Summary of OIG’s 2014 Work Plan

Lauren Gaffney*
Bass Berry & Sims PLC
Nashville, TN

Debra A. Geroux
Butzel Long, a Professional Corporation
Bloomfield Hills, MI

Stephanie M. Godfrey
Pepper Hamilton LLP
Philadelphia, PA

Rose J. Willis
Dickinson Wright PLLC
Troy, MI

Each year, the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG) issues a work plan summarizing new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs during the current fiscal year (FY) and beyond. For FY 2013, OIG reported exclusions of 3,214 individuals and entities from participation in federal health care programs; 960 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 472 civil actions, which include false claims and unjust-enrichment lawsuits filed in federal district court, civil monetary penalties (CMPs) settlements, and administrative recoveries.
related to provider self-disclosure matters. For FY 2013, OIG reported expected recoveries of more than $5.8 billion.

2014 promises to be another active year for health care providers facing increased audit, review, and enforcement activity. The 2014 OIG Work Plan outlines OIG’s current focus areas, including ongoing and new initiatives. The summary below highlights some of the most-significant reviews identified in the 2014 Work Plan.¹

MEDICARE PART A AND PART B

Hospitals

Hospital-Related Policies and Practices

Ongoing Initiatives

- Outlier Payments. As part of its 2014 Work Plan, OIG will continue to review outlier payments to hospitals to determine whether the Centers for Medicare & Medicaid Services (CMS) performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals’ associated cost reports.

- Provider-Based Status Cost and Compliance. Because provider-based status can result in additional Medicare payments and may increase beneficiaries’ coinsurance liabilities, OIG will determine the billing impact of provider-based status and will ensure that existing facilities meet CMS’ provider-based criteria.

- Critical Access Hospitals (CAHs). For CAHs, OIG will continue reviewing the payment policy for swing-bed services. Specifically, OIG will compare

reimbursement for swing-bed services at CAHs to the same level of care obtained at skilled nursing facilities (SNFs) to determine whether Medicare could achieve cost savings through a more cost-effective payment methodology. OIG also will work to determine the costs to Medicare beneficiaries for outpatient services received at CAHs.

- Long Term Care Hospitals (LTCHs). For LTCHs, OIG will identify readmission patterns to determine the extent to which LTCHs readmit patients after a certain number of days, thereby billing Medicare for higher-paying new stays and separate payments instead of for interrupted stays. Prior OIG work identified vulnerabilities in CMS’ ability to detect readmissions and appropriately pay the readmissions as interrupted stays instead of as higher-paying new admissions.

New Initiatives

- New Inpatient Admission Criteria. For hospitals, OIG is planning several new initiatives. First, OIG plans to determine the impact of new inpatient admission criteria on hospital billing, Medicare payments, and beneficiary payments. This review also will determine how billing varied among hospitals in FY 2014. This review will include an analysis of the two-midnight rule and its impact on hospital billing and Medicare payments.²

- Defective Medical Devices. To address a long-standing CMS concern, OIG also will review Medicare claims to identify the costs resulting from additional utilization of medical services associated with defective medical devices to determine the impact of the cost on the Medicare Trust Fund.

- Provider-Based Versus Freestanding Clinics. Likewise, because provider-based facilities often receive higher payments for some services than do freestanding

² CMS has delayed implementation of the two-midnight rule until October 1, 2014. This is the third time CMS delayed implementation of the rule.
clinics, OIG will review and compare Medicare payments for physician office visits in both settings.

- Cost Reports and Employee Compensation. Currently Medicare does not provide any specific limits on salary amounts that can be reported on the hospital cost report, although employee compensation may be included in allowable provider costs only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and furnished in connection with patient care. As a result, OIG will review data from Medicare cost reports and hospitals to identify salary amounts included in operating costs reported to and reimbursed by Medicare. OIG will determine the potential impact on the Medicare Trust Fund if the employee compensation amount that could be submitted to Medicare for reimbursement on future cost reports had limits.

**Hospital Billing and Payments**

**Ongoing Initiatives**

Ongoing reviews of hospital claims to ensure compliance with Medicare guidelines will continue under the 2014 Work Plan. Areas of focus will include inpatient hospital claims for mechanical ventilation services under the 96-hour rule, the identification of duplicate graduate medical education payments, and hospital outpatient payments for dental services. OIG also will review Medicare payments to acute care hospitals to determine compliance with selected billing requirements and recommended recovery of overpayments. Notably, OIG will survey or interview hospitals’ leadership and compliance officers to provide contextual information related to hospitals’ compliance programs.
**New Initiatives**

In addition to the ongoing efforts to identify and address billing and payment issues, OIG will review Medicare outpatient payments made to hospitals for evaluation and management (E/M) services for clinic visits billed at the new patient rate to determine whether they were appropriate and recommend recovery of overpayments. According to federal regulations, the meaning of “new” and “established” pertains to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past three years. OIG also will review the appropriateness of Medicare payments made to hospitals for claims related to kwashiorkor and bone marrow or stem cell transplants. Due to previous OIG reviews identifying inappropriate payments when hospitals were paid for separate right heart catheterization (RHC) procedures when the services were already included in payments for heart biopsies, OIG will review RHC payments for compliance with Medicare billing requirements. Finally, OIG will review provider data to determine whether indirect medical education payments were made in accordance with federal regulations and guidelines.

**Quality of Care and Safety**

**Ongoing Initiatives**

As Medicare programs shift from volume-based reimbursement to quality-focused reimbursement, OIG will continue to focus on the quality of care and safety in the hospital setting. This will include continuing oversight of quality improvement organizations (QIOs). Medicare will spend about $1.3 billion in the current three-year QIO contract period. Also, due to rapid growth over the past decade in inpatient rehabilitation care, OIG will continue to monitor the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care in inpatient rehabilitation facilities.
New Initiatives

CMS’ conditions of participation require that hospitals develop and maintain a hospital environment that ensures the safety and well being of patients and have adequate medical and nursing staff during disasters. As a result, OIG will assess and describe hospital preparedness and response during Hurricane Sandy. Likewise, after the disastrous meningitis outbreak resulting from contaminated injections of compounded drugs, OIG will describe Medicare’s oversight of pharmaceutical compounding in Medicare-participating hospitals. Finally, because robust hospital privileging programs contribute to patient safety, OIG will determine how hospitals assess medical staff candidates prior to granting initial privileges, including verification of credentials and review of the National Practitioner Data Bank.

