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OIG 2015 Work Plan, Part 2: Do fewer projects mean a sharper focus?

- » Managed care compliance is under the microscope.
- » Encounter data and risk adjustments in Medicare Advantage are hot topics.
- » Medicaid MLR rates and reimbursement will be scrutinized.
- » Far fewer new projects are in Parts C and D this year.
- » Use the Work Plan as a guide when conducting risk assessments.

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This is Part 2 of a 2-part article. Part 2 addresses Medicare Parts C and D, Medicaid, and public health and department reviews. Part 1 addressed Medicare Parts A and B, and appeared in our previous issue.

At the beginning of each new fiscal year, the Office of Inspector General (OIG) at the Department of Health & Human Services (HHS) issues its Work Plan, setting forth the compliance and enforcement projects and priorities OIG intends to pursue in the coming year. The FY 2015 Work Plan contains only 11 new projects that affect providers, suppliers, and payers, as well as Part C, Part D, and Medicaid (a significant decrease from the 47 new projects in FY 2014). Eight other new projects, such as public health reviews and Department-specific reviews, are included, as well as 13 new projects related to the Patient Protection and Affordable Care Act of 2010 (ACA).



Lacktman

Compared to last year's Work Plan, the 2015 Work Plan reflects a narrowed scope of projects, possibly attributable to budgetary concerns or increased coordination among agencies, or both. Compelling new projects include a review of the accuracy of hospital wage data reporting, and payments made to independent clinical laboratories with respect to those laboratories' compliance with billing requirements. OIG's summary suggests that "suspect" laboratories may have already been identified by prior OIG audits, investigations, and inspections, and that it will focus on independent clinical laboratories with claims "that may be at risk of overpayments."

Below is an overview of some of the major projects from the 2015 Work Plan, with particular emphasis on new projects. The summaries also indicate which OIG office has primary responsibility for the project. Providers and suppliers relying on the Work Plan to influence their own compliance agendas for the upcoming year should review the Work Plan in full, or speak with their compliance professionals and legal counsel about specific projects that affect their business.

Medicare Part C

The 2015 Work Plan continues the two projects OIG initiated for Medicare Part C in its 2014 Work Plan. There are no new projects this year. OIG will continue to scrutinize the accuracy of information CMS receives from Medicare Advantage (MA) organizations which affects the risk adjustment calculations and is incorporated in the risk-adjusted component of the managed care capitated payments. The two projects for Medicare Part C are the following:

Encounter Data—

CMS oversight of data integrity (OEI)

OIG will continue to review the completeness, consistency, and accuracy of MA encounter data, which reflect the items and services provided to MA plan enrollees, and the verification of such data by CMS. Prior CMS and OIG audits have indicated vulnerabilities in the accuracy of risk adjustment data reported by MA organizations.

Risk Adjustment Data—

Sufficiency of documentations supporting diagnoses (OAS)

OIG will continue to review the medical record documentation of enrollees to ensure that it supports the diagnoses MA organizations submitted to CMS for use in risk-score calculations and determine whether the diagnoses submitted comply with federal requirements. Prior OIG reviews have indicated the medical record documentation does not always support the diagnoses submitted by MA organizations to CMS. MA organizations are required to submit risk adjustment data to CMS in accordance with CMS instructions. Because payments to MA organizations are adjusted based on the health status of each beneficiary, inaccurate diagnoses may cause CMS to pay MA organizations inappropriate amounts.

Medicare Part D

There are nine projects related to the Medicare Part D program in this year's Work Plan (down from 12 projects in 2014 and 18 projects in 2013). Only one of the nine projects in this year's Work Plan is new. The OIG work planning efforts for FY 2015 continue its focus on implementation of safeguards intended to limit drug overutilization and improper payments. Notable projects from this year's plan include the following:

Oversight of conflicts of interest in Medicare prescription drug decisions (OEI)

In this new project, OIG plans to determine what steps CMS has taken to improve its oversight of Part D sponsors' Pharmacy and Therapeutics (P&T) committee conflict-of-interest procedures. Medicare Part D P&T committees are required under federal law to make prescription drug coverage decisions on the basis of scientific evidence and standards of practice. A March 2013 OIG report, *Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions* (OEI-05-10-00450), found that CMS does not adequately oversee Part D sponsors' P&T committee compliance with federal conflict-of-interest requirements. OIG plans to conduct a follow-up review intended to address this issue.

