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Recent Developments and What to Expect in the Year Ahead

December 2021

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Overview

- Health and Human Services (HHS) Office of Inspector General (OIG) semi-annual report
- Department of Justice (DOJ) healthcare fraud updates
- Comprehensive Error Rate Testing (CERT) program update and CERT reporting trends
- OIG enforcement updates
- Other noteworthy regulatory enforcement topics
- Keeping an eye out – additional risk considerations

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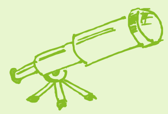
HHS-OIG semi-annual report highlights

HHS-OIG's Semiannual Report: Overview



Setting the Stage: HHS-OIG's Semiannual Report describes OIG's work identifying significant risks, problems, abuses, deficiencies, remedies, and investigative outcomes relating to the administration of HHS programs and operations

The table below highlights significant results (across three semiannual periods) of selected audits, evaluations, and enforcement activities

45% decrease in new audit and evaluation recommendations from the prior reporting period

22% increase in criminal actions from the prior reporting period

Statistic	Reporting Period: Oct. '20-March '21	April '20-Sept. '20	Oct. '19-March '20
Audit Report Issued	75	97	81
Evaluations	20	27	14
Expected Audit Recoveries	$566.46 million	$337 million	$605.2 million
Questioned Costs	-	$446 million	$288.4 million
Potential Savings	$919.97 million	$2 billion	$911.3 million
New Audit and Evaluation Recommendations	228	416	273
Recommendations Implemented by HHS Operating Divisions	181	156	130
Expected Investigative Recoveries	$1.37 billion	$1.62 billion	$1.51 billion
Criminal Actions	221	181	443
Civil Actions	272	421	370
Exclusions	1,036	1,245	903

Source: https://oig.hhs.gov/reports-and-publications/archives/semiannual/2021/2021-spring-sar.pdf

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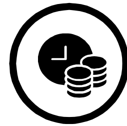
HHS-OIG's Semiannual Report: Program Integrity

Most recent Medicare audits, evaluations, inspections, investigations, and enforcement actions

CERT / Error Prone Providers

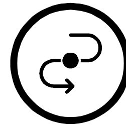
There were 100 error-prone providers identified from 2014 through 2017. Of the $5.8 million reviewed by CERT for these providers, there was an improper payment rate of 60.7 percent. It was determined that, Medicare made $19.1 billion in fee-for-service (FFS) payments to these 100 error-prone providers.

See more about other CERT updates in following section



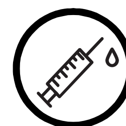
Cardiac Device Credits

911 Hospitals likely did not comply with Medicare requirements associated with reporting manufacturer credits for recalled or prematurely failed cardiac medical devices, resulting in $33 million in potential overpayments.



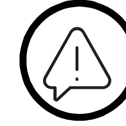
High Severity DRGs

In the years leading up to the COVID-19 pandemic (i.e. FY 2014 through FY 2019), the number of inpatient stays billed at the highest severity level in the diagnosis-related group (DRG) increased by almost 20 percent, accounting for nearly half of all Medicare spending on inpatient hospital stays.



Spinal Facet joint injections

The Medicare administrative contractors (MACs) in 11 jurisdictions with a coverage limitation made improper payments of $748,555 for selected facet-joint injection sessions.



Risk Adjustment diagnosis coding

A Michigan health plan submitted selected diagnosis codes to Center for Medicare and Medicaid Services (CMS) for use in its risk adjustment program which did not comply with Federal requirements. OIG found that the codes resulted in net overpayments of $668,264, estimating $14.5 million in overpayments for 2015 and 2016.

Source: https://oig.hhs.gov/reports-and-publications/archives/semiannual/2021/2021-spring-sar.pdf

