New Items in the OIG’s Work Plan
Update—April 2019

The Office of Inspector General (OIG) has publicized the latest additions to its Work Plan, which includes five new noteworthy items related to oversight and monitoring of Medicaid personal care services, review of monthly end-stage renal disease (ESRD) related visits billed by physicians or other qualified healthcare professionals, Medicaid managed care organization denials, access increases in mental health and substance abuse services funding for health centers, and review of state uncompensated care pools.

Background

Each month, the OIG publishes the most recent additions to its Work Plan. The work planning process is dynamic and requires adjustments throughout the year to meet the OIG’s “priorities and to anticipate and respond to emerging issues with resources available.” With a goal of transparency, the OIG updates its Work Plan website monthly, outlining recently added information. The following is a summary of the latest additions, the agencies affected, and what they mean for compliance leaders in healthcare organizations.

Medicaid Personal Care Service (CMS)

According to the OIG Work Plan update:

Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. Prior OIG reviews identified significant problems with States’ compliance with PCS requirements. Some reviews also showed that program safeguards intended to ensure medical necessity, patient safety, and quality, and prevent improper payments were often ineffective. We will determine whether improvements have been made to the oversight and monitoring of PCS and whether those improvements have reduced the number of PCS claims not in compliance with Federal and State requirements.

What You Need to Know:

Cases regarding fraud in Medicaid PCS were a substantial and growing percentage of Medicaid Fraud
Control Unit (MFCU) cases and outcomes. MFCUs have made recommendations to State Medicaid agencies to strengthen PCS program safeguards. MFCUs lack the Federal funding authority to pursue prosecution of the abuse or neglect that occurs in beneficiaries’ homes—the location where PCS is often provided.

Unfortunately, fraud, abuse, and/or neglect by PCS aides and attendants will likely continue to be a major concern until further safeguards are taken by both personal care agencies and regulators to better protect Medicaid beneficiaries. In addition to conducting standard due diligence, PCS providers must screen all applicants (before hire), employees, vendors, and contractors, against all Federal and State exclusion databases, every 30 days.

Review of Monthly ESRD-Related Visits Billed by Physicians or Other Qualified Healthcare Professionals (CMS)

According to the OIG Work Plan update:

Most physicians and other practitioners (e.g., clinical nurse specialists, nurse practitioners, or physician’s assistants) who manage the care of patients who receive outpatient dialysis services at end-stage renal disease (ESRD) facilities are paid a monthly capitation payment (MCP) for ESRD-related physician services. The MCP amount is based on the number of visits provided within each month and the age of the ESRD beneficiary. The physician or other practitioner can bill only one of three current procedural terminology (CPT) codes for ESRD-related visits of one per month, two to three per month, or four or more per month (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, chapter 8, § 140.1). The Comprehensive Error Rate Testing program’s special study of the Healthcare Common Procedure Coding System codes for ESRD-related services found that for some codes, approximately one-third of the payments for ESRD-related services were improper payments due to insufficient documentation, incorrect coding, or no documentation submitted (CMS, Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors, volume 5, issue 3, April 2015). We will review whether physicians or other qualified healthcare professionals billed monthly ESRD-related visits in accordance with Federal requirements (Social Security Act, §§ 1815(a) and 1833(e)).

What You Need to Know:

Medicare’s MCP is paid to physicians and practitioners for most of the outpatient dialysis-related services they provide to ESRD patients. Services in the MCP include, but are not limited to, assessments and decisions regarding patient diet and nutrition, patients’ tolerance of dialysis, transplant qualification, dialysate, modality, access, dialysis-related neuropathy, short- and long-term care plans, and coordination with other care staffs. It is important to note: for ESRD billing, one month equals a calendar month.

Each visit must be face-to-face with a physician, nurse practitioner, clinical nurse specialist, or physician assistant, and proper detail must be included in the documentation to support the CPT® code selected for billing. However, the services for the month should be billed under the National Provider Identifier (NPI) of the physician or practitioner who provides the comprehensive assessment. If a non-physician provider (NPP) performs the comprehensive visit for the month, it should be billed under the NPP’s NPI. All healthcare providers included in the beneficiary’s MCP care must be a partner, an employee of the same group practice, or an employee (Form W-2 or 1099) of the MCP physician or
practitioner.

