

Top Management and Performance Challenges

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Top Management and Performance Challenges

Top 10:

1. **Protecting an Expanding Medicaid Program** from Fraud, Waste, and Abuse
2. **Fighting Fraud, Waste, and Abuse in Medicare Parts A and B**
3. The Meaningful and Secure Exchange and Use of **Electronic Information and Health Information Technology**
4. **Administrative Reform, Contracts, and Financial and Administrative Management Systems**
5. Ensuring Appropriate Use of **Prescription Drugs**
6. **Assessing Quality in Nursing Home, Hospice, and Home and Community-Based Care**
7. Implementing, Operating, and Overseeing the **Health Insurance Marketplaces**
8. **Reforming Delivery and Payment** in Health Care Programs
9. Effectively **Operating Public Health and Human Services** Programs
10. Ensuring the **Safety of Food, Drugs, and Medical Devices**

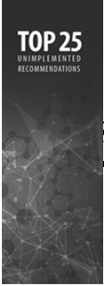
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OIG Top 25 Unimplemented Recommendations

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OIG Top 25 Unimplemented Recommendations

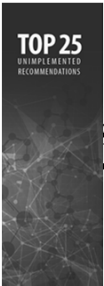


Medicare Parts A and B

- CMS should seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system payment rates from budget neutrality adjustments for ambulatory surgical center approved procedures.
- CMS should change regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.
- CMS should ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements.
- CMS should enhance efforts to identify adverse events to ensure quality of care and safety.
- CMS should reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays.
- CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at Critical Access Hospitals.

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OIG Top 25 Unimplemented Recommendations



Medicare Parts A and B – cont.


- CMS should consider pursuing rulemaking to expand the price substitution policy.
- CMS should reevaluate and reform the way Medicare pays skilled nursing facilities for therapy service.

Medicare Parts C and D

- CMS should implement policies and procedures to notify Medicare Advantage (MA) organizations of unlawful-presence information and hereby prevent enrollment in MA organizations, prevent enrollment of beneficiaries in Part D, disenroll beneficiaries who are unlicensed, automatically reject prescription drug event records, and recoup any improper payments.
- CMS should restrict certain beneficiaries to a limited number of pharmacies or prescribers.
- CMS should require plan sponsors to report all potential fraud and abuse to CMS and/or the Medicare Drug Integrity Contractor.

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OIG Top 25 Unimplemented Recommendations



Human Services Programs

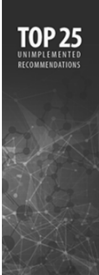
- ACF should amend current policy and regulations to require that any prospective or current employee be disqualified for or terminated from employment with a Head Start grantee if the individual has been convicted of sexual abuse of a child, other forms of child abuse and neglect, or a violent felony.
- ACF should expand the scope of the Child and Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans.

Food and Drug Safety

- FDA should seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading.

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OIG Top 25 Unimplemented Recommendations



Medicaid

- CMS should work with State Medicaid programs to perform utilization reviews of second-generation antipsychotic drugs prescribed to children.
- CMS should seek legislative authority to limit State Medicaid durable medical equipment prosthetics, orthotics, and supplies reimbursement rates to Medicare program rates and encourage further reduction of Medicaid reimbursement rates through competitive bidding or manufacturer rebates.
- CMS should provide States with definitive guidance for calculating the Medicaid payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data.
- CMS should require each State Medicaid agency to report all terminated organizations experienced a breach in 2014.
- CMS should promulgate regulations to reduce significant variation in States' personal care services laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.
- CMS should ensure that Medicaid data are complete, accurate, and timely. This can be achieved through CMS's monitoring of State-submitted managed care encounter data and by implementing the national Transformed Medicaid Statistical Information System.

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OIG Top 25 Unimplemented Recommendations



Affordable Care Act: Marketplaces

- CMS should implement computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on qualified health plan issuers' attestations in calculating payments.
- CMS should take action to improve the Federal marketplace's internal controls related to verifying applicants' eligibility and resolving and expiring inconsistencies to address the specific deficiencies we identified.
- CMS should improve acquisition planning and oversight, including completing acquisition strategies, as required by regulation.

Improper Payments Information

- HHS should: (1) report an improper payment estimate for Temporary Assistance for Needy Families, and (2) reduce the Medicare Fee-for-Service program's error rates below 10 percent.

Health Information Technology

- ONC and CMS should collaborate to develop a comprehensive plan to address fraud vulnerabilities in electronic health records.

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Illustrative cases and enforcement expectations from Top 25

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Illustrative cases and enforcement expectations from Top 25

Ensuring Quality in Nursing Home, Hospice, and Home and Community Based Care



Issue: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries

"The OIG found that **more than one in five** Medicare beneficiaries experienced adverse events during their SNF stays, and that many of these adverse events were preventable."


Impact: Over half of the beneficiaries who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of \$208 million in August 2011. This equates to **\$2.8 billion** in additional hospital treatment for harm caused in SNFs in FY 2011.

Recommendation: CMS should enhance efforts to identify adverse events to ensure quality of care and safety.

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Illustrative cases and enforcement expectations from Top 25

Ensuring Quality in Nursing Home, Hospice, and Home and Community Based Care



Issue: Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities

"The OIG found that Hospices provided care **much longer** and received **much higher** Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings."


Impact: Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling **\$2.1 billion** in 2012.

Recommendation: CMS should reform payments to reduce the incentive for Hospices to target beneficiaries with certain diagnoses and those likely to have long stays.

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Illustrative cases and enforcement expectations from Top 25

Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse



Issue: CMS System for Sharing Information about Terminated Providers Needs Improvement and Providers Terminated from One State Medicaid Program Continued Participating in Other States

"The OIG found that, as of June 1, 2013, Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS) contained records on terminated providers submitted by CMS and **33 State Medicaid agencies** and **did not contain** records from the **remaining** State Medicaid agencies."

Impact: The report identified **continued participation** by **terminated providers** in other States' Medicaid programs. **12 percent (295 of 2,539)** of providers terminated "for cause" in 2011 continued to participate in other States' Medicaid programs **as late as January 2014**.

Recommendation: CMS should require each State Medicaid agency to report all terminated providers.

*"For cause" terminations, as defined by CMS in implementing regulations, means termination or revocation of billing privileges for reasons that may include, but are not limited to, fraud, integrity or quality.

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Illustrative cases and enforcement expectations from Top 25



Issue: Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology

"The OIG found that nearly all hospitals with EHR technology had RTI International (RTI)-recommended audit functions in place, but they may **not be using them to their full extent**. The OIG also found that **only about one-quarter** of hospitals had policies regarding the use of the **copy-paste** feature in EHR technology, which, if used improperly, **could pose a fraud vulnerability.**"

Impact: The annual cost of health care fraud is between **\$75 billion and \$250 billion**. Experts in health information technology caution that EHR technology can **make it easier to commit fraud**. Certain EHR **documentation features**, if poorly designed or used inappropriately, can result in poor data quality or fraud through. Two such features are **Copy-Pasting** and **Overdocumentation**.

Recommendation: ONC and CMS should collaborate to develop a comprehensive plan to address fraud vulnerabilities in electronic health records (EHR).

Conclusion

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Conclusion

OIG wish list.....
 Your action steps..... Turn the tape over to the B side!!
 Best keep secret for your annual risk assessment....

85%

of large health organizations experienced a data breach in 2014

For more information



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