An Overview of the Office of Inspector General’s 2017 Work Plan

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OIG’s FY 2017 Work Plan


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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 Inspection (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 review; and
  – Timeliness.
Key

NEW
= Making its first appearance in the OIG Work Plan

REVISED
= 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-Midnight Policy

• **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 by comparing claims for hospital stays in the year prior to and 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.*
Hospital Billing

• **Medicare Payments for Overlapping Part A Inpatient Claims and Part B Outpatient Claims**
  
  – Overlapping claims can occur when a beneficiary is an inpatient of one hospital and sent to another hospital to obtain outpatient services not otherwise available at the originating hospital.
  
  – Certain items/supplies/services furnished in inpatients are covered by Part A and cannot be separately billed to Part B. 42 C.F.R. §§ 409.10 and 410.3.
  
  – *We will review Medicare payments to certain types of inpatient hospitals to determine whether outpatient claims billed to Medicare Part B for services provided during inpatient stays were made in accordance with Federal Requirements.*
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.

• § 603 of the Bipartisan Budget Act of 2015 – Medicare payment for most items and services at new, off-campus hospital outpatient departments will be paid under the “applicable payment system” (Physician Fee Schedule or Ambulatory Surgical Center Payment System). Effective Jan. 1, 2017.

• Policy concerns:
  – OPPS payment rates are higher than if services were reimbursed under payment systems for ASCs or physician offices.
  – Beneficiaries’ coinsurance liabilities are higher for hospital outpatient services than for ASC services or physician office visits.
Provider-Based Status (continued)

• **CY 2017 OPPS Final Rule:**
  – CMS will make payment for non-excepted Provider-Based Departments (i.e., off-campus PBD not billing OPPS prior to Nov. 2, 2015) at 50% of OPPS rate;
  – CMS will not finalize a prohibition on new services not offered prior to Nov. 2, 2015; and
  – CMS will prohibit most relocations and changes in ownership for excepted location.

• **21st Century Cures Act:**
  – Provided criteria by which off-campus PBDs that were “mid-build” before Nov. 2, 2015 can nonetheless qualify as excepted from payment changes under § 603 and continue to receive full OPPS payments starting in 2018.
  – Requires submission of certain documentation to the MAC.
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.*

  – *We will also assess the potential impact on Medicare and beneficiaries of hospitals’ claiming provider-based status for such facilities.*

• See “CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, but Vulnerabilities Remain,” OEI-04-12-00380, June 2016.
Hospital-Reported Data

- **Review of Hospital Wage Data Used to Calculate Medicare Payments**
  - Previously identified millions of $ in incorrect wage data.
  - *We will review hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments.*

- **CMS Validation of Hospital-Submitted Quality Reporting Data**
  - Required reporting (or face payment reduction) utilized in value-based purchasing & acquired condition reduction program.
  - *We will determine the extent to which CMS-validated hospital inpatient quality reporting data are accurate and complete.*
Other New Hospital Items

• **Incorrect Medical Assistance Days Claimed by Hospitals**
  
  - Determine whether, with respect to Medicaid patient days, MACs properly settled Medicare cost reports for Medicare DSH payments in accordance with Federal requirements

• **Inpatient Psychiatric Facility Outlier Payments**

  - Determine whether IRFs nationwide complied with Medicare documentation, coverage and coding requirements for stays that resulted in outlier payments.

• **Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy**

  - Assess sample of IRF admissions to determine whether patients participated in and benefited from intensive therapy.
Other Hospital Billing Items

• **Intensity-Modulated Radiation Therapy**
  – Prior reports showed hospitals were inappropriately billing certain services of IMRT planning as IMRT delivery.
  – *We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.*

• **Nationwide Review of Cardiac Catheterizations and Endomyocardial Biopsies**
  – Medicare generally pays for the catheterizations & biopsies as a single encounter, unless “separate and distinct” with modifier 59.
  – Prior reports showed that hospitals were inappropriately including modifier 59.
  – *We will review Medicare payments to hospitals nationwide for outpatient RHCs and endomyocardial biopsies performed during the same patient encounter.*
NURSING HOMES, HOSPICE, HOME HEALTH
Skilled Nursing Facilities

• **SNF Prospective Payment Requirements**
  – Prior reports found SNF services uncompliant with 3-day inpatient stay within 30 days of inpatient admission.
  – *We will review compliance with SNF PPS related to 3-day qualifying inpatient hospital stay.*

