Key Highlights of the Fiscal Year 2017 OIG Work Plan

INTRODUCTION

On November 10, 2016, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its annual Work Plan for Fiscal Year (FY) 2017. The 2017 Work Plan identifies audits and evaluations that the OIG plans to initiate as new projects beginning in FY 2017. The Work Plan also includes ongoing projects initiated prior to FY 2017, as well as revised projects that will undergo changes beginning in FY 2017. Finally, the Work Plan lists projects that have been completed since the issuance of the FY 2016 Work Plan.

Similar to previous versions, a significant overlap exists between the OIG Work Plan for FYs 2016 and 2017. However, the FY 2017 Work Plan also contains a substantial number of new initiatives, including: skilled nursing facility (SNF) reimbursement; hospice compliance with Medicare requirements; Medicare payments for service dates after individuals' dates of death; and implementation of the Quality Payment Program (QPP). The FY 2017 Work Plan also revises several initiatives since FY 2016, including: review of long-term-care employee background checks; inpatient rehabilitation payment system requirements; and ambulance services supplier compliance with payment requirements.

The OIG protects the integrity of the Medicare and Medicaid programs through its directed reviews and audits. This brief underscores both new and revised reviews that will affect a broad range of Medicare and Medicaid providers and suppliers. Strategic Management selected reviews based on current client practice areas, high risk areas, and new initiatives. The OIG Office of Audit Services (OAS) or the OIG Office of Evaluation and Inspection (OEI) perform the reviews noted below. Health care providers and organizations may use the FY 2017 OIG Work Plan to identify corporate compliance risks, prioritize audit focus areas, and facilitate compliance program activities.

MEDICARE PART A AND PART B

Hospitals

Incorrect Medical Assistance Days Claimed by Hospitals (New) – Medicare allows participating hospitals that serve a disproportionate share of low-income patients to claim a disproportionate share of hospital payments. These payments are calculated based on the number of Medicaid patient days that the hospitals furnish. Hospitals provide this information in Medicare cost reports to Medicare administrative contractors (MACs). The OAS will review whether MACs properly settled the cost reports for disproportionate share payments in accordance with federal requirements.

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Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy (New) – Freestanding inpatient rehabilitation (rehab) hospitals, which provide intensive rehab therapy after injury, illness, or surgery, must only admit patients suited for intensive therapy. The OEI will review a sample of rehab hospitals to determine whether patients participated in and benefited from the therapy. The OEI will also identify patients that were not suited for such therapy, and note reasons for their inability to participate and benefit from therapy.

Nursing Homes

Skilled Nursing Facilities – Unreported Incidents of Potential Abuse and Neglect (New) – Skilled nursing facilities (SNFs) provide rehabilitation and nursing care for some of Medicare's most vulnerable beneficiaries. Previous OIG reviews have demonstrated a potential for abuse and neglect in SNFs. The OAS will review the incidence and handling of neglect and abuse incidents at SNFs to ensure compliance with federal and state requirements. Further, the OAS will interview state officials to ensure that sampled incidents were reported, investigated, and prosecuted, where appropriate.

Skilled Nursing Facility Reimbursement (New) – Certain SNF patients have complex needs and require assistance in all facets of their daily lives. SNFs are required to periodically assess patients using the Minimum Data Set, a tool for classifying patients into utilization groups. Payment for SNF services varies depending on the level of care and therapy provided, and the OIG has found that SNFs periodically bill for higher categories than are reasonable or necessary for patients. The OAS will review the documentation at certain SNFs for compliance with the appropriate utilization group requirements.

Skilled Nursing Facility Adverse Event Screening Tool (New) – The OIG's adverse event trigger tool is a resource that allows SNFs to share practical information for dealing with adverse events. The OEI plans to release a guidance document detailing the purpose, use, and benefits of the tool, as well as the methodology used for its development.

National Background Checks for Long-Term-Care Employees — Mandatory Review (Revised) – The Affordable Care Act (ACA) provides participating states with grants to run background check programs for long-term-care employees,[1] known as the National Background Check Program. The ACA further mandates that the OIG evaluate the Program after its completion. The OEI will review the procedures of states participating in the Program to assess whether the background checks resulted in any unintended consequences.

Hospices

Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio (New) – The Medicare hospice program provides important end-of-life services to beneficiaries. However, the

[1] The Patient Protection and Affordable Care Act, Pub. Law No. 111-148, § 6201 (2010).