Nursing Homes

In 2009, an OIG study found that SNFs billed one-quarter of all claims in error, resulting in $1.5 billion in inappropriate Medicare payments. OIG will continue to look at variation within SNF billing practices. OIG also will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents during stays not paid under Part A (e.g., foot care, stays during which benefits are exhausted, or failure to meet the three-day prior inpatient-stay requirement).

As stated in the 2014 OIG Outlook,3 the quality of care and safety in nursing homes is an ongoing area of focus for OIG. OIG will continue to determine whether state survey agencies verify correction plans for deficiencies identified during nursing home recertification surveys. Likewise, after an OIG review found that 92% of nursing homes employed at least one individual with at least one criminal conviction, OIG will continue monitoring the effectiveness of the program for national background checks for long

3 See https://oig.hhs.gov/newsroom/outlook/index.asp. The OIG Outlook is a video program in which OIG’s senior executives discuss emerging trends in combating fraud, waste, and abuse in federal health care programs, OIG’s top priorities for 2014, and upcoming projects in the 2014 Work Plan.
term care employees. Finally, OIG will review the extent to which Medicare beneficiaries residing in nursing homes are hospitalized for conditions thought to be manageable or preventable in the nursing home setting.

Hospices

In 2014, OIG will continue its review of the use of hospice care in the general inpatient setting. To do this, it will review hospice medical records to address concerns that this level of hospice care is being misused. Also, because assisted-living facility (ALF) residents have the longest lengths of stay in hospice care, OIG will review the extent to which hospices serve Medicare beneficiaries who reside in ALFs. OIG will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs. Pursuant to the Affordable Care Act, Section 3132, CMS must reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. The review of hospice care provided in ALFs is intended to provide HHS with information relevant to these requirements.

Home Health Services

As designated by CMS, newly enrolling home health agencies (HHAs) are considered high-risk providers. A prior OIG report found that one in four HHAs had questionable billing. Since 2010, nearly $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit. As a result, OIG will review compliance with various aspects of the home health prospective payment system, including the documentation required in support of the claims paid by Medicare.
Medical Equipment and Supplies

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers continue to garner significant attention from OIG in 2014. This includes both new and ongoing initiatives.

Power Mobility Devices

Although certainly not a new topic within OIG’s work plans, there is a renewed focus in the 2014 Work Plan on power mobility devices (PMDs). OIG will determine whether savings can be achieved by Medicare if certain PMDs are rented over a 13-month period rather than acquired through a lump-sum purchase. OIG also is reviewing Medicare Part B payments for PMDs to determine whether the Medicare requirements for a face-to-face examination were met. More generally, Medicare Part B payments to PMD suppliers will continue to be scrutinized for medical necessity and overall compliance with Medicare requirements.

Diabetes Testing Supplies

In the wake of the Competitive Bidding Program, the world of mail-order diabetic testing supplies has changed dramatically. As a result, OIG will conduct a mandatory market share review of different types of diabetic testing strips immediately following implementation of round two of the Competitive Bidding Program. OIG also will continue to review Medicare Part B payments for home blood glucose test strips and lancet supplies to determine their appropriateness (e.g., physicians’ orders must be complete and retained by suppliers and suppliers must use the correct modifier codes). Finally, OIG will continue reviewing Medicare’s claims processing edits to identify inappropriate payment made to multiple medical equipment suppliers for test strips and lancets dispensed to the same beneficiaries with overlapping service dates.
**Comparing Medicare Payments for DMEPOS to Other Payers**

After finding that Medicare overpays for various types of medical equipment when compared to other payers, OIG will begin a new study assessing the reasonableness of the Medicare fee schedule amount for various medical equipment items, including commode chairs, folding walkers, and transcutaneous electrical nerve stimulators. OIG also will determine the reasonableness of Medicare reimbursement rates for parenteral nutrition compared to amounts paid by other payers.

**Supplier Compliance with Medical Necessity, Frequency, and Other Requirements**

OIG will continue to review claims for frequently replaced medical equipment and supplies to determine whether medical necessity, frequency, and other Medicare requirements are met. Also being reviewed are Medicare Part B payments for claims submitted for lower limb prosthetics to determine whether the requirements of CMS’ *Benefits Policy Manual*, Pub. No. 100-02, ch. 15, Section 120, were met. Additionally, OIG will begin reviewing Medicare Part B payments for nebulizer machines and related drugs to determine if Medicare requirements are being met. The focus on nebulizer machines comes after an OIG study found that suppliers were overpaid approximately $46 million for inhalation drugs used with nebulizer machines.

**Other Providers and Suppliers**

**Ambulatory Surgical Centers and Hospital Outpatient Departments**

OIG will determine whether a payment disparity exists between the ambulatory surgical center (ASC) and hospital outpatient department payment rates for similar surgical procedures provided in both settings. OIG also will review physicians’ coding of Medicare Part B for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service. Additionally, OIG will
continue to review the appropriateness of Medicare’s methodology for setting ASC payment rates under the current payment system.

**End-Stage Renal Disease Facilities**

**Ongoing Initiatives**

Effective January 1, 2011, federal law required CMS to begin implementation of a new system that bundles all costs related to end-stage renal disease (ESRD) care (including drugs that were previously separately billable) into a single per-treatment payment. The bundled rate must be updated annually to reflect changes in the price of goods and services used in ESRD care. OIG will continue to review Medicare payments for and utilization of renal dialysis services and related drugs pursuant to the bundled ESRD prospective payment system. This will include comparing facilities’ acquisition costs for certain drugs to inflation-adjusted cost estimates to determine how costs for the drugs have changed.

**New Initiatives**

State agencies conduct onsite surveys of dialysis facilities on behalf of CMS. Researchers have raised concerns that these surveys fail to identify poorly performing ESRD facilities. In response, OIG will determine the extent, nature, and outcomes of Medicare’s survey and certification process of ESRD facilities.

**Rural Health Clinics**

The Balanced Budget Act of 1997 (BBA) authorized CMS to remove rural health program clinics that no longer meet location requirements. CMS has failed to promulgate the final regulations to implement the BBA. As a result, rural health clinics that no longer meet eligibility requirements continue to receive enhanced Medicare
reimbursement. Under the 2014 Work Plan, OIG will continue to determine the extent to which these non-qualifying rural health clinics receive Medicare reimbursement.

