Summary of OIG’s 2015 Work Plan

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Fraud and Abuse Practice Group

Compliance Committee

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Each year, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) issues a work plan summarizing new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs during the current Fiscal Year (FY) and beyond. For FY 2014, OIG reported exclusions of 4,017 individuals and entities from participation in federal health care programs; 971 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 533 civil actions, which include false claims and unjust-enrichment lawsuits filed in federal district court, Civil Monetary Penalties (CMPs) settlements, and administrative recoveries related to provider self-disclosure matters. For FY 2014, OIG reported expected recoveries of more than $4.9 billion, consisting of nearly $834.7 million in audit receivables and approximately $4.1 billion in investigative receivables, which include about $1.1 billion in non-HHS investigative receivables resulting from collaborations with states.

The 90-page 2015 Work Plan anticipates an active year for health care providers facing increased audit, review, and enforcement activity. The 2015 OIG Work Plan outlines OIG’s current focus areas, including ongoing and new initiatives. The summary below highlights some of the most significant reviews identified in the 2015 Work Plan.¹

Outlier Payments. As in past years, OIG will continue to review Medicare outlier payments made to hospitals to determine whether the Centers for Medicare & Medicaid Services (CMS) performed timely reconciliations and whether Medicare contractors referred all of the hospitals that met criteria for outlier reconciliations to CMS.

New Inpatient Admission Criteria. OIG will review: (1) the impact that new inpatient admission criteria may have on hospital billing, Medicare payments, and beneficiary copayments; and (2) how billing varied among hospitals in FY 2014.

Defective Medical Devices. OIG will review Medicare claims to identify additional costs incurred for medical services associated with defective medical devices and the impact on Medicare.

Salaries Included in Hospital Cost Reports. OIG will review data to analyze salary amounts included in operating costs reported to and reimbursed by Medicare. While it is permissible to include employee compensation in allowable provider costs, such amounts must represent reasonable remuneration for managerial, administrative, professional, or other services related to the operation of the facility and furnished in
connection with patient care. The purpose of this review will be to evaluate the potential impact on Medicare if employee compensation amounts had limits.

- Medicare Oversight of Provider-Based Status. Because provider-based clinics can result in higher Medicare payments for services and may increase beneficiaries’ coinsurance liabilities, OIG will review provider-based facilities to determine whether the facilities meet CMS’ criteria for qualification.

- Comparing Provider-Based and Freestanding Clinics. Provider-based clinics usually receive higher payments than freestanding clinics. With that in mind, OIG will review and compare payments for physician office visits in provider-based clinics and freestanding clinics. The purpose of the review will be to determine the difference in the payments and assess the potential impact on Medicare.

- Critical Access Hospitals (CAHs). OIG will compare the reimbursement of swing-bed services at CAHs to the same level of care obtained at a traditional Skilled Nursing Facility (SNF). OIG will seek to determine whether Medicare could achieve cost savings through a more cost-effective payment methodology.

The FY 2015 Work Plan does not identify any new initiatives for hospital-related policies and practices.

**Hospital Billing and Payments**

*Ongoing Initiatives*

- Inpatient Claims for Mechanical Ventilation. OIG will review inpatient claims with certain Medicare Severity-Diagnosis Related Group (MS-DRG) assignments that
require mechanical ventilation to determine whether the hospital’s DRG assignments and resultant Medicare payments were appropriate.

- Selected Inpatient/Outpatient Billing Requirements. Prior audits, investigations, and inspections have identified areas at risk for noncompliance with Medicare billing requirements. OIG will review Medicare payments to acute care hospitals, determine the level of compliance with selected billing requirements, and recommend, where necessary, overpayment recovery.

- Duplicate Graduate Medical Education (GME) Payments. OIG will review provider data from CMS’ Intern and Resident Information System (IRIS), determine if hospitals have received duplicate or excessive GME payments, and assess the effectiveness of IRIS in preventing duplicate payments.

- Indirect Medical Education (IME) Payments. OIG will review provider data to determine whether hospitals’ IME payments were made pursuant to federal regulations and whether IME payments were calculated properly.

- Outpatient Dental Claims. Dental services typically are excluded from Medicare coverage, with only a few exceptions. OIG audits have demonstrated that hospitals received payment for non-covered dental services, resulting in overpayments. Thus, OIG will review such outpatient payments for dental services to determine whether the payments met Medicare requirements.

- Outpatient Evaluation and Management (E/M) Billed at the New-Patient Rate. OIG will review E/M services for clinic visits billed at the new-patient rate to determine if they were appropriate. If not, recommendations for overpayment recovery will be made.
• Nationwide Review of Cardiac Catheterizations and Endomyocardial Biopsies. OIG will review Medicare payments for right heart catheterizations and endomyocardial biopsies billed during the same operative session to determine whether hospitals followed Medicare billing requirements.

• Payments for Patients Diagnosed with Kwashiorkor. A Kwashiorkor diagnosis significantly increases a hospital’s Medicare reimbursement. A Kwashiorkor diagnosis is typically not found in the United States, and prior OIG reviews have noted inappropriate payments to hospitals for this diagnosis. Therefore, OIG will review payments made to hospitals for claims with a Kwashiorkor diagnosis and determine whether the diagnosis was appropriate and in accordance with Medicare guidelines.

• Bone Marrow and Stem Cell Transplants. Bone marrow or stem cell transplants are covered only for specific diagnoses. Procedure codes must be accompanied by diagnosis codes that meet specific criteria to be covered by Medicare. Because prior OIG reviews demonstrated that hospitals have incorrectly billed for bone marrow and stem cell transplants, a review will be conducted to ensure compliance with federal rules and regulations.

New Initiatives

• Hospital Wage Data Used to Calculate Medicare Payments. OIG will review hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments. Prior work in this area identified hundreds of millions of dollars in incorrectly reported wage data. This resulted in policy changes by CMS regarding how hospitals can report deferred compensation.
Hospitals—Quality of Care and Safety

Ongoing Initiatives

- Participation in Projects with Quality Improvement Organizations (QIOs). OIG will continue to assess the extent and nature of hospitals’ participation in quality improvement projects with QIOs and determine the extent to which these projects may overlap with projects offered by other entities.

