OIG Work Plan: A Roadmap to Identify Health Care Compliance Risk

Each year, the US Department of Health and Human Services (HHS) Office of Inspector General (OIG) issues a Work Plan that summarizes new and ongoing OIG reviews and areas of focused attention for the coming year and beyond. The current Fiscal Year (FY) 2016 Work Plan was issued in November 2015 and supplemented by a Mid-Year Update in April 2016. OIG considers work planning a “dynamic process” with adjustments made throughout the year to meet priorities and in response to new issues as necessary. Accordingly, the Work Plan provides health care providers and related entities with a “roadmap” of issues that are currently being addressed or will be addressed in the coming year by OIG. As we look towards OIG’s issuance of the FY 2017 Work Plan in a few months, we are revisiting OIG’s FY 2016 plans, projections, results and mid-year updates that reflect the trajectory of ongoing and future examinations and enforcement priorities.

The Work Plan is generally framed around the following HHS top management and performance challenges:

- Fighting fraud, waste and abuse in Medicare Parts A and B
- Protecting an expanding Medicaid program from fraud, waste and abuse
- The meaningful and secure exchange and use of electronic information and health information technology, including electronic health records (EHRs)
- Administration of grants, contracts, and financial and administrative management systems
- Ensuring appropriate use of prescription drugs
- Ensuring quality in nursing home, hospice, and home- and community-based care services (HCBS)
- Implementing, operating and overseeing the health insurance marketplaces through the Patient Protection and Affordable Care Act (ACA)
- Reforming delivery and payment in health care programs, including tying traditional Medicare payments to alternative payment models (APMs)
- Effectively operating public health and human services programs
- Ensuring the safety of foods, drugs and medical devices, working through the Food and Drug Administration (FDA)

OIG expected recoveries of more than $3 billion in FY 2015, with nearly $1.13 billion coming from audit receivables and $2.22 billion from investigative receivables. In FY 2015, OIG reported 4,112 exclusions and pursued 925 criminal actions against individuals and entities “engaged in crimes against HHS programs.” In light of the audit and investigative issues covered in FY 2016, we expect that recoveries will continue to steadily increase.

Centers for Medicare & Medicaid Services

Accounting for more than 80 percent of HHS’s budget, the programs of the Centers for Medicare & Medicaid Services (CMS) comprise a substantial portion of OIG’s audit and investigatory resources. These programs—which include Medicare, Medicaid and the Children’s Health Insurance Program (CHIP)—constituted nearly $985 billion in federal program spending in FY 2015. For FY 2016, OIG focused its Medicare audit resources on identifying improper payments, preventing and deterring fraud, and fostering economical payment policies. Beyond identifying issues, OIG intends to offer recommendations to improve the Medicare program and will continue to focus attention on providing additional oversight of hospice care (including certification surveys and hospice worker licensure requirements), oversight of skilled nursing facility (SNF) compliance with patient admission requirements and evaluation of CMS’s Fraud Prevention System.¹

¹ The Fraud Prevention System is CMS’s “big data” solution to identify and prevent improper Medicare payment, rather than the traditional “pay and chase” recovery model. In July 2015, CMS reported that in its first three years of operations, the Fraud Prevention System identified and prevented $820 million in inappropriate payments using predictive analytics to identify “troublesome billing patterns” and outlier claims.
While this summary does not delve into each of the reviews undertaken by OIG in FY 2016, below are a few of the ongoing studies related to hospitals, including several that will be the subject of additional postings to the Health Care Compliance and Defense Resource Center.