**Partial Hospitalization Programs**

OIG will continue to review supporting documentation, including patient plans of care and physician supervision and certification to ensure that payments for partial hospitalization program psychiatric services in hospital outpatient departments and free-standing community mental health centers are appropriate.

**Mental Health Providers**

As a new 2014 Work Plan initiative, OIG will review and describe Medicare’s mental health provider enrollment and credentialing requirements and assess CMS’ oversight efforts to verify the qualifications of mental health service providers.

**Sleep Disorder Clinics**

An analysis of 2010 Medicare payments for certain sleep-testing procedures (CPT codes 95810 and 95811), which totaled approximately $415 million, showed high utilization. OIG will continue to examine Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures to determine the appropriateness of the Medicare payment.

**Ambulance Services**

**Ongoing Initiatives**

OIG will continue to examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports that potentially never occurred or potentially medically unnecessary transports to dialysis facilities. In addition, OIG will
continue to determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements.

**New Initiatives**

The *Medicare Benefit Policy Manual* Section 10.2.1 states that Medicare covers ambulance transports when a beneficiary’s medical condition at the time of the transport is such that using other means of transportation would endanger the beneficiary’s health. OIG will synthesize its evaluations, audits, investigations, and compliance guidance related to ground ambulance transport services paid by Medicare Part B and make recommendations to improve detected vulnerabilities.

**Anesthesia Services**

OIG will continue to review the appropriateness of Medicare Part B claims for personally performed anesthesia services, including the use of the AA and QK modifiers.

**Chiropractic Services**

**Ongoing Initiatives**

Medicare Part B only pays for a chiropractor’s manual manipulation of the spine to correct a subluxation if there is a neuro-musculoskeletal condition for which such manipulation is appropriate for treatment. Chiropractic maintenance therapy is not reimbursable. OIG will continue to review Part B payments to determine whether such payments were claimed in accordance with Medicare requirements.

**New Initiatives**

Because previous OIG work has demonstrated a history of vulnerabilities relative to inappropriate payments for chiropractic services, OIG will work to determine the extent
of questionable billing for chiropractic services. This will include the identification of trends suggestive of maintenance therapy billing (which is not reimbursable by Medicare).

**Laboratory Tests**

Medicare is the largest payer of clinical lab services in the nation. Costs for Part B clinical laboratory tests have skyrocketed over the past six years and much of the growth is due to the increased volume of ordered services. As a result, OIG will continue reviewing billing characteristics for Part B clinical laboratory tests to identify questionable billing practices.

**Diagnostic Radiology**

OIG will continue to review Medicare payments for high-cost diagnostic radiology tests to determine medical necessity and a potential increase in utilization.

**Imaging Services**

OIG will continue to review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether utilization rates reflect industry practices. For selected imaging services, OIG will focus on the practice expense components (e.g., office rent, wages, and equipment), including the equipment-utilization rate.

**Portable X-Ray Equipment**

As part of a new 2014 *Work Plan* initiative, OIG will review Medicare payments for the transportation and setup of portable X-ray equipment to determine whether the payments were correct and supported by documentation. OIG also will assess the qualifications of the technologists who performed the services and determine whether
the services were ordered by a medical doctor or a doctor of osteopathic medicine. Although Medicare generally reimburses for transportation and setup of portable X-ray equipment if the conditions for coverage are met, OIG has found that Medicare improperly paid portable X-ray suppliers for multiple trips to nursing facilities in one day and for services ordered by non-physicians.

**Electrodiagnostic Testing**

OIG will continue to review Medicare claims data to identify questionable billing of electrodiagnostic testing services.

**Documentation of E/M Services**

OIG will continue to determine the extent to which selected payments for E/M services were inappropriate. Also, because Medicare contractors have noted an increased frequency of medical records with identical documentation across services, OIG will continue reviewing multiple E/M services associated with the same providers and beneficiaries to determine whether the medical records have documentation vulnerabilities.

**Ophthalmologists**

In 2010, Medicare allowed more than $6.8 billion for services provided by ophthalmologists. OIG will continue to review Medicare claims data to identify inappropriate payments and/or questionable billing for ophthalmological services during 2012.

**Physicians**

OIG will continue to review the extent to which physicians and suppliers participated in Medicare and accepted claims assignment during 2012. It also will assess the effects of
their participation and claims assignments on the Medicare program. For example, OIG will look for noncompliance with assignment rules and the excessive billing of beneficiaries’ share of charges.

**Physical Therapists**

OIG will continue to review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations.

**Prescription Drugs**

**Policies and Practices**

**Ongoing Initiatives**

OIG will continue to review Medicare Part B drug prices by comparing average sales prices (ASPs) to average manufacturer prices (AMPs) to identify drug prices that exceed a designated threshold. When OIG finds that the ASP for a drug exceeds the AMP by 5%, OIG notifies the Secretary of HHS, who may disregard the ASP for the drug when setting reimbursement amounts (e.g., apply a price substitution policy).

**New Initiatives**

One of the new OIG initiatives includes determining the potential effect on ASP reporting if all manufacturers of Part B-covered drugs were required to submit ASPs to CMS. Notably, OIG also will determine how much Medicare Part B spending could be reduced if Medicare were able to share in the savings for 340B-purchased drugs. This study is being done, in part, because previous OIG work revealed that some state Medicaid agencies have developed strategies to take advantage of the discounts on 340B drugs.
Billing and Payments

Under the 2014 Work Plan, OIG will continue to review Medicare outpatient payments to providers for certain drugs (e.g., chemotherapy drugs) and the administration of the drugs to identify overpayments because of incorrect billing. As part of another ongoing effort, OIG will determine whether Part B payments for immunosuppressive drugs that were billed with a service code modifier “KX” met Medicare documentation requirements.

Quality and Safety

Ongoing Initiatives

OIG will continue to identify potential conflicts of interest in anti-cancer and non-anti-cancer drug therapies included in the authoritative prescription drug compendia recognized by CMS.

New Initiatives

OIG will review oversight actions CMS and its claims processing contractors take to ensure that payments for “on-label” and appropriate “off-label” uses for Part B drugs meet the appropriate coverage criteria. OIG also plans to examine Medicare administrative contractors’ (MACs’) policies and procedures for reviewing and processing Part B claims for compounded drugs.