- Oversight of Pharmaceutical Compounding. Medicare oversees the safety of pharmaceuticals compounded at Medicare-participating hospitals through the accreditation and certification process. OIG will assess the effectiveness of this oversight and the extent to which it addresses recommended practices.

- Oversight of Hospital Privileging. Hospitals are required to assess medical staff candidates before granting membership and privileges. This must include the verification of credentials and a review of the National Practitioner Data Bank. Having robust practices in this regard contributes to patient care and safety. OIG will assess hospitals’ privileging processes to ensure they satisfy federal requirements.

- Inpatient Rehabilitation Facilities (IRFs). IRFs provide 11% of the post-acute facility care, have experienced rapid growth over the last decade, and accounted for $7 billion in Medicare expenditures in 2011. OIG will estimate national incidence of adverse, temporary harm events for Medicare beneficiaries in IRFs. OIG will seek to identify contributing factors, determine the extent to which the events were preventable, and estimate the approximate costs to Medicare.
New Initiatives

- Long Term Care Hospitals (LTCHs)—Adverse Events in Post-Acute Care for Medicare Beneficiaries. Similar to IRFs above, OIG will estimate the national incidence of adverse, temporary harm events for Medicare beneficiaries receiving care in LTCHs. OIG will seek to identify contributing factors, determine the extent to which the events were preventable, and estimate the approximate costs to Medicare.

Nursing Homes

A recent study revealed that one quarter of all SNF claims were billed in error resulting in $1.5 billion in inappropriate Medicare payments. CMS has made significant changes in how SNFs can bill for Medicare Part A stays. In FY 2015, OIG will describe changes in SNF billing patterns from FY 2011–2013. In addition, Congress directed OIG to monitor Part B billing for abuse during non-Part A stays. OIG will work to identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services.

The quality and safety of nursing home care remains a priority for OIG. With this in mind, OIG will continue to: (1) determine whether state survey agencies verified correction plans for deficiencies identified during recertification surveys; (2) review procedures implemented by participating states to conduct background checks on prospective employees and providers who will have direct access to patients and determine the costs of the associated background checks; and (3) assess the extent that Medicare beneficiaries residing in a nursing home are hospitalized as a result of a condition thought to be manageable or preventable in the nursing home setting.
Hospices

Section 3132 of the Affordable Care Act (ACA) requires that CMS reform the hospice payment system, collect relevant data, and develop quality measures. In FY 2015, OIG will work to provide HHS with information relevant to this work. OIG will review: (1) the extent to which hospices serve Medicare beneficiaries in assisted living facilities, determining the length of stay, level of care received, and common terminal illnesses; and (2) the appropriateness of hospitals’ general inpatient care claims and content of election statements for hospice beneficiaries receiving inpatient care. OIG will review medical records to determine whether this level of hospice care is being misused.

Home Health Services

Home Health Agencies (HHAs) are considered high-risk providers for questionable billing. OIG will review compliance with the home health Prospective Payment System (PPS), including documentation in support of Medicare claims. In addition, OIG will review the extent to which HHAs employ individuals with criminal convictions.

Medical Equipment and Supplies

Power Mobility Devices

In FY 2015, OIG will continue its work to: (1) determine whether Medicare can achieve potential savings if certain Power Mobility Devices (PMDs) are rented over a 13-month period rather than purchased outright; (2) review Medicare Part B payments for suppliers of PMDs to determine whether such payments were in accordance with Medicare requirements with a focus on medical necessity; and (3) review Medicare Part
B payments for PMDs to determine if the Medicare requirements for a face-to-face examination were met.

**Diabetes Testing Supplies**

OIG will continue to focus on three primary areas in Diabetes Testing Supplies: (1) reviewing Medicare Part B payments for home blood glucose test strips and lancet supplies to determine appropriateness; (2) reviewing Medicare’s claims processing edits designed to prevent payments to multiple suppliers of home blood glucose test strips and lancets to determine if they are preventing inappropriate payments; and (3) completing a study requested by CMS to determine the market share of different types of diabetes test strips for a three-month period from October–December 2013. The Medicare Improvements for Patients and Providers Act (MIPPA) requires that contracts for mail-order diabetes test strips be awarded to suppliers that provide at least 50%, by volume, of all types of diabetic testing strips.

**Competitive Bidding for Medical Equipment Items and Services**

OIG will review the process used by CMS to conduct competitive bidding and make subsequent pricing determinations for certain medical equipment items and services. MIPPA requires that OIG conduct post-award audits to assess this process.

**Supplier Compliance with Medical Necessity, Frequency, and Other Requirements**

OIG will focus on three primary areas when reviewing supplier compliance with payment requirements: (1) lower limb prosthetics; (2) nebulizer machines and related drugs; and (3) frequently replaced supplies. OIG will review lower limb prosthetic Part B payments
for claims to assess whether the requirements of CMS’ *Benefit Policy Manual* were met. Likewise, OIG will review Part B payments for nebulizer machines and related drugs to determine whether suppliers’ claims were medically necessary and supported in accordance with Medicare requirements. OIG will review frequently replaced medical equipment supplies to determine whether medical necessity, frequency, and other Medicare requirements are met. Prior OIG reviews found that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies even when no physician orders for refills were in effect. These claims are improper and should not be submitted for payment.

**Other Providers and Suppliers**

**Ambulatory Surgical Centers**

Beginning in 2008, a revised payment system for surgical services furnished in an Ambulatory Surgical Center (ASC) was implemented. OIG will review the appropriateness of this new methodology for setting ASC payment rates and will determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar procedures.

**End-Stage Renal Disease Facilities**

In 2011, federal law required CMS to begin implementation of a new system that bundles all costs related to End-Stage Renal Disease (ESRD) care into a single per-treatment payment. This bundled rate must be updated annually to reflect changes in the price of goods and services used in ESRD care. OIG will continue to review Medicare payments for, and utilization of, renal dialysis services and related drugs pursuant to the new bundled ESRD PPS, and compare facilities’ acquisition costs for

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2 Centers for Medicare & Medicaid Services, *Benefit Policy Manual*, Pub. No. 100-02, Ch. 15, Sec. 120.
certain drugs with inflation-adjusted cost estimates to determine how costs may have changed.