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program contains vulnerabilities in payment, compliance, and quality-of-care issues. The OEI will develop a portfolio that underscores key recommendations to improve the program using OIG audits, reviews, and investigations of Medicare hospices.

Review of Hospices' Compliance with Medicare Requirements (New) – Hospice offers palliative care for the terminally ill and their family members, providing services for both the terminal illness and related conditions. Medicare sets forth conditions and limitations for hospice service payments, as outlined in federal regulations.[2] The OAS will perform a review of hospice medical records and billing documentation to ensure that Medicare payments comply with the relevant requirements for hospice services.

Hospice Home Care — Frequency of Nurse On-Site Visits to Assess Quality of Care and Services (New) – In 2013, Medicare hospice payments totaled over $15 billion for more than 1.3 million beneficiaries. Hospices are required to comply with federal, state, and local laws and regulations governing patient health and safety.[3] For instance, Medicare requires that registered nurses make on-site visits to a patient's home at least once in every 14 days to review quality of care and services provided by hospice aides. The OAS will review whether nurses adequately complied with the on-site visit requirement.

Medical Equipment and Supplies

Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment (New) – Medicare Part B covers certain therapies and supplies for beneficiaries whose stay in a SNF exceeds 100 days. This is known as a "non-Part A stay." In 2006 alone, inappropriate payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided for non-Part A stays totaled $30 million. The OEI will conduct a study to assess the extent of inappropriate payments for Medicare Part B DMEPOS to non-Part A stay beneficiaries, and review whether the Centers for Medicare & Medicaid Services (CMS) has adequate systems to identify and recover improper payments from suppliers.

Other Providers and Suppliers

Comparing HHA Survey Documents to Medicare Claims Data (New) – Home health agencies (HHAs) make available patient rosters, schedules, and other information during the recertification survey process to alert CMS and state agencies of fraud. However, state agencies do not have access to Medicare claims data to verify the information provided during the survey process. The OEI will review whether HHAs are providing accurate patient information to states for recertification surveys.

Medicare Payments for Transitional Care Management (New) – Transitional Care Management (TCM) concerns patients with medical and/or psychosocial problems that require moderate to high-complexity

[2] 42 CFR § 418 (G) (2015).
[3] 42 CFR § 418.116 (2015).

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medical decision-making during transitions in care between various settings, such as SNF to assisted living. In 2013, Medicare covered TCM services under the physician fee schedule. Those services cannot be billed in the same service period as certain other Medicare-covered services. For instance, TCM services cannot be billed if end-stage renal disease, chronic care management, or prolonged services without direct patient contact are also billed. The OAS will review payments for TCM services and ensure they are made in accordance with Medicare requirements.

Ambulance Services – Supplier Compliance with Payment Requirements (Revised) – Medicare pays for a variety of ambulance services[4] when the medical condition at the time of transport would be exacerbated or endanger the beneficiary if other modes of transportation were used.[5] Previous OIG studies revealed substantial inappropriate payments for advanced life support emergency transports. The OAS will review Medicare payments for ambulance services to ensure they were made in compliance with Medicare requirements.

Billing and Payments

Medicare Payments for Service Dates After Individuals' Dates of Death (New) – The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to create policies and procedures, and install claim edits, to ensure that payments are not made for services provided to deceased individuals.[6] The OAS will review the relevant policies and procedures to ensure that payments are not made for service dates occurring after individuals' dates of death.

Management Review: CMS's Implementation of the Quality Payment Program (New) – MACRA established the Quality Payment Program (QPP) to promote high quality care by offering adjustments for high performing providers, measured on several categories. The OEI will monitor and review the early implementation of the new payment system. Further, the OEI will report on the timelines, milestones, challenges, and vulnerabilities CMS encounters during the implementation period.

MEDICARE PART C AND PART D

Part C (Medicare Advantage)

Medicare Part C Payments for Service Dates After Individuals' Dates of Death (New) – In 2011, $20 million of the $23 million in improper payments made for services furnished after a beneficiary's death were related to Part C payments. Regulations require Medicare Advantage (MA) organizations to disenroll deceased beneficiaries, effective the first day of the month following death. The OAS will

[4] 42 CFR § 410.40(b) (2010).
[5] 42 USC § 1395x (S)(7) (2010).
[6] The Medicare Access and CHIP Reauthorization Act of 2015, Pub. Law No. 114-10, § 502 (2016).

