

**MEMORANDUM**

**TO:** State Executives

**FROM:** Dianne De La Mare  
VP, Legal Affairs

Elise Smith  
Sr. VP, Finance Policy & Legal

**SUBJECT:** **OIG's 2012 Work Plan**

**DATE:** October 19, 2011

As we stated in a recent *Capitol Connections* article, HHS, Office of Inspector General (OIG) has released its 2012 Work Plan at <http://oig.hhs.gov/reports-and-publications/workplan/index.asp>, which it does annually, detailing the issues and activities it plans to focus on in the upcoming year. AHCA/NCAL carefully reviews and analyzes this document each year, as it is in essence, a roadmap to healthcare providers of the Federal government's plan for upcoming audits and enforcement activities.

Below is an account of some of the most pressing compliance concerns for LTC providers and the issues that the OIG will focus on in 2012. Please note that typically, a report designated as "work in progress," will result in a report issued in FY 2012; but a review slated to begin in FY 2012 ("new start") could result in FY 2012 or 2013 reports depending on the complexity of the review. We realize that the list is long, but it would be unwise for us to try to prioritize them or provide just a few of the items. If you have any questions or items that you would wish to discuss, please let me know.

**Under Part I: Medicare Part A and Part B:**

**Nursing Homes:**

1. Medicare Requirements for Quality of Care in SNFs - OIG will review how SNFs have addressed certain Federal requirements related to quality of care. OIG will determine the extent to which SNFs developed plans of care based on assessments of beneficiaries, provided services to beneficiaries in accordance with the plans of care, and planned for beneficiaries' discharges. OIG will also review SNFs' use of Resident Assessment Instruments (RAI) to develop nursing home residents' plans of care. Prior OIG reports revealed that about a quarter of residents' needs for care, as identified through RAIs, were not reflected in care plans and that nursing home residents did not receive all the psychosocial services identified in care plans. Federal laws require nursing homes participating in Medicare or Medicaid to use RAIs to assess each nursing home resident's strengths and needs. (Social Security Act, §§ 1819(b)(3) and 1919(b)(3).) (OEI; 02-09-00201; expected issue date: FY 2012; work in progress)
2. Safety and Quality of Post-Acute Care for Medicare Beneficiaries (NEW) - OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to post-acute care. OIG will evaluate the transfer process and also identify rates of adverse events

and preventable hospital readmissions from post-acute-care settings. OIG will focus on three post-acute settings: SNFs, IRFs and long-term-care hospitals. Average hospital stays for Medicare beneficiaries have fallen steadily over several decades, resulting in increased transfers to post-acute-care facilities. Patients recovering in these facilities often require substantial clinical care, and the capabilities of the facilities to care for residents vary by facility type and access to appropriate equipment and staffing. The hospital discharge planning process and the degree of communication and collaboration between acute-care and post-acute-care providers also affect a beneficiary's experience and the ability of providers to ensure a smooth and safe transition. (OEI; 06-11-00370; expected issue date: FY 2013; work in progress)

3. Nursing Home Compliance Plans (NEW) – OIG will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in OIG's compliance program guidance. OIG will assess whether CMS has incorporated compliance requirements into Requirements of Participation and oversees provider implementation of plans. Section 6102 of the Affordable Care Act requires nursing homes to operate a compliance and ethics program, containing at least 8 components, to prevent and detect criminal, civil, and administrative violations and promote quality of care. The Affordable Care Act requires CMS to issue regulations by 2012 and SNFs to have plans that meet such requirements on or after 2013. OIG's compliance program guidance is at 65 Fed. Reg. 14289 and 73 Fed. Reg. 56832. (OEI; 00-00-00000; expected issue date: FY 2013; new start; Affordable Care Act)
4. Oversight of Poorly Performing NHs - OIG will review CMS's and States' use of enforcement measures to determine their impact on improving the quality of care that beneficiaries received in poorly performing nursing homes and evaluate the performance of these nursing homes. OIG will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement correction plans. Federal requirements include a survey-and-certification process, including an enforcement process, to ensure that nursing homes meet Federal standards for participation in Medicare and Medicaid. (Social Security Act, §§ 1819(g) and 1864) OIG will examine enforcement decisions resulting from inspections and other oversight by CMS and States. (OEI; 00-00-00000; expected issue date: FY 2013; new start)
5. NH Emergency Preparedness and Evacuations During Selected Natural Disasters - OIG will review nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors to determine the sufficiency of the nursing homes' plans and their implementation of the plans. OIG will also describe the experiences of selected nursing homes, including challenges, successes, and lessons learned, when they implemented their plans during recent disasters, such as hurricanes, floods, and wildfires. Federal regulations require that Medicare- and Medicaid-certified nursing homes have plans and procedures to meet all potential emergencies and train all employees in emergency procedures. (42 CFR § 483.75(m).) In 2006, OIG reported that nursing homes in certain Gulf States had plans that lacked a number of features suggested by emergency preparedness experts and that staff members did not always follow plans during emergencies. (OEI; 06-09-00270; expected issue date: FY 2012; work in progress)
6. Medicare Part A Payments to SNFs - OIG will review the extent to which payments to SNFs meet Medicare coverage requirements. OIG will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009. The amount paid to SNFs for all covered services is established by the Social Security Act, § 1888(e). Medicare pays Part A SNF stays using a system that categorizes each beneficiary into a group according to care and resource needs. The groups are referred to as Resource Utilization Groups (RUG). In a prior report, OIG found that 26 percent of claims had