Part A and B Contractors

As part of its oversight function, OIG will continue to determine how CMS is managing and maintaining its contracts with its contractors, which are worth an estimated $4.8 billion. In addition to continuing to review contractor administrative costs, pension costs, and post-retirement health benefit costs, OIG also will review senior executive
compensation for contractors to ensure compliance with regulatory benchmarks. The focus on senior executive compensation comes on the heels of ongoing criticism regarding exorbitant salaries for contractor executives.

As part of its review of contractor functions and performance, OIG will continue to determine the extent to which MACs used and evaluated their local claims processing system edits in 2011. Local claims processing edits are a key safeguard for identifying improper payments before Medicare payment is made. As a new initiative, OIG will review and report the level of benefit integrity activity being performed by Medicare benefit integrity contractors including program safeguard contractors (PSCs), zone program integrity contractors (ZPICs), and Medicare drug integrity contractors. Additionally, OIG will review the procedures for tracking collections on overpayments identified by the ZPICs and PSCs and quantify the total overpayments that were identified and collected by these contractors in 2013.

**Information Technology Security, Protected Health Information, and Data Security**

Recent breaches related to federal computers, including one involving a CMS contractor, have heightened concerns about protecting sensitive information. In response, OIG will evaluate security programs of contractors as well as hospitals, including security controls to prevent the loss of protected health information (PHI) stored on portable devices (e.g., laptops, jump drives, etc.). OIG also will review whether hospitals’ security controls over networked medical devices (e.g., dialysis machines, radiology systems, and medication dispensing systems) are sufficient to effectively protect electronic PHI. Finally, OIG will work to ensure that the Physician Compare website\(^4\) contains accurate information on health care providers.

Other Part A and Part B Program Management Issues

In addition to ongoing provider eligibility review efforts, OIG has indicated that it will identify active Medicare providers who have not billed Medicare for more than one year. Federal regulations allow CMS to deactivate the billing privileges of Medicare providers who do not submit any claims for 12 consecutive months. Deactivation can serve as a prevention measure for fraud.

MEDICARE PARTS C AND D

Part C—Medicare Advantage

Medicare Advantage Organizations Compliance with Part C Requirements

OIG is initiating a review of Medicare Advantage (MA) organizations’ compliance with Part C requirements because prior CMS and OIG audits have indicated vulnerabilities in the accuracy of risk-adjustment data reporting by MA organizations and have shown that medical record documentation does not always support diagnoses submitted to CMS by MA organizations. OIG will review the extent to which MA encounter data reflecting items and services provided to plan enrollees are complete and consistent and are verified for accuracy by CMS. OIG also will review medical record documentation to ensure that it supports the diagnoses submitted by MA organizations and will determine whether such diagnoses complied with federal requirements.

Part D—Prescription Drug Program

Medicare, Sponsor, and Manufacturer Policies and Practices

OIG will analyze the risk-sharing payments between Medicare and Part D sponsors to determine whether to widen or retain the existing risk-corridor thresholds, which determine the amount of unexpected profits or losses Medicare and plan sponsors
share. Further, OIG will determine whether Part D sponsors receive the discount drug prices available to the general public at certain retail pharmacies by reviewing the number and percentage of Part D claims for which the amounts paid were equal to the discount prices.

OIG will initiate a new review comparing pharmacy reimbursement and rebate amounts for a sample of brand-name drugs paid by Medicare Part D and by Medicaid. A previous OIG review revealed that Part D sponsors and state Medicaid agencies paid pharmacies roughly the same amounts for brand-name drugs but statutorily defined Medicaid unit rebate amounts for brand-name drugs exceeded Part D unit rebate amounts by a substantial margin, resulting in lower drug-program costs for Medicaid. In addition, OIG will work to identify safeguards that pharmaceutical companies have in place to prevent beneficiaries from using copayment coupons to purchase drugs paid for by Part D. OIG believes that such coupons may create an incentive for beneficiaries to choose more-expensive brand-name drugs, causing Medicare to pay more than necessary for drugs with a suitable generic alternative.

**Sponsor Compliance with Part D Requirements**

OIG plans to evaluate sponsor compliance with Part D requirements by reviewing: (1) compliance by Part D sponsors with Medicare requirements for reporting direct and indirect remunerations; (2) CMS’ policies, procedures, instructions, and processes for reopening final payment determinations and the adequacy of sponsor compliance and sponsor-submitted data; and (3) the extent to which drug formularies developed by Part D sponsors include drugs commonly used by dual-eligible beneficiaries as required.

**Part D Billing and Payments**

OIG will conduct additional reviews of selected retail pharmacies identified in a prior OIG report as having questionable Part D billing practices and will determine whether Medicare Part D prescription drug event records submitted by the selected pharmacies
were adequately supported and complied with applicable federal requirements. OIG will review Medicare Part D claims to determine whether they were duplicated in Part A or Part B billings and will determine the extent to which payments for the sampled Part D claims were correct and were supported. OIG will describe human immunodeficiency virus (HIV) drugs covered under Medicare Part D and will determine the extent to which beneficiaries had questionable utilization patterns. OIG also will describe the characteristics of beneficiaries associated with questionable utilization patterns and the associated pharmacies and prescribers. Finally, OIG will review data submitted by Part D sponsors for use in calculating the coverage gap discount to assess the accuracy of the data and will consider whether beneficiary payments are correct and amounts paid to sponsors are supported.

MEDICAID

OIG’s continuing and new Medicaid-related reviews in FY 2014 will address prescription drugs, long term and community care, other services, program integrity and accountability, administration, information systems, and managed care.

Medicaid Prescription Drug Reviews

State and Manufacturer Compliance with Medicaid Requirements

OIG will assess state and manufacturer compliance with Medicaid requirements through the following activities:

- Reviewing the education and enforcement actions states have taken on the basis of information generated by their drug utilization review programs related to inappropriate dispensing and potential abuse of prescription opiates;

- Evaluating the causes and resolution of Medicaid rebate disputes with manufacturers and the methods states use to resolve them;
- Assessing manufacturer compliance with AMP reporting requirements and determining the percentage of manufacturers that complied with the requirements and whether stepped-up enforcement actions by CMS and OIG are reflected in increased compliance by manufacturers;

- Verifying whether states collected the increased amount of manufacturer rebates for brand-name and generic drugs and reported those amounts to the federal government, as required;

- Reviewing drug manufacturers’ compliance with Medicaid drug-rebate requirements for drugs that are new formulations of existing drugs; and

- Ascertaining whether states have established adequate accountability and internal controls for collecting Medicaid rebates on physician-administered drugs by assessing their processes for collecting national drug code information on claims for physician-administered drugs and subsequent processes for billing and collecting rebates.

