OIG Work Plan for 2017

Presented by:
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More than just coding....
Responsibility of the OIG

- Detecting fraud, waste and abuse
- Identifying opportunities to improve program economy, efficiency and effectiveness
- Mandates accountability
- Focus on Medicare and Medicaid services as well as HHS programs including the health insurance marketplace
Overall Operations

• Independent Oversight
• Adheres to standards of the
  • Government Accountability Office,(GAO)
  • Department of Justice
  • Inspector General
• Protects the Integrity of HHS programs
• Nationwide audits, investigations and evaluations
• Outreach, compliance and educational activities
• Issues fraud alerts and bulletins and advisory opinions
• Determines exclusions from participation
Departments

- Office of Audit Services, (OAS)
- Office of Evaluation and Inspections, (OEI)
- Office of Investigations, (OI)
- Office of Counsel to the Inspector General, (OCIG)
- Executive Management, (EM)
Establishing a Work Plan

• Dynamic process which evolves over the course of the year
• Based on
  • Mandatory requirements for OIG reviews
  • Requests made by Congress, HHS, Office of Management and Budget
  • Top management and performance challenges
  • Oversight organizations, (GAO)
  • Management’s action to implement OIG recommendations
• Assessment of civil monetary penalties after investigation
Medicare Program Payments

• Medicare: $371 Billion in program payments serving 37 million people
• Medicare Part D: $85 billion in payments serving 41 million people
• There is a revised plan to review the eligibility verification transaction for Part D services to ensure CMS is appropriately monitoring to determine if the transactions were created for necessary services
Objectives

• Review new, revised and established work plans for 2017
• Assess the work plan across areas of responsibility which include:
  • CMS- Center for Medicare and Medicaid Services
  • HHS- Health and Human Services
  • IHS- Indian Health Services
  • FDA- Food and Drug Administration
  • CDC- Center for Disease Control
New OIG Plans for 2017
Hyperbaric Oxygen Therapy Services

• HBO involves giving the patient high concentrations of oxygen in a pressurized chamber
• Used for nonhealing wounds
• Concerns that beneficiaries received treatments for noncovered services
• Medical documentation did not support treatments
• Beneficiaries received more treatments than were medically necessary
Incorrect Medical Assistance Days Claimed by Hospitals

- Hospitals report Medicaid patient days
- Based on disproportionate share of low-income patients
- Submitted on the Medicare cost reports
- Medicare administrative contractors review and settle
- Risk for overpayment
- Plan to assess cost reports to ensure appropriate payments
Inpatient Psychiatric Facility Outlier Payments

• Payments to psychiatric treatment facilities increased 28 %
• Total Medicare payments increased from $450.2 million to $534.6 million (19%)
• Will assess documentation, coverage and coding requirements
Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy

- Assess a sample of rehabilitation hospital admissions to determine whether the patients participated in and benefited from intensive therapy
- Identify why patients did not participate and benefit from therapy
- Plan to determine whether the patient required multiple intensive therapies and whether inappropriate payments were made. This is a revised plan from previous reviews
Nursing Home Complaint Investigation Data Brief

• Nursing Home complaints are categorized as immediate jeopardy
• Investigations occur within a 2-10 day timeframe
• Retrospective review determined State agencies did not investigate some of the most serious complaints
• Plan to review investigation data
Skilled Nursing Facilities- Unreported Incidents of Potential Abuse and Neglect

- OIG reviews found potential for unreported instances of abuse and neglect
- Plan to assess incidence of abuse and neglect
- Determine if incidents were properly reported and investigated
- Determine if confirmed cases were prosecuted
Skilled Nursing Facility Reimbursement

• Some SNF patients require total assistance with activities of daily living
• SNFs must periodically assess patients using the Minimum Data Set to classify each patient into a resource utilization group
• The more care required, the higher the Medicare payment
• Previous OIG work found SNFs were billing at higher levels than justified by care provided
• Review will determine if documentation supports billing for each resource utilization group
Skilled Nursing Facility Adverse Event Screening Tool

- Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries
- Released in 2014
- Objective is to disseminate information for using the tool in the skilled nursing industry
Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement

• Hospice program is important for beneficiaries at end of life
• Vulnerabilities identified in payment, compliance and oversight as well as quality of care
• Plan to summarize evaluations and highlight recommendations to protect beneficiaries and to improve program
Review of Hospice Compliance with Medicare Requirements

• Hospice agency assumes responsibility for medical care related to the terminal illness and related conditions
• Plan to review medical records and payments to ensure compliance with regulations
Hospice Home Care-Frequency of Nurse On Site Visits to Assess Quality of Care and Services

- 1.3 million beneficiaries receive hospice services
- Payments totaled $15.1 billion
- On site nurse visits required Q 14 days to assess quality of care
- Plan to determine whether on site visits were made in compliance with the program
Comparing HHA Survey Documents to Medicare Claims Data

• Home Health Agencies supply patient information to State agencies during recertification surveys
• State agencies have no access to Medicare claims data to verify information
• Fraudulent HHAs may intentionally omit certain patients to avoid scrutiny
• Prior OIG reviews found that the home health program is prone to fraud, waste and abuse
• Plan to determine if HHAs are accurately providing patient information to State agencies during recertification surveys
Medical Equipment and Supplies

• If a beneficiary resides in a SNF over 100 days they may be eligible for Medicare Part B coverage of therapy and supplies

• In 2009 OIG identified $30 million in inappropriate payments for DME

• Plan to is determine extent of inappropriate payments

• Determine whether CMS has a system in place to identify inappropriate payments and to recoup those payments
Medicare Market Share of Mail-Order Diabetic Testing Strips: April 1 through June 30, 2016
Mandatory Review

- OIG is required to report market share before and after competitive bidding program process
- Three reports will be compiled. The first preceding bidding, the second for the 3 month period after implementation and the third will be for 6 months post implementation
- Plan to assess market shift impacts
Positive Airway Pressure Device Supplies-Compliance with Documentation, Frequency and Medical Necessity

- Positive airway pressure devices, (PAP), require supply replacement
- Physician orders and caregiver requests are required
- Prior OIG review found suppliers were sending supplies without orders or requests
- Medicare payments in 2014-2015 were $953 million
- Plan to review claims to determine whether medical documentation supports medical necessity and frequency of replacement
CMS is required to replace current system of assessing payment rates for Medicare Part B clinical diagnostic laboratory tests

OIG will conduct an analysis of the top 25 laboratory tests and Medicare payments

This review builds on reviews conducted in 2014 and 2015 as plans to implement a new payment system for clinical diagnostic laboratory tests is implemented

There is also a revised plan that includes review of testing required for bone marrow and sold organ transplantation services and the accuracy of payments
Medicare Payments for Transitional Care Management

• Transitional Care Management, (TCM), includes payment for services provided to a patient whose medical and or psychosocial problems require moderate or high complexity medical decision making during transitions of care from an inpatient hospital to another care facility.

• Medicare covered services for chronic care management, end stage renal disease and prolonged services without direct patient contact cannot be billed with TCM.

• OIG will determine whether TCM services are paid according to Medicare requirements.
Medicare Payments for Chronic Care Management

• Chronic Care Management (CCM), is non face to face services provided to Medicare beneficiaries with two or more significant chronic conditions such as Alzheimer's, arthritis, cancer, diabetes, etc. that place them at risk for death, acute exacerbation or functional decline.

• These conditions are expected to last 12 months or until the death of the patient.

• CCM services cannot be paid at the same time as home health or hospice care or transitional care.

• Plan to determine whether payments were made according to Medicare requirements.
Data Brief on Financial Interests Reported Under the Open Payments Program

• Physician Payments Sunshine Act requires manufacturers to disclose CMS payments made to physicians and teaching hospitals
• Manufacturers must report ownership and investment interests held by physicians
• Plan is to analyze data to determine the number and nature of financial interests
• Plan to determine how much Medicare paid for drugs and DMEs ordered by physicians who had financial relationships with manufacturers
Drug Waste of Single-Use Vial Drugs

• Modifier JW is used to indicate the amount of waste in a single use vial
• Other countries have single vial sizes that are smaller which could be introduced in the U.S. with a lower price
• Plan to determine the amount of waste for the top 20 single use vial drugs to determine where a different size vial could significantly reduce waste
Management Review: CMS Implementation of the Quality Payment Program