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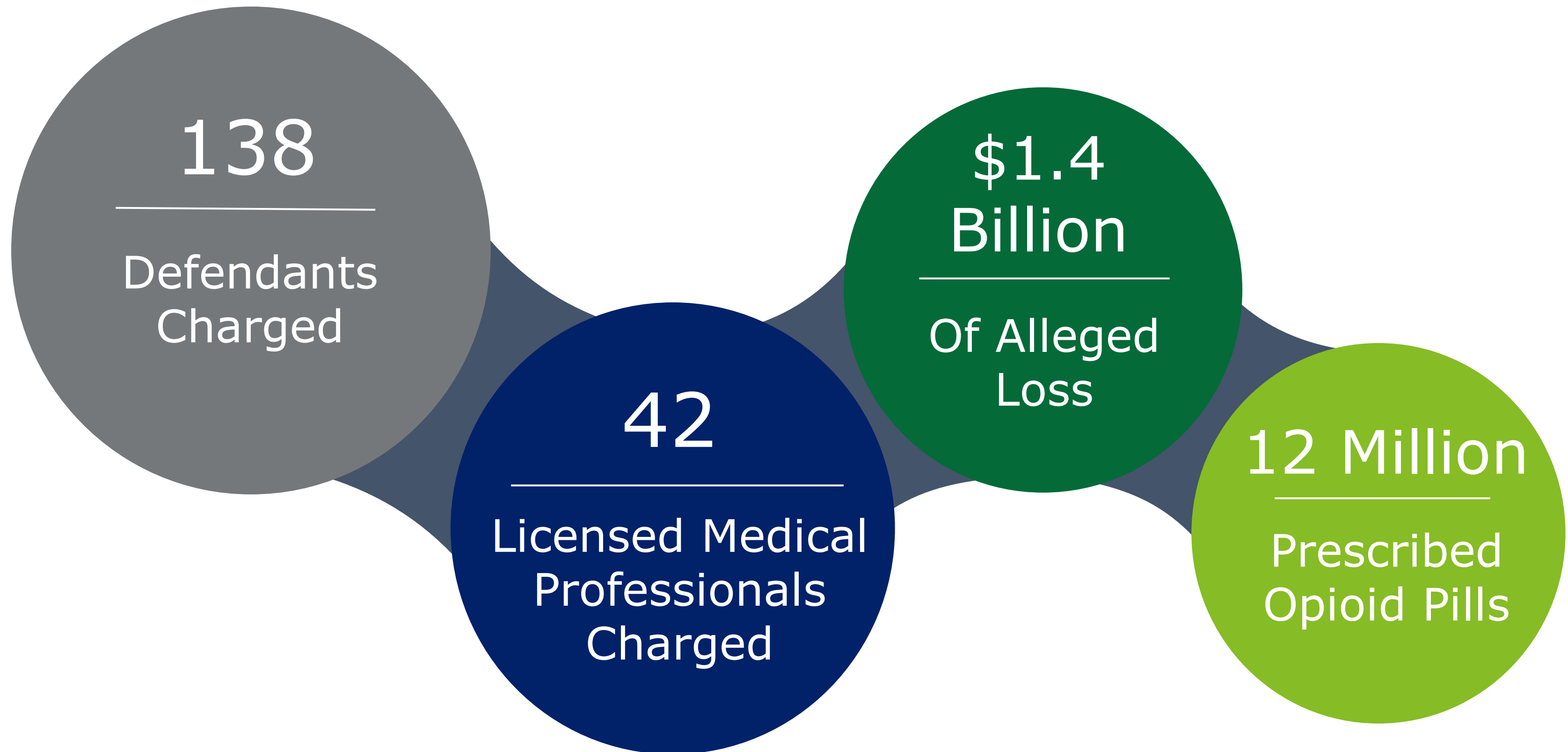
DOJ healthcare fraud updates

2021 Health Care Fraud National Enforcement Action

The DOJ announced criminal charges against defendants allegedly involved in various health care fraud schemes



Source: https://www.justice.gov/criminal-fraud/2021-national-health-care-fraud-enforcement-action

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Breakdown of Alleged Losses

False and Fraudulent Charges Leading to **$1.4 Billion** in Alleged Losses

Telemedicine

$1.1 Billion

- 43 Telemedicine executives allegedly paid doctors to order unnecessary durable medical equipment (DME), genetic & other diagnostic testing, and pain medications without seeing the patient or having only a brief phone call
- DME companies, genetic testing laboratories, and pharmacies then purchased those orders for illegal kickbacks and submitted to Medicare and other government insurers

COVID-19 Health Care Fraud

$29 Million

- 9 Defendants exploited CMS policies to enable increased access to care during the COVID-19 pandemic
- 5 Defendants allegedly misused Provider Relief Funds for their own personal expenses, including for gambling at a Las Vegas casino