**Ambulance Services**

Medicare covers ambulance services “where the use of other methods of transportation is contraindicated by the individual’s condition . . .”\(^3\) The Medicare Manual more specifically states that ambulance transports are covered when the beneficiary’s medical condition at the time of the transport is such that using other means of transportation would endanger the beneficiary’s health. In FY 2015, OIG will review Medicare claims data to assess the extent of questionable billing for ambulance services and will analyze and synthesize OIG evaluations, audits, investigations, and compliance guidance related to ground ambulance transport services paid by Medicare Part B to identify vulnerabilities, inefficiencies, and fraud trends. OIG will then offer recommendations to improve such vulnerabilities and minimize inappropriate payments for ambulance services.

**Anesthesia Services**

OIG will continue its work reviewing the appropriateness of Medicare Part B claims for personally performed anesthesia services and whether these were supported per Medicare requirements (including the use of the AA and QK modifiers).

**Chiropractic Services**

Medicare Part B pays only for a chiropractor’s manual manipulation of the spine to correct a subluxation if there is a neuro-musculoskeletal condition for which the

\(^3\) Social Security Act, § 1861(s)(7).
manipulation is appropriate. In prior reviews, OIG found that inappropriate payments were made for chiropractic services. In response, OIG will continue its work reviewing Part B payments to determine whether such payments were claimed in accordance with Medicare requirements.

Previous OIG reviews have shown a history of vulnerabilities related to the billing of chiropractic services. In FY 2015, OIG will continue to determine and describe the extent of questionable billing practices and compile these results along with prior OIG audits, evaluations, and investigations to identify trends in payment, compliance, and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities.

**Diagnostic Radiology**

OIG will continue to review Medicare payments for high-cost diagnostic radiology tests to determine whether these tests were medically necessary and whether use has increased.

**Imaging Services**

OIG will continue its work reviewing Part B payments for imaging services with the goal of determining whether the payments reflect expenses incurred and whether utilization rates reflect industry practices. For some imaging services, OIG will focus on practice expense components such as office rent, wages, and equipment.

**Independent Clinical Laboratory Billing Requirements**

In its prior audits, investigations, and inspections, OIG found that independent clinical laboratory areas were at risk for noncompliance with Medicare billing requirements. As a result, OIG will review payments to independent clinical laboratories to determine their
compliance with selected billing requirements. OIG will then use the results to identify clinical laboratories that routinely submit improper claims and recommend recovery of overpayments.

**Ophthalmologists**

In 2010, Medicare paid more than $6.8 billion for services provided by ophthalmologists. This year, OIG will continue to review claims data to identify potentially inappropriate and questionable billing for ophthalmology services during 2012.

**Physicians**

OIG will continue its work reviewing physician coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether physicians properly coded the place of service. Medicare pays a higher amount when a service is performed in a non-facility setting than when the service is performed in a hospital outpatient department or, with some exceptions, in an ASC.

**Physical Therapists**

Previous OIG work found that claims for therapy services were not reasonable, not properly documented, or not medically necessary. In FY 2015, OIG will continue to review outpatient physical therapy services performed by independent therapists to determine if they are in compliance with Medicare reimbursement requirements.
Portable X-Ray Equipment

OIG will review payments for portable X-ray equipment services to determine whether payments were correct and supported by the necessary documentation. This review also will assess the qualifications of the technologists who performed these tests.

Sleep Disorder Clinics

OIG will continue to review Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures to determine the appropriateness of Medicare payment for high-use sleep testing procedures.

Prescription Drugs

Policies and Practices

OIG will continue to review Medicare Part B drug prices by comparing Average Sales Prices (ASPs) to Average Manufacturer Prices (AMPs) and by identifying drug prices that exceed a designated threshold. When OIG finds that the ASP for a drug exceeds the AMP by 5%, OIG notifies the Secretary of HHS, who may disregard the ASP for the drug when setting reimbursement amounts (e.g., apply a price substitution policy).

OIG also will continue to determine how much Medicare Part B spending could be reduced if Medicare were able to share in the savings for 340B-purchased drugs. OIG will calculate the overpayments and estimated potential savings. OIG noted that some Medicaid state agencies have developed strategies to take advantage of the discounts on 340B drugs. The 340B Drug Pricing Program (340B Program) requires drug manufacturers to provide discounted outpatient drugs to approximately 10,000 covered
entities, including tribal health centers, children’s hospitals, and tuberculosis clinics. Medicare Part B providers that purchase drugs under the 340B Program can fully retain the difference between the ASP-based payment amount and the 340B purchase price.

**Billing and Payments**

Under the 2015 *Work Plan*, OIG will continue to review Medicare outpatient payments to providers for certain drugs (e.g., chemotherapy drugs) and the administration of the drugs to identify overpayments due to incorrect billing. OIG will focus on whether providers are billing accurately and completely for services provided and on the number of units of service.

**Quality and Safety**

*Ongoing Initiatives*

OIG will continue to focus great attention on payments for “on-label” and appropriate “off-label” uses for Part B drugs when the drug is supported in major drug compendia or clinical evidence in authoritative medical literature supports an off-label use. OIG also will identify challenges that CMS contractors face when making coverage decisions for drugs, and OIG will require effective oversight mechanisms.

OIG identified recent concerns regarding the transparency of publishers of authoritative prescription drug compendia for evaluating anti-cancer drug therapies and identifying conflicts of interest.
Part A and B Contractors

As part of its oversight function, OIG will continue to determine how CMS is managing and maintaining its contracts with its contractors, which are worth an estimated $5.4 billion. In addition, OIG will focus oversight and monitoring on timely and effective contract closeout programs to protect the government’s financial interests and recover excess funds. OIG also will monitor whether costs claimed by terminated Medicare contractors were “reasonable, allocable, and allowable.”

Executive compensation for contractor employees charged to Medicare will continue to be an important issue for OIG. OIG will analyze the potential effect of expanding the executive compensation benchmark to all employees. OIG noted that the term “senior executive” means the top-five compensated employees of each organizational segment. OIG also noted in the Work Plan that the media has examined the high salaries for executives of government contractors. OIG also will continue to review contractor pension costs and post-retirement health benefit costs.

As part of OIG’s review of contractor functions and performance, OIG will review the procedures for tracking collections on overpayments identified by Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs). OIG also has added reporting requirements that will improve overpayment tracking among the claims processors and ZPICs and PSCs.

