HHS OIG ISSUES 2015 WORK PLAN SERIES

Installment One - A Look At What's New This Year

Sara M. Lord

In an effort to assist our clients and friends with reviewing the OIG Work Plan for Fiscal Year 2015, we will be publishing a series of articles focusing on different aspects of the Work Plan. In this first article of the Series, we focus on the new reviews and projects that have been added to the OIG's portfolio.

On October 31, 2014, the Department of Health and Human Services Office of Inspector General (OIG) posted the 2015 Work Plan. Typically, the OIG Work Plan highlights the areas the agency believes are particularly susceptible to fraud and abuse, and thus, also provides a blueprint of the agency's future enforcement actions. Describing the plans for this year, however, the OIG carefully noted that, "The amount of work conducted in each category is set by the purpose limitations in the money appropriated to OIG," and pointedly stated that the funding for the oversight of Medicare and Medicaid "constitutes a significant portion of its total funding (approximately 76 percent in 2014)." The remaining share of OIG's "efforts and resources focuses on HHS's other programs and management processes." In its Introduction to the Work Plan, the OIG outlined its plans:

> In FY 2015 and beyond, we will continue to focus on emerging payment, eligibility, management, and IT systems security vulnerabilities in health care reform programs, such as the health insurance marketplaces. OIG plans to add to its portfolio of work on care quality and access in Medicare and Medicaid, as well as on public health and human services programs. OIG's examination of the appropriateness of Medicare and Medicaid payments will continue, with possible additional work on the efficiency and effectiveness of payment policies and practices in inpatient and outpatient settings, for prescription drugs, and in managed care. Other areas under consideration for new work include, for example, the integrity of the food, drug, and medical device supply chains; the security of electronic data; the use and exchange of health information technology; and emergency preparedness and response efforts.

In large part, the 2015 Work Plan continues to focus on Medicare Part A and Part B reviews, as well as prescription drug plans. Hospitals, hospice providers, long-term care facilities, community-based care, free-standing clinics, and laboratories remain under scrutiny for access to care, quality of care, improper payments, and opportunities to reduce payments. The OIG continues to ramp up its scrutiny of electronic health records (EHR), making EHR a new focus area in the plan, continuing most of the EHR-related reviews initiated in the 2014 Work Plan, and adding, for the first time, a review of hospitals' EHR contingency plans.

This year, however, much of the Work Plan focuses on managed care, and the implementation of Affordable Care Act programs. "To this end, we are prioritizing work in three main areas: the health insurance marketplaces, including financial assistance payments; Medicare and Medicaid reforms; and grant expenditures for public health programs." The OIG also will initiate "at least" five to ten new additional reviews addressing ACA programs, including possibly: potential vulnerabilities that may arise in connection with the second open enrollment period; implementation of additional marketplace functionality, such as the redetermination process; the premium stabilization programs; Medicaid expansion; new Medicare payment and delivery models; and new grant programs.

As part of our continuing series of articles on the 2015 Work Plan, this installment focuses exclusively on the *new* reviews and projects that have been added to the OIG's portfolio. Forthcoming articles in the series will address aspects of the Work Plan by subject area, and from other perspectives.

As has frequently been the case, many of the OIG's planned new reviews have developed from previous audits and studies that identified vulnerabilities to possible fraud and abuse within programs or from common practices within an industry.

Review of hospital wage data used to calculate Medicare payments
Prior OIG wage index work identified hundreds of millions of dollars in incorrectly reported wage data and resulted in policy changes by CMS with regard to how hospitals reported deferred compensation cost. The OIG intends to review hospital controls over the reporting of wage data used to calculate the wage indexes for Medicare payments.

Long-term-care hospitals—Adverse events in post-acute care for Medicare beneficiaries
The OIG plans to estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving care in long-term-care hospitals (LTCHs), identifying the factors contributing to these events, determining the extent to which the events were preventable, and estimating the associated costs to Medicare. The OIG specifically noted that LTCHs are the third most common type of post-acute care facility after skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs), accounting for nearly 11 percent of Medicare costs for post-acute care.

Selected independent clinical laboratory billing requirements
OIG will review Medicare payments to independent clinical laboratories to determine their compliance with selected billing requirements, and will use the results of these reviews to identify clinical laboratories that routinely submit improper claims and recommend recovery of overpayments.