**State Claims for Federal Reimbursement**

OIG will initiate a new review of states’ claims for the federal share of Medicaid payments for the breast cancer drug Herceptin to determine whether providers properly billed the states for the drug. OIG also will review whether providers’ claims to states were complete and accurate and were billed in accordance with the regulations of the selected states.

**Quality of Care and Safety of Beneficiaries**

OIG will determine the extent to which Medicaid claims for atypical antipsychotic drugs were for treatment of children aged 18 years and younger, whether claims submitted for those drugs were for uses and indications not listed in one or more of the approved-drug compendia, and the extent to which the medical reviews identified concerns about
the treatment of the children with the prescribed drugs related to dosage, duration of treatment, indications for use, monitoring, side effects, reactions to combinations of drugs (polypharmacy), and patient age.

**Home Health Services and Other Community-Based Care**

**Billing and Payments**

OIG will review HHA claims submitted to state Medicaid programs to determine whether the billing providers met applicable criteria to provide home health services to Medicaid beneficiaries and whether the beneficiaries met the criteria to receive such services. OIG also will evaluate Medicaid payments by states for adult day-care services to determine whether the providers complied with federal and state requirements. Following up on a state commission’s findings that more than 50% of the service hours billed by continuing day treatment (CDT) providers in that state could not be substantiated, OIG will review Medicaid payments to CDT mental health services providers to determine whether their claims were adequately supported.

**State Claims for Federal Reimbursement**

OIG will determine whether selected states claimed federal reimbursement for unallowable room and board costs associated with services provided under home and community-based services (HCBS) waiver programs and whether HCBS payments included the costs of room and board and will identify the methods the states used to determine the amounts paid.

**Quality of Care and Safety of Beneficiaries**

OIG will review health-screening records of Medicaid HHA health care workers to determine whether they were screened in accordance with federal and state requirements.
Other Medicaid Services, Equipment, and Supplies

Policies and Practices

OIG will determine whether opportunities exist for lowering Medicaid payments for selected items of medical equipment and supplies and the amount of Medicaid savings that could be achieved for selected items through rebates, competitive bidding, or other means.

Billing and Payment

OIG will review Medicaid payments by states to providers for transportation services to determine the appropriateness of the payments for such services. In addition, OIG plans to identify questionable billing patterns with respect to state payments for Medicaid outpatient mental health services by reviewing combined Medicaid and Medicare claims data. OIG also will determine whether selected states made Medicaid payments for health care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid funds spent on such conditions.

State Claims for Federal Reimbursement

OIG will review Medicaid payments by states for dental services to determine whether states have properly claimed federal reimbursement and will review family planning services in several states to determine whether states improperly claimed enhanced federal funding for such services and the resulting financial impact on Medicaid.

Quality of Care and Safety of Beneficiaries

OIG will review billing patterns of pediatric dentists and their associated clinics in selected states and describe the extent to which children enrolled in Medicaid received services from them. OIG will determine what steps CMS has taken to address OIG’s recommendations to improve the provision of Medicaid early and periodic screening, diagnostic, and treatment (EPSDT) services and what obstacles it faces in
implementing these recommendations, as well as whether the underutilization of EPSDT services continues to be a challenge for children enrolled in Medicaid.

**State Management of Medicaid**

**State Mechanisms to Fund Their Medicaid Programs**

Focusing on the mechanism states use to raise revenue through provider taxes, OIG will review state health care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable federal requirements. In particular, OIG will determine whether states are complying with federal regulations for claiming certified public expenditures, which are normally generated by local governments as part of their contribution to the coverage of Medicaid services.

**State Claims for Federal Reimbursement**

OIG will review administrative costs claimed by several states to determine whether they were properly allocated and claimed or directly charged to Medicaid. OIG will determine whether Medicaid payment rates to state-operated facilities are reasonable and the federal share is claimed in accordance with federal and state requirements and whether payments to such providers may be excessive. OIG will review public-assistance cost-allocation plans and processes for selected states to determine whether the states claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems that deviated from acceptable statistical sampling practices. OIG will review states’ Medicaid claims to determine whether the states correctly applied enhanced federal medical assistance percentage (FMAP) payment provisions of the Affordable Care Act and will determine the extent to which state Medicaid programs improperly enrolled individuals who did not meet eligibility criteria and then estimate national enrollment error rates. Finally, OIG also will conduct a new review of Medicaid eligibility determinations in selected states and calculate a Medicaid eligibility error rate.
State Adjustments of Federal Reimbursement

OIG will review the Medicaid monetary draw-downs that states received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the states on the Form CMS-64, which shows the disposition of Medicaid funds used to pay for actual medical and administrative expenditures for the reporting period. OIG will determine whether states accurately captured Medicaid collections on their Form CMS-64 and returned the correct federal share related to those collections, complied with requirements to recover Medicaid costs from deceased Medicaid beneficiaries’ estates, and properly reported any such recoveries to CMS. OIG also will review states’ Medicaid claims records to determine whether the states used the correct FMAP when processing claim adjustments reported on the Form CMS-64.

State Program Integrity Activities and Compliance with Federal Requirements

OIG will review corrective actions that state Medicaid agencies have implemented (or failed to implement), determine the reasons for the action or inaction, and examine steps taken by CMS to ensure that states implemented corrective actions and the evidence reviewed by CMS to ensure that states took such actions.

In addition, OIG will review states’ compliance with a new mandate to terminate Medicaid program providers already terminated by Medicare or another state Medicaid program. The purpose of the review is to determine whether such all state Medicaid programs terminated affected providers, to assess the status of the supporting information-sharing system and whether CMS is ensuring that states share complete and accurate information, and to identify obstacles states face in complying with the termination requirement.

Other plans include a review of providers’ patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances and an evaluation of the extent to which states and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. OIG will review states’ and CMS’ practices for collecting and verifying provider ownership information and determine
whether they have comparable ownership information on file for providers enrolled in
both programs. Finally, OIG will review states’ progress toward rescreening or
revalidating all Medicaid providers by 2016 and will conduct a new review of states’
suspension of payments processes with respect to providers involved in pending
investigations of credible fraud allegations.