<table>
<thead>
<tr>
<th>Number/Type of Visits</th>
<th>CPT® Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4+ Visits with Continuous Hemodialysis (CHD)</td>
<td>90960</td>
</tr>
<tr>
<td>2-3 Visits with CHD</td>
<td>90961</td>
</tr>
<tr>
<td>1 CHD visit</td>
<td>90962</td>
</tr>
<tr>
<td>Home Hemodialysis Patients or Peritoneal Dialysis</td>
<td>90966</td>
</tr>
</tbody>
</table>

**Medicaid Managed Care Organization Denials (CMS)**

According to the OIG Work Plan update:

The State Medicaid agency and the Federal Government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO, which can create an incentive to deny beneficiaries’ access to covered services. Our review will determine whether Medicaid MCOs complied with Federal requirements when denying access to requested medical and dental services and drug prescriptions that required prior authorization.

**What You Need to Know:**

Under Medicaid managed care, the Federal government pays a fixed rate per patient to the MCOs, whose job is to coordinate patient care effectively and efficiently. The MCOs are required to reimburse healthcare providers and make sure patients receive follow-up care with specialists, therapists, or rehabilitation facilities following a medical procedure. In theory, the managed care system is supposed to improve patient care and lower costs by avoiding preventable emergency room visits or hospital readmissions.

However, several State Medicaid agencies' report that instead of managing care, MCOs are managing company costs by way of excessive denials of claims and delayed payments, especially for facilities known as safety-net hospitals, which serve large numbers of Medicaid and uninsured patients, and small, rural “critical access” hospitals that have 25 or fewer beds.

The OIG announced it is investigating denials by MCOs that contract with State Medicaid agencies. In its announcement, the OIG recognized that the arrangement between MCOs and the States “shifts financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO, which can create an incentive to deny beneficiaries’ access to covered services.”

**Access Increases in Mental Health and Substance Abuse Services Funding for Health Centers (HRSA)**

According to the OIG Work Plan update:

As part of [Department of Health & Human Services (HHS’s)] efforts to fight the national
opioid epidemic, the Health Resources and Services Administration (HRSA) awarded $200 million in Access Increases in Mental Health and Substance Abuse Services (AIMS) supplemental funding to 1,178 health centers nation-wide. Health centers use AIMS funding to expand access to critical mental health services and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse. The AIMS funding was awarded to health centers in September 2017 and covers 12-month budget periods from January 2018 through June 2018. AIMS funding can be used to increase mental health and substance abuse services personnel, leverage health information technology, and provide additional training. We will determine whether health centers used their AIMS funding in accordance with Federal requirements and grant terms.

What You Need to Know:

The expanded AIMS funding is part of the HHS’s five-point strategy to fight the opioid epidemic by:

- Improving access to treatment and recovery services.
- Targeting use of overdose-reversing drugs.
- Strengthening understanding of the epidemic through better public health surveillance.
- Providing support for cutting-edge research on pain and addiction.
- Advancing better practices for pain management.

This review will evaluate HRSA’s internal controls to determine whether they are appropriate for awarding AIMS grants and monitoring AIMS grant recipients.

Review of State Uncompensated Care Pools (CMS)

According to the OIG Work Plan update:

Some State Medicaid agencies operate uncompensated care pools (UCPs) under waivers approved by CMS. Section 1115 of Title XIX of the Social Security Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to help promote the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations. To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State. The purpose of the UCPs is to pay providers for uncompensated cost incurred in caring for low-income (Medicaid and uninsured) patients. Through UCPs, States pay out hundreds of millions of dollars to providers and receive Federal financial participation. However, in some States there has previously been little oversight of the payments. We will determine whether selected States’ Medicaid agencies made payments to hospitals under the UCPs that were in accordance with the STCs of the waiver and with applicable Federal regulations.

What You Need to Know:

CMS will use hospitals’ charity care and bad debt, together known as uncompensated care, to calculate their disproportionate-share hospital payments. Those payments were previously based mostly on how many Medicaid, dual-eligible, and disabled patients hospitals served, but the Affordable Care Act included the switch under the assumption that more people would gain coverage under Medicaid and
subsidized plans.

Hospitals should watch for the OIG to report on its assessment of how well States subject to Section 1115 adhered to UCPs and whether they will experience any trickle-down impact related to the OIG’s concerns.

How PYA Can Help

PYA regulatory compliance consultants combine regulatory expertise with practical experience in healthcare organizations. Our compliance subject matter experts will provide a customized approach to assist your organization with today’s ever-changing compliance landscape.

If you would like more information about any matter involving compliance, valuation, or strategy and integration, contact one of our PYA executives below at (800) 270-9629.


© 2019 PYA
No portion of this article may be used or duplicated by any person or entity for any purpose without the express written permission of PYA.