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review prospective payments made for Part C benefits to ensure that payments made after death complied with Medicare requirements.

Extent of Denied Care in Medicare Advantage and CMS Oversight (New) – MA plans are paid based on capitated payment systems, which pay per person rather than per service. As a result, such payment systems potentially create incentive to underserve beneficiaries. The OEI will review national trends and CMS oversight of denied care within MA organizations from 2013-2015. The OEI will further compare rates of denials, appeals, and overturns across plans and evaluate CMS's efforts to monitor and prevent denial of care.

Part D (Prescription Drug Program)

Medicare Part D Payments for Service Dates After Individuals' Dates of Death (New) – CMS contracts with private prescription drug plans and MA plans to offer prescription drug coverage to eligible beneficiaries. In 2011, $1 million of the $23 million in improper payments made for services furnished after a beneficiary's death were related to Part D payments. Regulations require Part D sponsors to disenroll deceased beneficiaries, effective the first day of the month following death. The OAS will review payments made after a beneficiary's death to ensure that the payments were in accordance with Medicare requirements.

Medicare Part D Eligibility Verification Transactions (Revised) – An E1 transaction is a Medicare Eligibility Verification transaction[7] that pharmacies submit to Part D transaction facilitators, who determine eligibility for the Part D program or other drug coverage information. The facilitator subsequently provides information to the pharmacy to submit the prescription drug event. The OAS will review CMS oversight of E1 transactions processed by contractors to ensure the transactions were used and created as intended. Further, the OAS will assess the validity of the data used to make such determinations.

MEDICAID

Prescription Drug Reviews

States' MCO Medicaid Drug Claims (New) – CMS provides states with a quarterly list of covered outpatient drugs, along with coverage termination dates, if applicable. Drug manufacturers must have a rebate agreement for the manufacturer's drugs to be covered under Medicaid. CMS guidance prompts states to review coverage of the drugs for reimbursement purposes. The OAS will review capitation payments to ensure that managed care organizations providing Medicaid services do not include reimbursement for drugs that are not covered under Medicaid.

[7] Medicare Prescription Drug Benefit Manual, Pub. No. 100-18, Ch. 14, § 30.4 (2016).

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State Management of Medicaid

Medicaid Overpayment Reporting and Collections (New) – States are required to report Medicaid overpayments to CMS. Overpayments are considered "discovered" when a federal official notifies the state, in writing, of an overpayment with a specified amount subject to the recovery.[8] Past OIG audits have identified Medicaid overpayments in multiple states. The OAS will determine whether overpayments have been recouped and are being properly reported to CMS.

Overview of States' Risk Assessments for Medicaid-Only Provider Types (New) – The ACA requires elevated screening for initial provider enrollment, reenrollment, or revalidation in the Medicare, Medicaid, or CHIP programs.[9] When Medicaid recognizes a provider type and Medicare does not, the states are responsible for assessing the provider type's risk in relation to fraud, waste, and abuse, and assigning the provider type to an appropriate risk category.[10] The OEI will review the states' assignment determinations, and note any challenges states have faced in screening providers.

OTHER HHS-RELATED REVIEWS

Financial Reviews

Compliance with the Digital Accountability and Transparency Act (DATA Act) – Mandatory Review (New) – The DATA Act of 2014 sets forth standards for financial and payment data, and mandates reliable agency reporting of such data by May 2017. The DATA Act also requires the OIG to review a statistically valid sampling of spending data for quality, completeness, and accuracy. The OAS will retain an independent auditor to perform this review, and will make the resulting report publicly available.

CONCLUSION

This brief highlights the FY 2017 reviews that are pertinent to Strategic Management's clients. Providers should review the full OIG Work Plan for further details on the OIG's audit and evaluation plans for FY 2017. Providers should also consider the topics listed in the Work Plan in determining risk areas for their organization and prioritizing compliance goals.

The OIG Work Plan for FY 2017 is available at:
https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/hhs%20oig%20work%20plan%202017.pdf.

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[8] 42 CFR § 433.316(e) (2010).
[9] The Patient Protection and Affordable Care Act, Pub. Law No. 111-148, § 6402 (2010).
[10] 42 CFR 455.450; 76 Fed. Reg. 5862 (February 2, 2011).

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