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OIG Work Plan Monthly Updates (March-May 2019)

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All Federal

Post-Hospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries

Patients admitted to skilled nursing facilities ("SNFs") are often dually eligible for both Medicare and Medicaid benefits. Because Medicare reimburses providers at a higher rate than Medicaid, OIG is concerned that physicians at SNFs will sometimes inappropriately certify that a patient requires "skilled" services when skilled services are not reasonable or necessary, allowing the facility to bill Medicare rather than Medicaid. OIG will evaluate whether post-hospital SNF care provided to dually eligible beneficiaries meets Medicare's level of care requirements. Specifically, OIG will determine whether:[1]

1. the SNF level of care was certified by a physician or a physician extender;
2. the condition treated at the SNF was a condition for which the beneficiary received inpatient hospital services or a condition that arose while the beneficiary was receiving care in the SNF;
3. daily skilled care was required;
4. the services delivered were reasonable and necessary for the treatment of a beneficiary's illness or injury; and
5. improper Medicare payments were made on claims.

Review of Monthly ESRD-Related Visits Billed by Physicians or Other Qualified Healthcare Professionals

Monthly capitation payments (MCP) are paid to most physicians and other practitioners who manage the care of outpatient dialysis patients at end-stage renal disease (ESRD) facilities. These MCP payments are based on the number of visits during the month and the age of the patient. CMS's Comprehensive Error Rate Testing (CERT) program found that many of the MCPs made for ESRD-related services were improper. CERT found that these improper MCPs were a result of insufficient documentation, the use of incorrect billing codes, or no documentation being submitted. OIG will review billing records for ESRD-related services and determine whether or not physicians and other practitioners utilized the proper billing codes and provided proper documentation.

Access Increases in Mental Health and Substance Abuse Services Funding for Health Centers

In September 2017, $200 million in Access Increases in Mental Health and Substance Abuse Services (AIMS) supplemental funding was awarded to health centers nationwide to combat the opioid crisis. AIMS funds can be used to increase mental health and substance abuse services personnel, leverage health information technology, and on additional training. OIG will be auditing whether or not the use of AIMS funds was compliant with the terms of the grant and federal requirements.

Medicaid Personal Care Services

Medicaid covers personal care services ("PCS") for certain patient populations. PCS include activities of daily living such as bathing, dressing, housework, meal preparation, transportation, and money management. In past reviews, the OIG has found that states have had significant issues ensuring compliance with PCS requirements. Now, OIG will review whether improvements have been made by states in the oversight and monitoring of PCS, and thereby reducing the number of noncompliant PCS claims.

National Institute of Health (NIH)

NIH awards significant grant funding for research initiatives through affiliated institutes and centers. The OIG will conduct a review to ensure the integrity of NIH's grant funding process and possibly address duplicative funding issued by the various institutes and centers. The OIG will also conduct a review of NIH's electronic health record system to determine if any interoperability or use challenges are serving as a barrier to NIH's operations and research programs.

Medicaid Managed Care Organization Denials

Generally, state Medicaid agencies and the federal government bear the financial risk for the costs of Medicaid services. However, the state Medicaid agencies also contract with managed care organizations ("MCOs") to provide Medicaid services to beneficiaries and shifts financial risk to the MCOs. This risk-shifting creates a potential incentive for MCOs to deny beneficiaries access to covered services. The OIG will conduct a review to determine if MCOs are complying with federal requirements in the denial of services to beneficiaries.

Other areas of focus of the OIG in March, April and May are as follows:

- The OIG announced a new adverse event screening tool for SNFs. OIG will release additional guidance issued by CMS regarding the development and use of the tool for use by providers involved in the skilled nursing industry.
- As mandated by the Cures Act, the OIG will survey State Medicaid agencies regarding their enrollment of fee-for-service and managed care providers.
- The OIG will draft an annual report to quantify savings to Medicare that are a direct result of CMS's price substitution policy for drugs which exceed average manufacturer prices.
- The OIG will conduct a study to ensure the accuracy of manufacturer reported average sales price for drugs.

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[1] Factors quoted in part from OIG work plan:
https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000355.asp