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KILLIAN HEATH & LYMAN

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OIG RELEASES ITS 2014 COMPENDIUM OF PRIORITY RECOMMENDATIONS

WHAT IS THE "COMPENDIUM OF PRIORITY RECOMMENDATIONS"?

In March 2014, the Department of Health and Human Services Office of the Inspector General ("OIG") published the 2014 "Compendium of Priority Recommendations" ("Compendium"), a compilation of 25 of its most significant open recommendations that, in OIG's view, would best protect the integrity of HHS programs, if implemented. These recommendations, previously published in past OIG audit and evaluation reports and then summarized in *Semiannual Reports to Congress*, identify "problems, abuses or deficiencies" in HHS programs for which corrective actions have not been completed, which, if pursued, could save money, improve program management and ensure safety and quality of care for beneficiaries.

The programs of the Centers for Medicare and Medicaid Services ("CMS"), which include Medicare, Medicaid and the Children's Health Insurance Program, account for about 80% of HHS's budget. HHS oversees other agencies and programs, including the FDA, HRSA, the CDC and NIH. This article will summarize some of the Compendium's significant recommendations affecting CMS programs.

In addition to the Compendium, OIG publishes an annual "Work Plan." The Work Plan *differs* from the Compendium insofar as the Work Plan identifies OIG's audit and enforcement-related work in progress and new projects for the upcoming year. The Compendium identifies older, significant recommendations (many of which derive from past years' Work Plans), OIG believes should be resurrected and implemented by legislative, regulatory or administrative action or some combination of these in order to protect the integrity of HHS programs.

Although many of the recommendations in the Compendium have received some attention by providers, OIG believes that more progress can be achieved. The Compendium succinctly outlines the issues, links those issues to previous OIG work and provides specific recommendations to assist providers in moving forward. This article summarizes a handful of OIG key initiatives. The Compendium can be found here.

A SUMMARY OF SELECT COMPENDIUM RECOMMENDATIONS AFFECTING CMS PROGRAMS

1. *Problem: Wasteful Medicare Policies and Payment Rates for Clinical Labs*. OIG determined that Medicare pays more for clinical lab tests than other insurers. In 2011 alone, Medicare could have saved $910 million on 20 high volume/high expenditure lab tests if it had paid lab providers at the lowest established rate for the particular geographical area. Additional savings could be achieved if Medicare reinstates beneficiary co-pays and deductibles.*Recommendation*: OIG recommends pursuing legislation that would permit CMS to establish lower payment rates for lab tests and to reinstate beneficiary copays and deductibles.

2. *Problem: Wasteful Medicare Policies and Payment Rates for Critical Access Hospitals.*
   a. Background. CMS created a critical access hospital ("CAH") certification to ensure rural beneficiary access to hospital services. In order to be designated as a CAH, which is reimbursed by Medicare at 101% of its reasonable costs (higher than payment rates under the inpatient and outpatient prospective payment systems), the CAH must meet certain "location" requirements. The hospital must be located in a rural area (rural requirement), and it must be located more than 35 miles from the nearest hospital or CAH, or, in the case of mountainous terrain, more than 15 miles from the nearest hospital or CAH (distance requirement). CAHs, further designated as "necessary provider" ("NP") CAHs, are permanently exempt from the so-called distance requirement, again, to ensure access to care.

   b. Waste Issue. OIG determined that two-thirds of CAHs would not meet the location requirements, and the majority of CAHs would not meet the distance requirements if required to re-enroll in Medicare today. Further, if CMS had decertified CAHs that were 15 or fewer miles from their nearest hospitals in 2011 and paid them at the non-CAH rates, Medicare would have saved $449 million.

      Recommendation: OIG recommends securing legislative authority to remove NP CAHs' permanent exemption from the distance requirement thereby permitting CMS to reassess CAHs on a case-by-case basis. It also recommends revision of the CAH conditions of participation ("CoPs") to allow for alternative location-related requirements, periodic review of CAHs' compliance with location-related CoPs and application of a uniform definition of "mountainous terrain" to all CAHs.

3. Problem: Hospital Payment Policies and Transition of Care - the DRG Payment Window and Early Transfers to Hospice.
   a. Background. The 72-hour rule or DRG payment window provides that diagnostic services and non-diagnostic services clinically related to an inpatient admission, provided by a wholly-owned or operated hospital entity within 72 hours of the inpatient admission, are not separately reimbursed but paid as part of the lump sum DRG inpatient payment.In a separate transition of care-related payment policy, currently, Medicare pays discharging hospitals a reduced rate for early discharges to other care settings. This early discharge reduced payment policy does not apply to transfers to hospice care.

   b. Waste Issue. OIG concluded in a February 2014 report that expanding the window of time covered by Medicare's lump sum payments for inpatient care to a period beyond 72 hours would save millions of dollars. In a May 2013 report, OIG found that if Medicare had implemented a hospital transfer payment policy for early discharges from hospitals to hospice care in 2009 and 2010, it could have saved over $600 million. 30% of all hospital discharges to hospice care were early discharges that could have resulted in reduced payments.