Substance Abuse Treatment Facilities "Sober Homes"

$133 Million

- 12 Defendants allegedly participated in illegal kickback and bribery schemes by referring patients to sober homes for medically unnecessary drug testing and therapy sessions that frequently didn't occur

Other Fraud and Illegal Opioid Distribution

$160 Million

- 19 Defendants provided illegal prescriptions and distributed 12 million doses of opioids, while submitting $14 million in false billings
- 60 defendants allegedly submitted $145 million in false claims to Medicare, Medicaid, TRICARE, and private insurance

Source: https://www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion

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Additional DOJ enforcement highlights

"Pharmacy billed insurers for massive quantities of ***medically unnecessary prescription drugs****…directing employees to get medically unnecessary drugs for themselves, family members, and friends, changing prescriptions to add non-prescribed drugs because insurance would pay for them, automatically refilling prescriptions regardless of patient need, routinely waiving and discounting co-pays to induce patients to get and keep medically unnecessary drugs, and billing for drugs without patients' knowledge"*[1]

"Telemarketing firms allegedly participated in a scheme to operate a ***telemarketing*** *campaign targeting Medicare beneficiaries in an effort to induce them to accept* ***cancer genetic tests*** *regardless of whether the tests were medically necessary or eligible for Medicare reimbursement"*[2]

"Medical device manufacturer violated the physician ***Open Payments Program*** *(formerly known as the "Sunshine Act") by failing to fully report physician-entertainment expenses to the Centers for Medicare & Medicaid Services (CMS)"*[4]

"Genetic testing lab contracted with marketing companies to target and recruit elderly patients who were federal health care program beneficiaries in order to obtain their genetic material for conducting ***genetic tests****. Marketers, who were not health care professionals, obtained swabs from the mouths of the patients at nursing homes, senior health fairs, and elsewhere. The tests were then approved by* ***telemedicine*** *doctors who did not engage in the treatment of the patients, and often did not even speak with the patients"* [3]

"Defendants conspired with others to falsify data in connection with two ***clinical trials*** *by, among other things,* ***fabricating medical records*** *to make it appear as though subjects were participating in the clinical trials when, in truth, they were not"*[5]

Sources: 1) https://www.justice.gov/usao-ndal/pr/multiple-defendants-sentenced-major-compounding-pharmacy-fraud-conspiracy;
2) https://www.justice.gov/opa/pr/three-florida-men-charged-46-million-health-care-fraud-kickback-and-money-laundering;
3) https://www.justice.gov/usao-mdtn/pr/owner-spring-hill-based-crestar-labs-llc-charged-massive-medicare-fraud-scheme;
4) https://www.justice.gov/usao-edpa/pr/french-medical-device-manufacturer-pay-2-million-resolve-alleged-kickbacks-physicians
5) https://www.justice.gov/opa/pr/clinical-researchers-sentenced-connection-scheme-falsify-drug-trial-data-0

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Additional DOJ enforcement highlights (cont'd)

"Defendants engaged in various health care fraud schemes designed to ***exploit the COVID-19 pandemic****…misused the information and samples to submit claims to Medicare for unrelated, medically unnecessary, and far more expensive laboratory tests, including* ***cancer genetic testing, allergy testing, and respiratory pathogen panel tests****"[1]*

"The pharmacy services provider routinely abused the emergency prescription provisions of the CSA by requesting and obtaining ***verbal "emergency" refills*** *from prescribers, in the absence of any true emergency"[2]*

"Each time a patient checked into the facility, the university hospital's electronic ordering system triggered a ***pre-set "protocol" of tests*** *to be run for the patient at university laboratory. The government alleged that several tests on the protocol for all* ***kidney transplant patients*** *were medically unnecessary and dictated by financial considerations rather than patient care"[3]*

"Individual pleaded guilty last November and admitted he lied on applications in order to use approximately $4.1 million in ***grants*** *from NIH to develop China's expertise in the areas of* ***rheumatology and immunology****"[4]*

"Surgical clinic submitted claims for payment to Medicare and Medicaid for the in-office presumptive ***urine drug tests*** *that the they knew, or should have known, were not medically necessary, because they also ordered and received, from the independent reference laboratory, the more detailed and reliable definitive urine drug test results on the identical urine samples"[5]*