Documentation of pharmacies' prescription drug event data (OAS)

OIG intends to conduct additional reviews of selected retail pharmacies identified in a prior OIG report as having "questionable Part D billing." Based on its review, OIG plans to assess whether Medicare Part D prescription drug event records submitted by the selected retail pharmacies were adequately supported and complied with applicable federal requirements. Drug plan sponsors are to submit the information necessary for HHS to determine payments to the plans.

Ensuring access of dual eligibles to drugs under Part D (OEI)

Per the requirements of the ACA, Section 3313, OIG intends to review the extent to which drug formularies developed by Part D sponsors include drugs commonly used by dual-eligible beneficiaries (i.e., those beneficiaries that are enrolled in Medicaid but qualify for prescription drug coverage under Medicare Part D). OIG notes that as long as Part D plans meet certain limitations outlined in 42 C.F.R. § 423.120, they have discretion to include different Part D drugs and drug utilization tools in their formularies.

Medicaid

The 2015 Work Plan identifies 50 projects regarding state Medicaid programs (down from 53 last year and 79 in 2013). Of these, only six are new projects (down from 10 last year and 26 in 2013).

The Work Plan reflects OIG's continued emphasis on Medicaid prescription drug reviews; payments for home, community, and personal care services; payments for medical equipment, supplies, and other pediatric and family services; program integrity and accountability, including an emphasis on quality of care and safety of beneficiaries; management and administration at the state level; information systems; and managed care. New OIG Medicaid projects focus in part on requirements under the ACA and include the following:

State collection of rebates for drugs dispensed to Medicaid Managed Care Organization enrollees

OIG plans to review whether the states are collecting rebates from pharmaceutical manufacturers for prescription drugs dispensed by Medicaid MCOs, as required by Section 2501(c) of the ACA. Such drugs had been exempt until March of 2010. To aid the state's collection of rebates from manufacturers, the MCOs are required to report enrollees' drug utilization.

Community First Choice state plan option

OIG intends to review Community First Choice (CFC) payments to assess whether the payments are proper and allowable under section 2401 of the ACA. The provision added a new option to the Social Security Act, which enables states to provide home- and community-based services to individuals who meet financial eligibility criteria in lieu of institutional care. States electing this option will receive a 6% increase in federal matching funds for their CFC services.

Payments to states under the Balancing Incentive Program

OIG will review payments to states to ensure that state expenditures claimed under the Balancing Incentive Program (BIP) meet eligibility criteria for Medicaid long-term services and support (LTSS) and that the enhanced federal matching funds are used in accordance with Section 10202 of the ACA. States may only receive such payments if they agree to make structural changes to increase access to non-institutional LTSS and use the federal funding to expand non-institutional LTSS offerings. The program grants qualifying states a 2% or 5% increase in their federal medical assistance percentages (FMAP) for eligible Medicaid LTSS expenditures, though funding to states under BIP may not exceed \$3 billion over the program's four-year period.

Medicaid beneficiary transfers from group homes and nursing facilities to hospital Emergency Rooms

OIG will evaluate the quality of group homes and nursing facilities by reviewing the rate of—and reasons for—the transfer of beneficiaries from such facilities to hospital Emergency Departments. This project builds upon OIG's prior examination of transfer rates for nursing homes, an area of Congressional interest.

MCO payments for ineligible beneficiaries and services after beneficiaries' deaths

OIG identified two new projects related to improper MCO payments. The first project involves the identification of Medicaid managed care payments issued on behalf of deceased beneficiaries and the assessment of any trends in such claims. The second project involves the identification of Medicaid managed care payments made on behalf of ineligible beneficiaries. In both areas, prior OIG work has found that Medicaid has paid for services that allegedly started or continued where the beneficiary was not eligible for Medicaid or after the beneficiaries' date of death.

Legal activities

This year's Work Plan describes six projects under legal activities, all continuations from the previous year. OIG's legal activities consist of the resolution of civil and administrative healthcare fraud cases, including litigating the exclusion of individuals and entities from federal healthcare programs, pursuing Civil Monetary Penalty cases, resolving violations of fraud and abuse laws that are self-disclosed by providers and suppliers, working with prosecutors from the Department of Justice to develop federal False Claims Act cases against individuals and entities that defraud the government, and the negotiation of corporate integrity agreements with healthcare providers as part of the settlement of federal healthcare program investigations.