• The Quality Payment Program is intended to control expenditures and promote high value
• Providers receive enhanced reimbursement or decreased reimbursement based on performance criteria
• Plan to identify challenges to implementation of this program
Medicare Part C and Part D Payments for Service after Individual’s Death

- Part C or Medicare Advantage Plans made payments of $23 million after beneficiaries’ death
- Part D or Prescription coverage payments were also made post date of death
- Review planned to assess erroneous payments and plans for recoupment
Data Brief on Fraud in Medicaid Personal Care Services

• Data brief for personal care services will include information about investigations, indictments, convictions and recoveries involving fraud and patient abuse or neglect in the Medicaid personal care services

• A review of adult day health services will also be conducted based on noncompliance with regulations
Delivery System Reform Incentive Payments

• Incentive payments are available to hospitals that develop programs or strategies to enhance access to health care, increase quality and cost-effectiveness of care and increase the overall health of patients

• More than $6 billion was paid in incentives in a 5 year period

• Plan to ensure States comply with program and to assess appropriateness of payments
Accountable Care in Medicaid

• Accountability for the cost and quality of care is a focus
• ACO models will be reviewed to ensure compliance with State and Federal requirements
• Plan to assess whether allocations deviate from acceptable practices
• Also review planned to determine whether payments to providers were at least those of the Medicare rates
• Plan to determine whether States made inaccurate assessments of beneficiary eligibility
• Plan to review beneficiaries assigned multiple Medicaid identification numbers
Third-Party Liability Payment Collection in Medicaid

- Medicaid is the payor of last resort
- Plan to review State agencies to determine if third-party liability for health care services have been properly identified
- Review any overpayments to ensure recoupment
Overview of States’ Risk Assessments of Medicaid-Only Provider Types

- Medicaid-only provider types include nonemergency transport, personal attendants, and nursing home providers
- States must assess risk for fraud, waste, and abuse
- Plan to review risk categories to determine appropriate screening methodology performed by States
- Ensure suspension of payments to providers under investigation
- Strike Force teams operate in 9 major cities
- Plan to assess breach notifications related to unsecured release of patient health information as it was determined that States have insufficient security features
Health-Care Related Taxes: Medicaid MCO Compliance with Hold-Harmless Requirement

- In certain instances hospitals and providers are taxed to finance Medicaid spending.
- These taxes avoid hold-harmless rules that returns taxes directly or indirectly to taxpayers.
- Plan to review process to ensure compliance to the Hold-Harmless regulation.
FDA- Hospitals’ Reliance on Drug Compounding Facilities

• Review the extent that hospitals use compounding facilities that compound medication without a specific patient prescription
• Assess compounding facilities production of sterile preparations
Review of CMS Action on CERT Data

• Inaccurate payments totaled $43.3 billion or 12.1% of the Medicare payments for 2015
• Improper error rates and payments continue to rise
• Plan to review CERT program and whether CMS took appropriate action to target error-prone providers and to reduce payment errors.
• Capitated payments are per person based rather than per service based
• There may be incentive to underserve beneficiaries
• Plan to assess trends, denials and appeals and overturned decisions
• Plan to evaluate CMS oversight of Medicare Advantage Plans
• Review of accuracy of data provided by Medicare Advantage Plans is underway
Revised Work Plans for 2017
Intensity-Modulated Radiation Therapy (IMRT)

- Advanced high-precision radiotherapy using computer-controlled linear accelerators to deliver radiation
- Two treatment phases: planning and delivery
- Prior reviews determined hospitals billed incorrectly for IMRT
Background Checks for Long-Term Care Employees

- Review ongoing process for checking the background of any prospective employee who will have direct patient access
- Determine if the review identified unintended outcomes
Ambulance Services- Supplier Compliance with Payment Requirements

- Emergency and non-emergency transport includes basic life support, advanced life support and specialty care transport
- Plan to assess appropriateness of payments to ambulance service providers
CDC- Grantee’s Use of President’s Emergency Plan for AIDS Relief Funds

• Funds are available to provide international programs for prevention, treatment and care related to AIDS
• Prior investigations identified misallocations.
• Plan for ongoing scrutiny to ensure all funds are monitored and accounted for and whether distributed funds were used in accordance with the grant requirements
The World Trade Center health program was established to assist those responders and survivors with health conditions related to the September 11, 2001 terrorist attacks.