OIG Oversight of State Medicaid Fraud Control Units

OIG will review the overall management, operations, and performance of a sample of
Medicaid fraud control units (MFCUs) and identify effective practices and areas for
improvement in MFCU management and operations. OIG will determine whether each
of the U.S. territories—none of which currently operate a MFCU—have sought an
exemption as part of their state Medicaid plan as required by Section 1902(a)(61) of the
Social Security Act and whether North Dakota, which is the only state without a MFCU
as a result of an exemption granted in 1994, continues to operate under the conditions
that supported the state’s exemption.

Medicaid Information System Controls and Security

Controls to Prevent Improper Medicaid Payments

OIG will review Medicaid claims to determine the extent to which state agencies have
controls in place to identify claims associated with inactive or invalid National Provider
Identifiers, including claims for services alleged to have been provided after the dates of
the referring physicians’ deaths. OIG will review duplicate payments made by states on
behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and
identify states’ procedures or other controls for preventing such payments. OIG will
review Public Assistance Reporting Information System (PARIS) enrollment data and
determine the extent to which states use PARIS to prevent improper Medicaid
payments made on behalf of beneficiaries who are simultaneously enrolled in more than
one state. OIG also will review selected states’ implementation of National Correct
Coding Initiative (NCCI) edits for Medicaid claims and describe CMS’ oversight of NCCI
edits.
Controls to Ensure the Security of Medicaid Systems and Information

OIG will determine the adequacy of CMS’ oversight of states’ Medicaid system and information security controls, including the policies, technical assistance, and security and operational guidance provided to the states. For selected states, OIG will use automated assessment tools to assess controls for their information system networks, databases, web-facing applications, logical access, and wireless access. OIG also will review general controls, such as disaster recovery plans and physical security.

Medicaid Managed Care

State Payments to Managed Care Entities

OIG will conduct a new review of states’ managed care plan reimbursements to determine whether managed care organizations (MCOs) are appropriately and correctly reimbursed for services provided. OIG will ensure that the data used to set rates are reliable and include only costs for services covered under the state plan as required by—or costs of services authorized by—CMS and verify that payments made under a risk-sharing mechanism and incentive payments made to MCOs are within the limits set forth in federal regulations. OIG also will review managed care plans with contract provisions that require a minimum percentage of total costs to be expended for medical services (medical loss ratio) to determine whether a refund was made to the state agency when the minimum medical loss ratio threshold was not met and will determine whether plan expenses were properly classified as medical or administrative.

Data Collection and Reporting

OIG will determine the extent to which complete Medicaid managed care encounter data are included in Medicaid Statistical Information Systems (MSIS). OIG also will identify factors that enable states’ and Medicaid managed care entities to collect and report MSIS encounter data or prevent them from performing these functions. Further, OIG will assess CMS’ oversight of the reporting of MSIS encounter data.
Program Integrity in Managed Care

OIG will determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents and describe how states oversee MCOs’ efforts to identify and address fraud and abuse.

Beneficiary Protections in Managed Care

OIG will review Medicaid managed care provider networks and describe the extent to which managed care beneficiaries have access to services and describe state standards for ensuring access to primary and specialty care and will determine the extent to which states identify and address problems with access to care in their managed care plans. OIG will review the extent to which states monitor Medicaid MCOs’ grievances and appeals systems for compliance with federal requirements. OIG also will review state Medicaid agencies’ oversight policies, procedures, and activities to determine the extent to which states monitor Medicaid MCOs’ marketing practices and compliance with federal and state contractual marketing requirements and to determine the extent to which CMS ensures that states comply with federal requirements involving Medicaid MCO marketing practices.

CMS-RELATED LEGAL AND INVESTIGATIVE ACTIVITIES

Legal Activities

Among the litany of resources available to OIG to combat health care fraud, waste, and abuse is its authority to resolve civil and administrative cases through exclusions, CMPs and assessments, and corporate integrity agreements (CIAs). In addition, OIG has developed regulations and guidance to aide in providers’ ongoing compliance through issuance of fraud alerts, advisory bulletins, advisory opinions, as well as compliance program guidance, safe harbor regulations, and self-disclosure protocol when irregularities are discovered. In FY 2014, OIG will continue such ongoing activities as:
- Assisting the U.S. Department of Justice with its development and pursuit of False Claims Act cases, including litigation and settlement through mandatory CIAs aimed at ensuring future compliance with federal health care program requirements;

- Providers’ compliance with CIAs, including site visits and review of provider submissions to verify compliance and, where appropriate, pursue corrective action and sanctions, including penalties or exclusion, for breaches of CIA obligations;

- Issuing advisory opinions, fraud alerts, compliance, and other guidance to promote compliance;

- Continuing to provide online provider compliance training, including free webcasts, handouts, and slides that providers can utilize as part of their own compliance program training and development efforts; and

- Continuing encouragement of providers and suppliers to detect and prevent fraud and abuse through the updated Provider Self-Disclosure Protocol.

**Investigative Activities**

FY 2014 has OIG continuing its efforts to chill fraud and abuse in the federal health care programs, with significant resources devoted to investigation of Medicare and Medicaid fraud in close collaboration with other law enforcement entities on the federal, state, and local levels. OIG will continue its stepped-up efforts at curbing fraud and abuse with the Health Care Fraud Prevention and Enforcement Action Team strike forces currently operating in nine major cities through investigation of individuals, facilities, and entities for fraudulent activities (services not rendered, upcoding, and other false claims); investigation of business relationships that run afoul of the Anti-Kickback Statute and
self-referral laws (Stark); and examination of quality-of-care and failure-of-care cases in nursing facilities, institutions, and community-based settings.

OIG also will continue its assistance to CMS related to the Medicare and Medicaid Drug Benefit programs, as well as other pharmaceutical vulnerabilities and schemes, such as prescription shorting by pharmacies, illegal marketing and distribution of prescription drugs, and illegal street distribution of highly addictive drugs.

Finally, OIG will continue assisting state Medicaid fraud control units in their investigation and prosecution of false claims cases and strengthen collaborative efforts between the states and national organization dedicated to Medicaid fraud control and program integrity.

