HCCA Nashville Annual Regional Conference

Hot Topics - OIG Compendium of Unimplemented Recommendations

Friday, November 18, 2016
**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. Administration, Payments, Contracts, and Financial and Administrative Management Systems
5. Ensuring Appropriate Use of Prescription Drugs
6. Improving 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

**OIG Top 25 Unimplemented Recommendations**

85% of large health organizations experienced a data breach in 2014
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 in accordance with Federal requirements.
- CMS should enhance efforts to identify adverse events to ensure quality and patient 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 rendered at Critical Access Hospitals.

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 services.

Medicare Parts C and D

- OIG should implement policies and procedures to notify Medicare Advantage (MA) organizations of unlawful presence information and thereby prevent enrollment in MA organizations, prevent enrollment of unlawful presence beneficiaries in Part D, disenroll beneficiaries already enrolled, 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.

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 care according to the timelines specified in States' plans.

Food and Drug Safety

- FDA should seek statutory authority to review substantiation for adverse reaction claims to determine whether claims are truthful and not misleading.
**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 work with State Medicaid programs to encourage State Medicaid programs to use the Medicaid disproportionate share hospital hospital-to-hospital transfer rates to reduce variation in States’ personal care service rates.
- CMS should collaborate with State Medicaid programs to use facility-specific upper payment limit (UPL) rates to reduce variation in States’ personal care service laws and regulations.
- CMS should require each State Medicaid agency to report all terminated providers.
- CMS should promulgate regulations to reduce variation in States’ personal care service 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.

**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.
- HHS should improve acquisition planning and oversight, including completion of acquisition strategies, as required by regulation.
- 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**
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 those adverse events were preventable.”

Impact: Over half of the beneficiaries who experienced harm were sent to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on 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.

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.

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. In 2011, 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 terminations or revocations of billing privileges for reasons that may include, but are not limited to, fraud, integrity, or quality.
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 healthcare 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

OIG wish list.... 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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