Prior reviews determined that insufficient assessments were made related to the funding necessary to support expenditures for this health care.

Plan to determine whether effective controls are in place to avoid excessive administrative costs.
FDA’s Review of Networked Medical Device Cybersecurity During the Premarket Process

• More and more medical devices are wireless, internet activated and are used to diagnose and treat
• These devices are vulnerable to cybersecurity threats that may adversely impact the functionality of the device
• Plan to examine policies to ensure analysis premarket is robust
• The FDA has ongoing responsibility for monitoring the safety and effectiveness of these devices
Ongoing Reviews
Outpatient Outlier Payments for Short-Stay Claims

• Currently CMS makes additional payment for hospital outpatient services when a hospital’s charges exceed a fixed multiple of the normal Medicare payment
• Purpose is to ensure beneficiary access to services
• Determined excessive outlier payments made
• Will determine elimination of outlier payment program
Comparison of Provider Based and Freestanding Clinics

• Provided based facilities receive higher payments
• Will assess payments for both
• Determine impact on beneficiaries for hospitals claiming provider based status
• Assess compliance with corporate integrity agreements
• Ensure voluntary self-disclosures of fraud, waste and abuse
Hospitals Use of Outpatient and Inpatient Stays Under Medicare Two Midnight Rule

• Determine how hospitals use of outpatient and inpatient stays changed
• Review claims year prior to implementation and year subsequent to implementation of the new rule
• Determine variation between hospitals inpatient and outpatient stays
Medicare Costs Associated with Defective Medical Devices

- Recalls of medical devices nearly doubled from 2003-2012
- Concerns regarding impact of costs to replace these devices
- Plan to review claims to identify costs related to additional use of medical services directly related to recalled medical devices
- Current regulations require reductions in Medicare payments for replacement of implanted devices
Medicare Payments for Overlapping Part A Inpatient Claims and Part B Outpatient Claims

- Occurs when an inpatient at one facility requires services not available at that facility and goes to another facility that can provide service
- Certain services rendered to inpatients should not be billed separately under Part B for outpatient services
- Review planned to assess whether outpatient claims billed to Part B during inpatient stays were made appropriately
Selected Inpatient and Outpatient Billing Requirements

- Assess claims at risk for overpayment
- Recommend recovery of overpayments as identified
- Focus on hospitals at risk for overpayments
- There is a revised plan to ensure that the risk adjustment program focusing on allocation of payments for sicker patients is administered appropriately and CMS has sufficient oversight
Duplicate Graduate Medical Education Payments

• Two Payment Types
  • Direct Graduate Medical Education (DGME)
  • Indirect medical education (IME)

• Assess validity of Intern and Resident information System, (IRIS) in preventing duplicate reimbursement

• Identify any inappropriate payments
Outpatient Dental Claims

- Medicare excludes most outpatient dental services
- OIG audits found hospitals received payment for noncovered dental services
- Determine revisions to program to prevent overpayments
- Medicaid has similar exclusions
Nationwide Review of Cardiac Catheterizations and Endomyocardial Biopsies

• Payments for endomyocardial biopsies are generally for right heart catheterizations when performed during the same outpatient encounter

• In some instances use of a modifier 59 to indicate a separate and distinct session or encounter is appropriate

• OIG reviews found some hospitals did not comply with requirements and used modifier 59 during the same session

• Review planned for all right heart catheterizations and endomyocardial biopsies performed during the same patient encounter
Payments for Patients Diagnosed with Kwashiorkor

• Kwashiorkor is a severe protein malnutrition found in children living in tropical areas impacted by famine and insufficient food supply

• Typically not found in the United States

• OIG reviews identified inappropriate payments to hospitals for claims with Kwashiorkor diagnosis

• Plan for review of claims and compare documentation in medical record to determine if diagnosis is supported

• Recommendations for program changes may be made
Review of Hospital Wage Data Used to Calculate Medicare Payment

