pacific / 1:00 – 2:00 pm Mountain / 2:00 – 3:30 p.m. Central / 3:00 – 4:30 pm Eastern)

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OIG’s FY 2016 Work Plan

- Released Nov. 2, 2015
Overview of OIG

- OIG “was created to protect the integrity of HHS programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal health care laws”

- Primary operating components of OIG:
  - Office of Audit Services (OAS)
  - Office of Evaluation and Inspections (OEI)
  - Office of Investigations (OI)
What is the OIG Work Plan?

- The Work Plan summarizes new and ongoing OIG audits, evaluations, and certain legal and investigative initiatives with respect to HHS programs and operations.
- Published annually; updated mid-year.
- To set Work Plan priorities, OIG considers:
  - mandatory requirements for OIG reviews;
  - requests made or concerns raised by Congress, HHS, or OMB;
  - top management and performance challenges facing HHS;
  - work performed by partner organizations;
  - management’s actions to implement OIG recommendations from previous reviews; and
  - timeliness.
Key

- Making its first appearance in the OIG Work Plan
- Revised from last year’s edition
- Pay attention to this one!

Provider Perspective: This presentation focuses on items of greatest interest for hospitals
HOSPITALS
Two-Midnights

• Hospitals’ use of outpatient and inpatient stays under Medicare’s two-midnight rule
  – We will determine how hospitals’ use of outpatient and inpatient stays changed under Medicare’s two-midnight rule, as well as how Medicare and beneficiary payments for these stays changed, by comparing claims for hospital stays in the year prior to the effective date of the two-midnight rule to stays in the year following the effective date of that rule. We will also determine the extent to which the use of outpatient and inpatient stays varied among hospitals.
Provider-Based Status

• “Provider-based” status enables hospital-owned and operated facilities to bill as hospital outpatient departments paid under the outpatient prospective payment system (OPPS). 42 C.F.R. § 413.65.

• Policy concerns:
  – OPPS payment rates are higher than if services were reimbursed under payment systems for ambulatory surgical centers (ASCs) or physician offices
  – Beneficiaries’ coinsurance liabilities are higher for hospital outpatient services than for ASC services or physician office visits

• The Medicare Payment Advisory Commission (MedPAC) has advocated equalization of Medicare payments across settings
Provider-Based Status

• Medicare oversight of provider-based status
  – We will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing.
  – We will also determine the extent to which provider-based facilities meet requirements described in 42 CFR Sec. 413.65 and CMS Transmittal A-03-030, and whether there were any challenges associated with the provider-based attestation review process.
Provider-Based Status

• **Comparison of provider-based and freestanding clinics**
  
  - We 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 on Medicare of hospitals' claiming provider-based status for such facilities.
Device Credits

• **Medical device credits for replaced medical devices**

  – Federal regulations require reductions in Medicare payments for the replacement of implanted devices. 42 CFR §§ 412.89 and 419.45.

  – We will determine whether Medicare payments for replaced medical devices were made in accordance with Medicare requirements.
3-Day Payment Window

• Medicare payments during MS-DRG payment window
  – Rule: When a patient is admitted as an inpatient, Medicare payment for most preadmission services furnished within three days prior to admission by any entity wholly owned or operated by the hospital is bundled into the hospital’s DRG payment. 42 C.F.R. § 412.2(c)(5)(i).
  – We 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 were allowable and in accordance with the inpatient prospective payment system.
Quality of Care and Safety Issues

• Hospital preparedness and response to high-risk infectious diseases—Describe hospitals’ preparation efforts; identify lessons learned through recent Ebola experience

• Hospitals’ electronic health record system contingency plans—Determine compliance with HIPAA contingency planning requirements and with government- and industry-recommended practices

• CMS validation of hospital-submitted quality reporting data—Determine extent to which CMS validated quality reporting data
NURSING HOMES, HOSPICE, HOME HEALTH
Listener Poll

• **For in-house folk**—Does your hospital(s) have a hospital-based skilled nursing facility (SNF)?

• **For consultants**—Do you routinely advise SNFs?