Information Technology Security, Protected Health Information, and Data Security

OIG will review independent evaluations of Medicare contractor information systems security programs and report OIG’s assessment to Congress. OIG also will focus on hospitals’ security controls over networked medical devices to protect electronic Protected Health Information (ePHI). As in last year’s Work Plan, OIG recognized the growing threat to security and privacy of PHI with the increased use of computerized medical devices, dialysis machines, and medication dispensing systems that are
integrated into Electronic Medical Records. OIG reminded medical device manufacturers that they must provide Manufacturer Disclosure Statement for Medical Device Security to assist health care providers in assessing the vulnerability and risks associated with ePHI that is transmitted or maintained by a medical device.

**Other Part A and Part B Program Management Issues**

OIG will collect data on and report the enrollments approved and denied by CMS before and after the implementation of the enhanced screening procedures pursuant to the ACA, Section 6401. CMS will implement new efforts to prevent fraud, waste, and abuse of the Medicare enrollment process, including site visits, fingerprinting, and background checks.

OIG will conduct a risk assessment of the Pioneer Accountable Care Organization (ACO) Model to assess internal controls over the administration of Pioneer ACOs.

**MEDICARE PARTS C AND D**

**Part C—Medicare Advantage**

*Medicare Advantage Organizations’ Compliance with Part C Requirements*

OIG will continue its review of Medicare Advantage (MA) organizations’ compliance with Part C requirements related to identified vulnerabilities in the accuracy of risk-adjustment data reporting in prior CMS and OIG audits. OIG’s ongoing review will look at the extent to which MA encounter data reflecting items and services provided to plan enrollees are complete and consistent and are verified for accuracy by CMS. OIG also will continue its review of medical record documentation to ensure it supports the diagnoses that MA organizations submit to CMS for calculation of risk scores and to
determine if such diagnoses complied with federal requirements.

**Part D—Prescription Drug Program**

**Medicare, Sponsor, and Manufacturer Policies and Practices**

OIG will continue its analysis of the risk-sharing payments between Medicare and Part D sponsors to determine whether cost savings could have been realized had existing risk-corridor thresholds remained at 2006 and 2007 levels.

**Sponsor Compliance with Part D Requirements**

**New Initiatives**

As a follow-up to a recommendation in a prior OIG report, regarding CMS’ oversight of Part D sponsors’ Pharmacy and Therapeutics (P&T) committee compliance with federal conflicts-of-interest requirements, OIG plans to initiate a review of steps taken by CMS to improve its oversight of sponsors’ P&T committee conflict-of-interest procedures.

**Ongoing Initiatives**

OIG plans to continue its evaluation of Part D sponsors’ compliance with Part D requirements through the following reviews:

- The sufficiency of Part D sponsors’ documentation supporting administrative costs included in their annual bid proposals to CMS;
- Part D sponsors’ compliance with Medicare requirements for reporting direct and indirect remunerations;
• CMS’ policies, procedures, instructions, and processes for reopening final payment
determinations and the adequacy of sponsor compliance and sponsor-submitted
data; and

• Part D sponsors’ inclusion of drugs commonly used by dual-eligible beneficiaries on
their drug formularies as required by Part D.

Part D Billing and Payments

OIG will continue its reviews of selected retail pharmacies identified in a prior OIG report
as having questionable Part D billing practices and will determine whether these
pharmacies’ Medicare Part D Prescription Drug Event (PDE) records were adequately
supported and complied with applicable federal requirements.

OIG also will determine the extent to which Medicare Part D payments were made for
Human Immunodeficiency Virus (HIV) drugs for deceased beneficiaries. Finally, OIG will
review data Part D sponsors submitted for use in calculating the coverage gap discount
to assess the accuracy of the data and will consider whether beneficiary payments are
correct and whether amounts paid to sponsors are supported.

MEDICAID

OIG’s continuing and new Medicaid-related reviews in FY 2015 will address:
• prescription drugs; home health services and other community-based care; policies and
practices for medical equipment and supplies; billing and payment for transportation
services and health care-acquired conditions; state claims for federal reimbursement for
pediatric dental services; family planning services; Community First Choice (CFC) State
Plan Option and payment under the Balancing Incentive Program (BIP); quality-of-care
and safety issues; state management of Medicaid; information system controls and
security; and Medicaid managed care.
Medicaid Prescription Drug Reviews

State and Manufacturer Compliance with Medicaid Requirements

Now that the rebate requirement has been expanded under the ACA, OIG will initiate a new review of state collection of drug rebates from pharmaceutical manufacturers for Managed Care Organization (MCO) enrollees.

In addition, OIG will assess state and manufacturer compliance with Medicaid requirements through the following activities:

- Reviewing the education and enforcement actions states have taken on the basis of information generated by their Drug Utilization Review (DUR) programs related to inappropriate dispensing and potential abuse of prescription opiates. OIG also will review state DUR oversight activities;

- Assessing whether manufacturer compliance with AMP reporting requirements has changed since 2008 and identifying actions CMS has taken to improve manufacturers’ compliance;

- Ascertaining whether states have established adequate accountability and internal controls for collecting Medicaid rebates on physician-administered drugs by assessing states’ processes for collecting national drug code information on claims for physician-administered drugs and subsequent processes for billing and collecting rebates;

- With the increase in the basic federal minimum rebate amount under the ACA, which is to help lower the costs of Medicaid prescription drug programs, OIG will determine the amount of drug manufacturer rebates reported by states. OIG also will determine the amount of supplemental drug rebates collected for selected periods; and

- Conducting a follow-up review comparing pharmacy reimbursement and rebate amounts for a sample of brand-name drugs paid for by Medicare Part D and by
Medicaid after accounting for the changes in Medicaid rebates as enacted under the
ACA.

**State Claims for Federal Reimbursement**

OIG will continue to review states’ claims for the federal share of Medicaid payments for multi-use vials of the breast cancer drug Herceptin to determine whether providers properly billed the states for the drug. OIG also will review whether providers’ claims to states were complete and accurate and were billed in accordance with the regulations of the selected states.

**Home Health Services and Other Community-Based Care**

**Billing and Payments**

OIG will continue to review Medicaid payments by states for adult day care services to determine whether the providers complied with federal and state requirements. In addition, OIG will continue to review payments to Continuing Day Treatment mental health services providers to determine whether their claims were adequately supported.