Risk Assessment of CMS' Administration of the Pioneer Accountable Care Organization Model
The OIG will conduct a risk assessment of the Pioneer Accountable Care Organization (ACO) Model, which is administered by CMS. The planned risk assessment will focus on the internal controls over the administration of the model

State collection of rebates for drugs dispensed to Medicaid MCO enrollees
This review will determine whether the states are collecting prescription drug rebates from pharmaceutical manufacturers for Medicaid MCOs.

Community First Choice State plan option under the Affordable Care Act
The OIG will review Community First Choice (CFC) payments to determine whether the payments are proper and allowable. Section 2401 of the Accountable Care Act (ACA) added section 1915(k) to the Social Security Act, a new Medicaid state plan option that allows states to provide statewide home and community-based attendant services and support to individuals who would otherwise require an institutional level of care. States taking up the option will receive a 6-percent increase in their Federal Medical Assistance Percentages (FMAP) for Conditions for Coverage (CFC) services. To be eligible for CFC services, beneficiaries must otherwise require an institutional level of care and meet financial eligibility criteria.

Payments to States under the Balancing Incentive Program (BIP)
Under the BIP, eligible states can receive either a 2-percent or 5-percent increase in their FMAP for eligible Medicaid long-term services and support (LTSS) expenditures, although the funding may not exceed $3 billion over the program's 4-year period (through September 30, 2015). The OIG will review state-claimed expenditures to ensure that they were for eligible Medicaid LTSS and to determine whether the states used the additional enhanced federal match in accordance with § 10202 of the ACA.

Medicaid beneficiary transfers from group homes and nursing facilities to hospital emergency rooms
Prior OIG work examined transfers to hospital emergency departments, raising concerns about the quality of care provided in some nursing facilities. Based on this, and noting that "there is congressional interest in this area," the OIG will review the rate of and reasons for transfer from group homes or nursing facilities to hospital emergency departments.

Managed Care Organizations (MCO) payments for services after beneficiaries' deaths
Prior OIG reports have found that Medicare paid for services that purportedly started or continued after beneficiaries' dates of death. The OIG will identify Medicaid managed care payments for deceased beneficiaries, as well as trends in Medicaid claims with service dates after beneficiaries' dates of death.

MCO payments for ineligible beneficiaries
As with payments to deceased beneficiaries, prior OIG work has found that Medicaid paid for services that purportedly started or continued during periods where the beneficiary was not eligible for Medicaid. The OIG plans to identify Medicaid managed care payments made on behalf of ineligible beneficiaries that were not eligible for Medicaid, as well as trends in Medicaid claims within this population.

HRSA—Community health centers' compliance with grant requirements of the Affordable Care Act
The OIG will determine whether community health centers that received funds pursuant to the ACA are complying with federal laws and regulations, including determining the allowability of expenditures and the adequacy of the accounting systems that assess and account for program income.

Health Resources and Services Administration (HRSA)—Duplicate discounts for 340B purchased drugs
The ACA required states to begin collecting rebates for drugs paid through Medicaid MCOs and prohibited duplicate discounts under the 340B Program for such drugs. Because the existing tools and processes to prevent duplicate discounts in fee-for-service Medicaid may not be sufficient, the OIG plans to assess the risk of duplicate discounts for 340B-purchased drugs and to study the states' efforts to prevent them.

HRSA—Oversight of vulnerable health center grantees
The OIG will determine the extent to which HRSA awards grant money to Health Center Program (HCP) grantees that have documented compliance or performance issues.

Audits of Hurricane Sandy Disaster Relief Act
The Disaster Relief Appropriations Act provided funding for Hurricane Sandy disaster victims and their communities. Of this amount, $733.6 million was allocated to three operating divisions within HHS: the Administration for Children and Families, the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The OIG plans to audit grantees that received Disaster Relief Act grant funding through one of the above-mentioned HHS operating divisions, including their internal controls related to the oversight of Disaster Relief Act funds, the allowability of costs claimed and the appropriateness of costs that were budgeted but not yet expended.

Hospitals' electronic health record system contingency plans
The Health Insurance Portability and Accountability Act (HIPAA) requires hospitals (and other covered entities) to have a contingency plan that establishes policies and procedures for responding to an emergency or other occurrence that damages systems that contain protected health information. The OIG will determine the extent to which hospitals are complying with the contingency planning requirements, and will also compare hospitals' contingency plans with government- and industry-recommended practices.