PUBLIC HEALTH REVIEWS

OIG reviews a number of activities and programs of public health agencies within HHS. In its 2014 Work Plan, OIG has indicated it will focus on the following public health activities and programs:

- OIG will continue to review the policies and activities of patient safety organizations (PSOs) to determine the extent of hospitals’ participation, identify practices for receiving and analyzing adverse event reports, and determine the extent to which PSOs provide information to health care providers and the databases maintained by the Agency for Healthcare Research and Quality;

- OIG will start reviewing the expenditures of the World Trade Center Health Program, which provides medical services to responders and survivors with health conditions related to the September 11, 2001, terrorist attacks and is administered by the Centers for Disease Control and Prevention (CDC), to assess the reasonableness of billing, payments, and administrative costs;
• With respect to the CDC, OIG will continue to assess the CDC’s oversight of the HIV/acquired immune deficiency syndrome (AIDS) prevention and research grants and the CDC’s award process for the President’s Emergency Plan for AIDS Relief cooperative agreements for compliance with applicable laws, regulations, and guidance. Additionally, OIG will determine whether the CDC implemented OIG’s recommendations to improve the CDC’s control over property, including adjusting the system to reflect the results of the annual physical inventory, removing lost or missing property, ensuring correct barcoding of property, and reconciliation to resolve discrepancies. OIG will review the CDC’s efforts to ensure the nation’s pharmaceutical stockpile, which ensures pharmaceutical supplies are available for rapid distribution in the event of a biological or chemical incident in the United States or its territories, are secure from theft, tampering, or other loss;

• OIG will describe the extent of the U.S. Food and Drug Administration’s (FDA’s) inspections of generic drug manufacturers, the results of such inspections, and FDA’s enforcement actions taken in response to identified shortcomings or deficiencies;

• OIG will continue assessing the extent to which 340B covered entities and the Health Resources and Services Administration (HRSA) oversee contract pharmacies’ compliance with 340B Program requirements. Additionally, OIG will determine what steps HRSA has taken to address OIG’s recommendation to provide 340B covered entities with access to 340B ceiling prices, what obstacles HRSA faces in implementing this recommendation, and whether contract pharmacies are overcharging covered entities;

• OIG will examine the Indian Health Service (IHS) hospitals’ efforts to ensure quality of inpatient care and IHS’ efforts to monitor each hospital’s ability to provide high-quality care and maintain compliance with Medicare conditions of participation;
• With respect to the National Institutes of Health (NIH), OIG will continue to review uses of superfund money by the NIH, including payments, obligations, and reimbursements; whether facilities awarded extramural construction grants spent funds in accordance with federal requirements, including determining whether bidding procedures and allowable expenditures were followed; and colleges’ and universities’ compliance with selected cost principles based on federal grants. Additionally, OIG will continue to examine the NIH’s oversight of the grants administration processes implemented by the institutes and centers that award extramural grants. OIG also will review the appropriateness of the NIH’s obligation of appropriated funds for the services it obtains through contracts to ensure that appropriated funds were used only during their period of availability and for a bona fide need during the year in which the appropriation was made;

• OIG will determine the extent to which the Substance Abuse and Mental Health Services Administration and states are overseeing and reporting performance for the Substance Abuse Prevention and Treatment Block Grant program, which seeks to prevent substance abuse and to improve access, reduce barriers, and promote effective treatment and recovery services for people who have alcohol and drug abuse problems;

• OIG will begin describing the use of the Medical Reserve Corps volunteers in New Jersey and New York during the Hurricane Sandy response, the availability of those volunteers across specialties, how quickly they were deployed, how states ensured that they were properly qualified, and any challenges and successes with the volunteers. OIG also will assess guidance, disbursement, and reporting related to the $500 million in Hurricane Sandy disaster funding and describe challenges encountered in accessing and using disaster funding; and

• OIG will continue to coordinate efforts with the CDC, the Federal Bureau of Investigation, and the U.S. Department of Agriculture to investigate violations of federal requirements for the registration, storage, and transfer of select biological agents and toxins by academic institutions, commercial manufacturing facilities, and federal, state, and local laboratories.
HUMAN SERVICES REVIEWS

In FY 2014, OIG will review the activities of the Administration for Children and Families (ACF), and the Administration for Community Living (ACL), as follows:

- OIG will review the activities of the ACF program to determine compliance with monitoring and reporting requirements, controls for regulating and monitoring child care providers, and compliance with expenditure regulations. More specifically, OIG will review licensing, health, and safety standards at certain federally funded child-care facilities and determine whether foster care maintenance payments were compliant with federal requirements. Additionally, OIG will continue to examine the extent of states’ oversight and coordination of health services for children in foster care and health care services received by children in foster care. OIG also will continue to review how selected state and local child support enforcement programs protect child support information, and the extent to which they monitored access to data in child support enforcement systems and imposed penalties for unauthorized use; and

- With respect to the ACL, OIG will continue to review performance measures for the Senior Medicare Patrol projects (established to recruit and train senior citizens to recognize and report instances or patterns of health care fraud), including documentation supporting expected recoveries for the Medicare and Medicaid programs.

OTHER HHS-RELATED REVIEWS

OIG reviews a number of HHS department-wide matters such as financial statement audits, financial accounting, information systems management, grants management, and other departmental issues, some of which are mandatory reviews. Particularly noteworthy activities for FY 2014 include:
• OIG will continue to implement predictive analytics technologies for reducing improper Medicare fee-for-service payments, and evaluate past implementation of such technologies. OIG also will continue to assess the reporting of actual and projected savings for improper payments avoided and recovered and the relative return on investment. OIG will provide recommendations for modifying its methodologies and will assess the use of the technologies to determine whether improvements could be made to increase Medicare savings;

• OIG will continue to review HHS’ operating divisions’ compliance with security rules to provide adequate security of information and to confirm compliance with the Federal Information Security Management Act of 2002 and the National Institute of Standards and Technology. OIG also will begin to conduct network and web application penetration testing to determine HHS’ posture of network security and susceptibility to hackers. According to OIG, there has been an increase in activity from computer hacker groups compromising government systems and releasing sensitive data to the public or using such data to commit fraud;

• OIG will begin to assess the internal controls HHS has developed to provide stewardship over Hurricane Sandy funds;

• OIG will begin to review expenditures for conferences in a selected FY to ensure appropriateness and reasonableness and compliance with federal requirements; and

• OIG will begin to review its charge card programs to assess the risks of illegal, improper, or erroneous purchases.

AFFORDABLE CARE ACT REVIEWS [APPENDIX A]

Under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act, or ACA), OIG is tasked with additional oversight of new programs, affecting HHS. In FY 2014, as
part of its ACA oversight, OIG’s focus will continue to be the operation and implementation of the new health insurance marketplaces and expanding the Medicaid program.