**State Claims for Federal Reimbursement**

OIG will determine whether selected states claimed federal reimbursement for unallowable room-and-board costs associated with services provided under Home and Community-Based Services (HCBS) waiver programs and whether HCBS payments included the room-and-board costs. OIG also will identify the methods the states used to determine the amounts paid.
Quality of Care and Safety of Beneficiaries

OIG will review health-screening records of Medicaid HHA health care workers to determine whether they were screened in accordance with federal and state requirements.

Other Medicaid Services, Equipment, and Supplies

Policies and Practices

OIG will determine whether opportunities exist for lowering Medicaid payments for selected items of medical equipment and supplies and the amount of Medicaid savings that could be achieved for selected items through rebates, competitive bidding, or other means.

Billing and Payment

OIG will review Medicaid payments by states to providers for transportation services to determine the appropriateness of the payments for such services. OIG also will determine whether selected states made Medicaid payments for health care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid funds spent on such conditions.

State Claims for Federal Reimbursement

OIG is initiating two new reviews: one to determine whether CFC payments are proper and allowable and the second to review state expenditures claimed under the BIP to
ensure eligibility for these payments and that states used the enhanced match appropriately in accordance with ACA requirements.

OIG also will review Medicaid payments by states for pediatric dental services to determine whether states have properly claimed federal reimbursement and will review family planning services in several states to determine whether states improperly claimed enhanced federal funding for such services and the resulting financial impact on Medicaid.

**Quality of Care and Safety of Beneficiaries**

OIG is conducting a new review of the rate and reasons for transfers from group homes and nursing homes to a hospital emergency department to determine whether quality of care is in issue.

OIG will continue to review pediatric dentists’ billing patterns and their associated clinics in selected states and describe the extent to which children enrolled in Medicaid received services from them. OIG will determine whether access issues exist as well as whether there are unnecessary dental procedures being performed causing harm to children enrolled in Medicaid who are entitled to services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. OIG also will determine what steps CMS has taken to improve the provision of EPSDT services.

**State Management of Medicaid**

**State Mechanisms to Fund their Medicaid Programs**

Focusing on the mechanism states use to raise revenue through provider taxes, OIG will review state health care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable federal requirements. In particular,
OIG is concerned about states’ use of the health care-related taxes. OIG also will determine whether states are complying with federal requirements for claiming certified public expenditures.

**State Claims for Federal Reimbursement**

OIG will review administrative costs claimed by several states to determine whether they were properly allocated and claimed or directly charged to Medicaid. OIG will review public assistance cost-allocation plans and processes for selected states to determine whether the states claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems that deviated from acceptable statistical sampling practices. OIG will review states’ Medicaid claims to determine whether the states correctly applied enhanced Federal Medical Assistance Percentage (FMAP) payment provisions of the ACA. OIG also will determine the extent to which state Medicaid programs improperly enrolled individuals who did not meet eligibility criteria and assess how states addressed issues that contributed to these inaccurate determinations. For states making incorrect eligibility determinations, OIG will calculate the Medicaid eligibility error rate and determine the amount of payments associated with these incorrect Medicaid eligibility determinations.

**State Adjustments of Federal Reimbursement**

OIG will review the Medicaid monetary drawdowns that states received from the Federal Reserve System to determine whether they were supported by actual expenditures reported by the states on Form CMS-64, which shows the disposition of Medicaid funds used to pay for actual medical and administrative expenditures for the reporting period. OIG will determine whether states accurately captured Medicaid collections on Form CMS-64 and returned the correct federal share related to those collections, complied with requirements to recover Medicaid costs from deceased Medicaid beneficiaries’
estates, and properly reported any such recoveries to CMS. OIG also will review states’ Medicaid claims records to determine whether states used the correct FMAP when processing claim adjustments reported on Form CMS-64.

**State Program Integrity Activities and Compliance with Federal Requirements**

OIG will review corrective actions that state Medicaid agencies have implemented (or failed to implement), determine the reasons for the action or inaction, and examine steps taken by CMS to ensure that states implemented corrective actions and the evidence reviewed by CMS to ensure that states took such actions.

In addition, OIG will review states’ compliance with a new mandate to terminate Medicaid program providers already terminated by Medicare or another state Medicaid program. The purpose of the review is to determine whether terminated state Medicaid programs affected providers, to assess the status of the supporting information-sharing system and whether CMS is ensuring that states share complete and accurate information, and to identify obstacles states face in complying with the termination requirement.

OIG also will review providers’ patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances. OIG will determine whether states and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. OIG will review states’ and CMS’ practices for collecting and verifying provider ownership information and determine whether they have comparable ownership information on file for providers enrolled in both programs. Finally, OIG will review states’ use of enhanced screenings for moderate- and high-risk enrollment and revalidation of Medicaid providers and suppliers and assess the results of states' efforts to prevent risky providers and suppliers from either enrolling or continuing re-enrollment or seeking revalidation in federal health care programs.
OIG Oversight of State Medicaid Fraud Control Units

OIG will review the overall management, operations, and performance of a sample of Medicaid Fraud Control Units (MFCUs) and identify effective practices and areas for improvement in MFCU management and operations. OIG will determine whether each of the U.S. territories—none of which currently operate an MFCU—has sought an exemption as part of its state Medicaid plan as required by Section 1902(a)(61) of the Social Security Act, and whether North Dakota, the only state without an MFCU as a result of an exemption granted in 1994, continues to operate under the conditions that supported the state’s exemption.

Medicaid Information System Controls and Security

OIG will review duplicate payments made by states on behalf of Medicaid beneficiaries with multiple Medicaid identification numbers and identify states’ procedures or other controls for preventing such payments. OIG also will review selected states’ implementation of National Correct Coding Initiative (NCCI) edits for Medicaid claims and describe CMS’ oversight of NCCI edits.

Controls to Ensure the Security of Medicaid Systems and Information

OIG will determine the adequacy of CMS’ oversight of states’ Medicaid system and information security controls, including the policies, technical assistance, and security and operational guidance provided to the states. For selected states, OIG will use automated assessment tools to assess controls for states’ information system networks, databases, web-facing applications, logical access, and wireless access. OIG also will review general controls, such as disaster recovery plans and physical security.
Medicaid Managed Care

State Payments to Managed Care Entities

OIG will conduct two new reviews of states' payments to MCOs: to review payments and any trends in claims and service dates after beneficiaries' deaths; and to identify whether payments are made for ineligible beneficiaries.