RUGs that were not supported by patients' medical records. The percentage represented \$542 million in potential overpayments for FY 2002. (OEI; 02-09-00200; expected issue date: FY 2012; work in progress)

7. Hospitalizations and Rehospitalizations of NH Residents - OIG will review the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized and rehospitalized. OIG will also assess CMS's oversight of nursing homes whose residents have high rates of hospitalization. Hospitalizations and rehospitalizations of nursing home residents are costly to Medicare and may indicate quality-of-care problems at nursing homes. A 2007 OIG study found that 35 percent of hospitalizations during a SNF stay were caused by poor quality of care or unnecessary fragmentation of services. (OEI; 06-11-00040; expected issue date: FY 2012; work in progress)
8. Questionable Billing Patterns During Non-Part A Nursing Home Stay (NEW) - OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Part B services provided during a non-Part A stay must be billed directly by suppliers and other providers. (CMS's *Medicare Benefits Policy Manual*, Pub. 100-02, ch. 8, § 70.) Congress directed OIG to monitor these services for abuse. (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313.) A series of studies will examine podiatry, ambulance, laboratory, and imaging services. (OEI; 06-11-00280; various reviews; expected issue dates: FY 2012, 2013; work in progress)

#### Hospices:

1. Hospice Marketing Practices and Financial Relationships with NFs (NEW) – OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed their services to nursing facility residents. OIG will focus its review on hospices that have a high percentage of their beneficiaries in nursing facilities. (OEI; 02-10-00071; 02-10-00072; expected issue date: FY 2012; work in progress)
2. Medicare Hospice General Inpatient Care - OIG will review the use of hospice general inpatient care from 2005 to 2010. OIG will assess the appropriateness of hospices' general inpatient care claims and hospice beneficiaries' drug claims billed under Part D. Federal regulations address Medicare COPs for hospice at 42 CFR Part 418. OIG will review hospice medical records to address concerns that this level of hospice care is being misused and to determine the extent to which drugs are being inappropriately billed to Part D. (OEI; 02-10-00490; expected issue date: FY 2012; work in progress)

#### Medicare Part A and Part B Contractor Operations:

1. Oversight of the Medicare Administrative Contractors - OIG will review Quality Assurance Surveillance Plan (QASP) performance evaluation reports of MACs to determine whether the reports address the results of activities performed by the MACs. OIG will also determine how CMS addressed any deficiencies identified by the QASP reports. Federal law requires the Secretary to administer Medicare Part A and Part B through contracts with MACs and to develop specific performance requirements and standards for measuring the extent to which MACs meet

such requirements. (MMA, § 911.) To assist in its oversight, CMS developed the QASP review process for use in monitoring and evaluating MACs' performance. Each fiscal year, CMS prepares a QASP report of contractor performance that summarizes the results of oversight activities that occurred during the year. (OEI; 03-11-00740; expected issue date: FY 2012; work in progress)