**Health Insurance Marketplaces**

In FY 2014, OIG’s review of the newly created health insurance marketplace, including the federally facilitated marketplace (FFM) and the state-based marketplace (SBM), will focus on four main areas to ensure that taxpayer funds are spent for their intended purposes:

**Payment Accuracy**

Ongoing and new work planned for FY 2014 pertaining to payment accuracy will include a review of the effectiveness of HHS’ internal controls that are in place to ensure payments for advanced premium tax credits and cost-sharing reduction subsidies comport with federal requirements. The planned work will focus on the temporary systems HHS has in place to make these payments with subsequent reviews of the permanent system when it is established. OIG also will begin a new review of CMS’ efforts to ensure accuracy of reporting and payments in the risk corridors program applicable to qualified health plans (QHPs). OIG also will develop additional work reviewing CMS’ administration of other payment systems, including: HHS’ role in the risk-adjustment and reinsurance programs; CMS’ calculation of subsidies paid for consumers when circumstances change, or they drop coverage or move between Medicaid and insurance purchased through a marketplace; and the accuracy of information received from state exchanges upon which federal payments are based.

**Eligibility Systems**

OIG plans to conduct new, as well as continued ongoing reviews of effectiveness and efficiency of the FFM and SBM eligibility systems pursuant to the ACA and the
Continuing Appropriations Act of 2014 (CAA). Two new reviews slated for FY 2014 include a review of the ACA enrollment safeguards and procedures in place to prevent the submission of inaccurate or fraudulent information by applicants for enrollment in QHPs. The initial review will include the FFM and two SBMs to determine their conformity with the requisite verifications for eligibility in a QHP and tax credits and cost-sharing reductions and their compliance with applicable regulations to resolve inconsistencies through manual verification. The second review will supplement work in progress as mandated by the CAA, focusing on the marketplaces’ manual verification procedures for applicant information that cannot be verified electronically.

Contracts—Planning, Acquisition, Contracting, Management, and Performance

OIG plans to undertake a comprehensive review of HHS’ efforts to implement the FFM in light of the significant troubles that were encountered during the FFM’s launch in October 2013. Included in its review will be HHS’ overall efforts at planning, coordinating, and implementing the FFM, the significant issues encountered during implementation, and the changes made after October 2013. The comprehensive review also will address:

- HHS’ acquisition plans for implementation of the FFM, including contractor selection;

- HHS’ reporting and resolution of problems encountered during the FFM’s development in October 2013;

- HHS’ payment made to contractors of the FFM and the propriety of the same; and

- HHS’ oversight of and monitoring of FFM contractors, as well as the contractors’ compliance with their contractual obligations, the acquisition plan, and the ACA.
Security of Data and Consumer Information

Due to the sensitive nature of information stored in the marketplaces, security of this data and the systems that house it is of paramount importance. OIG plans to conduct the following reviews to address marketplace security in FY 2014:

- Review of CMS’ web infrastructure that hosts the FFM to ensure it meets requisite information security standards, recognized industry best practices, and federal information security standards. Included in the review will be a vulnerability scan of the HealthCare.gov website to identify known vulnerabilities and detect possible methods to permeate the system and gain unauthorized access and exfiltration of its data; and

- Review of the SBMs’ information security controls to determine their compliance with CMS guidelines, recognized industry best practices, and federal information security standards. Included in the review will be vulnerability scans of the SBMs’ web-based systems to identify known and potential security vulnerabilities and detect possible methods to permeate the system and gain unauthorized access and exfiltration of its data.

Medicaid Expansion and Other Medicaid Issues

In light of the ACA’s significant expansion of the Medicaid program, OIG will perform numerous reviews to address the effectiveness and efficiency of the Medicaid program’s growth. New reviews that are directly related to the ACA’s provision include:

- Enhanced FMAP;

- Medicaid eligibility enrollment-national error rates;

- Medicaid eligibility determination in selected states;
• Provider payment suspensions during pending investigations of credible fraud allegations; and

• National Correct Coding Initiative edits and CMS oversight.

Other ACA Requirements and Programs

OIG also will conduct new reviews related to changes to the Medicare program and other programs related to the ACA. Among the new reviews that will be undertaken in FY 2014 are the following:

• Hospice in ALFs;

• Consumer-Operated and Oriented Plan Loan Program—eligibility status and use of startup and solvency loans;

• Assessment of the CDC’s management of Prevention and Public Health Fund grants;

• HRSA-340B covered entity access to 340B ceiling prices; and

• Accuracy of the Physician Compare website.

RECOVERY ACT REVIEWS [APPENDIX B]

Under the American Recovery and Reinvestment Act of 2009 (Recovery Act), funding was allocated to OIG for discretionary oversight of HHS programs and operations that received supplemental funding from the Recovery Act. As part of its oversight activities, OIG has planned the following reviews to assess the propriety of HHS’ use of Recovery Act funds:
• Review of Medicare and Medicaid incentive payments to eligible health care professionals and hospitals for adoption of electronic health records (EHRs) and CMS’ safeguards to prevent erroneous incentive payments, including CMS’ plans for oversight of those incentive payments for the duration of the program;

• New review of various covered entities receiving incentive payments and their business associates, including EHR cloud service providers, to determine whether the security measures in place adequately protect the electronic information created or maintained by the certified EHR technology. The review will include audits of cloud service providers and other downstream service providers to assure compliance with the regulatory and contractual obligations; and

• Review of HHS’ Office for Civil Rights (OCR) oversight of covered entities’ compliance with the Health Insurance Portability and Accountability Act Privacy Rule and the Health Information Technology for Economic and Clinical Health Breach Notification Rule.

In addition, OIG expects that it will see an increase in the number of complaints it receives pertaining to allegations of fraud and misuse of Recovery Act funds, as well as anti-reprisal enforcement actions for those bringing such claims to OIG’s attention.

*The Fraud and Abuse Practice Group would like to thank Sarah L. Bimber, JD, MPH (Stoel Rives LLP, Portland, OR), Karen S. Lovitch, JD (Mintz Levin Cohn Ferris Glovsky and Popeo PC, Washington, DC), Alice H. Martin, JD (Martin Compliance Consulting LLC, Florence, AL), and Marilyn May, JD (Arnold & Porter LLP, Washington, DC), for their assistance in preparing this Executive Summary.
“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—from a declaration of the American Bar Association