OIG will continue to review states' managed care plan reimbursements to determine whether MCOs are appropriately and correctly reimbursed for services provided. OIG will ensure that the data used to set rates are reliable and include only costs for services covered under the state plan as required by, or costs of services authorized by, CMS. OIG will verify that payments made under a risk-sharing mechanism and incentive payments made to MCOs are within the limits set forth in federal regulations. OIG also will review managed care plans with contract provisions that require a minimum percentage of total costs to be expended for medical services (medical loss ratio (MLR)) to determine whether a refund was made to the state agency when the minimum MLR threshold was not met, and OIG will determine whether plan expenses were properly classified as medical or administrative.

Data Collection and Reporting

OIG will determine the extent to which complete Medicaid managed care encounter data are included in Medicaid Statistical Management Systems (MSIS). OIG also will identify factors that enable states' and Medicaid managed care entities to collect and report MSIS encounter data or prevent them from performing these functions. Further, OIG will assess CMS' oversight of the reporting of MSIS encounter data.
**Program Integrity in Managed Care**

OIG will determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents and describe how states oversee MCOs’ efforts to identify and address fraud and abuse.

**Beneficiary Protections in Managed Care**

OIG will review Medicaid managed care provider networks and describe the extent to which managed care beneficiaries have access to services. OIG also will describe state standards for ensuring access to primary and specialty care and will determine the extent to which states identify and address problems with access to care in their managed care plans.

OIG will review the extent to which states monitor Medicaid MCOs’ grievances and appeals systems for compliance with federal requirements. OIG also will review state Medicaid agencies’ oversight policies, procedures, and activities to determine the extent to which states monitor Medicaid MCOs’ marketing practices and compliance with federal and state contractual marketing requirements and to determine the extent to which CMS ensures that states’ comply with federal requirements involving Medicaid MCO marketing practices.

**CMS-RELATED LEGAL AND INVESTIGATIVE ACTIVITIES**

**Legal Activities**

OIG works to resolve both civil and administrative health care fraud cases using a variety of resources, including litigation of program exclusions, imposition of CMPs and assessments, negotiation and monitoring of Corporate Integrity Agreements (CIAs), and
issuance of fraud alerts, advisory bulletins, and advisory opinions. OIG also uses its authority to develop regulations, including safe harbor regulations under the federal Anti-Kickback Statute, and to provide Compliance Program Guidance (CPG). In FY 2015, OIG will continue such ongoing activities, including:

- Determining whether to exclude individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. OIG considers exclusions from both federal and state agencies for many reasons, including program-related convictions, patient abuse or neglect convictions, licensing board disciplinary actions, and other actions that pose a risk to beneficiaries or programs;

- Pursuing CMP cases, when supported by appropriate evidence, on the basis of submission of false or fraudulent claims;

- Collaborating with the U.S. Department of Justice (DOJ) to develop and pursue federal false claims cases against individuals and entities that defraud the government, including both litigation and settlement resolutions. When appropriate, OIG will require the implementation of CIAs aimed at ensuring compliance with federal health care program requirements;

- Ensuring provider’s compliance with CIAs by conducting site visits and review of provider submissions to verify compliance and, where warranted, pursuing corrective actions and sanctions for breaches of CIA obligations, including stipulated penalties or exclusions;

- Issuing Advisory Opinions, Fraud Alerts, Open Letters, CPG, and other industry guidance to foster compliance by providers and industry groups; and

- Encouraging providers and suppliers to avail themselves of the Provider Self-Disclosure Protocol (most recently updated in 2013) as a means for detecting and preventing health care fraud and abuse.
Investigative Activities

In FY 2015, OIG will continue its efforts to conduct and coordinate criminal, civil, and administrative investigations of health care fraud, waste, abuse, and misconduct related to more than 100 HHS programs and operations. Such investigations focus on areas including Medicare and Medicaid fraud, failure of care, child support enforcement violations, grant and contract fraud, network intrusions, and employee misconduct. OIG also devotes significant resources to investigating Medicare and Medicaid fraud in conjunction with other law enforcement entities (e.g., Federal Bureau of Investigation (FBI) and state MFCUs).

FY 2015 has OIG continuing its active involvement with the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an initiative started in 2009 by HHS and DOJ to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse. HEAT Strike Force teams operate in nine major cities throughout the United States and coordinate law enforcement operations among federal, state, and local enforcement agencies to identify and prosecute fraud. OIG supports HEAT Strike Force operations by investigating individuals, facilities, or entities for fraudulent activities (e.g., billing for services not rendered, submitting claims that manipulate payment codes to inflate reimbursement amounts, and submitting false claims to obtain program funds). OIG also shows support by investigating business arrangements that allegedly violate the Anti-Kickback Statute and the statutory limitation on self-referrals by physicians. Finally, OIG examines quality-of-care and failure-of-care issues in nursing facilities, institutions, community-based settings, and other care settings in instances where federal programs may have been billed fraudulently (e.g., services not medically necessary, services not rendered or not rendered as prescribed, or worthless services).

OIG also will continue in FY 2015 to investigate Medicare and Medicaid drug benefit issues and assist CMS in identifying program vulnerabilities and schemes, such as prescription shorting by pharmacies; illegally marketing, obtaining, and distributing prescription drugs; and illegal street distribution of highly addictive drugs.
Finally, in FY 2015 OIG will continue to assist MFCUs in the investigation of false claims submitted to state Medicaid programs. OIG will continue to strengthen its collaborative and coordination efforts with organizations such as the National Association of Medicaid Fraud Control Units and the National Association for Medicaid Program Integrity.

PUBLIC HEALTH REVIEWS

OIG reviews a number of activities and programs of public health agencies within HHS. In its 2015 Work Plan, OIG indicated it will focus on the following public health activities and programs:

New Initiatives

OIG will commence three new reviews of various activities of the *Health Resources and Services Administration (HRSA)*:

- OIG will begin a review of community health centers’ compliance with federal laws and regulations, including a determination of the allowability of expenditures and the adequacy of accounting systems that assess and account for program income;

- OIG will assess the risk of duplicate discounts for 340B-purchased drugs paid through Medicaid MCOs and describe states’ efforts to prevent the same; and

- OIG also will commence a review to determine the extent to which HRSA awards grant money to Health Center Program grantees that have documented compliance or performance issues.

