OIG Work Plan Hot Topics

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2017 OIG Work Plan Hot Topics

• Wage data
• Quality reporting and electronic health record program issues
• Hospice
• Medicare Advantage and Medicaid managed care encounter data
• Medicaid healthcare-acquired condition/provider preventable condition payments
• Will review hospital controls over wage data reported
• Prior OIG work showed substantial incorrect reporting (according to the OIG)
• Prior work led to significant change in policy regarding deferred compensation costs
• Status of litigation challenging policy change for fiscal years 2007 and 2008
Hospital Wage Data

- Issues in prior OIG audit:
  - Pension and other deferred compensation costs (unliquidated liabilities)
  - Fringe benefits costs relating to nonallowable activities
  - Unsupported contract labor costs
  - Physician and nurse practitioner costs for services separately billable to Part B
  - Misstated or misclassified hours and wages

Electronic Health Records and Quality Reporting
Medicare and Medicaid Electronic Health Record (EHR) Payments

- More than $30 billion in incentives have been paid through the two EHR incentive programs. “These programs may be at greater risk of improper payments than other programs because they have complex requirements.”
- Focus on Work Plan on Medicare EHR payments (failing to meet meaningful use) and security of certified EHR technology
- Both have been reviewed in CMS audits

Medi-Cal EHR Payments

- Prior work plans included audits of Medicaid incentive payments for adopting electronic health records
- Subsequently:
  - OIG Audits
  - Medi-Cal Inquiry
  - Medi-Cal Audits
Structure of Medicaid EHR Program

- Program is entirely funded by federal funds, but implemented by states
- Payment methodology established by federal statute and federal regulations, but in general terms
- Perambulatory text in *Federal Register* reflects CMS view on specific terms, but not codified in regulations
- Program implemented by states via various State Medicaid Health Information Technology Plans (SMHPs)

Payments under Medicaid EHR Programs

- Payments made based on “estimates”; no reconciliation like the Medicare EHR program
- Aggregate Medicaid EHR incentive payment is equal to the product of the overall EHR amount and the Medicaid share for a theoretical four-year period (explained on next slide)
Overall EHR Amount and Medicaid Share

- The overall EHR amount is equal to the product of the initial amount, the Medicare share and the transition factor
  - The initial amount is equal to the sum of the base amount of $2 million plus the discharge related amount. The discharge related amount is based on the number of inpatient discharges and a growth rate based on the average annual growth rate over the prior three years’ cost reports
  - The Medicare share is equal to 1
  - The transition factor is 1 for the first of the theoretical 4 years, \( \frac{3}{4} \) for the second of the theoretical 4 years, \( \frac{1}{2} \) for the third of the theoretical 4 years and \( \frac{1}{4} \) for the fourth of the theoretical 4 years

Overall EHR Amount and Medicaid Share

- The Medicaid share is equal to a ratio for which the numerator is the “estimated number of acute-care inpatient bed days which are attributable to” Medicaid fee-for-service and managed care individuals and for which the denominator is the product of the “estimated number of acute-care inpatient bed days” for all payors and the “estimated total amount of the eligible hospital’s charges during such period[.]”
OIG Audit of Medicaid EHR Payments

- OIG conducted audits of numerous states regarding their implementation of Medicaid EHR programs
- OIG issued California findings on September 29, 2016
- Audit of 64 hospitals that received 53% of Medi-Cal EHR payments
- OIG found overpayments to 61 hospitals, total of $22 million

OIG Audit of Medicaid EHR Payments

OIG findings based on inclusion of:
- Unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (30 hospitals);
- Non-acute-care services (23 hospitals);
- Hospital data not supported by documentation required to be retained (21 hospitals);
- Bad debt within charity-care charges (13 hospitals);
- Medicaid dual-eligible acute inpatient bed-days in the numerator (5 hospitals); and
- Clerical errors, such as reporting an incorrect charity-care charge because of a keying error (5 hospitals)
OIG Audit of Medicaid EHR Payments

OIG also found the following should have been included:

- Labor and delivery services (12 hospitals),
- NICU services (10 hospitals), and
- Intensive-care services (8 hospitals)

Some errors were caused by the instructions from DHCS as to what cost report fields to submit in attestation; instructions were approved by CMS

