HEALTH CAPITAL Topics

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Office of Inspector General (OIG) Work Plan 2009 Overview

The Office of Inspector General (OIG) recently issued its 2009 Work Plan,[1] in which it details those enforcement activities which it plans to initiate or continue reviewing regarding the programs and operations of the Department of Health and Human Services. The 2009 Work Plan includes proposed changes for both Medicare (Parts A, B, C, and D) and Medicaid. [2]

One particular focus of the 2009 Work Plan is to review *provider-based* status for inpatient and outpatient facilities, as well as hospital ownership of physician practices. A *provider-based entity* is defined as:

> *"a provider of health care services…that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider…. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility".*[3]

Further, *provider-based status* is "*the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of [the provider-based rule].*"[4] When a hospital is the main provider under such a relationship, services provided at the provider-based entity qualify for hospital-level inpatient or outpatient reimbursement rates, rather than freestanding facility rates.[5] According to OIG, freestanding facilities can also benefit from such arrangements through "*enhanced disproportionate share hospital (DSH) payments, upper payment limit (UPL) payments, or graduate medical education payments for which they would not normally be eligible.*"[6]

The OIG 2009 Work Plan addresses *provider-based status* through two different cost-report reviews: one focusing on the variety of compliance issues arising from the regulations; and, the second focused on whether hospital-owned physician practices properly hold the claimed provider-based designation.[7] Part of the reasoning behind the OIG's review is the ongoing issue of hospitals that bill Medicare for reimbursement under the provider-based rates for services provided in off-site entities that are not appropriately approved provider-based entities.[8] Because Medicare reimbursement rates are higher for provider-based entities than they are for freestanding entities, improperly claimed provider-based status has the potential to increase costs to the Medicare Program resulting from the higher reimbursement rates associated with provider-based entity relationships.[9] An additional concern the OIG will consider in its review is the possibility of increase coinsurance liability for Medicare beneficiaries due to provider-based status for outpatient clinics.[10] The OIG plans to review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities to determine the impact on the Medicare Program resulting from hospitals which improperly claim such provider-based status.[11]

Additionally, under Medicare Part A, the 2009 Work Plan seeks to review hospital wage data that has been used to calculate the Hospital Inpatient Prospective Payment System (IPPS) to determine if hospitals have been complying with Medicare requirements for reporting wage data. This proposal is due to "*hundreds of millions of dollars in misreported wage data.*"[12] The OIG will also review DSH payments and payments for new services and technologies to ensure appropriate submittals by hospitals. Further, in response to the recent passage of non-payment for "*Never Events*," the OIG will evaluate the "*extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events; and the extent to which beneficiaries paid for such services.*" [13]

Under Medicare Part B, the OIG will review medical records to evaluate CMS' Comprehensive Error Rate Testing (CERT) methodology in order to determine if patients were "*home bound*" at the time of discharge as well as if there was supporting documentation that sufficiently documented the need for home health services. Because the OIG found that 31% of claims submitted for Part B mental health services did not meet appropriate guidelines (thereby resulting in $185 in over-payments), the OIG will evaluate the

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mental health needs of patients in nursing homes to determine appropriateness of the level of care received. The OIG will look specifically for appropriateness in patients who were over the age of 65 and received antipsychotic drugs. Additionally, the OIG will review payments to Medicare providers for colonoscopy to ensure physicians were appropriate billing Medicare for their services. Given that a 2006 OIG review found improper payments to Independent Diagnostic Testing Facilities (IDTF) of over $71.5 million, the OIG seeks to review the provider and beneficiary profiles and billing patterns of geographic areas with a high concentration of IDTFs.[14]

The 2009 Work Plan for Medicare Part B also addresses several items for review that involve payment for durable medical equipment (DME). Interviews with home health providers and reviews of DME users have found that home health patients often did not need the DME prescribed, and in some cases, such as power mobility devices, the DME *"was not ordered by physicians, not delivered to the beneficiaries, or not needed by the beneficiaries."*[15] Accordingly, the OIG will review Part B claims for DME for home health services and nursing home services, with a specific focus on DME used for prosthetics, orthotics, power mobility devices, blood glucose testing strips, and pressure reducing support surfaces.[16]

Under Medicare Part C, the 2009 Work Plan outlines its intent to review capitated payments sent to Medicare Advantage Plans. The OIG will examine payments for enrollees who are deceased as well as payments that have continued when a beneficiary has disenrolled from a plan.[17]

The 2009 Work Plan focus under Medicare Part D will examine duplicate payments for Part D drugs, which may occur when a beneficiary has changed plans, as well as to review duplicate payments between Medicare A, B and Medicare D. In response to the "Donut Hole," or coverage gap, present in Part D (i.e., when a beneficiary has reached his cost-sharing limit and must cover 100% of the cost until that individual reaches that out of pocket threshold), the OIG will review the out of pocket costs for beneficiaries; levels of catastrophic coverage; and, payment for beneficiaries who entered into the coverage gap. Additionally, the OIG will compare reimbursement rates for Medicare Part D and Medicaid and may use the comparison to suggest adjustments in future Medicare drug reimbursement.[18]

Finally, in its review of Medicaid services, the OIG will examine DSH funding provided to hospitals to pay for individuals residing in institutions for mental illnesses. The OIG will also review individual state controls to prevent excessive Medicaid payments to providers of both inpatient and outpatient services. Given that many nursing facilities are owned by private equity or investor firms, the OIG will review the ownership structure of these facilities to help determine if that entity is legally liable for the care of the patients and will also examine their cost-cutting strategies to determine if they have compromised the level of quality care.[19] Additionally, the OIG will review claims to determine if providers billed for more time than is feasible in a day. Also focusing on providers, the OIG will review states' own processes for not enrolling excluded providers. While states are required to review the background of providers, many states do not verify the information. The 2009 Work Plan outlines its intention to review the overall process of enrolling Medicaid providers as well as how much excluded providers have been reimbursed by Medicaid.[20]

[1] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).
[2] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, page i, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).
[3] 42 C.F.R. § 413.65(a)(2).
[4] 42 C.F. R. §413.65(a)(2).
[5] "OIG Work Plan Focuses on Quality, DME, and Part D," Legal News Alert, Foley & Lardner, LLP, October 14, 2008, http://www.foley.com/publications/pub_detail.aspx?pubid=5369 (Accessed 11/25/08).
[6] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, page 4, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).
[7] "OIG Work Plan Focuses on Quality, DME, and Part D," Legal News Alert, Foley & Lardner, LLP, October 14, 2008, http://www.foley.com/publications/pub_detail.aspx?pubid=5369 (Accessed 11/25/08).
[8] "HCFA Management of Provider-Based Reimbursement to

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Hospitals," By June Gibbs Brown, Inspector General, Department of Health and Human Services, August 2000, http://www.oig.hhs.gov/oei/reports/oei-04-97-00090.pdf (Accessed 11/25/08).

[9] "HCFA Management of Provider-Based Reimbursement to Hospitals," By June Gibbs Brown, Inspector General, Department of Health and Human Services, August 2000, http://www.oig.hhs.gov/oei/reports/oei-04-97-00090.pdf (Accessed 11/25/08).

[10] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 4, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[11] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 4, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[12] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 4, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[13] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, pp. 4-8, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[14] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 8-15 http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08),

[15] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 18 http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[16] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 18-22, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[17] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 31-32, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[18] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 34-41, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[19] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 43-45, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

[20] "Work Plan Fiscal Year 2009," Office of Inspector General, Department of Health and Human Services, p. 54-57, http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf (Accessed 11/25/08).

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

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