- Comparison of Provider-Based and Freestanding Clinics — Expected to be issued in FY 2016
- Reconciliation of Outlier Payments — Expected to be issued in FY 2016
- Hospitals’ Use of Outpatient and Inpatient Stays under Medicare’s Two-Midnight Rule — Expected to be issued in FY 2017
- Medicare Costs Associated with Defective Medical Devices — Expected to be issued in FY 2016
- Medical Device Credits for Replaced Medical Devices — Expected to be issued in FY 2016
- Medicare Payments for Overlapping Part A Inpatient Claims and Part B Outpatient Claims — Expected to be issued in FY 2016
- Inpatient Claims for Mechanical Ventilation — Expected to be issued in FY 2016
- Duplicate Graduate Medical Education Payments — Expected to be issued in FY 2016
- Indirect Medical Education Payments — Expected to be issued in FY 2016
- Outpatient Dental Claims — Expected to be issued in FY 2016
- Nationwide Review of Cardiac Catheterizations and Endomyocardial Biopsies — Expected to be issued in FY 2016
- Payments for Patients Diagnosed with Kwashiorkor — Expected to be issued in FY 2016
- Review of Hospital Wage Data Used to Calculate Medicare Payments — Expected to be issued in FY 2016
- CMS Validation of Hospital-Submitted Quality Reporting Data — Expected to be issued in FY 2016
- Rehabilitation Hospitals – Adverse Events in Post-Acute Care for Medicare Beneficiaries — Expected to be issued in FY 2016
- Long-Term-Care Hospitals – Adverse Events in Post-Acute Care for Medicare Beneficiaries — Expected to be issued in FY 2016
- Hospital Preparedness and Response to Emerging Infectious Diseases — Expected to be issued in FY 2017
- Hospitals’ Electronic Health Record System Contingency Plans — Expected to be issued in FY 2016

Details regarding ongoing reviews relate to nursing homes, hospices, home health services, medical equipment and supplies, other providers and suppliers, and several other areas of focus are discussed in the Mid-Year Update. The Mid-Year Update also reports the progress OIG has already made on the FYI 2016 goals, including completion of several reviews (with links to the final reports), as well as the revision or removal of certain reviews from the FY 2016 Work Plan. Those adjustments to CMS program reviews are noted below:

**Medicare Parts A and B**

- OIG has **completed** reviews of the following issues:
  - Medicare Did Not Pay Select Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance with Medicare Requirements — Issued February 2016
  - Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care — Issued March 2016
  - CMS Has Not Performed Required Closeouts of Contracts Worth Billions — Issued December 2015
  - National Background Check Program for Long-Term-Care Employees: Interim Report — Issued January 2016
  - Enhanced Enrollment Screening Process for Medicare Providers: Early Implementation Results — Issued April 2016
  - Part B Payments for 340B Purchased Drugs — Issued November 2015

- OIG **added** the following new reviews with the Mid-Year Update:
  - Outpatient Outlier Payments for Short-Stay Claims — Expected to be issued in FY 2017
  - Skilled Nursing Facility Prospective Payment System Requirements — Expected to be issued in FY 2016
  - National Background Checks for Long-Term-Care Employees — Expected to be issued in FY 2019
  - Potentially Avoidable Hospitalizations of Medicare and Medicaid Eligible Nursing Home Residents for Urinary Tract Infections — Expected to be issued in FY 2016
  - Accountable Care Organizations: Beneficiary Assignment and Shared Savings Payments — Expected to be issued in FY 2017
  - Medicare Home Health Fraud Indicators — Expected to be issued in FY 2016
  - CMS’s Implementation of New Medicare Payment System for Clinical Diagnostic Laboratory Tests — Expected to be issued in FY 2016
  - Intensity-Modulated Radiation Therapy — Expected to be issued in FY 2016

- OIG **revised** the following reviews with the Mid-Year Update:
  - Medicare Oversight of Provider Based Status — Expected to be issued in FY 2016
  - Analysis of Salaries Included in Hospital Cost Reports — Expected to be issued in FY 2016
- Home Health Prospective Payment System Requirements — Expected to be issued in FY 2016
- Histocompatibility Laboratories – Supplier Compliance with Payment Requirements — Expected to be issued in FY 2017
- Covered Uses for Medicare Part B Drugs — Expected to be issued in FY 2016
- Inpatient Rehabilitation Facility Payment System Requirements — Expected to be issued in FY 2016