2. Zone Program Integrity Contractors' Activities to Detect and Deter Potential Fraud and Abuse - OIG will describe the extent to which Zone Program Integrity Contractors (ZPIC) performed program integrity activities including investigations, case referrals, requests for information, and administrative actions; determine any barriers ZPICs encountered in performing their program integrity activities; and determine any barriers affecting CMS oversight of ZPICs. As a result of contracting reform under section 911 of the MMA, CMS is in the process of replacing the Program Safeguard Contractors (PSC), who perform program integrity work in Medicare Parts A and B, with ZPICs. (OEI; 03-09-00520; expected issue date: FY 2012; work in progress)
3. Conflicts of Interest in the Zone Program Integrity Contracting Process - OIG will review CMS's process for overseeing contractors' organizational conflicts of interest during the ZPIC award process and throughout the period of performance. OIG will determine the extent to which ZPICs disclosed conflicts of interest, examine how they resolved them, and determine how CMS addresses personal conflicts of interest among members of the Technical Evaluation Panel used during the awards process. Federal regulations and other authorities prescribe responsibilities, general rules, and procedures to identify, evaluate, and resolve organizational conflicts of interest. (The FAR (48 CFR subpart 9.5), the *Health and Human Services Acquisition Regulation*, and other authorities.) (OEI; 03-10-00300; expected issue date: FY 2012; work in progress)
4. Vulnerabilities Identified by Medicare Benefit Integrity Contractors - OIG will review how CMS addresses vulnerabilities identified by PSCs, ZPICs, and Medicare Drug Integrity Contractors (MEDIC) and determine the numbers and types of actions CMS took to address such vulnerabilities. CMS requires PSCs and ZPICs, whose responsibilities include preventing, detecting, and deterring fraud and abuse, to report vulnerabilities on monthly cost reports and on quarterly vulnerability reports. (CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.31). Medicare MEDICs also submit quarterly vulnerability reports. (Section 8.2.12 of the MEDIC Statement of Work.) (OEI; 03-10-00500; expected issue date: FY 2012; work in progress)
5. Recovery Audit Contractors' Performance and Identification and Recoupment of Improper Payments – OIG will review the performance of the Recovery Audit Contractor (RAC) program and CMS's oversight of the program. The RACs conduct post payment reviews to identify overpayments and underpayments and attempt to recoup any overpayments they identify. On completion of a 3-year demonstration project, Congress mandated nationwide implementation of a permanent RAC program for Medicare Part A and Part B. (Tax Relief and Health Care Act of 2006, § 302.) Subsequently, Congress expanded the RAC program, giving it additional responsibilities to address improper payments in Medicare (including Part C and Part D), and Medicaid. (Affordable Care Act, § 6411.) (OEI; 04-11-00680; expected issue date: FY 2012; work in progress; Affordable Care Act)
6. Variation in Coverage of Services and Medicare Expenditures due to Local Coverage Determinations - OIG will review variation in Medicare spending and coverage of services due to LCDs and the evidence Medicare contractors use to develop LCDs. OIG will also assess CMS's monitoring and oversight of LCDs. A contractor may establish an LCD to enforce its decision about whether a particular item or service is considered reasonable and necessary and is therefore covered under Medicare. (BIPA § 521 and Social Security Act, § 1862(a)(1)(A).) These coverage decisions are not national, meaning Medicare could pay for a service for a beneficiary in one location, but deny payment for that service to a beneficiary elsewhere. Over 2,800 LCDs

are in effect, but it is not possible to readily calculate the number of claims and the amount of Medicare spending associated with LCDs because claims do not indicate whether an LCD is involved. (OEI; 01-11-00500; expected issue date: FY 2012; work in progress)

7. Provider Education and Training: Medicare-Affiliated Contractors' Progressive Corrective Action - OIG will review the progressive corrective action (PCA) provider education and training programs conducted by Medicare-affiliated contractors to determine whether such programs have reduced billing and payment error rates and noncompliance. OIG will also assess CMS's processes for overseeing the education and training programs of affiliated contractors. PCA is a medical review tool used by Medicare contractors. In FY 2000, CMS included PCA as a strategy for conducting medical reviews and provider education and training. (*Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3.) The Secretary coordinates educational activities provided through Medicare contractors to maximize the effectiveness of Federal education efforts for providers and oversee contractors' education and training programs. (MMA, § 921(d).) (OEI; 00-00-00000; expected issue date: FY 2013; new start)

### **Under Part III: Medicaid Review:**

#### **Other Medicaid Services and Payments:**

1. Hospice Services: Compliance With Reimbursement Requirements - OIG will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients' illness and death. An individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS's State Medicaid Manual, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than \$816 million. (OAS; W-00-11-31385; various reviews; expected issue date: FY 2012; new start. OEI; 00-00-00000; expected issue date: FY 2013; new start)
2. Payments for Physical, Occupational, and Speech Therapy Services - OIG will determine the extent to which payments for Medicaid physical, occupational, and speech therapy services comply with State standards and limits on coverage. Previous OIG studies found that some therapy services provided under Medicare were billed incorrectly. Through a review of selected States, OIG will determine whether Medicaid has similar program integrity issues. States may provide physical, occupational, and speech therapy services to Medicaid beneficiaries pursuant to the Social Security Act, § 1905(a), and regulations at 42 CFR § 440.110. (OEI; 07-10-00370; expected issue date: FY 2012; work in progress)
3. Medicaid Medical Equipment - OIG will determine whether Medicaid payments for medical supplies and equipment were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines. Rules and guidance about necessary medical supplies and equipment for home health services; physical therapy services; occupational therapy services; services for individuals with speech, hearing, and language disorders; and HCBS are in Federal regulations at 42 CFR pt. 440 and various provisions of CMS's State Medicaid Manual. (OAS; W-00-11-31390; various reviews; expected issue date: FY 2012; new start)
4. Payments for Transportation Services - OIG will review payments to providers for transportation services to determine the appropriateness of State Medicaid agencies' payments

for such services. Federal regulations require States to ensure necessary transportation for Medicaid beneficiaries to and from providers. (42 CFR § 431.53.) Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. (OAS; W-00-09-31121; W-00-10-31121; W-00-11-31121; various reviews; expected issue date: FY 2012; work in progress)

