U.S. Department of Health and Human Services

Presentation at Third National Medicare RAC Summit

March 4, 2010

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HHS OIG FY 2010 WORK PLAN

Creation, Execution, Use of Results

OIG MISSION

- Protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs.
- OIG responsible to report both to the Secretary and to the Congress program and management problems and recommendations to correct them.
- OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions performed by OIG components.

Inspector General
Daniel Levinson

Office of Inspector General Organization Chart

- Inspector General
  - Principal Deputy Inspector General
    - Deputy Inspector General for Audit Services
      - Deputy Inspector General for Evaluation and Inspections
        - Deputy Inspector General for Management and Policy
    - Deputy Inspector General for Investigations
      - Chief Counsel to the Inspector General

The Inspector General is appointed by the President with Senate confirmation.

OIG Work Products: (www.oig.hhs.gov)

- Publications
  - HCFAC Program Report
  - MFCU Annual Report
  - Semiannual Report
  - Top Management Challenges
  - Unimplemented Recommendations
  - Work Plan

- Audit/Evaluation Reports

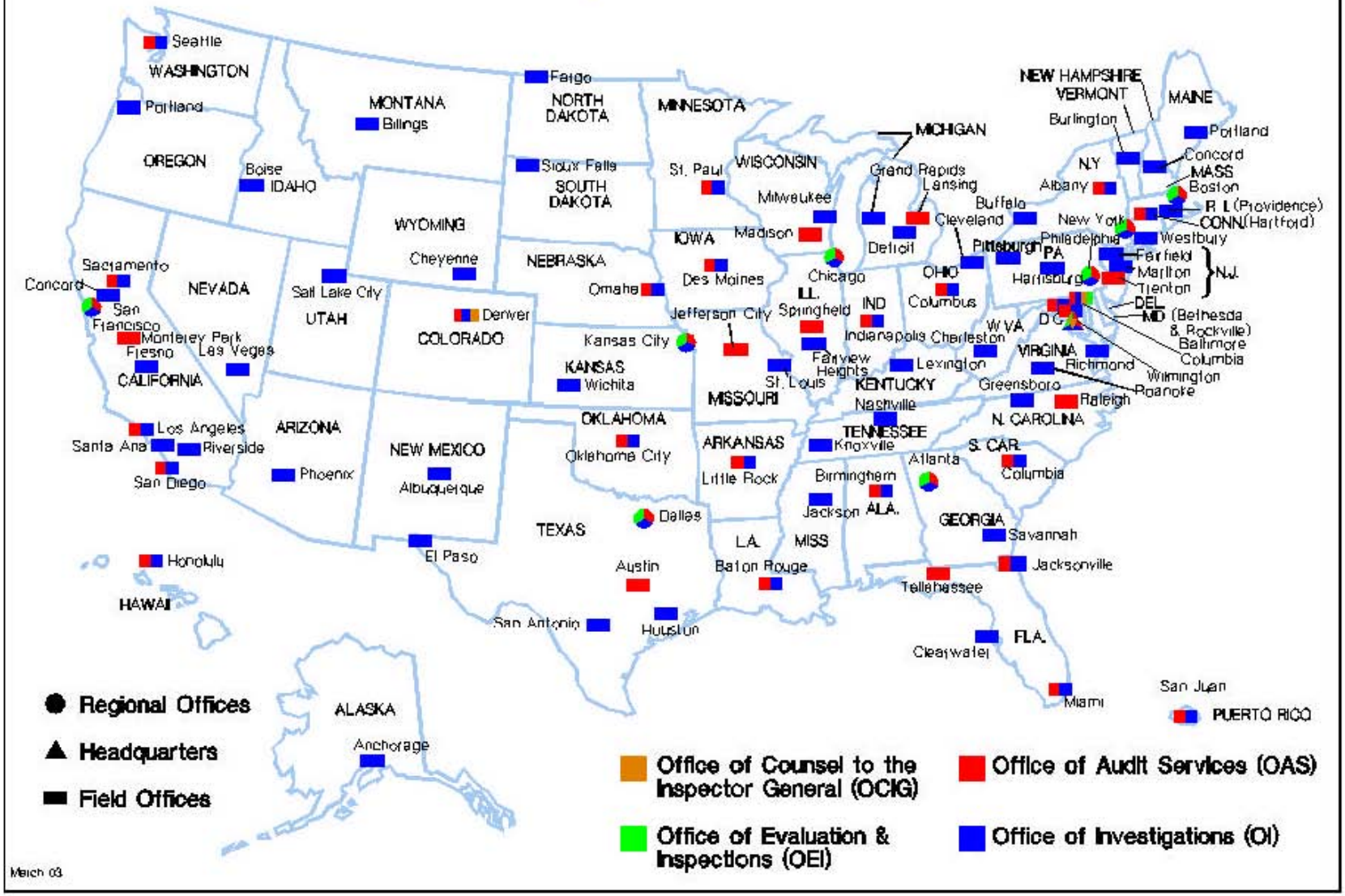
OIG Work Products (cont'd)