• **SNF Reimbursement**
  – Previous OIG work found that SNFs are billing higher levels of therapy than were provided or reasonable/necessary.
  – *We will review documentation at selected SNFs to determine if it meets requirements for each resource utilization group (RUG).*
Long-Term Care

- National Background Checks for LTC Employees – Mandatory Review
  - § 6201 of the ACA provides grants to States to implement background checks on LTC employees and providers and requires the OIG to evaluate the program.
  - For States that closed grants in the prior year, we will review the procedure implemented.
  - We will determine the outcomes of the States’ programs and whether the checks led to any unintended consequences.
Hospice

• To be eligible to elect hospice care under Medicare, CMS requires that beneficiaries be certified as terminally ill. 42 C.F.R. § 418.20.
  – Requires written certification for initial 90-day period; subsequent 90-day period and unlimited number of subsequent 60-day periods. Certification must specify prognosis is for life expectancy of 6 months or less. 42 C.F.R. §§ 418.21-418.22.
  – For the third and subsequent periods, the beneficiary must be examined face-to-face by physician or NP. 42 C.F.R. § 418.22.

• Hospices are targets of recent enforcement actions.
  – See, e.g., Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care, OEI-02-10-00491, March 2016.
  – See, e.g., Hospices Should Improve Their Election Statements and Certifications of Terminal Illness, OEI-02-10-00492, September 2016.
Hospice (continued)

• **Review of Hospices’ Compliance with Medicare Requirements**
  
  *We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.*

• **Hospice Home Care – Frequency of Nurse On-Site Visits to Assess Quality of Care and Services**
  
  *We will determine whether registered nurses made required on-site visits (at least once every 14 days) to homes of Medicare beneficiaries in hospice care.*
Home Health Services

• Comparing HHA Survey Documents to Medicare Claims Data
  – Previous OIG work has shown that the home health program is prone to fraud, waste and abuse, with some HHAs intentionally omitting certain patients from information supplied to State agencies to avoid scrutiny.
  – We will determine whether HHAs are accurately providing patient information to State agencies for recertification surveys.
OTHER PROVIDERS AND SUPPLIERS
Clinical Lab Services

- Monitoring Medicare Payments for Clinical Diagnostic Laboratory Tests
  - § 216 of Protecting Access to Medicare Act of 2014 requires CMS to replace current system of paying for clinical lab tests with new market-based system using rates paid to labs by private payors.
  - We will analyze Medicare payments for clinical diagnostic lab tests performed in 2016 and monitor CMS’s implementation of the new Medicare payment system for these tests.
Transitional and Chronic Care

- **Medicare Payments for Transitional Care Management**
  - Provided to patients whose medical/psych problems require moderate/complex decision-making in care transition from hospital/SNF to community. Now covered services on PFS.
  - *We will determine whether payments for TCM services were in accordance with Medicare requirements.*

- **Medicare Payments for Chronic Care Management**
  - Non-face-to-face services provided to beneficiaries with multiple chronic conditions; cannot be billed during same period as TCM, home health, hospice. Now covered services under PFS.
  - *We will determine whether payments for CCM services were in accordance with Medicare requirements.*
IRFs and ASCs

• **Inpatient Rehabilitation Facility Payment System Requirements**
  – Prior reviews have identified substantial Medicare overpayments.
  – *We will determine whether IRFs nationwide billed claims in compliance with Medicare documentation and coverage requirements.*

• **Ambulatory Surgical Centers – Quality Oversight**
  – Previously, OIG identified problems related to certification survey frequency, poor CMS oversight of State survey agencies and little public information on quality of ASCs.
  – *We will review the frequency of Medicare’s certification surveys for ASCs.*
  – Note: OIG removed 2016 review of ASC payment system from Work Plan.
Supplier Billing

• **Payments for Medicare Services, Supplies, and DMEPOS Referred or Ordered by Physicians – Compliance**
  – Review whether physicians/practitioners ordering DMEPOS are Medicare-enrolled and legally eligible to refer/order services.