5. State-Operated Facilities: Reasonableness of Payment Rates (NEW) - OIG will determine whether Medicaid payment rates to State-operated facilities are reasonable and in accordance with Federal and State requirements. OIG will determine in selected States the extent to which payments to providers have exceeded the requirements. Payments for services must be consistent with efficiency, economy, and quality of care. (Social Security Act, §1902(a)(30)(A).) Federal regulations state that a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. (2 CFR § 225, Appendix A, § C. 2.) (OAS; W-00-11-31398; various reviews; expected issue date: FY 2012; work in progress)
6. Payments for Health-Care-Acquired Conditions (NEW) - OIG will determine whether selected State agencies made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions. As of July 1, 2011, Federal payments to States under the Social Security Act, § 1903, are prohibited for any amounts expended for providing medical assistance for health care-acquired conditions. (Affordable Care Act, § 2702.) Federal regulations prohibiting Medicaid payments by States for services related to health care-acquired conditions and provider-preventable conditions are at 42 CFR § 447.26. (OAS; W-00-12-31452; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)
7. Medicaid Nursing Facility Incentive Payments - OIG will review Medicaid incentive payments by States to nursing facilities based on the facilities' quality-of-care performance measures. OIG will determine whether States have sufficient controls to assess nursing facilities' quality-of-care performance measures and determine whether incentive payments were in accordance with program requirements. States are authorized to establish programs to reward nursing facilities (through public recognition, incentive payments, or both) that provide the highest quality care to their Medicaid-eligible residents. (Social Security Act, § 1919(h)(2)(F).) (OAS; W-00-10-31331; W-00-11-31331; various reviews; expected issue date: FY 2012; work in progress)
8. Emergency Payments by State Medicaid Agencies (NEW) - OIG will determine whether emergency payments to providers made by State Medicaid agencies were adequately supported. OIG will review the emergency payments and assess States' overpayment reconciliation and recoupment processes to determine whether charges to Medicaid were based on actual expenditures. Emergency payments often occur during transitions between fiscal agents or when systems are upgraded. These payments have a substantial additional risk of inaccuracy because they may bypass the usual payment edits and claim-support requirements. One State Medicaid agency recently made \$792 million in emergency payments to providers, for which the State auditor identified numerous deficiencies, including that such payments were not supported by valid claims but based on estimates. Federal regulations require States to account for Medicaid funds based on expenditures, not estimates. (42 CFR § 430.30 .) (OAS; W-00-12-31454; various reviews; expected issue date: FY 2012; new start)

#### Medicaid Integrity and Accountability:

1. Early Results From Medicaid Integrity Contractors - OIG will review the progress of CMS's Medicaid Integrity Contractors (MIC) in completing program integrity tasks outlined in their contracts. OIG will also examine the results of the MICs' work. An integral part of the Medicaid Integrity Program (MIP) is the program integrity work that will be performed by MICs. MICs are tasked with preventing and detecting Medicaid fraud, waste, and abuse through the review of the actions of individuals or entities furnishing items or services under Medicaid. CMS began awarding contracts in April 2008 and subsequently awarded contracts covering CMS's 10 regions. The MIP was established by the Social Security Act, § 1936, as amended by the DRA, § 6034. (OEI; 05-10-00200; 05-10-00210; expected issue date: FY 2012; work in progress)
2. Medicare and Medicaid Data Matching Project - OIG will review CMS's oversight and monitoring of the Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi task orders. OIG will also determine the extent to which Medi-Medi contractors identified potential fraud, waste, and abuse through the Medi-Medi project. This review matches Medicare and Medicaid data to proactively identify program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data individually. CMS began the Medi-Medi project in 2001 in partnership with California to improve coordination of Medicare and Medicaid program integrity efforts pursuant to the Social Security Act, § 1893. As of 2007, there were 10 active Medi-Medi task orders in California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois. Federal regulations provide policies and establish responsibilities for agencies to record and maintain contractor performance information. (48 CFR §§ 42.1500 to 42.1503.) (OEI; 09-08-00370; expected issue date: FY 2012; work in progress)
3. Addressing Vulnerabilities Identified During Medicaid State Program Integrity Reviews NEW - OIG will review corrective actions that State Medicaid agencies have implemented to address the findings and recommendations from State Medicaid program integrity reviews conducted by CMS. OIG will determine why States have not implemented all corrective actions, examine the follow-up CMS performed to ensure that corrective actions were taken by States, and examine the evidence CMS reviews to ensure that corrective actions were implemented. As part of the MIP, CMS conducts a triennial review of each State's program integrity functions to assess their effectiveness and compliance with Federal requirements. CMS issues to the State a final report of findings and recommendations and requires the State to provide a corrective action plan within 30 days of the report issuance. The MIP was established by DRA, § 6034. (OEI; 00-00-00000; expected issue date: FY 2012; new start)
4. State Medicaid Fraud Control Units Performance Standards - OIG will review the overall management, operations, and performance of a State Medicaid Fraud Control Unit (MFCU). The Secretary has delegated to OIG the responsibility for administering the MFCU grants and providing oversight and guidance to the MFCUs. Part of that oversight responsibility, as required by 42 CFR § 1007.15(d), includes certifying and then annually recertifying every State MFCU. Section 1902(a)(61) of the Social Security Act required the Secretary to establish performance standards that could be used in evaluating a