- OIG removed the following reviews from the FY 2016 Work Plan:
  - Imaging Services – Payments for Practice Expenses
  - End-Stage Renal Disease Facilities – Payment System for Renal Dialysis Services and Drugs
  - Contract Management at the Centers for Medicare & Medicaid Services

**Medicare Parts C and D**

- OIG added the following new reviews with the Mid-Year Update:
  - Increase in Prices for Brand-Name Drugs under Part D — Expected to be issued in FY 2017
  - Generic Drug Price Increases in Medicare Part D — Expected to be issued in FY 2017
  - Part D Data Brief Update — Expected to be issued in FY 2016

- OIG revised the following reviews with the Mid-Year Update:
  - Review of Financial Interests Reported under the Open Payments Program — Expected to be issued in FY 2017
  - Federal Payments for Part D Catastrophic Coverage — Expected to be issued in FY 2017
  - Medicare Part D Eligibility Verification Transactions — Expected to be issued in FY 2017

- OIG removed the following review from the FY 2016 Work Plan:
  - Reconciliation of Payments – Sponsor Reporting of Direct and Indirect Remuneration

**Medicaid**

- OIG has completed reviews of the following issues:
  - Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments — Issued April 2016
  - Most Children with Medicaid in Four States Are Not Receiving Required Dental Services — Issued January 2016

- OIG added the following new reviews with the Mid-Year Update:
  - Physician-Administered Drugs for Dual Eligible Enrollees — Expected to be issued in FY 2017
  - Oversight and Effectiveness of Medicaid Waivers — Expected to be issued in FY 2017
  - State Medicaid Fraud Control Unit FY 15 Annual Report — Expected to be issued in FY 2016
  - States’ Compliance with Requirements for Treatment of Health-Care Related Taxes on Medicaid Managed Care Organizations — Expected to be issued in FY 2017
  - State Medicaid Agency Breach Protections and Responses — Expected to be issued in FY 2017

- OIG revised the following review with the Mid-Year Update:
  - Medical Loss Ratio — Expected to be issued in FY 2016

- OIG removed the following review from the FY 2016 Work Plan:
  - Analysis of Generic Price Increases Compared to Price Index

**CMS-Related Legal and Investigative Activities**

While OIG’s Work Plan is particularly helpful to leadership and compliance teams wanting to get ahead of the curve on areas of focus in the coming years, it also serves as a reminder of the role that OIG plays in the resolution of civil and administrative health care fraud cases. OIG legal staff is directly involved in litigation of exclusions and civil monetary penalties (CMPs). OIG has the authority to exclude entities participation in Medicare, Medicaid and other federal health programs for a multitude of reasons ranging from program-related convictions, patient abuse or neglect convictions, licensing board disciplinary actions, or other activities that threaten federal programs or beneficiaries. OIG also handles CMP cases arising out of the submission of false or fraudulent claims, kickbacks and issues related to patient standards of care, among other authorities delegated to OIG.

At the top end of the risk spectrum for providers is the significant role that OIG plays in False Claims Act (FCA) cases and related corporate integrity agreements (CIAs). OIG works with the US Department of Justice (DOJ) to investigate and develop cases against individuals and entities that have allegedly defrauded the federal government. OIG is often the first and last point of communication with a FCA defendant—on the front end, OIG issues subpoenas to facilitate investigations into alleged fraud, and on the back end, OIG can require a FCA defendant to implement a CIA. Based on OIG’s assessment of the defendant’s compliance program and conduct, CIAs are typically an intrusive and expensive undertaking for a defendant that is likely coming off of a lengthy investigation or litigation.
OIG is also responsible for promoting compliance among providers and industry groups through responses to requests for formal advisory opinions, issuing fraud alerts and advisory bulletins, and providing other guidance throughout the year. Some of these resources are available below:

- Advisory opinions
- Fraud alerts
- Compliance guidance
- Open letters
- Other guidance

We encourage you to continue to visit the Health Care Compliance and Defense Resource Center for additional updates on the FY 2016 Work Plan, as well as insight into the FY 2017 Work Plan once it is issued later this year.

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