- Wage data is reported annually to CMS
- This information is used to calculate the wage index rates based on geographic area labor market costs
- OIG identified incorrect reporting
- Policy changes made
- Updated review of data planned to assess accuracy and to update wage index data for Medicare payments
CMS Validation of Hospital Submitted Quality Reporting Data

- Acute care hospitals are required to submit quality data to prevent payment reduction.
- Used for value based purchasing program and hospital acquired condition program.
- Plan to validate quality reporting data.
Long Term Care Hospitals- Adverse Events Post acute Care for Medicare Beneficiaries

• LTCHs are the third most common type of post acute care facility after SNFs and inpatient rehab facilities
• Account for 11% of Medicare costs or $5.4 Billion in FY 2011
• Plan to estimate national incidence of adverse or temporary harm events
• Plan to identify factors contributing to these events
• Determine the extent to which they are preventable
Hospital Preparedness and Response to Emerging Infectious Diseases

- Prior OIG investigations noted shortcomings
- Examples include community preparedness for pandemic (2009) and preparedness for natural disasters i.e. Superstorm Sandy, 2013)
- Plan to describe hospitals efforts to prepare for public health emergencies resulting from infectious disease threats
- Plan to assess hospitals use of HHS resources
- Plan to identify lessons and challenges faced by hospitals as they respond to infectious disease threats such as Ebola
- Ensure strategic stockpiles of pharmaceuticals for rapid distribution
Skilled Nursing Facility Prospective Payment System Requirements

- Beneficiary must be an inpatient in a hospital for 3 days prior to eligibility for SNF admissions.
- Admission must occur within 30 days after discharge
- Prior OIG reviews identified non compliance
- Plan is to review compliance
Potentially Avoidable Hospitalizations of Medicare and Medicaid Eligible Nursing Facility Residents

• High occurrences of patient transfers from SNF to hospital for preventable conditions could indicate poor quality of care

• Examples include UTI, a condition that is preventable and treatable in the SNF without hospitalization

• Prior OIG audits concluded SNFs did not provide prevention and detection services placing residents at risk for infection and hospitalization

• Plan to review transfers for preventable conditions

• A similar plan is underway for Medicaid beneficiaries
Home Health Compliance with Medicare Requirements

- Improper payments identified 51.4% of the time totaling $9.4 billion
- Patients in this category were not home bound and did not require skilled services
- Plan to review compliance and review medical documentation related to claims submitted
Orthotic Braces- Reasonableness of Medicare Payments Compared to Amounts Paid by Other Payers

- Payments for orthotic braces including back and knee have more than doubled and in some instances tripled for certain types of knee braces
- Plan is to determine reasonableness of fee schedule amounts for orthotic braces
- Plan to compare Medicare payments to non Medicare payments
- Plan to identify wasteful spending
- Plan to estimate financial impact of fee schedule update to align with non Medicare payers
Osteogenesis Simulators-Lump Sum Purchase vs Rental

• Bone growth stimulators are used for failed fusions and for multilevel fusions
• Payments from 2012-2014 were $286 million
• Plan to assess whether 13 month rental with a Medicare cap will result in potential savings rather than a lump sum purchase of device
Power Mobility Devices - Lump Sum Purchase vs Rental

- Scooters and power wheelchairs fall into this category
- Effective in 2011 Medicare eliminated lump sum purchase option for power wheelchairs
- Other PMDs, not affected by this change can either be rented or purchased
- Plan to determine whether a 13 month rental with a Medicare cap will result in potential savings
Competitive Bidding for Medical Equipment Items and Services – Mandatory Review

- Plan to assess effectiveness of CMS competitive bidding process
Nebulizer Machines and Related Drugs - Supplier Compliance with Payment Requirements

• Prior OIG review identified that 50% of claims were not paid in accordance with Medicare requirements of reasonable and necessary

• Plan to review payments to determine whether suppliers meet medical necessity requirements
Access to Durable Medical Equipment in Competitive Bidding Areas