- MFCU's performance for recertification purposes; the twelve standards were published at 59 Federal Register 49080. Periodically, OIG conducts an in depth, on-site review of each State MFCU as part of the recertification process. OIG will determine the extent to which a State MFCU operates in accordance with the twelve published performance standards and identify areas for improvement in the MFCU's management and operations. (OEI, 02-11-00440, expected issue date: FY 12; work in progress; multiple reviews; new start)
5. State Agencies' Terminations of Providers Terminated Under Medicare or by Other States (New) - OIG will review States' compliance with a new requirement that State Medicaid agencies terminate providers that have been terminated under Medicare or by another State. OIG will determine whether such providers are terminated by all States, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify obstacles States face in complying with the termination requirement. This new requirement became effective January 1, 2011. (Social Security Act, § 1902(a)(39), as amended by the Affordable Care Act, § 6501.) OIG will compare lists of providers terminated from Medicare and each State Medicaid program and examine the information-sharing system being implemented to comply with the requirement. (Affordable Care Act, § 6401(b)(2).) (OEI; 00-00-00000; expected issue date: FY 2012; new start; Affordable Care Act)
  6. Federally Excluded Providers and Suppliers - OIG will review Medicaid payments to providers and suppliers to determine the extent to which payments were for services provided during periods of exclusion from Medicaid. Excluded providers and suppliers are not permitted to receive payments for services provided during periods of exclusion. (Social Security Act, §§ 1128, 1128A, and 1156, and 42 CFR § 1001.1901.) (OAS; W-00-10-31337; W-00-11-31337; various reviews; expected issue date: FY 2012; work in progress)
  7. States' Contingency Fee Payment Arrangements - OIG will determine the extent to which State Medicaid agencies have contracted with consultants through contingency fee payment arrangements and determine how the impact the arrangements have affected the submission of questionable or improper claims to the Federal Government. Previous OIG work in one State found that improper claims had been submitted by the State as a result of a contingency fee payment arrangement. Some State Medicaid agencies use consulting firms to help identify ways to maximize Federal Medicaid reimbursement. In some cases, States pay the consulting firms a percentage of the increase in Federal Medicaid funding. The claiming of the costs of such contingency fee arrangements from the Federal Government are precluded by OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments. (OAS; W-00-07-31045; W-00-08-31045; W-00-11-31045; various reviews; expected issue date: FY 2012; work in progress)
  8. Federal Funds Generated Through Medicaid Provider Taxes (New) - OIG will review State health care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable Federal requirements. OIG's work will focus on the mechanism States use to raise revenue through provider taxes and determine the amount of Federal funding generated. Previous OIG work has raised concerns about States' use of health-care-related taxes. Many States finance a portion of their Medicaid

spending by imposing taxes on health care providers. Health-care-related taxes are defined by Federal regulations that set forth the standard for permissible health-care-related taxes. (42 CFR §§ 433.55 and 433.68.) (OAS; W-00-12-31455; various reviews; expected issue date: FY 2013; new start)