Sources: 1) https://www.justice.gov/opa/pr/doj-announces-coordinated-law-enforcement-action-combat-health-care-fraud-related-covid-19;
2) https://www.justice.gov/usao-ndga/pr/alixarx-llc-agrees-pay-275-million-resolve-allegations-it-improperly-dispensed;
3) https://www.justice.gov/opa/pr/university-miami-pay-22-million-settle-claims-involving-medically-unnecessary-laboratory;
4) https://www.justice.gov/opa/pr/university-researcher-sentenced-prison-lying-grant-applications-develop-scientific-expertise;
5) https://www.justice.gov/usao-ct/pr/connecticut-addiction-medicine-provider-pays-1-million-settle-improper-billing

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Additional DOJ enforcement highlights (cont'd)

Home Health Care

- 05/2021: A woman has been ordered to prison for 25 years and 3 years of supervised release following her convictions of conspiracy and aiding and abetting health care fraud. The woman owned and operated a medical clinic in Richmond. She paid doctors to approve patients for home health care regardless of whether it was medically necessary. Potential clients were given brief exams, often by unlicensed people posing as doctors, and then quickly approved for medical services that were unnecessary. The woman then sold those approvals to various corrupt home health care providers.

- 05/2021: The final of eight conspirators was sentenced to 17.5 years in prison for conspiracy to commit health care fraud and wire fraud. The organization recruited and directed nominee owners to fraudulently purchase home health agencies, as well as to open sham corporations in their names, along with corresponding personal and corporate bank accounts. After the acquisition of the home health agency was completed, the group began fraudulently billing Medicare for services that were never provided. The home health agencies had no medical staff and provided no services to any beneficiaries.

Non-Covered Inpatient Admissions

- 08/2021: A medical group in California agreed to pay approximately $11.4 million to resolve alleged violations of the False Claims Act for submitting or causing the submission of claims to Medicare for non-covered inpatient admissions. The medical group admitted certain patients for whom inpatient care was not medically reasonable or necessary, including patients who were admitted for reasons other than medical status, including social reasons and lack of available alternative placements. They then billed Medicare for such patients despite knowledge that the costs for admitting them were not reimbursable by Medicare.

Sources: 1) https://www.justice.gov/usao-sdtx/pr/texas-woman-handed-significant-sentence-health-care-fraud-scheme
2) https://www.justice.gov/opa/pr/final-defendant-sentenced-80-million-health-care-fraud-conspiracy
3) https://www.justice.gov/opa/pr/county-medical-center-and-county-agree-pay-114-million-resolve-false-claims-act-allegations

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Additional DOJ enforcement highlights (cont'd)

EHR Kickbacks

- 04/2021: A Miami-based developer of electronic health records (EHR) software products and related services, has agreed to pay $3,806,966.70 to resolve allegations that it paid unlawful kickbacks to generate sales of its EHR products. It is alleged that between 2012 and 2017, the EHR developer offered and provided its existing clients cash equivalent credits, cash bonuses and percentage success payments to recommend their EHR products to prospective clients. Prospective clients were not told about this referral-kickback arrangement or about the contract that prohibited participants from sharing negative company information with them.

Source: https://www.justice.gov/usao-sdfl/pr/miami-based-carecloud-health-inc-agrees-pay-38-million-resolve-allegations-it-paid

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CERT program / reporting trends

CERT Program: Update

CMS resumed CERT program activities that were temporarily suspended

Update

Effective August 11, 2020, CMS resumed CERT program activities that were temporarily suspended in response to the COVID-19 pandemic.

Background

CMS estimates the Medicare FFS program improper payment rate through the CERT program. Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules.

Details

CMS adjusted CERT program data collection by reducing the sample size for Reporting Year (RY) 2021 and RY 2022 to account for the challenges incurred by providers and suppliers during the PHE, while continuing to maintain appropriate accountability measures and meet statutory obligations.