The 2015 Work Plan also notes that OIG issues Advisory Opinions and other industry guidance on the federal Anti-Kickback Statute and other fraud and abuse statutes.

Investigative activities

The 2015 Work Plan describes one project under investigative activities this year, and

it is a continuation from last year's Work Plan. OIG's investigative activities include the review and investigation of allegations of fraud, waste, abuse, and misconduct. These investigations lead to criminal prosecutions and exclusions of individuals and entities from federal healthcare programs and the recovery of damages and penalties through criminal, civil, and administrative proceedings. Through its Medicare Strike Force Team, OIG collaborates with other law enforcement agencies, such as the Internal Revenue Service, state Medicaid Fraud Control Units, the Federal Bureau of Investigation, and the United States Postal Service to investigate Medicare and Medicaid fraud.

In the 2015 Work Plan, specific areas of interest for the OIG's Strike Force Team include individuals, facilities, or entities that bill Medicare and/or Medicaid for claims not rendered, the submission of false claims, and claims that manipulate payment codes to inflate reimbursement amounts; business arrangements that violate the federal Anti-Kickback Statute and/or physician self-referral law (Stark); quality-of-care issues in nursing facilities, institutions, community-based settings, and other care settings, including the billing of unnecessary services; and illegal schemes involving Medicare and Medicaid drug benefits.

Public health reviews

OIG conducts reviews of the public health agencies within the HHS. There are 19 projects identified in the 2015 Work Plan (there were 19 in 2014 and 35 in 2013), five of which are new this year:

Review of community health center compliance with grant requirements of the ACA (OAS)

Community health centers that received funds under the ACA are required to comply with

federal laws and regulations. OIG will assess whether the community health centers are doing so.

Review of the risk of duplicate discounts for 340B-purchased drugs (OEI)

The ACA prohibits duplicate discounts under the 340B Program for drugs paid through Medicaid MCOs. OIG will assess the risk of such duplicate discounts and describe states' efforts to prevent them.

Oversight of vulnerable

Health Center Program grantees (OEI)

The Health Resources and Services Administration (HRSA) is responsible for monitoring Health Center Program (HCP) grantees on program compliance, clinical performance, and financial health. OIG will determine the extent to which HRSA selects grantees that have documented compliance or performance issues.

Review of audits of Hurricane Sandy Disaster Relief Act (OAS)

The Disaster Relief Appropriations Act provided funding to HHS for use in aiding Hurricane Sandy disaster victims and their communities. OIG will perform audits of grantees that have received funding to evaluate the internal oversight controls each grantee has in place. OIG will also review the allowability of costs claimed and the appropriateness of costs that were budgeted but not yet expended.

Review of hospitals' Electronic Health Record System contingency plans (OEI)

The Health Insurance Portability and Accountability Act (HIPAA) requires 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. OIG will determine the extent to which hospitals comply with such contingency planning requirements and will compare hospital plans with recommended practices.

Department-wide issues

OIG engages in a number of department-wide reviews, including reviews related to financial statements, financial accounting, and information systems management. The 2015 Work Plan identifies 14 reviews of department-wide matters (down from 18 in 2014 and 26 in 2013), including only one new project:

Prevent grant awards to individuals and entities who were suspended and/or debarred (OAS)

To protect the government's interests, the government suspends or debars firms and individuals who have engaged in various types of misconduct. These suspensions and debarments are then reported on the General Service Administration's System for Award Management to ensure that the suspended or debarred firms and individuals are precluded from receiving federal grants or contracts. OIG will determine whether HHS operating divisions are taking sufficient steps to ensure that suspended or debarred individuals and entities are not awarded federal grants or contracts.

Conclusion

The 2015 Work Plan represents a notable narrowing of the breadth of new OIG projects compared to prior years. With fewer projects, OIG will have a narrowed focus, and possibly a greater attention on those projects listed. Ultimately, healthcare providers and suppliers are advised to keep in mind the OIG projects related to their line of business, as it can help shed light on those areas of compliance that the OIG believes are important. 🗨