9. Overpayments: Medicaid Credit Balances - OIG will review patient accounts of providers to determine whether there are Medicaid overpayments in the accounts with credit balances. Previous OIG work found Medicaid overpayments in patients' accounts with credit balances. Medicaid is the payer of last resort and providers are to identify and refund overpayments received. (Social Security Act, § 1902(a)(25); 42 CFR pt. 433, subpart D; various State laws; and CMS's State Medicaid Manual, Pub. No. 45, pt. 3, § 3900.1.) (OAS; W-00-10-31311; W-00-11-31311; various reviews; expected issue date: FY 2012; work in progress)
10. States' Efforts To Improve Third-Party Liability Payment Collections in Medicaid - OIG will review States' procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries to determine the extent to which States' efforts have improved since OIG's last review. OIG will also examine changes to State laws and Medicaid procedures and determine whether such changes have improved States' identification of third-party liabilities. Many Medicaid beneficiaries may have additional health insurance through third-party sources, such as employer-sponsored health insurance. OIG work in 2006 described problems that State Medicaid agencies had in identifying and collecting third-party payments. States are to take all reasonable measures to ascertain the legal liabilities of third parties with respect to health care items and services. (Social Security Act, § 1902(a)(25).) The DRA, § 6035, clarified the provision for entities defined as third-party payers. (OEI; 05-11-00130; expected issue date: FY 2012; work in progress)
11. Form CMS-64: Medicaid Overpayment Reporting and Collections (NEW) - OIG will determine whether States are reporting overpayments identified by Federal audits on the Form CMS-64, as Federal regulations require. For cases in which CMS concurred with OIG's prior recommendations, OIG will determine whether the overpayments have been recouped. Prior OIG reviews identified Medicaid overpayments in various States, and OIG recommended collection of those overpayments. If a Federal review indicates that a State has failed to identify an overpayment, CMS is to consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery. (42 CFR § 433.316(e).) Federal regulations require States' use of the Form CMS-64. (42 CFR part 433, subpart F). (OAS; W-00-11-31399; various reviews; expected issue date: FY 2012; work in progress)
12. Payment Error Rate Measurement: Fiscal Year 2008 Error Rate - OIG will evaluate certain aspects of CMS's Medicaid Payment Error Rate Measurement (PERM) process for determining the FY 2008 Medicaid fee for service (FFS) payment error rate. OIG will also determine whether the independent medical review organization met its contractual obligations to CMS and will analyze the organization's review. OIG will also evaluate the methodology and medical review determinations underlying the error rate testing conducted by the PERM contractor. Federal agencies are to annually develop a statistically valid estimate of improper payments under programs with a significant risk of erroneous payments. (Improper Payments Information Act of 2002 (IPIA) and the

OMB implementation of IPIA in Memorandum M-06-23.) CMS contracted with an independent medical review organization to perform a random independent review of its PERM contractor's payment determinations for 250 Medicaid FFS claims. (OAS; W-00-10-40045; W-00-11-40045; expected issue date: FY 2012; work in progress)

13. Payment Error Rate Measurement Program: Error Rate Accuracy and Health Information Security - OIG will review CMS's implementation of the PERM process to determine whether it has produced valid and reliable error rate estimates for Medicaid and Children's Health Insurance Program (CHIP) FFS, managed care, and eligibility. OIG will also review the physical and data security of health information transmitted by various States for use in the PERM. OIG will also verify CMS's actions to implement recommendations from a March 2010 OIG review. Annually, Federal agencies must develop statistically valid estimates of improper payments under programs with a significant risk of erroneous payments, including Medicaid and CHIP. (Improper Payments Elimination and Recovery Act (IPERA) and OMB's implementation of IPERA.) CMS developed the PERM process to comply with the IPERA. The process includes conducting FFS, managed care, and eligibility reviews. (42 CFR, pt. 431, subpart Q.) OMB's instructions on protecting sensitive information and reporting incidents involving potential and confirmed breaches of personally identifiable information are provided by OMB Memorandums M-06-16 and M-07-16. OIG has oversight and monitoring responsibilities related to CMS's error rate process pursuant to the Chief Financial Officers Act of 1990. (OAS; W-00-11-40046; various reviews; expected issue date: FY 2012; new start)

Program Administration, Information Systems, and Data Integrity:

1. Provider Enrollment: Collection and Verification of Provider Ownership Information by State Medicaid Agencies - OIG will review State practices for collection and verification of Medicaid provider ownership information, assess the accuracy of the information on file, and assess the effectiveness of the practices. Payments to providers that have not disclosed the required information are not eligible for FFP. State Medicaid agencies cannot approve a provider participation agreement or contract with any entity that has not disclosed the required information. Federal regulations require Medicaid providers to disclose the name and address of each person with an ownership or control interest in the provider. (42 CFR § 455.104.) (OEI; 04-11-00590; expected issue date: FY 2012; work in progress)
2. Beneficiary Eligibility: State Agencies' Redeterminations of Medicaid Eligibility (NEW) - OIG will review State agencies' procedures for redetermining the eligibility status of Medicaid beneficiaries and determine the amount of unallowable payments associated with beneficiaries who did not receive the required Medicaid eligibility redeterminations. During recent audits of Medicaid payments for services provided to beneficiaries with concurrent eligibility in two States, OIG found that eligibility status reviews were not always performed in a timely manner. Federal regulations require that State agencies redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. (42 CFR § 435.916.) (OAS; W-00-11-31140; various reviews; expected issue date: FY 2012; work in progress)

3. CMS Oversight and Accuracy of Nursing Home Minimum Data Set Data - OIG will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. OIG will also review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. Nursing homes must conduct accurate comprehensive assessments for residents using an instrument that includes the MDS. (Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act.) Federal regulations specify the requirements of the assessment instrument. (42 CFR § 483.20.) CMS implemented a skilled nursing facility prospective payment system based on MDS data in July 1998 and began posting MDS-based quality performance information on its Nursing Home Compare Web site in 2002. About half of the States base their Medicaid payment systems on MDS data. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