Correspondence from DHCS to Hospitals

- In December, many hospitals received e-mails from DHCS requesting responses to OIG findings
- Different e-mails based on different circumstances of hospitals, many errors!
- Some e-mails required response for program year 2016 attestation to be unlocked
- Some e-mails indicated future audit by DHCS
- No instruction on report/repay obligations
DHCS Audits

• General confusion about audit process
• Some audits have concluded and applied non-OIG methodology
• Audits have used different data sources
• Appears to be a reconciliation, even though Medicaid statute does not allow one
• Some audits are now under appeal before the Office of Administrative Hearings and Appeals

Work Plan Focuses on Quality Reporting Data

• CMS to conduct validation of hospital inpatient quality reporting data for hospital value-based purchasing program and hospital acquired condition reduction program
• For EHR incentive payments, CMS has not been concerned about accuracy of data, so long as it comes from certified EHR technology
• Difficult for providers with “buggy” software
Updates on EHR Attestation and IQR Submission and Tips

- On February 6, 2017, CMS extended deadline to submit for program year 2016 to March 13, 2017
- Confirm timely and correct filing, even if using a contractor (problems with timeliness, file types for IQRs)
- Confirm contact e-mails address and monitor incoming e-mails
- Monitor appeal deadlines closely

Hospice Audits
Hospice Audits

• Will summarize OIG prior work on Medicare hospices and highlight key recommendations
• Hospice has been a hot area for investigations

Hospice Audits

• Issues include:
  • Certificates of Terminal Illness
  • Medical necessity (does patient have a terminal condition?)
  • Kickbacks for hospice elections
  • Billing for general inpatient care
  • Inadequate/false notice of election
  • Face-to-face visit requirement
Medicare Advantage and Medicaid Managed Care Encounter Data

Integrity of Medicare Advantage Encounter and Risk Adjustment Data

- Encounter data utilized to determine utilization for plan payments (both Medicare Advantage and Medi-Cal managed care)
- Likewise, plan payments risk adjustment to determine plan payments
  - CMS estimates 9.5% of payments to Medicare Advantage organizations improper due to unsupported diagnoses
CMS Audits of Medicare Advantage Plans

- CMS audits approximately 5% of Medicare Advantage organizations per year for risk adjustment data validation
- Audited through review of medical records
- Providers continue to receive requests both for CMS audits and for Medicare Advantage organizations’ internal reviews

Encounter Data

- OIG to review CMS’ oversight of Medicare Advantage (MA) encounter data validation and assess the extent to which CMS’ Integrated Data Repository contains timely, valid, and complete MA encounter data
- Both Medicare Advantage organizations and Medicaid managed care plans required to implement compliance plans (Medicaid effective 7/1/17)
- Increased sensitivity from plans regarding accuracy and statements supporting accuracy of encounter data
Medicaid Provider Preventable Conditions Reporting/Payments

Provider Preventable Conditions

- Since 2011, federal law prohibits Medicaid payment for healthcare-acquired conditions and provider-preventable conditions as identified in state plans
- DHCS implemented effective July 1, 2012
- State plan governs non-payment and reporting requirement
Provider Preventable Conditions

- Provider Preventable Conditions consist of Healthcare-Acquired Conditions and Other Provider-Preventable Conditions
- Healthcare-Acquired Conditions consist of the 11 hospital-acquired conditions defined by Medicare, except Medicaid does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age
- Other Provider-Preventable Conditions are: wrong surgery/invasive procedure; surgery/invasive procedure performed on the wrong patient and surgery/invasive procedure performed on the wrong body part

Hospitals must report both Healthcare-Acquired Conditions and Provider-Preventable Conditions “that are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available”
- Form at http://files.medi-cal.ca.gov/pubsdoco/Forms/dhcs_7107.pdf
- Reporting should occur after discovery and confirmation that the patient is a Medi-Cal beneficiary; should be sent within five working days of discovery
- No need to report conditions present on admission
- Report should go to DHCS and to plan (if contracted). Preference is to send by secure fax
Provider Preventable Conditions

- Process different than Medicare; adjustments not made solely based on coding
- After submission of report, Audits and Investigations to review to determine whether any adjustment to be made to payments
  - Adjustment directly to fee-for-service payment or capitation payment
  - DRG payments will be adjusted by excluding diagnoses and procedures attributable to provider preventable condition

Questions?
Thank you

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