Source: https://https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT

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CERT Program: Reporting Trends

National CERT improper payment rate by reporting year

Improper Payment Rates and Additional Data

Reporting Year[1]	Total Expenditures (B)	Improper Payment Rate[2]	95% Improper Payment Rate Confidence Interval	Improper Payment Amount (B)
2012	$349.7	8.5%	8.1% - 8.9%	$29.6
2013	$357.4	10.1%	9.5% - 10.7%	$36.0
2014	$360.2	12.7%	11.9% - 13.5%	$45.8
2015	$358.35	12.09%	11.4% - 12.7%	$43.33
2016	$373.65	11.00%	10.2% - 11.8%	$41.08
2017	$380.76	9.51%	8.9% - 10.1%	$36.21
2018	$389.30	8.12%	7.6% - 8.6%	$31.62
2019	$398.62	7.25%	6.9% - 7.6%	$28.91
2020	$410.81	6.27%	5.8% - 6.7%	$25.74

[1] Each reporting year contains claims submitted July 1 two years before the report through June 30 one year before the report. For example, reporting year 2019 contains claims submitted July 1, 2017 through June 30, 2018
[2] Adjusted for A/B rebilling

Source: https://https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT

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OIG enforcement actions

Recent OIG enforcement actions - Overview

Spotlight Reports

Cholesterol Blood Tests

- Payments made to providers for direct low-density lipoprotein (LDL) tests that were billed in addition to lipid panels did not comply with Medicare requirements
- In total, there were **$20.4M** of Medicare payments made to at-risk providers for direct LDL tests

Chronic Care Management Services

- Not all payments made by Center for Medicare and Medicaid Services (CMS) to providers for noncomplex and complex chronic care management (CCM) services rendered complied with Federal requirements
- In total, **$1.9M** was made in overpayments

Hospital Compliance Audits

3	~$21M	128 out of 300	77%	16%
Hospitals audited	In estimated overpayments	Total claims reviewed did not comply with Medicare billing requirements	Inpatient claims were incorrectly billed as inpatient rehabilitation facility	Inpatient claims were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation

Hospice Audits

8	>$120M	267 out of 800	87%	12%
Hospice providers audited	In estimated overpayments	Total claims reviewed did not comply with Medicare billing requirements	Clinical record did not support the terminal prognosis	Clinical record did not support the level of care claimed for Medicare reimbursement

Source: https://oig.hhs.gov (links to specific reports provided in the following pages)

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Recent OIG activity – Other audits and reviews

- Payments made to providers for direct LDL tests that were billed in addition to lipid panels did not comply with Medicare requirements. It was determined that some providers billed LDL tests in addition to lipid panels for the same beneficiary on the same date of service more than 75 percent of the time.
- In total, the review identified $20.4 million of Medicare payments made to at-risk providers for direct LDL tests.
- Under certain circumstances, it may be medically necessary for a provider to perform both tests for the same beneficiary on the same date of service. However, CMS and Medicare contractors explained that these circumstances should happen with only limited frequency.

- Not all payments made by CMS to providers for noncomplex and CCM services rendered during CYs 2017 and 2018 complied with Federal requirements, resulting in $1.9 million in overpayments.
- 38,447 claims identified resulted in $1.4 million in overpayments for instances in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period.
- 10,882 claims identified resulted in $438,262 in overpayments for instances in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods.
- 863 claims identified resulted in $52,086 in overpayments for incremental complex CCM services that were billed along with complex CCM services.

Source: https://oig.hhs.gov/oas/reports/region9/91903027.pdf; https://oig.hhs.gov/oas/reports/region7/71905122.pdf

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Recent OIG activity – Provider compliance audits

- New York hospital did not fully comply with Medicare billing requirements for 40 of the 100 inpatient and outpatient claims reviewed, resulting in overpayments of $666,021 for the audit period, January 2016 through December 2017.
- Based on sample results, inpatient and outpatient claims, which had billing errors, resulted in an estimation of $4.8 million in overpayments.
  - 30/40 inpatient claims were incorrectly billed as inpatient rehabilitation facility.
  - 6/40 inpatient claims were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation.
  - 1/40 inpatient claims had the incorrect diagnosis-related group (DRG) code.
  - 1/40 outpatient claims had an incorrect modifier.
  - 2/40 inpatient claims had the incorrect healthcare common procedure coding system codes (HCPCS).