- Hearing Testimonies
- Fraud Prevention and Detection
  - Advisory Opinions/Alerts/Bulletins
  - Compliance Guidance/Integrity Agreements
  - Exclusion Program

Differences in Programs

- Medicare
  - Large Federal Insurance Company
  - Does not Own Health Care Providers
  - Relies on Contractors to Pay Claims and Perform Oversight
- Medicaid
  - 50 Different State Programs---Follow General Federal Guidelines
  - States Can Own Health Care Providers
  - Rely on Contractors to Pay Claims and Perform Some Oversight
  - Have State Operated Oversight and Investigative Groups

OIG Component Locations



HHS FY 2011 Budget
$911 Billion in Outlays

• Medicare	51%
• Medicaid	33%
• Discretionary Programs	10%
• Children's Entitlement Programs	3%
• TANF	2.3%
• Other Mandatory	0.4%

OIG Health Reform Activities

- Options to Reduce Expenditures
  - Compendium of Unimplemented Recommendations
- Counsel Sought on Program Integrity Issues
  - Combat Fraud, Waste, and Abuse
  - Budget Savings: How to Score Behavior Changes
- Dialogue With Staffers Linked to OIG's Five-Principle Strategy

Five-Principle Strategy Areas

- Providers and Suppliers Enrollments
- Payment Mechanisms
- Practices That Promote Compliance
- Vigilant Oversight
- Response to Fraud Schemes

Strategy Area: Enrollment

- Scrutinize Individuals and Entities
- Make Participation in Programs a Privilege Not a Right
- Suggestions:
  - Require Providers to Meet Accreditation Standards
  - Require Surety Bonds
  - Periodic Recertifications and Onsite Verifications
  - Mandate Full Disclosure of Ownership and Control Interests

Strategy Area: Payment

- Excessive Payments are Lucrative Targets for Criminals
- Establish Methodologies That are Reasonable and Responsive to Changes in Marketplace
- Sufficient to Ensure Access to Care
- Suggestions:
  - Reduce Payments for DME
  - Cap Administrative Costs in Parts C and D
  - Eliminate Bad Debt Payments to Providers
  - Use Invoice Data for Medicaid Prescription Reimbursements
  - Rebase Part C Benchmarks and Include Investment Income
  - Cap HHA Outlier Payments

Strategy Area: Compliance

- Theory: Providers and Suppliers are Our Partners in Ensuring Program Integrity
- OIG Compliance Program Guidance; Advisory Opinions; Fraud Alerts
- Industry Benefit of Early Detection and Correction of Problems
- New York: Requires Compliance Program as Condition of Participation in Medicaid
- Suggestions:
  - Medicare and Medicaid Should Require Compliance Programs
  - Require Providers and Suppliers to Repay Overpayments Discovered Internally

Strategy Area: Oversight

- Fraud Schemes More Sophisticated and Migratory Now
- Real Time Data and Advanced Data Analysis Critically Important
- Claims Processing Edits Need to Work Upfront
  - Paying for Same Service Twice
  - Paying Deceased Physicians

Strategy Area: Oversight (cont'd)

- Suggestions:
  - Real Time Access to Claims for Law Enforcement
  - Uniform, Comprehensive Data Elements Needed
  - More Timely Collection and Validation of Data
  - Ability to Draw and Analyze Claims and Provider Data Across and Within Medicare and Medicaid
  - Consolidate and Expand Provider Databases

Strategy Area: Response to Fraud Schemes

- Respond Quickly
- Impose Sufficient Punishment to Deter Others
- Promptly Remedy Program Vulnerabilities

HEAT: HealthCare Fraud Prevention and Enforcement Action Team

- Secretary and Attorney General Created Joint Task Force
- Data Mining In Process to Identify Additional Strike Force Cities and Target Health Care Issues
- Initial Interest in Non-Facility Health Providers