• Suppliers compete on pricing to supply specific demographic areas
• Anecdotal reports indicate this process has reduced beneficiary access
• Plan to assess competitive bidding process and compromised access to DME
• Medicare sets minimum health and safety requirements for ASCs
• ASCs must become certified
• Previous OIG reviews determined that recertification surveys were not timely, there was poor oversight and little public information about the quality of ASCs
• Plan to assess program
Medicare Part B covers anesthesia services
Plan to review claims for services
Plan to determine if they were provided in accordance with Medicare requirements
Assess claims to determine if a related service was provided
Anesthesia Services-Payments for Personally Performed Services

• The AA modifier indicates service was personally performed
• QK modifier results in a 50% reduction in payment if the service was not personally performed
• Plan to assess payments to determine if AA modifier was used appropriately
Physician Home Visits- Reasonableness of Services

- 2013 to 2015 Medicare paid $718 million for home visits
- Medical necessity must be documented
- Medicare will not pay for services that are not reasonable and necessary
- Plan to assess payments to determine validity of a home visit instead of an outpatient visit
Prolonged Services- Reasonableness of Services

• Prolonged services are for additional care of a beneficiary beyond the evaluation and management service
• Prolonged services are rare and unusual
• Plan to assess whether payments were made appropriately
Chiropractic Services- Part B Payments for Non-Covered Service

- Medicare Part B pays for manipulation of the spine to correct a subluxation if there is a neuro-muscular condition warranting the manipulation.
- Medicare Part B does not pay for chiropractic maintenance therapy.
- Prior review identified inappropriate payments.
- Plan to assess reasonable and necessary nature of paid services.
- Plan is to identify trends in payment, compliance and fraud vulnerabilities and offer recommendations to reduce vulnerabilities.
Selected Independent Clinical Laboratory Billing Requirements

• Concerns exist regarding noncompliance with billing requirements
• Plan to review payments and focus on claims that may be at risk for overpayment
• Based on outcome of review will recommend recovery of overpayments
Physical Therapists- High Use of Outpatient Physical Therapy Services

- Prior OIG review indicated high instance of services that were not reasonable and were improperly documented
- Plan to review physical therapy services to determine compliance
Portable X-ray Equipment-Supplier Compliance with Transportation and Setup Fee Requirements

• Services provided at patient homes and in group living facilities such as nursing homes
• Prior reviews found return trips, multiple trips in one day
• Plan to review payments to assess whether they were correct and had supporting documentation
• Plan to review qualifications of technicians performing services
CPT 95810 and CPT 95811 totaled payments of $415 million in 2010.

Plan to assess reasonable and necessary services particularly related to repeat diagnostic testing.
Potential Savings from Inflation-Based Rebates in Medicare Part B

• Each year mandated rebates enable Medicaid to recoup a substantial portion of the billions spent on prescription drugs from the pharmaceutical manufacturers

• No similar program exists for Medicare Part B

• Plan to assess 50-100 Part B drugs to determine difference between existing Medicare policy and an inflation-based rebate program
Comparison of Average Sales Prices to Average Manufacturers Prices-Mandatory Review

• Medicare pays for Part B drugs using average sales prices,(ASP)
• If ASP exceeds AMP by a certain threshold, the ASP will be disregarded in determining reimbursement amounts
• OIG will compare ASP to average manufacturer prices,(AMP)
Payments for Immunosuppressive Drug Claims with KX Modifiers

• The KX modifier is used by suppliers to indicate they maintain the date of transplant and this date is prior to supply of immunosuppressive drug

• Prior OIG reviews indicated non compliance

• Plan to review to assess supporting documentation for claim
Part A and B Contractors

- CMS administers Medicare program through contractors
- Plan to review administrative costs claimed by contractors including those contractors who have been terminated by the program
Contractor Pension Cost Requirements

- Medicare will reimburse contractors a portion of their pension costs
- Plan to determine whether contractors have appropriately calculated and claimed reimbursement for pension costs
- Will assess future costs and determine the amount of pension assets
- Plan also to review post retirement health benefit costs and supplemental employee retirement costs
Medicare Contractor Information Systems Security Programs Annual Report to Congress Mandatory Review

- Independent evaluations will be conducted of the security programs for Medicare Administrative Contractors
- Plan to assess scope and sufficiency of information system security
Collection Status of ZPIC and PSC Identified Medicare Overpayments