- New York hospital did not fully comply with Medicare billing requirements for 37 of the 100 inpatient and outpatient claims reviewed, resulting in overpayments of $830,291 for the audit period, CY 2016 – 2017.
- Based on sample results, inpatient and outpatient claims, which had billing errors, resulted in an estimation of $11.8 million in overpayments.
  - 29/37 inpatient claims were incorrectly billed as inpatient rehabilitation facility.
  - 5/37 inpatient claims were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation.
  - 3/37 outpatient claims had an incorrect modifier.

Source: https://oig.hhs.gov/oas/reports/region2/21801018.pdf; https://oig.hhs.gov/oas/reports/region2/21801025.pdf

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Recent OIG activity – Provider compliance audits

- Illinois hospital did not fully comply with Medicare billing requirements for 51 of the 100 inpatient and outpatient claims reviewed, resulting in overpayments of $862,429 for the audit period, CY 2017 – 2018.
- Based on sample results, inpatient and outpatient claims, which had billing errors, resulted in an estimation of $4.4 million in overpayments.
  - 38/51 inpatient claims were incorrectly billed as inpatient rehabilitation facility.
  - 4/51 inpatient claims had the incorrect DRG code.
  - 9/51 inpatient claims were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation.

- Florida home health agency did not fully comply with Medicare billing requirements for 39 of the 100 home health claims* reviewed, resulting in overpayments of $92,345 for the audit period, CY 2014 – 2015.
- Based on sample results, inpatient and outpatient claims, which had billing errors, resulted in an estimation of $4.4 million in overpayments.
- Specifically, the home health agency incorrectly billed Medicare for:
  - (1) services provided to beneficiaries who were not homebound
  - (2) services provided to beneficiaries who did not require skilled services
  - (3) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) payment codes.

*All 100 claims in the sample were outside of the Medicare 4-year claim-reopening period

Source: https://oig.hhs.gov/oas/reports/region5/51900024.pdf; https://oig.hhs.gov/oas/reports/region4/41606195.pdf

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Recent OIG activity – Hospice provider audits

Medicare Hospice Provider

- California hospice provider
  - Did not fully comply with Medicare billing requirements for 21 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $3.3 million.
    - 21/21 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 1/21 claims, no documentation that a hospice physician or hospice nurse practitioner had a required face-to-face encounter with the beneficiary.
- California hospice provider
  - Did not fully comply with Medicare billing requirements for 19 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $3.9 million.
    - 19/19 claims, clinical record did not support the beneficiary's terminal prognosis.
- California hospice provider
  - Did not fully comply with Medicare billing requirements for 34 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $10.5 million.
    - 33/34 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 1/34 claims, clinical record did not support the level of care claimed for Medicare reimbursement.
- California hospice provider
  - Did not fully comply with Medicare billing requirements for 47 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $11.2 million.
    - 43/47 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 4/47 claims, clinical record did not support the level of care claimed for Medicare reimbursement.

Source: https://oig.hhs.gov/oas/reports/region9/91803028.pdf; https://oig.hhs.gov/oas/reports/region9/92003035.pdf; https://oig.hhs.gov/oas/reports/region9/91803009.pdf; https://oig.hhs.gov/oas/reports/region9/91803024.pdf

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Recent OIG activity – Hospice provider audits

Medicare Hospice Provider

- California hospice provider
  - Did not fully comply with Medicare billing requirements for 24 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $7.3 million.
    - 16/24 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 8/24 claims, clinical record did not support the level of care claimed for Medicare reimbursement.
- Wisconsin hospice provider
  - Did not fully comply with Medicare billing requirements for 49 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $47.4 million.
    - 30/49 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 20/49 claims, clinical record did not support the level of care claimed for Medicare reimbursement.
    - 2/49 claims, claimed a service intensity add-on (SIA) payment for services that were not provided.
- California hospice provider
  - Did not fully comply with Medicare billing requirements for 52 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $24.6 million.
    - 52/52 claims, clinical record did not support the beneficiary's terminal prognosis.
- California hospice provider
  - Did not fully comply with Medicare billing requirements for 21 of the 100 claims.
  - Based on sample results, it was estimated that the hospice received overpayments of at least $13 million.
    - 19/21 claims, clinical record did not support the beneficiary's terminal prognosis.
    - 2/21 claims, no documentation to support the hospice services billed to Medicare.