Hurricane Sandy—Emergency preparedness and response plans for child care facilities
In February 2011, the Office of Child Care (OCC) in ACF recommended that states develop plans to address preparedness, response, and recovery efforts specific to child care services and programs, including outlining a framework to consider in developing and updating these plans. The OIG will determine the extent to which states develop and/or update emergency preparedness and response plans specific to child care services and programs, and will also describe emergency responses and experiences of states and child care providers during and after recent disasters

Head Start—Implementation of Head Start grant competition (new)
The OIG will determine the extent to which Head Start grant competition resulted in new entities' competing for and winning Head Start grants in 2013 and 2014.

Prevent grant awards to individuals and entities who were suspended and/or debarred
To protect the government's interests, federal agencies are required to make awards only to responsible sources—those that are determined to be reliable, dependable, and capable of performing required work. The OIG will review whether HHS operating divisions are taking adequate precautions to ensure that individuals and entities suspended or debarred are not awarded federal grants or contracts.

Accuracy of Advance Premium Tax Credits and Cost Sharing Reductions payments for individual enrollees under the Affordable Care Act
This work will focus on the processes and controls in place to make and ensure the accuracy of financial assistance payments for individual enrollees. The OIG will review the accuracy of financial assistance payments for individual enrollees, including: (1) verification of financial assistance payment amounts calculated by the marketplaces, (2) confirmation of the payment of monthly premiums for individuals to remain eligible to receive financial assistance payments, (3) determination of any subsequent changes in eligibility status affecting calculated financial assistance payment amounts, and (4) reconciliation of estimated financial assistance payments made to actual payment amounts.

CMS's Internal Controls Over Advance Premium Tax Credit obligations and payments Under the Affordable Care Act
As part of a joint project with the Treasury Inspector General for Tax Administration (TIGTA), the OIG will determine whether CMS has established adequate accountability and internal controls for generating, reviewing, and approving advance premium tax credit payments, and assess the coordination between CMS and the Internal Revenue Service (IRS) to ensure that Advanced Premium Tax Credits (APTCs) are accurate and made to eligible policyholders.

Programmatic Justification for CMS's involvement in Premium Tax Credit obligations under the Affordable Care Act
This review will describe CMS's involvement in Premium Tax Credit obligations and programmatic justification for structuring program responsibilities in such a manner between CMS and IRS.

Review of Affordable Care Act establishment grants for State marketplaces
The ACA authorized funding to states that elected to establish their own marketplaces. The OIG intends to determine whether nine states complied with federal requirements for the development and implementation of the marketplaces. As part of this review, the OIG will assess whether federal funds were used as intended and whether the state agencies' procurement process and internal controls for monitoring and oversight were effective, and will also review policies and procedures issued by CMS to state agencies relating to establishment grants for marketplaces.

Review of the Federally Facilitated Marketplace's Eligibility Verifications for Premium Tax Credits
The Federally Facilitated Marketplace (FFM) is required to verify an applicant's information, including household income, to determine his or her eligibility for Premium Tax Credit. Using a statistically valid sample of applicants, the OIG will review whether the FFM performed the required verifications when determining applicants' eligibility, and resolved inconsistencies between applicant information and data sources used for verification. This work is planned to supplement a prior OIG review related to enrollment safeguards mandated by the Continuing Appropriations Act (CAA).

Conclusion

As always, the Work Plan includes the accounting for the previous year: In FY 2014, the OIG reported its second highest recoveries ever of over $4.9 billion, which included $4.1 billion in investigative receivables. The OIG also reported increasing numbers for exclusions (4,017), criminal actions involving HHS programs (971), and civil actions, including false claims and unjust-enrichment lawsuits filed in federal district courts, civil monetary penalty settlements, and administrative recoveries related to provider self-disclosure matters (533).

With the focus on results and success measured by numbers, providers should continue to expect scrutiny of their claims and internal practices from the OIG. With recent statements from the Department of Justice emphasizing reviews of health care fraud cases for potential criminal prosecution, the stakes are higher than ever. Providers should promote transparency, have frequent and open communications with Medicare contractors and look to their compliance programs for robust enforcement and training.

Authors and Contributors

Sara M. Lord
Partner, DC Office
202.677.4054
sara.lord@agg.com

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Atlanta Office
171 17th Street NW
Suite 2100
Atlanta, GA 30363

Washington, DC Office
1775 Pennsylvania Ave., NW,
Suite 1000
Washington, DC 20006

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