OIG Release Semi-Annual Report to Congress

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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.

On December 10, 2014, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its *Semi-Annual Report to Congress*, covering the period from April 1 through September 30, 2014. For the latter half of FY 2014, the OIG reported 506 criminal and 267 civil actions against individuals or entities that engaged in healthcare offenses. Investigative receivables to HHS for the period totaled $1.26 billion, with a further $300.7 million in non-HHS investigative receivables due.

For the full year, expected recoveries exceeded $4.9 billion, making FY 2014 recoveries the second highest reported by the Department. Investigative receivables were about $3 billion, with a further $1.1 billion in non-HHS investigative receivables. The remaining $834.7 million derived from audit receivables. OIG reported 971 criminal actions and 533 civil actions against individuals or entities that engaged in healthcare-related offenses, including false claims and unjust-enrichment actions, civil monetary penalties settlements, and administrative recoveries from providers' self-disclosures. During the year, 4,017 individual and entities were excluded from participation in federal health care programs.

The Report underscores the continuing reliance on, and commitment to, the Strike Force Healthcare Enforcement Action Teams (HEAT) that began operations in March 2007, and now are in nine major cities. During FY 2014, the Strike Forces were responsible for bringing charges against 28 individuals or entities, 232 criminal actions, and $441 million in investigative receivables. A nationwide Strike Force takedown resulted in charges against 90 individuals for different health care fraud schemes involving home health care, mental health services, psychotherapy, physical and occupational therapy, durable medical equipment, and pharmacy fraud, and involving approximately $260 million in false claims to Medicare.

A summary of key accomplishments and some of the more notable reports and recommendations from the second half of the fiscal year is below.

Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs (OEI-02-11-00170)

The OIG's Office of Evaluation and Inspection (OEI) found that, in 2012, almost 1,600 Medicare Part D beneficiaries, who had no indication of HIV in their medical histories, had received an excess of HIV drugs, received HIV drugs from a high number of pharmacies or prescribers, or received contraindicated drugs, at a cost of $32 million. The Report noted that these patterns were possible indicators that a beneficiary was receiving inappropriate drugs and diverting them for illegal sale, that a pharmacy was billing for drugs that were not provided to the beneficiaries, or that a beneficiary's identification number was stolen. CMS agreed with OIG's recommendations to:

- expand sponsors' drug utilization review programs,

- expand sponsors' use of beneficiary-specific controls,
- restrict certain beneficiaries to a limited number of pharmacies or prescribers,
- increase monitoring of beneficiaries' utilization patterns, and follow up on questionable utilization patterns.

Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs (OEI-05-12-00540)

OEI determined that pharmaceutical manufacturers' safeguards may not prevent coupons from being used for Part D covered drugs, raising concerns that copayment coupons may encourage Part D beneficiaries to purchase higher cost brand drugs. OEI further noted that manufacturers also may risk liability under the Anti-Kickback Statute if they offer coupons in order to induce the purchase of drugs paid for by Part D or any other Federal health care program. As a result, the OIG's Special Advisory Bulletin affirmed that pharmaceutical manufacturers could be sanctioned for failing to take appropriate steps to ensure that their copayment coupons do not induce the purchase of items or services covered by federal health care programs.

Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to ASC Payment Rates (A¬05-12-00020)

The Audit Division found that Medicare saved almost $7 billion during 2007 through 2011 and could potentially save $12 billion from 2012 through 2017 because ambulatory surgical center (ASC) rates are frequently lower than outpatient department rates for surgical procedures. Medicare could also generate savings of as much as $15 billion for 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs.

Although CMS did not agree, the OIG intends to continue to recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system (OPPS) payment rates from budget neutrality adjustments for ASC-approved procedures and
- if Congress passes the budget-neutrality exemption for the reduced expenditures, CMS should:
- reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then
- develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

Limited Compliance With Medicare's Home Health Face-to-Face Documentation Requirements (OEI-01-12-00390)

For 32 percent of home health claims that required face-to-face encounters, OEI found that the documentation did not meet Medicare requirements and that physicians had inconsistently completed the narrative portion of the face-to-face documentation, resulting in $2 billion in improper payments. OIG's recommendations, agreed to by CMS, were to:

- consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation,
- develop a specific strategy to communicate directly with physicians about the face-to-face requirement, and
- develop other oversight mechanisms for the face-to-face requirement.

Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010 (OEI-04-10-00181)

In 2010, Medicare inappropriately paid $6.7 billion for claims for incorrectly-coded and insufficiently-documented

evaluation and management (E/M) services, which represented 21 percent of Medicare E/M services payments for that year.

Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy (A-09-13-02036)

Medicare inappropriately paid hospital inpatient claims subject to its postacute care transfer policy, which resulted in overpayments of $19.5 million over four years.

Questionable Billing for Medicare Electrodiagnostic Tests (OEI-04-12-00420)

OEI found that, In 2011, 4,901 physicians had questionable billing for Medicare electro-diagnostic tests, totaling $139 million. On the basis of OEI's findings, CMS agreed or partially agreed to:

- take appropriate action regarding physicians identified as having inappropriate or questionable billing,
- increase monitoring of billing for electrodiagnostic tests, and
- provide additional guidance and education to physicians regarding electrodiagnostic tests.

