E-BRIEF SERIES

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January 2024 OIG Work Plan Updates

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New year, new Work Plan updates from the U.S. Health and Human Services (HHS) Office of Inspector (OIG) General! Let's take a look at some important new additions to review.

OPTOMETRISTS AND NURSING FACILITIES

For many Medicare beneficiaries, nursing facilities become a de facto living situation. As patients become older and often cannot take care of their own health needs, many families turn to nursing facilities to fill that responsibility. This usually means patients are not able to travel to certain health care providers for ongoing care, so many providers visit beneficiaries at the nursing facility.

Optometrists are among the types of providers who might offer services to Medicare beneficiaries while they are in a nursing facility. Common on-site services that an optometrist might offer include following up on cataract surgeries, treating dry or itchy eyes, and providing annual eye exams. The OIG believes that opportunities for fraudulent, excessive, or unnecessary Part B billing could exist because a nursing facility may not be aware of the services a provider is billing for when submitting a claim to Medicare.

With this newly added work plan item, the OIG plans to identify line items billed by optometrists for services performed in a nursing facility. They will then review medical records to determine whether the services were appropriately documented and billed according to Medicare requirements.

MEDICAID AND HOSPICE

Hospice is an important end of life care option for many patients. In order for Medicare beneficiaries to qualify for hospice, certain criteria must be met. One of the requirements is the patient accepts comfort care (palliative care) instead of care to cure the underlying illness. This means if a patient chooses hospice care, Medicare will not cover treatment intended to cure the underlying terminal illness and/or related conditions. Similarly, Medicare will not pay for prescription drugs to cure the underlying illness. Under Medicare, the Centers for Medicare & Medicaid Services (CMS) requires two annual limits to ensure that hospice care does not exceed the cost of conventional medical care at the end of life: the inpatient cap and the aggregate cap.

But, under Medicaid, CMS only requires states to calculate the hospice inpatient cap, and calculating the aggregate cap is optional for each state. If a state applies the hospice caps, any amount paid to a hospice for its claims in excess of each cap is considered an overpayment and must be repaid to Medicaid.

With the risk of overpayments in mind, the OIG will audit selected states to determine whether the hospice caps were calculated correctly, whether cap overpayments were collected, and whether the Federal share of the collected cap overpayments was properly refunded.

Were your hospice caps calculated correctly?

NURSING HOME SURVEYS

State agencies are supposed to perform nursing home surveys. These comprehensive nursing home inspections—standard surveys—are one of the main tools CMS uses to ensure that nursing homes meet the minimum stanards necessary for the safety and wellbeing of residents. Prior work performed by the OIG has demonstrated a significant backlog in these surveys (see: https://oig.hhs.gov/oei/reports/OEI-01-20-00431.asp).

To address the backlog, state survey agencies have increasingly used third-party contractors to conduct the surveys. CMS may also rely on these same third-party contractors to conduct comparative surveys to ensure that states meet other requirements.

The OIG wants to make sure CMS is exercising the proper oversight related to the use of these third-party contractors. This Work Plan item is designed to determine if the use of third-party contractors to conduct nursing home surveys is done in accordance with federal requirements.

NIH'S USE AND OVERSIGHT OF ITS OTHER TRANSACTION AUTHORITY

The National Institutes of Health (NIH) is one of the most significant sources of federal grants in the healthcare industry. Most NIH grants and funds must be awarded based on strict guidelines and application processes. However, the NIH is one of very few federal entities that also has the authority to award Other Transactions (OTs). OTs are, by definition, awards other than procurement contracts, cooperative agreements, or grants. OTs are intentionally flexible and are generally not subject to the Federal Acquisition Regulation (FAR), the Uniform Guidance, or other regulations, unless otherwise noted in the terms and conditions of the OT award. Learn more about OTs here: https://grants.nih.gov/funding/other-transactions.htm

Because of this flexibility, OTs are considered higher risk than traditional awards and should generally only be used when the objectives of a federally funded project cannot be accomplished under a traditional award, such as a contract or grant.