Work Plan Process

- Input Sought
  - Centers for Medicare & Medicaid Services, Office of Management and Budget, Congress
  - Regional Auditors
  - Latest News and Events

Work Plan Process (cont'd)

- Considerations Given to:
  - Mandates by Statute/OMB
  - Congressional Requests
  - Top Management Challenges Document
  - Status of Prior Recommendations
  - Size and Impact of Program
  - New/Untested Programs or Services
  - Improper Payment Rate Computations
  - Potential Dollar Recoveries or Savings

Work Plan Process (cont'd)

- 80% Medicare and Medicaid
  20% Discretionary Programs

- Published October 1st – Snapshot in Time

Desired Audit Outcome

- Improper Payment Recoveries
- Identify Savings Opportunities
- Improve Program Efficiencies

Typical Audit Approach

- GAO Yellow Book Followed
- Audit Objective Developed
  - Specific But With Eyes Open
- Program Criteria Analyzed
  - What Was the Program Objective?
- Claims Data Identified
  - 2-3 Years---up to 10 Years
  - National Claims History File
  - Prescription Drug Event Data
  - Medicaid Paid Claims File

Typical Audit Approach (cont'd)

- Data Mining/Analysis Performed
  - Unbundling Potential
  - Utilization Trends
  - Illogical Situations
- Statistical Sampling Used
- Substantive Testing Performed
  - Minimal Internal Control Analysis

FY 2010 WORK PLAN

- AREAS OF INTEREST
  - Claims Analysis Projects
  - Financial Management and Accountability

CLAIMS ANALYSIS: HOSPITALS

- Inpatient Psychiatric Interrupted Stays
  - *Make it look like two stays*
- Nonphysician Outpatient Services for Inpatients
  - *Bill for diagnostic tests that are part of inpatient stays*
- Readmissions
  - *Original and subsequent stays for similar medical conditions are to be single claim*
- Excessive In/Outpatient Payments
  - *Billing errors, diagnosis codes, admission codes, units of services*
- ER Diagnostic Imaging Services
  - *Increased expenditures raise medical necessity concerns*

CLAIMS ANALYSIS: HOME HEALTH CARE

- Unbundling of Services
  - *Billing for medical services and supplies included in payment rate*
- Payments for Insulin Injections
  - *When considered a skilled nursing service, this can generate outlier payments*
- Payment System Controls
  - *Billing for services where business is located not where beneficiary received services*
- Physician Orders; Services Rendered
  - *Major problems in Medicaid program*

CLAIMS ANALYSIS: PHYSICIANS/OTHER HEALTH PROFESSIONALS

- Place of Service Errors
  - *Physician claim and facility claim does not match*
- Clinical Social Workers
  - *Unbundling of prospective payment rates*
- Physical Therapy by Independents
  - *Medical necessity of services*
- Laboratory Unbundling
  - *Split claim between two days*

CLAIMS ANALYSIS: DURABLE MEDICAL EQUIPMENT

- Basic Medical Necessity
  - *Support for power mobility devices; beds; oxygen concentrators; nutrition*
- Documentation Requirements
  - *Support for proof of delivery; usage limitations; medical studies*

CLAIMS ANALYSIS: PRESCRIPTION DRUGS

- Duplicates Among Programs
  - *Physician administered and retail pharmacy; hospice and fee-for-service*
- Less-Than-Effective and Terminated Drugs
  - *Compliance with rules*
- Aberrant Usage
  - *Immunosuppressive drugs and Schedule II*
- Claims Support
  - *Physician script, pharmacy records, beneficiary use*

CLAIMS ANALYSIS: MISC

- Excluded Providers
- Claims Involving Deceased Providers or Beneficiaries
- Beneficiary: Managed Care and Fee-for-Service Duplications
- Transportation Services

FINANCIAL MANAGEMENT AND ACCOUNTABILITY

- Improper Payments Information Act
- Provider Input for Computing Reimbursement Base
  - Hospital Wage Data
  - Resident and Intern Counts
  - Managed Care Encounter Data
- Investment Income as Part of Capitated Payments
- Reasonableness of Payments
  - Evaluation and Management Services During Global Surgery Periods
  - Imaging Services: Equipment Usage
  - Hospital Outlier Payments

QUESTIONS?