Questionable Billing for Medicare Part B Clinical Laboratory Services (OEI-03-11-00730)

In 2010, over 1,000 labs exceeded the thresholds (i.e., had unusually high billing) for 5 or more measures of questionable billing for Medicare lab services. Medicare allowed $1.5 billion across all labs for claims associated with questionable billing. CMS agreed to:

- review the labs identified as having questionable billing and take appropriate action,
- review existing program integrity strategies to determine whether these strategies are effectively identifying program vulnerabilities associated with lab services, and
- ensure that existing edits prevent claims with invalid and ineligible ordering-physician numbers from being paid.

Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals. OEI-04-12-00490. 2014 June

OEI found several vulnerabilities in the Long-Term Care Hospitals (LTCH) interrupted-stay policy, including inappropriate payments, financial incentives to delay readmissions, and potential overpayments to co-located LTCHs, raising concerns that financial incentives, rather than medical conditions, may have influenced readmission decisions. *Contingent on receiving more information from OIG*, CMS agreed to:

- review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays and
- take appropriate action on inappropriate payments and overpayments we identified. Although CMS did not agree, we continue to recommend that CMS:
- conduct additional analysis to determine the extent to which financial incentives influence LTCHs' readmission decisions,
- develop a system to enforce the 5-percent readmission threshold, and
- take appropriate action regarding LTCHs exhibiting certain readmission patterns.

Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs (OEI-12-13-00040)

In Q3 2012, at least one-third of the more than 200 manufacturers of Part B drugs did not submit average sales prices (ASPs) for some of their products. CMS agreed to:

- continue to assist OIG in identifying and penalizing manufacturers that do not meet ASP reporting requirements;

- ensure the accuracy of product information for national drug codes listed in the background and crosswalk files; and
- finalize the implementation of automated ASP-related procedures.

Although CMS did not agree, OIG intends to continue to recommend that CMS:

- seek a legislative change to directly require all manufacturers of Part B drugs to submit ASPs.

Quality of Care and Licensing Issues:

While these studies and the recommendations, in particular, provide a useful road map of the OIG's intentions for the future, it is noteworthy that a significant number of reports from the latter half of the year focused on staffing and quality of care issues in care facilities. In several instances, OIG specifically criticized the states and CMS for relying on inadequate licensing requirements and surveys, and the agency's continuing interest in these areas makes it likely that care facilities will remain under increasingly strict scrutiny in the future.

Nursing Facilities' Compliance With Federal Requirements for Reporting Allegations of Abuse or Neglect (OEI-07-13-00010)

OEI found that, in 2012, 85 percent of nursing facilities reported at least one allegation of abuse or neglect, and recommended that CMS:

- maintain policies related to reporting allegations of abuse or neglect;
- notify covered individuals of their obligations
  - to report reasonable suspicions of crimes; and
  - report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals, as required.

CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries (A-09-12-02037)

CMS's reliance on California's licensing surveys of nursing homes could not ensure the quality of care provided to Medicare and Medicaid beneficiaries. CMS agreed to work with the California state agency to ensure that:

- nursing homes (1) implement and follow adequate policies and procedures for employee health examinations and (2) request approval for optional service units,
- the state agency conducts all required licensing surveys and reviews employee health examination records during those surveys, and
- the state agency improves licensing survey procedures for (1) reviewing employee health examination records and the three required components and (2) determining whether optional service units operated by the nursing homes are approved and optional services are listed on the licenses.

CMS's Reliance on Illinois Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries (A-05-12-00028)

The Audit Division estimated that $13.4 million in Medicaid payments for Illinois hospice care services were provided by unqualified hospice workers. CMS agreed to:

- work with Illinois to ensure that hospices meet the State licensure requirements for hospice workers and
- consider working with Illinois to modify its hospice payment conditions by implementing provisions similar to Illinois licensure requirements for hospice workers

CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries (A-05-12-00086)

The Audit Division estimated that 15,550 of the 103,668 claims reviewed involved unqualified hospice workers. CMS and Ohio generally agreed with recommendations to:

- work with the Ohio Department of Job and Family Services and the Ohio Department of Health to ensure that hospices meet Ohio licensure requirements for hospice workers and
- consider working with the Ohio Department of Job and Family Services to modify its hospice payment conditions by implementing provisions similar to the Ohio licensure requirements for hospice workers.

Focus On Family and Child Care Providers

In addition to skilled nursing facilities and hospice care services, the OIG also focused on child care centers, reviewing facilities in several states. In Connecticut, Michigan, Maine, and Louisiana, OIG found that child care center providers did not always comply with applicable state licensing requirements.

The four states generally agreed with the recommendations to:

- ensure through more frequent and thorough onsite monitoring that providers comply with health and safety requirements and
- ensure that all providers' employees who provide direct services to children have had criminal records and child abuse and neglect registry checks.

Michigan, Maine, and Louisiana generally agreed with the following recommendations:

- consider state regulatory changes to ensure that unannounced inspections are required to be conducted at least annually,
- ensure adequate oversight by reducing licensing inspectors' caseloads, and
- require providers to complete specific training requirements related to health and safety regulations.

In Michigan, Maine, and Louisana, the OIG found that licensed family and group child care homes (home providers) did not always comply with applicable state licensing requirements. The three states generally agreed with OIG's recommendations to:

- ensure through more frequent onsite monitoring that home providers comply with health and safety regulations,
- ensure adequate oversight by reducing licensing inspectors' caseloads,
- ensure that home providers obtain required criminal record checks and protective services checks for all child care employees who provide direct services to children, and
- develop a mandatory training program to improve home provider compliance with health and safety regulations.

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