• **Anesthesia Services – Noncovered Services and Payments for Personally Performed Services**
  – Review whether beneficiary had related Medicare services, as required.
  – Review whether services were personally performed (“AA”) or medically directed (“QK,” which limits payment by 50%) and claimed accordingly under Medicare requirements.
Supplier Billing (continued)

• **Physician Home Visits – Reasonableness of Services**
  – Medicare requires documentation of medical necessity of home visit in lieu of office/outpatient visit.
  – *We will determine whether Medicare payments to physicians for E/M home visits were made in accordance with Medicare requirements.*

• **Prolonged Services – Reasonableness of Services**
  – OIG says “necessity of prolonged services [provided after an E/M service] are rare and unusual.”
  – *We will determine whether Medicare payments to physicians for prolonged E/M services were reasonable and made in accordance with Medicare requirements.*
PRESCRIPTION DRUGS
Prescription Drugs

• HRSA withdrew 340B “Mega Guidance” (released in August 2015) from regulatory review by OMB on January 30, 2017. Among other things, the Mega Guidance had proposed to revise the definition of “eligible patient.”


• Payments for Immunosuppressive Drug Claims with “KX” Modifiers
  – KX modifier is used to annotate claims showing that a supplier retains documentation of beneficiary’s organ transplant date and that such date preceded DOS for furnishing the drug.
  – We will determine whether Part B payments for immunosuppressive drugs that were billed with “KX” met Medicare documentation requirements.
PART A AND PART B
PROGRAM MANAGEMENT ISSUES
Delivery System Reform: ACOs

• **Beneficiary Assignment and Medicare Shared Savings Program ("MSSP")**
  – *We will review MSSP to determine whether beneficiary assignment to ACOs and shared savings payments for assigned beneficiaries complied with Federal requirements; determine whether CMS properly assigned beneficiaries to ACOs in the MSSP; examine CMS’s shared savings program to ensure no duplication of payments.*

• **Savings, Quality, and Promising Practices**
  – *We will review ACOs and described performance on quality measures/cost savings over first 3 years of program; describe characteristics of high-performing ACOs; identify ACOS’ strategies for and challenges to achieving quality/cost savings.*
MEDICARE ADVANTAGE (PART C)
Part C

**Extent of Denied Care in MA and CMS Oversight**
- Concern that capitated payments create financial incentives for plans to underserve beneficiaries.
- *We will examine national trends and oversight by CMS of denied care within MA. We will determine the extent to which services were denied, appealed, and overturned in MA. . . . Future work may include medical record reviews.*

**Integrity of MA Encounter Data**
- Concern that MAOs are not accurately reporting encounter data reflecting items/services provided to MA plan enrollees.
- *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.*
MEDICAID
Drug Pricing and Rebates

- **States’ MCO Medicaid Drug Claims**
  - Determine whether MCO capitation payments include reimbursement for non-covered Medicaid drugs.

- **States’ Collection of Drug Rebates**
  - Physician-Administer Drugs
  - Drugs Dispensed to Medicaid MCO Enrollees

- **Manufacture Rebates – Federal Share**
  - Determine whether States are correctly identifying and reporting increases in rebate collections.

- **Drug Pricing**
  - Review manufacturers treatment of sales of authorized generics in calculation of AMP for rebate program.
  - Determine how States define specialty drugs and determine payment.
**State Management of Medicaid**

- **Third-Party Liability Payment Collections**
  - *We will determine if States have taken action to ensure that Medicaid is the payer of last resort by identifying whether a third-party payer exists and if the State correctly reports the third-party liability to CMS.*

- **Medicaid Overpayment Reporting & Collections**
  - *For OIG audits in which CMS concurred with the overpayment determination, we will determine whether recouped and properly reported to CMS.*
OTHER OIG ACTIVITIES
Electronic Health Records

• **Medicare Incentive Payments for Adopting Electronic Health Records**
  
  – Hospitals/physicians are eligible for incentive payments upon demonstrating meaningful use of EHR technology.
  
  – *We will review Medicare incentive payments . . . to prevent erroneous incentive payments.* *We will review data to identify payments to providers that should have not received incentive payments.*
  
  – *We will also assess CMS’s plans to oversee incentive payments . . . and corrective actions taken regarding erroneous incentive payments.*
Food and Drug Administration

• Hospitals’ Reliance on Drug Compounding Facilities
  – Large-scale facilities that compound without a patient-specific prescription are regulated by § 503B of FDCA and called “outsourcing facilities.”
  – *We will determine extent to which hospitals obtain compounded drugs, including from outsourcing facilities, and extent to which compounders without a patient-specific prescription have registered with the FDA.*

• Review of Networked Medical Device Cybersecurity During the Premarket Process
  – Computerized medical devices (dialysis, radiology, medication dispensing systems), integrated with EHRs, pose growing security/privacy threat.
  – *We will examine FDA’s premarket review of cybersecurity controls of networked devices.*
Questions?

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