- Zone Program Integrity Contractors (ZPIC), and Program Safeguard Contractors (PSC), must assess overpayments.
- They conduct investigations and report claims for recovery of funds.
- Plan to determine the total amount of overpayments and will review procedures for tracking collection of overpayments.
Accountable Care Organizations: Beneficiary Assignment and Shared Savings Payments

• Accountable Care Organizations, (ACO), were developed to promote accountability and coordination of services for high quality, efficient health services

• Plan to review assignment of beneficiaries to ACOs and to determine whether there are any overlapping payments from other savings programs

• Performance and savings of ACOs will also be assessed

• Assessment of impact of use of EMRs for exchange of health information will be conducted
Medicare Payments for Service Dates after Individual’s Death

• Claim edits exist to prevent payment of services after the date of death
• Previous reviews found payments made after beneficiary’s death
• Review will be conducted to determine whether policies and procedures ensure that no payments are made post date of expiration.
• Similar reviews are underway for Medicaid
Medicare Payments for Incarcerated Beneficiaries—Mandatory Review

- In 2009 prior OIG review identified $33.6 million in payments for services rendered to incarcerated individuals
- No payment is to be made for incarcerated individuals unless they are responsible for payment of medical care
- Plan to review CMS processes for preventing payment and for recouping erroneous payments
Questionable Billing for Compounded Topical Drugs in Part D

- Spending for compounded drugs grew by more than 3400% totaling $224 million
- Growth in spending and ongoing OIG investigations suggest a fraud risk.
- Assessments will continue to identify pharmacies with questionable Part D billing for these drugs
- Generic drugs are also a focus of review as is the exchange in the drug supply chain and obstacles to tracking this information
Increase in Prices for Brand-Name Drugs Under Part D

- Prices for Part D brand name drugs increased 13% in 2013 which was 8 times greater than the general inflation rate
- Plan to evaluate pharmacy reimbursement
- Similarly, Payments for Part D catastrophic coverage, which is implemented when a beneficiary exceeds a threshold for prescription drug spending, will be assessed
- Pharmacies are not required to enroll in Medicare and concerns exist regarding potential for fraud
- Review is also planned for dual eligible’s access to Part D
- Plan to assess conflicts of interest in committee assessing drug coverage
• Drug event records are submitted by pharmacies
• Assessment of accuracy and compliance to be initiated
• Similarly, a review of the coverage gap discounts will be done for beneficiaries who must pay for their own prescriptions during coverage gaps
States’ MCO Medicaid Drug Claims

• Drug manufacturers must have a rebate agreement with CMS to have outpatient drugs covered under Medicaid
• MCOs make independent decisions regarding formularies
• Plan to assess whether MCO capitation payments included reimbursement for non-covered drugs under the Medicaid program
Physician Administered Drugs for Dual Eligible Enrollees

• States are required to collect rebates on physician administered drugs
• NDC numbers are submitted to manufacturers for a rebate
• Medicare mandates a copay for physician administered drugs which Medicaid must pay
• Plan to assess impact of Medicare policy on ability of State agencies to invoice rebates for dual eligible beneficiaries
Specialty Drug Pricing and Reimbursement in Medicaid

• Specialty drugs require special handling and administration
• Treatment examples include Hepatitis C, HIV and certain cancers
• Plan to assess how State Medicaid agencies define specialty drugs and how much was paid for these drugs and how payment methodologies are established
• Drug utilization review programs will be assessed regarding inappropriate dispensing and potential abuse of prescription drugs including opiates
Medicaid Payments for Multiuse Vials of Herceptin

• Herceptin is used to treat breast cancer
• Provider noncompliance has been demonstrated related to claims
• Assessment to be made regarding claims, and payment accuracy
Oversight and Effectiveness of Medicaid Waivers

- Oversight of the State waiver program is problematic
- Assessments will include a review of the efficiency, economy and quality of care
- Concerns exist regarding inflation of Federal costs
- A review of the CMS oversight of these waiver programs will also be conducted
- Room and board costs are not reimbursable. Assessments regarding payments received via waiver programs will be conducted
Express Lane Eligibility-Mandatory Review

• Eligibility for children and the CHIP program is expedited
• Assessment will be made regarding inaccurate eligibility and associated payments
• Challenges to program will be addressed
Transportation Services- Compliance with Federal and State Requirements