1. Yes
2. No
SNF PPS

- Skilled nursing facility prospective payment system requirements
  - FOCUS: Therapy!
  - We will review compliance with various aspects of the skilled nursing facility (SNF) prospective payment system, including all documentation requirements—i.e., (1) physician order; (2) comprehensive assessment; and (3) comprehensive plan of care.
  - Prior OIG reviews have found that SNFs have increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same.
Hospice

- **Hospice general inpatient care**
  - We will review the use of the general inpatient care level of the Medicare hospice benefit.
  - We will assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
  - We will also review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary.
Background Checks

- National Background Check Program for long-term-care employees

  - Section 6201 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of Health and Human Services to carry out a nationwide program for States to conduct national and State background checks for prospective employees of nursing facilities and other long-term-care providers.

  - We will report on the implementation status and early results for the National Background Check Program for long-term-care employees from the first 4 years of the program.
OTHER PROVIDERS AND SUPPLIERS
ASCs

• **Ambulatory surgical centers—payment system**
  
  – We will review the appropriateness of Medicare’s methodology for setting ASC payment rates, and will determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures.

• **Ambulatory surgical centers—quality oversight**
  
  – Previous OIG work found problems with Medicare’s oversight system, including finding spans of five or more years between certification surveys for some ASCs, poor CMS oversight of State survey agencies and ASC accreditors, and little public information on the quality of ASCs.
New OIG Initiatives Relating to Supplier Billing

• **Physicians—referring/ordering Medicare services and supplies**—OIG to determine whether ordering practitioners are Medicare-enrolled physicians or nonphysician practitioners legally eligible to refer/order services, supplies and DME.

• **Anesthesia services—non-covered Services**—OIG to review anesthesia services to determine whether the beneficiary had a related Medicare service.
New OIG Initiatives Relating to Supplier Billing (cont’d)

- **Physician home visits—reasonableness of services**—Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit.

- **Prolonged services—reasonableness of services**—Necessity of prolonged evaluation and management (E/M) services, i.e., additional time spent with a beneficiary beyond a usual companion E/M service, is considered to be rare and unusual.
Histocompatibility Labs

- Histocompatibility laboratories–supplier compliance with payment requirements
  - Histocompatibility laboratories are reimbursed on the basis of reasonable costs.
  - Costs claimed in the cost report must be related to the care of beneficiaries; reasonable, necessary, and proper (42 CFR § 413.9(a), (b), and (c)(3)); and cost information must be accurate and in sufficient detail to support payments made for services provided (42 CFR § 413.24(a) and (c)).
PRESCRIPTION DRUGS
340B

• Part B payments for drugs purchased under the 340B Program
  – We will determine the financial impact on 340B-covered entities, the Medicare program, and Medicaid beneficiaries of three different shared savings arrangements that would enable Medicare and its beneficiaries to share in the cost savings resulting from 340B discounts.
  – We will also calculate the amount by which ASP-based payments exceed 340B prices.
Quality of Care and Safety

• Covered uses for Medicare Part B drugs
  – We 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.
  – We will also identify challenges contractors face when making coverage decisions for drugs. If Part B MACs do not have effective oversight mechanisms, Medicare and its beneficiaries may pay for drug uses that are not medically accepted.
PART A AND PART B
PROGRAM MANAGEMENT ISSUES
Delivery System Reform: ACOs

• Use of electronic health records to support care coordination through ACOs
  – OIG will review ACOs’ use of electronic health records (EHRs) to exchange health information to achieve their care coordination goals, and will identify best practices and possible challenges to exchange and use of health data.