   Recommendation: OIG recommends that CMS:

   - Seek legislative authority to expand the length of the DRG payment window to a period beyond 72 hours;
   - Seek legislative authority to apply the expanded DRG window to other hospital ownership structures such as affiliated hospital groups; and
   - Amend the regulations to establish a hospital transfer payment policy providing for reduced payment for early discharges to hospice care.

4. *Problem: Hospices May Seek Beneficiaries in Nursing Homes*. Medicare pays hospices an all-inclusive daily rate under Medicare Part A. OIG observed that Medicare spending on hospice care for nursing facility residents increased nearly 70% from $2.55 billion in 2005 to $4.31 billion in 2009, an increase unaccounted for by beneficiary demographics.

   Recommendation: OIG recommends:

   - Monitoring Medicare hospices that depend heavily on nursing facility residents; and
   - Considering whether the integrity of the Medicare program would be best protected by modifying the payment system for hospice care in nursing facilities.

5. *Problem: Improper Billing by Community Mental Health Centers ("CMHCs"), Home Health Agencies ("HHAs") and Skilled Nursing Facilities ("SNFs").* OIG reported the following:
   - In 2010, at least half of the CMHCs reviewed met or exceeded thresholds that indicate unusually high billing for at least one of nine questionable billing characteristics; more than 90% of the CMHCs with billing issues were in states that do not require licensure or certification of CMHCs;
   - One in four HHAs reviewed exceeded a threshold that indicated unusually high billing for at least one of six measures of questionable billing. Further, HHAs owed CMS $408 million in known overpayments incurred between 2007 and 2011. At least $39 million could have been recovered if CMS had required each HHA to obtain a $50,000 surety bond. SNFs submit inaccurate, medically unnecessary and fraudulent claims with a big increase in payments noted for "ultra-high" therapy; and
   - SNFs billed one quarter of all claims in error in 2009.

   Recommendation: OIG recommends reviewing and taking appropriate actions against CMHCs, HHAs and SNFs with questionable billing; monitoring billing and payments to CMHCs and HHAs; and implementing an HHA surety bond requirement. OIG also advises changing the current method for determining how much therapy is required to ensure appropriate payments, and improving the monitoring of SNFs that disproportionately bill for higher paying resource utilization groups.

6. *Problem: Medicare Makes Improper Payments for Services to Incarcerated, Unlawfully Present (1) or Deceased Individuals. OIG determined that between 2009 and 2011, CMS paid a staggering $33.6 million on behalf of incarcerated beneficiaries in Part A and Part*

B. (Prisons, not Medicare, pay the health care costs of otherwise eligible incarcerated beneficiaries.) During the same period, CMS erroneously paid $91.6 million to unlawfully present beneficiaries in Part B and, in 2011, Medicare paid $23 million for dates of service after beneficiaries' deaths.

Recommendation: OIG recommends improving existing safeguards to detect and recoup future improper payments of this kind. This may include working with other entities (e.g., Social Security Administration) to improve the timeliness of receipt of incarceration information and implementing policies not only to detect but also to recoup improper payments made on behalf of incarcerated, deceased and unlawfully present beneficiaries.

7. *Problem: Medicare Hospital Outlier Payments.* Outlier payments are extra payments hospitals receive for cases that are extraordinarily expensive. OIG reported on the existence of "high-outlier" hospitals that charge Medicare significantly more for the same DRG groups even though their patients had similar lengths of stay as patients in other hospitals.

   Recommendation: OIG recommends instructing Medicare contractors to increase the monitoring of outlier patients and implementing an automated system that will recalculate outlier claims to facilitate reconciliations.

8. *Problem: Medicare Part C and Waste, Fraud and Abuse Programs. OIG reported that 19% of the Medicare Advantage ("MA") organizations it reviewed reported no potential fraud and abuse incidents in 2009.* Further, 95% of incidents reported were identified by only 3 of 137 organizations reporting.

   Recommendation: OIG intends to ensure that MA organizations are implementing fraud and abuse detection programs as required by their compliance plans. It also recommends:

   - Reviewing MA organizations to determine why particular organizations reported substantially high or low volume of potential Part C and D fraud and abuse incidents;
   - Requiring MA organizations to report to CMS aggregate data on their fraud and abuse initiatives; and
   - Developing specific guidance for MA organizations in defining potential Part C and D fraud and abuse incidents and inquiries.