Source: https://oig.hhs.gov/oas/reports/region9/91803016.pdf; https://www.oig.hhs.gov/oas/reports/region2/21801001.pdf; https://oig.hhs.gov/oas/reports/region9/91803017.pdf; https://oig.hhs.gov/oas/reportwhy s/region9/92003034.pdf

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Recent OIG activity – Other audits and reviews

- Most of the selected diagnosis codes (seven high-risk groups) that a health plan submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements.
- For 123 of the 203 enrollee-years, the diagnosis codes that the health plan submitted to CMS were not supported in the medical records and resulted in $354,016 of net overpayments for the 203 enrollee-years.
- On the basis of sample results, it was estimated that the health plan received at least $3.47 million of net overpayments for these high-risk diagnosis codes in 2015 and 2016.

Source: https://oig.hhs.gov/oas/reports/region7/71901187.pdf

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Other noteworthy regulatory enforcement topics

Other noteworthy regulatory enforcement topics

HRSA Uninsured Program Payments

A Texas Hospital had to pay over $555,000 for improperly submitted claims to the COVID-19 uninsured program. The OIG alleged the Hospital presented reimbursement claims for testing, treatment and vaccine administration to the program for services rendered to patients without a COVID-19 primary diagnosis, or pregnancy with COVID-19 as a secondary diagnosis.

Inpatient Rehabilitation Facilities (IRF) Review

The American Hospital Association (AHA) has asked CMS to withdraw the proposed review choice demonstration (RCD) that would implement program integrity audits at IRFs in Alabama, California, Pennsylvania, and Texas due to several concerns such as inadequate timing (i.e. during a public health emergency), and history of inadequate OIG, RAC, and CERT auditors.

Undisclosed Prices

CMS sent 32 hospitals requests for a corrective action plan after they still were not in compliance with the price disclosure rule. CMS has proposed (if passed, would be effective Jan. 1) increasing the minimum fine for price transparency violations. Under the proposed rule, hospitals with more than 30 beds in violation of the rule would pay $10 per day for each bed, up to $5,500 per day. Hospitals with 30 beds or fewer would continue to pay up to $300 per day. This would make the annual penalty at least $109,500, or as high as $2 million a year for large hospitals that fail to make prices public.

Source: 1) https://oig.hhs.gov/fraud … legedly-violating-the-civil-monetary-penalties-law-by-submittir … imed/
2) https://revcycleintelligence.com/news/aha-asks-cms-to-retract-plans-for-inpatient-rehab-facilities-review
3) https://www.beckershospitalreview.com/finance/cms-requests-corrective-action-plan-from-32-hospitals-over-undisclosed-prices.html

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Keeping an eye out – additional risk considerations

Looking Ahead - OIG Priority Areas

Christi Grimm, Principal Deputy Inspector General from the OIG, shared the following four priority areas during the American Health Law Association (AHLA) Annual Meeting PDIG Keynote Address on 6/29/21

Ensuring the integrity and effectiveness of the pandemic response and recovery

Data point: Since 2020, Congress has passed more than $5 trillion in COVID relief (that's more than all Fed spending in 2019)
Data point: Since pandemic, more than 2,400 calls to OIG hotline re: COVID fraud

- OIG COVID work includes over 60 reviews across HHS programs, focused on both financial integrity of fund use and effectiveness of public health response
    - Examples cited include **audits of Provider Relief and Uninsured Funds, impact of waivers/flexibility**

Ensuring quality of care and patient safety in nursing homes

- Cited recent OIG report released. Nursing home mortality increased one-third from 2019 to 2020. Also race disparity with COVID cases in nursing home
- Need to address long-standing issues that the pandemic shines light on – **improved infection control, incident reporting, staffing**

Realizing the potential of telehealth

- There is a significant body of ongoing telehealth work
- Program integrity will cover non "traditional compliance" areas – **interoperability, cyber, and patient access to technology**

Advancing health equities

- OIG oversees number of HHS programs meant to reach underserved populations
- New work underway to examine disparities**, including reviewing grants** (e.g., recipients of CDC REACH grants awarded to reduce disparities among racial/ethnic populations with highest burden of chronic disease)
    - Questions like – is funding distributed to account for potential health disparities? Is the demographics data used to inform public health response, complete and accurate? How is data used to address inequities?

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Thank you!