OIG also will begin two new *Other Public Health-Related Reviews* in 2015:

- The first is an audit of grantees of funding under the Hurricane Sandy Disaster Relief Appropriations Act (Disaster Relief Act), specifically those allocated to three HHS
operating divisions: National Institutes of Health (NIH), Administration for Children and Families (ACF), and Substance Abuse and Mental Health Services Administration (SAMHSA). OIG will review the grantees’ internal controls related to oversight of the funds and the allowability of costs claimed and appropriateness of budgeted costs that have not yet been expended.

- The second new initiative will involve a review of hospitals’ Electronic Health Record (EHR) system contingency planning as required by the Health Insurance Portability and Accountability Act Security Rule. OIG will compare hospitals’ contingency plans with government- and industry-recommended practices to ensure that policies and procedures are in place to respond to an emergency or other occurrence that can damage systems containing PHI.

**Ongoing Initiatives**

- **Agency for Health Research and Quality (AHRQ).** OIG will continue its review of the policies and activities of Patient Safety Organizations (PSOs) to determine the extent of hospitals’ participation in such activities and determine the extent to which PSOs provide information to health care providers and AHRQ’s Network of Patient Safety Databases. OIG also will evaluate PSOs’ efforts to identify and resolve patient safety problems in hospitals and identify any barriers to the full and effective implementation of the PSO program.

- **Centers for Disease Control and Prevention (CDC).** OIG will continue its ongoing review of the World Trade Center Health Program’s expenditures to assess whether required internal controls have been established and whether such controls are adequate to detect and prevent fraudulent or duplicate billing and payment for inappropriate medical services and whether they are effective in preventing excessive administrative payments. Additional CDC reviews will include ongoing review of the following programs:
o CDC’s award process for the President’s Emergency Plan for AIDS Relief cooperative agreements for compliance with applicable laws, regulations, and guidance, including awards made to both foreign and domestic recipients;

o The effectiveness of CDC’s management of the Prevention and Public Health Fund Program and select grantees’ compliance with grant requirements;

o CDC’s implementation of prior OIG recommendations to improve CDC’s control over property, including adjusting the system to reflect the results of the annual physical inventory, removing lost or missing property from the system, ensuring newly acquired property is properly barcoded and added to the system, and reconciliation of the general ledger to identify and resolve any discrepancies; and

o CDC’s oversight efforts regarding the United States’ strategic pharmaceutical stockpiles to ensure the stockpiles are secure from theft, tampering, or other loss in accordance with the guidelines issued by the U.S. Department of Homeland Security.

• **U.S. Food and Drug Administration.** OIG will determine the extent to which the U.S. Food and Drug Administration (FDA) conducts inspections of generic drug manufacturers and will describe the results of such inspections and FDA’s enforcement actions taken in response to noted deficiencies or shortcomings. OIG also will determine the extent to which FDA requires Postmarketing Studies and Clinical Trials (Postmarketing Requirements or PMRs) for new drug applications and will assess FDA’s monitoring of PMRs and FDA’s enforcement action taken against applicants for non-compliance with the PMRs. In addition, OIG will assess FDA’s designation and inspection of high-risk food facilities to ensure facilities’ compliance with food safety and applicable regulations. OIG also will review drug supply chain partners’ (manufacturers, wholesale distributors, and dispensers) early experiences in exchanging transaction information and history as required by the Drug Supply Chain Security Act through interviews of trading partners regarding their successes in exchanging information and any obstacles that they encountered. Finally, OIG will
determine the extent to which drug sponsors complied with clinical trial reporting requirements and the manner in which FDA is ensuring the requirements are met.

- **Indian Health Service (IHS).** OIG will continue its examination of IHS’ efforts to ensure that its hospitals provide quality inpatient care and IHS’ efforts to monitor each hospital’s ability to provide high-quality care and maintain compliance with Medicare Conditions of Participation and identify the most common quality or compliance issues.

- **NIH.** OIG will continue its ongoing reviews of various NIH activities, including:
  
  o Continued review of Superfund activities, including payments, obligations, reimbursements, and other uses by NIH’s National Institute of Environmental Health Sciences;

  o Review select facilities awarded extramural construction grants to determine if funds were spent consistent with federal requirements, including determining whether bidding procedures were followed and if expenditures were allowable under the terms of the grants and applicable federal requirements;

  o Assessment of colleges’ and universities’ compliance with selected cost principles based on federal grants and conduct reviews of select colleges and universities based on the dollar value of the federal grants received and input from HHS;

  o Continued examination of NIH’s oversight of the three basic requirements for post-award grants administration among the 24 recipient Institutes and Centers (ICs) and the NIH’s oversight of each IC’s compliance with regulations, HHS directives, and agency policies; and

  o The appropriateness of NIH’s obligation of appropriated funds for the services NIH obtains through contracts to ensure that appropriated funds were used only during their period of availability and for a bona fide need during the year in
which the appropriation was made. The review will include contracts and any contract modifications to quantify any errors.

- **SAMHSA.** OIG will assess the data collection and reporting methods used by states on national outcome measures for the Substance Abuse Prevention and Treatment Block Grant program, as well as SAMHSA’s oversight activities related to states’ reporting obligations.

- **Other Public Health-Related Reviews.** OIG will continue its review of the use of Medical Reserve Corps (MRC) volunteers in New Jersey and New York during the Hurricane Sandy response, and describe the use generally, as well as the challenges and successes encountered while using MRC volunteers. Additionally, OIG will continue to assess guidance, disbursement, and reporting related to the $500 million in Hurricane Sandy disaster funding transferred to the Social Services Block Grant, including the guidance provided by HHS and the states to grantees, timeliness of disbursements, and reporting requirements put in place. OIG also will describe the challenges encountered by states and their subgrantees in accessing and using disaster funding.