#### **Under Part IV: Legal and Investigative Activities Related to Medicare and Medicaid:**

##### **Legal Activities:**

1. Exclusions From Program Participation - OIG may exclude individuals and entities from participation in Medicare, Medicaid, and all other Federal health care programs for many reasons, some of which include program-related convictions, patient abuse or neglect convictions, licensing board disciplinary actions, or other actions that pose a risk to beneficiaries or programs. (Social Security Act, § 1128, § 1156, and other statutes.) Exclusions are generally based on referrals from Federal and State agencies. OIG works with these agencies to ensure the timely referral of convictions and licensing board and administrative actions. In fiscal year (FY) 2010, OIG excluded 3,340 individuals and entities from participation in Federal health care programs. The total for FY 2011 will be published in OIG's Fall FY 2011 Semiannual Report to Congress. Searchable exclusion lists are available on OIG's Web site at: <http://exclusions.oig.hhs.gov/>.
2. Civil Monetary Penalties - OIG pursues CMP cases, when supported by appropriate evidence, based on the submission of false or fraudulent claims; the offer, payment, solicitation, or receipt of remuneration (kickbacks) in violation of the Social Security Act, § 1128B(b); violations of the Emergency Medical Treatment and Labor Act of 1986; items and services furnished to patients of a quality that fails to meet professionally recognized standards of health care; and other conduct actionable under the Social Security Act, § 1128A, or other CMP authorities delegated to OIG.
3. False Claims Act Cases and Corporate Integrity Agreements - When adequate evidence of violations exists, OIG staff members work closely with prosecutors from the Department of Justice (DOJ) to develop and pursue Federal false claims cases against individuals and entities that defraud the Government. Authorities relevant to this work come from the False Claims Amendments Act of 1986 and the Fraud Enforcement and Recovery Act of 2009. OIG assists DOJ prosecutors in litigation and settlement negotiations arising from these cases. OIG also considers whether to invoke the OIG exclusion authority based on the defendants' conduct. When appropriate and necessary, OIG requires defendants to implement CIAs aimed at ensuring compliance with Federal health care program requirements.
4. Providers' Compliance With Corporate Integrity Agreements - OIG often negotiates compliance obligations with health care providers and other entities as part of the settlement of Federal

health care program investigations arising under a variety of civil false claims statutes. Subsequently, OIG assesses providers' compliance with the terms of the integrity agreements. For example, OIG conducts site visits to entities that are subject to integrity agreements to verify compliance, to confirm information submitted to us by the entities, and to assess the providers' compliance programs. OIG reviews a variety of information submitted by providers to determine whether their compliance mechanisms are appropriate and identify problems and establish a basis for corrective action. When warranted, OIG imposes sanctions, in the form of stipulated penalties or exclusions, on providers that breach integrity agreement obligations. Active CIAs, Certification of Compliance Agreements, and settlement agreements with integrity provisions are listed on OIG's Web site at: [http://www.oig.hhs.gov/fraud/cia/cia\\_list.asp](http://www.oig.hhs.gov/fraud/cia/cia_list.asp).

5. Review of Entities That Do Not Enter Into Corporate Integrity Agreements (NEW) - OIG will review entities, including providers and/or suppliers that settled fraud cases with the Government but declined to enter into CIAs with OIG. CIAs promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all Federal health care programs, as defined in 42 U.S.C. § 1320a-7b(f). OIG reviews may be similar to or more extensive than those that would be performed by Independent Review Organizations under CIAs to assess the entity's compliance with Federal health care program standards. (OAS; W-00-12-30070; various reviews; expected issue date: FY 2012; new start)
6. Advisory Opinions and Other Industry Guidance - To foster compliance by providers and industry groups, OIG responds to requests for formal advisory opinions on applying the anti-kickback statute and other fraud and abuse statutes to specific business arrangements or practices. Advisory opinions provide meaningful advice on statutes in specific factual situations. OIG also issue special fraud alerts and advisory bulletins about practices that OIG determines are suspect and CPG for specific areas. Examples are available on OIG's Web site at:
  - Advisory Opinions: <http://www.oig.hhs.gov/fraud/advisoryopinions.asp>
  - Fraud Alerts: <http://www.oig.hhs.gov/fraud/fraudalerts.asp>
  - Compliance Guidance: <http://www.oig.hhs.gov/fraud/complianceguidance.asp>
  - Open Letters: <http://www.oig.hhs.gov/fraud/openletters.asp>
7. Provider Compliance Training - In spring 2011, OIG and its government partners provided in-person provider compliance training in Houston, Tampa, Kansas City, Baton Rouge, Denver, and Washington, D.C. The training sessions focused on the realities of Medicare and Medicaid fraud and the importance of implementing an effective compliance program. To expand access to providers nationwide, OIG broadcasted a free online live Webcast of the May 18 training in Washington. A complete video of the training as well as 16 video modules containing individual presentations from May 18 are available on OIG's Provider Compliance Training Web site along with slides and written handouts corresponding to each session. OIG provider compliance training effort continues.
8. Provider Self-Disclosure - OIG is committed to assisting health care providers and suppliers in detecting and preventing fraudulent and abusive practices. Since 1998, OIG has made available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. The Provider Self-Disclosure Protocol gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation might entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from participation in Federal health care programs. The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in being overpaid by a Federal program). After making an initial disclosure, the provider or supplier is

expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

- The self-disclosure guidelines are available on the OIG Web site at <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>
- See also: Open Letters at <http://www.oig.hhs.gov/fraud/openletters.asp>

#### Investigative Activities:

1. Medicare Strike Force Teams and Other Collaboration - OIG devotes significant resources to investigating Medicare and Medicaid fraud. OIG conducts investigations in conjunction with other law enforcement entities, such as the Federal Bureau of Investigation, the United States Postal Inspection Service, the Internal Revenue Service and State Medicaid Fraud Control Units (MFCU).

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and DOJ to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse. Using a collaborative model, Medicare Fraud Strike Force teams coordinate law enforcement operations among Federal, State, and local law enforcement entities. These teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force teams began in March 2007 and are operating in nine major cities. The effectiveness of the Strike Force model is enhanced by interagency collaboration within the Department of Health & Human Services (HHS). For example, OIG refers credible allegations of fraud to the Centers for Medicare & Medicaid Services (CMS) so it can suspend payments to perpetrators. During Strike Force operations, OIG and CMS work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets.

OIG and its partners investigate individuals, facilities, or entities that, for example, bill or are alleged to have billed Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes to inflate reimbursement amounts, and false claims submitted to obtain program funds. OIG also investigate business arrangements that allegedly violate the Federal health care anti-kickback statute and the statutory limitation on self-referrals by physicians.

OIG also examines quality-of-care issues in nursing facilities, institutions, community-based settings, and other care settings and instances in which the programs may have been billed for medically unnecessary services, for services either not rendered or not rendered as prescribed, or for substandard care that is so deficient that it constitutes “worthless services.”

Other areas of investigation include Medicare and Medicaid drug benefit issues and assisting CMS in identifying program vulnerabilities and schemes such as prescription shorting (a pharmacy dispensing fewer doses of a drug than prescribed, charging the full amount, and then instructing the customer to return to pick up the remainder). Working with law enforcement partners at the Federal, State, and local levels, OIG investigates schemes to illegally market, obtain, and distribute prescription drugs. In doing so, OIG seeks to protect Medicare and Medicaid from making improper payments, deter the illegal use of prescription drugs, and to curb the danger associated with street distribution of highly addictive medications. OIG assists

State MFCUs to investigate allegations of false claims submitted to Medicaid and will continue to strengthen coordination between OIG and organizations such as the National Association of Medicaid Fraud Control Units and the National Association for Medicaid Program Integrity.

Highlights of recent enforcement actions to which OIG has contributed are posted to OIG's Web site at: <http://www.oig.hhs.gov/fraud/enforcement/criminal/>.

**Under Part VI: Human Service Reviews:**

**Administration on Aging:**

1. Performance Data for the Senior Medicare Patrol Projects - OIG will review Medicare and Medicaid monetary recoveries attributable to the Senior Medicare Patrol projects, including documentation supporting amounts recovered for the Medicare and Medicaid programs, beneficiaries, and providers. This information will support AoA's efforts to evaluate and improve the performance of the projects. In 1997, AoA established demonstration projects that recruit retired professionals to serve as educators and counselors to help beneficiaries detect fraud, waste, and abuse in the Medicare and Medicaid programs. The initiative stemmed from recommendations in a congressional committee report accompanying the Omnibus Consolidated Appropriations Act of 1997. (OEI; 00-00-00000; expected issue date: FY 2012; new start)
2. State Long-Term-Care Ombudsman Programs: Efforts To Identify, Investigate, and Resolve Elder Abuse Cases (NEW) - OIG will determine whether Ombudsmen follow statutory requirements to identify, investigate, and resolve elder abuse cases. (42 U.S.C. § 3058g(a)(3)(A).) OIG will also assess AoA's oversight of the ombudsman programs. Ombudsman responsibilities include identifying, investigating, and resolving cases made by or on behalf of residents in long-term-care facilities, including cases involving elder abuse. (42 U.S.C. § 3058g(a)(3)(A).) AoA's data on elder abuse show significant variation between State Long-Term-Care Ombudsman programs. AoA administers the State Long-Term-Care Ombudsman programs pursuant to 42 U.S.C. § 3058g, as set forth by the Older Americans Act Amendments of 2000, § 704. (OEI; 00-00-00000; expected issue date: FY 2012; new start)