• Accountable Care Organizations: Strategies and Promising Practices
  – OIG will describe ACOs’ performance on quality measures and cost savings over the first three years of the program; describe characteristics high-performing ACOs that achieved savings; and identify ACOs’ strategies for and challenges to achieving quality and cost savings.
Certain Improper Payments

• OIG will review CMS’s procedures to prevent and recoup Medicare payments for items and services furnished to:
  – Illegal immigrants
  – Incarcerated beneficiaries
ICD-10

• CMS management of the ICD-10 implementation
  – We will review aspects of CMS’s early management of the implementation of the 10th version of the International Classification of Diseases (ICD-10) codes in Medicare Parts A and B, including:
    ▪ MACs’ assistance and guidance to hospitals and physicians
    ▪ How the transition to ICD-10 is affecting claims processing, including claims resubmissions, appeals, and medical reviews
    ▪ How ICD-10 diagnosis codes are being applied to selected CMS payment rules and safeguards
MEDICARE ADVANTAGE (PART C)
Encounter Data

- Medicare Advantage encounter data—CMS oversight of data integrity
  - In 2012, CMS began collecting from MA organizations a more comprehensive set of encounter data reflecting 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.
  - We 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.
Risk Adjustment

• Risk adjustment data—sufficiency of documentation supporting diagnoses
  
  We will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS’s risk-score calculations and determine whether the diagnoses submitted complied with Federal requirements.
MEDICAID
Drug Rebates

• OIG will review States’ compliance, accountability, and controls with respect to Manufacturer drug rebates, including:
  – Collection of rebates on physician-administered drugs
  – Collection of rebates for drugs dispensed to Medicaid MCO enrollees
  – Reporting of the Federal share of Medicaid rebate collections
Drug Pricing

• **Analysis of generic price increases compared to price index**—OIG to determine whether prices increased more than the increases in inflation as measured by the consumer price index for urban consumers (CPI-U).

• **Treatment of authorized generic drugs**—OIG to review manufacturers’ treatment of sales of authorized generics in their calculation of AMP for the Medicaid drug rebate program.

• **Specialty drug pricing and reimbursement in Medicaid**—OIG to determine how State Medicaid agencies define specialty drugs, how much States paid for these drugs, how States determine payment methodologies, and differences in reimbursement amounts by State.
Quality of Care and Beneficiary Safety

- Medicaid beneficiary transfers from group homes and nursing facilities to hospital emergency rooms—We will review the rate of and reasons for transfer from group homes or nursing facilities to hospital emergency departments.

- State agency verification of deficiency corrections—We will determine whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.
OTHER OIG ACTIVITIES
Public Health Reviews—Examples

- CDC—award process for Ebola preparedness and response funding

- CDC—oversight of security of the strategic national stockpiles of pharmaceuticals

- CDC—oversight of the Select Agent Program, which regulates the possession, use, and transfer of biological agents and toxins that could pose a severe threat to public health and safety
Public Health Reviews—FDA

- Controls over networked medical devices at hospitals
  - Computerized medical devices, such as dialysis machines, radiology systems, and medication dispensing systems that are integrated with electronic medical records (EMRs) and the larger health network, pose a growing threat to the security and privacy of personal health information.

  - We will examine whether FDA’s oversight of hospitals’ networked medical devices is sufficient to effectively protect associated electronic protected health information (ePHI) and ensure beneficiary safety.
Public Health Reviews—HRSA

- HRSA—duplicate discounts for 340B-purchased drugs
  - We will assess the risk of duplicate discounts for 340B-purchased drugs paid through Medicaid MCOs and describe States’ efforts to prevent them.
Grant Compliance—Examples

- NIH—colleges’ and universities’ compliance with *Cost Principles for Educational Institutions*—reviews to be conducted at selected schools on the basis of the dollar value of Federal grants received and input from HHS operating divisions.

- NIH—controls over subcontracting of NIH grant and contract work—OIG to assess colleges’ and universities’ controls over the subcontracting of NIH grant and contract work.
Human Subjects Research

• Review of Office for Human Research Protections compliance evaluations to ensure human subject protection
  – We will describe the extent and scope of OHRPs’ compliance evaluations from 2000 to 2014.
  – We will also describe how OHRP works with relevant government entities and institutional review boards during its compliance evaluations, and how OHRP’s working with these entities enhances or constrains its capacity to conduct compliance evaluations.
Security of ePHI

- Office for Civil Rights’ oversight of the security of electronic protected health information
  - We 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 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.
Questions?

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