- Transportation must be made available to beneficiaries
- States have different criteria for coverage
- Plan to review appropriateness of payments
Health Care Acquired Conditions- Prohibition on Federal Reimbursements

• No payment will be made by Medicaid for health-care-acquired conditions
• Preventable conditions will have zero reimbursement to hospitals
• Plan is to quantify any payments made by States on behalf of Medicaid beneficiaries
Community First Choice State Plan Option
Under the Affordable Care Act

- States receive an additional 6% in funding if they utilize Community First Choice.
- These services are for home and community based attendants for individuals who otherwise would require institutional care.
- Plan to review payments to assess beneficiary eligibility and to determine if payments to the States were appropriate.
- Similar reviews will be conducted for long term care.
- There is a revised plan for ongoing review of Consumer Operated and Oriented Plan Loan Program which assists in developing non profit member controlled health plans.
State Agency Verification of Deficiency Corrections

• Nursing homes must submit a corrective action plan for any deficiencies noted during survey
• State agencies are to confirm implementation of those corrective action plans
• Plan to assess whether State follow through has been thorough and consistent
Health Insurance Marketplaces

• Review of the accuracy of payments, eligibility determinations, management and administration as well as security of consumer information

• Review of accuracy of financial assistance payments to reduce beneficiary liability
Electronic Health Records

• More than $30 billion in payments to providers for meaningful use of the EMR
• Payment reductions for providers who do not implement the EMR
• Security of data scrutinized
FDA-Tobacco Establishment Compliance with the Family Smoking Prevention and Tobacco Control Act

- Registration is required by manufacturers of tobacco products
- Will assess FDA inspections of these facilities as well as compliance of the manufacturers with requirements
FDA-Monitoring of Domestic and Imported Food Recalls

- FDA can order recalls if there is reasonable probability that the food will cause serious adverse health consequences
- Plan to review monitoring efforts of FDA
- This includes inspections of food facilities
• Assessment of management of grant funds for patients receiving service who are unable to pay
• $1.5 billion provided over a 5 year period for home visiting services to families at risk with children under the age of 5
• $9.5 billion provided to health centers
• Plan to determine compliance with programs
Indian Health Service

- Objective is to raise health status and provide a comprehensive health service to 2.2 million American Indians and Alaska Natives.
- The Purchased/Referred Care program coordinates services with private providers when no IHS program is available.
- There are 28 hospitals providing free inpatient care to eligible individuals.
- Concerns regarding quality of care exist and are under review.
- Plan to audit program payments of $333.7 million in 2016.
National Institutes of Health

- Objective is to foster research
- Review to ensure privacy of volunteers participating in programs
- Assess programs related to grants provided to colleges and universities
- Determine accuracy of payments related to SuperFund research
• Objective is to reduce the impact of substance abuse and mental health illness across the nation
• Plan to assess States’ monitoring of the Opioid Treatment Program
Other Public Health Services

• Review of Temporary Assistance for Needy Families (block grants total $16 billion annually)

• Review of the Unaccompanied Children Program In 2014 $911 million spent on 57,500 children and to determine if sponsors where children are placed meet qualifications for participation in the program

• Review of Head Start program grantees

• Review of Foster Care Program related to issuance of prescription psychotropic medication Additionally there will be ongoing monitoring of complaint resolution

• Ongoing monitoring of the subsidizing of child care
Conclusion

• Future focus will be on
  • Health information technology
  • Electronic exchange of information
  • Security of patient health information
  • Outcomes of investment in health IT

• The amount of review is determined by the funds available and the purpose limitations in funding provided to the OIG

• 78% is directed to Medicare and Medicaid Programs
Reporting Fraud to the OIG

- Phone: 1-800-TIPS or 1-800-447-8477
- Fax: 1-800-223-8164
- TTY: 1-800-377-4950
- Mail:
  - US Department of Health and Human Services
  - Office of Inspector General
  - ATTN: OIG HOTLINE OPERATIONS
  - P.O.Box 23489
  - Washington, DC 20026
Contact Information

Name
Title
H.I.M. ON CALL, Inc.
Phone number
email.com
Thank you.