9. *Problem: Medicare Part D - Questionable Billing and Prescribing Practices for Prescription Drugs.*
   a. Background. Under Medicare Part D, CMS contracts with private insurance companies (sponsors) to provide prescription drug coverage to beneficiaries who elect this benefit. Sponsors submit prescription drug event records ("PDE") to CMS for each prescription dispensed to beneficiaries enrolled in their plans. Each PDE has information about the pharmacy, prescriber, beneficiary and drug. OIG analyzed all of the PDE records for 2009 and identified a number of questionable billing and prescribing practices for prescription drugs, including Schedule II drugs.

   b. Waste/Abuse Issues. OIG reported on 2,600 pharmacies with very high billing for at least one of eight measures of questionable billing. For example, many pharmacies billed very high dollar amounts or had unusually high numbers of prescriptions per beneficiary or per prescriber. OIG also identified 700 general-care physicians with high, aberrant prescribing practices, as well as high numbers of incidents in which controlled substances were prescribed by individuals without prescriptive authority. Notably, $25 million of Schedule II drugs were billed as refills in 2009, in violation of federal law.

      Recommendation: OIG made a number of recommendations addressing Part D fraud and abuse:

   - Strengthen integrity contractors' monitoring of pharmacies and prescribers and instruct contractors to expand their analysis of prescribers;
   - Follow up on pharmacies identified as having questionable billing practices
   - Require Part D sponsors to refer potential fraud and abuse that may warrant investigation;
   - Ensure that Medicare does not pay for prescriptions from unauthorized prescribers; and
   - Exclude Schedule II refills when calculating payments to sponsors.

10. *Problem: Substandard Treatment and Inadequate Resident Monitoring in Nursing Homes.* A February 2014 report revealed that about 33% of beneficiaries experienced adverse events during a SNF stay. Of these events, 59% were "clearly or likely preventable" and resulted from "substandard treatment, inadequate resident monitoring or delay of necessary care." A 2011 report questioned safeguards against inappropriate use of antipsychotic medications for nursing home residents. OIG reviewed a six-month period in 2007 and found that a staggering 95% of claims for antipsychotic drugs were used for nursing home residents' conditions for which the drugs' use were not approved by the FDA or were prescribed for residents with dementia, the very condition specified in an FDA warning about these antipsychotic drugs. OIG made 10 separate recommendations in the Compendium, a few of which are listed below.

    Recommendation: OIG recommends:

    - CMS should include potential events and information about resident harm in its quality guidance to nursing homes;
    - Nursing home surveyors should be instructed to review facility practices for identifying and reducing adverse events;
    - CMS should assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes; and
    - Take action with respect to claims determined by OIG to have been erroneously paid.

PRACTICAL TAKEAWAYS

The Compendium is significant because OIG's recommendations, though not brand new, have been revived, suggesting that OIG sees room for improvement and intends to pursue them. No provider is immune from scrutiny, nor is CMS, its contractors or even states. Given the anticipated activity surrounding OIG's recommendations, providers should determine which recommendations apply to them and take deliberate action, as necessary, as part of an effective compliance program.

Some of OIG's recommendations are certainly controversial. For example, in the case of CAHs, more restrictive location requirements and reduced CAH payments, if implemented, could cause multiple small hospital closures and decreased access to health care for rural patients.2 We would expect to see political advocacy by CAH administrators, national and local Rural Health Associations and the American Hospital Association to try to shape or temper certain proposed changes.

Few would argue with the notion that improving program safeguards to prevent Medicare payments to providers for services rendered to deceased or incarcerated individuals is a laudable goal, promising enormous cost-savings to CMS and imposing no legitimate hardship on providers. However, this is not the case with respect to OIG's recommendation to lengthen the DRG payment window. Though consistent with the trend toward more payment bundling, the inclusion of many additional services in the lump sum inpatient DRG payment will, likely, further exacerbate the financial stress hospitals are under today.

Although this article touches on only a handful of OIG's many recommendations, primarily those involving Medicare policies and payments to hospitals, the other recommendations are equally important and include: Medicare Quality of Care and Safety Issues; Medicaid Program Policies and Payments; Medicaid Quality of Care and Safety Issues; Oversight of Food Safety; HHS Grants and Contracts; and HHS Financial Stewardship. The Compendium is a valuable resource to assist a wide array of providers in identifying areas of potential risk and to help direct future compliance initiatives. The Compendium further illustrates how vitally important it is for providers to continue to take a leading role in advancing health policy initiatives, particularly when proposed measures impact care and reimbursement.

If you have any questions or would like additional information about this topic, please contact:

- Adele Merenstein at (317) 752-4427 or amerenst@hallrender.com;
- Katherine A. Kuchan at (414) 721-0479 or kkuchan@hallrender.com; or
- Your regular Hall Render attorney.

Please visit the Hall Render Blog at http://blogs.hallrender.com/ for more information on topics related to health care law.

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1 An "unlawfully present" individual refers to an alien beneficiary who was not lawfully present in the United States on the date of service.

2 "Big Changes Ahead for CAH Program?" AHA News, November 8, 2013, available here.