With this work plan item, the OIG plans to analyze the NIH's use of OTs and determine the extent to which NIH is documenting required and encouraged parts of OTs. Additionally, they would like to determine what mechanisms NIH uses to oversee funds awarded through OTs to help ensure the effective oversight of NIH funds.

New efforts are ensuring CMS is exercising proper oversight relating to the use of third-party contractors conducting nursing home surveys.

MEASURING IMPROPER PAYMENTS

Improper payments in health care can be a significant problem. In fact, it is one of the reasons many compliance programs exist in the first place. Congress is also concerned with improper payments. They passed the Payment Integrity Information Act of 2019 (PIIA). This law requires the head of each Federal agency with programs or activities that may be susceptible to significant improper payments to report certain information to Congress. For any program or activity with estimated improper payments exceeding $10 million and 1.5 percent, or $100 million regardless of the improper payment rate, HHS must report to Congress improper payment estimates, corrective action plans, and reduction targets.

To comply with this requirement, CMS has instituted many programs that healthcare compliance professionals are likely to be familiar with. Some examples include:

- **Comprehensive Error Rate Testing (CERT)** -- The CERT program measures the improper payment rate in the Medicare Fee-for-Service (FFS) program. The CERT program reviews a statistically valid stratified random sample of all Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules.

- **Medicare Part C Improper Payment Measurement (Part C IPM**) -- The Part C IPM activities verify that diagnosis codes submitted for payment by an MA organization are supported by medical record documentation for an enrollee. Payment validation ensures the accuracy of Medicare Part C program payments, and protects the Medicare Trust Fund.

- **Medicare Part D Improper Payment Measurement (Part D IPM)** -- The Part D IPM measures error in payments due to invalid and/or inaccurate PDE records, which results in adjustments to beneficiaries' benefit phases and reinsurance subsidy payments. Payment validation ensures the accuracy of Medicare Part D program payments, and protects the Medicare Trust Fund.

- **Payment Error Rate Measurement Program (PERM)** -- The PERM program measures improper payments in Medicaid and Children's Health Insurance Program (CHIP) and produces improper payment rates for each program. The improper payment rates are based on reviews of the Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Reporting Year under review.

The OIG will review HHS compliance with PIAA, as well as how HHS assesses the programs it reports and the accuracy and completeness of the reporting in the HHS Agency Financial Report. OIG also plans to make recommendations as needed.

Are you implementing any of these programs that support the Payment Integrity Information Act of 2019 (PIIA)?

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CJ Wolf is a healthcare professional with more than 20 years of experience in hospital and physician revenue cycle, practice management, compliance, coding, billing, and client services. He has provided healthcare consulting and solution services to hospitals and physician organizations throughout the country.

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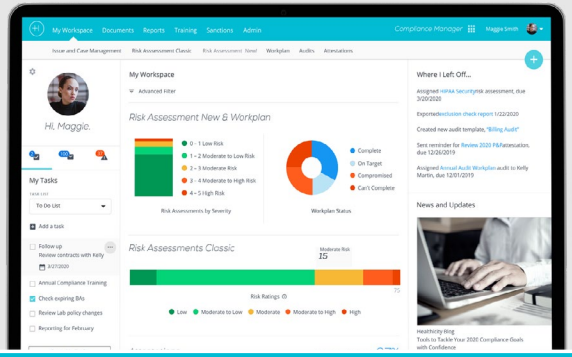

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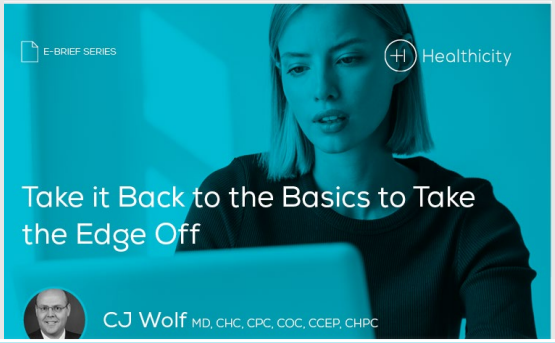

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