- OIG will continue assisting DOJ in resolving civil, administrative, and criminal matters involving fraud and non-compliance involving HHS grantees of public funds from NIH and other public health service agencies. As part of its 2015 *Work Plan*, OIG will continue to coordinate efforts with CDC, FBI, and the U.S. Department of Agriculture to investigate violations by academic institutions, commercial manufacturing facilities, and federal, state and local laboratories of applicable federal requirements for the registration, storage, and transfer of select biological agents and toxins.
HUMAN SERVICES REVIEWS

In FY 2015, OIG will perform the following reviews of the activities of ACF and the Administration for Community Living (ACL):

**New ACF Initiatives**

- OIG will begin reviewing the states’ emergency preparedness and response plans specific to child care services and programs, specifically the development and/or update of states' plans. OIG also will describe states' and child care providers' emergency responses and experiences during and after recent disasters.

- Pursuant to the limitations imposed on Head Start grantees under the Improving Head Start for School Readiness Act of 2007, which limited grants to five years, rather than indefinitely with the possibility of future five-year extensions on a non-competitive basis for grantees providing high-quality services (based on meeting seven conditions), OIG will determine the extent to which new entities competed for and were awarded Head Start grants in 2013 and 2014. In addition, OIG will describe the characteristics of grantees that were not deemed “high quality” by the Head Start Designation Renewal System in 2013 and 2014.

**Ongoing ACF Initiatives**

- OIG will review ACF’s oversight of states’ compliance with the work verification and reporting requirements of the Temporary Assistance for Needy Families (TANF) program. OIG also will review ACF’s oversight of tribes’ compliance with the Tribal Family Assistance Plan requirements under TANF.
• With respect to state foster care and adoption services, OIG will determine whether state agencies claimed foster care maintenance payments and adoption assistance payments in accordance with federal requirements. In addition, OIG will determine the extent to which states provide required oversight and coordination of health services for children in foster care, specifically looking at the extent to which children in foster care in select states receive health care services as outlined in states’ health oversight and coordination plans.

• OIG also will continue its encouragement and coordination efforts with states, particularly those that have not pursued prosecutions in non-support cases, in accordance with Project Save Our Children, which seeks to identify, investigate, and prosecute individuals who have not complied with their court-ordered support obligations.

ACL. OIG will continue to review performance measures for Senior Medicare Patrol projects, which were established to recruit and train senior citizens to recognize and report instances or patterns of health care fraud. This review will include documentation supporting expected recoveries for the Medicare and Medicaid programs.

OTHER HHS-RELATED REVIEWS

OIG FY 2015 Work Plan includes the review of a number of matters that cut across HHS, including work in the areas of financial statement audits, financial reviews, automated information systems, and other department issues. The highlights of each are summarized below.
Financial Statement Audits

OIG will review the independent auditor’s workpapers to determine if the financial statement audits of HHS and its components were conducted in accordance with federal requirements. OIG will want to ensure that the financial statements present fairly, in all material respects, the financial position of the audited entity for FY 2014 and FY 2015.

Financial Reviews

Much of OIG’s work in the area of Financial Reviews is a continuation of prior years. OIG will review HHS’ compliance with the Improper Payments Information Act of 2002, especially regarding the reporting of improper payments. OIG also will review HHS’ compliance with the Improper Payment Elimination and Recovery Act of 2010. OIG will review data presented in HHS’ Agency Financial Report (and will make recommendations for modification).

OIG will evaluate an assessment of HHS’ implementation of predictive analytics technologies to determine if HHS has reduced improper Medicare fee-for-service payments. OIG will follow up on corrective actions made in response to OIG’s prior year’s recommendations and will determine if improvements could be made to increase Medicare savings.

OIG will: (1) review controls the HHS Program Support Center has implemented to ensure compliance with requirements specified in appropriations statutes when awarding contracts; (2) review HHS agencies’ compliance with the requirement that agencies spending funds on National Drugs Control Program activities submit to the Office of National Drug Control Policy an annual accounting of the expenditure of such funds and review the quality of audits conducted by non-federal auditors; and (3) conduct a number of audits as part of HHS’ cognizant-agency responsibility under Office of Management (OMB) Circular A-133.
Finally, OIG receives requests throughout the year from Congress, HHS, and other federal organizations to conduct a variety of financial-related audit services (i.e., contract and grant closeouts, indirect cost audits, bid proposal audits, and other reviews). OIG will evaluate these requests upon receipt.

**Automated Information Systems**

The Federal Information Security Management Act of 2002 (FISMA) requires that agencies and their contractors maintain programs that provide adequate security for all information collected, processed, transmitted, stored, or disseminated in general support systems and major applications. To this end, OIG will review various HHS operating divisions’ compliance with FISMA and conduct network and web application penetration testing that will help to determine if HHS and HHS’ operating divisions’ network and applications are susceptible to hackers.

**Other Department Reviews**

In FY 2013, HHS awarded nearly $344 billion in grants making HHS the largest grant-making agency in the federal government. Oversight of these funds is incredibly important, and, therefore, OIG will assist by determining how HHS awarding agencies mitigate grantee risk and whether these agencies receive and/or share information on grantees about which they have concerns. In a new effort for FY 2015, OIG will determine whether HHS operating divisions are taking adequate precautions to ensure that individuals and entities suspended or debarred are not awarded federal grants or contracts. A previous report by the U.S. Government Accountability Office suggested that some agencies needed greater attention, and oversight should be improved.

OIG also will continue its review of HHS charge card programs to determine if there are any illegal, improper, or erroneous purchases.
Under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, OIG has substantial responsibilities for initiating reviews that assess HHS' implementation and operation of ACA programs and progress toward achieving program goals. For FY 2015, OIG will prioritize this work in three main areas:

- Health insurance marketplaces (including financial assistance programs);
- Medicare and Medicaid reforms; and
- Grant expenditures for public health programs.

In FY 2015, OIG also is committed to initiating at least five to ten additional reviews addressing ACA programs, and as appropriate, will seek to work with other federal and state oversight agencies to address emerging vulnerabilities.

**Health Insurance Marketplaces, Financial Assistance Payments, and Market Stabilization Payments**

In FY 2015, OIG’s oversight strategy for the health insurance marketplaces and related programs will continue to focus on proper expenditure of taxpayer funds and the efficient and effective operation of the marketplaces. These reviews will address questions regarding payments (whether taxpayer funds are being expended correctly for their intended purposes), eligibility and enrollment (whether the right people are getting the right benefits), management and administration of marketplace programs (whether HHS is managing and administering marketplace programs effectively and efficiently), and security of information technology and consumer information.
In FY 2015, OIG will continue to examine the accuracy of aggregate payments to qualified health plan insurers for Advanced Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs) and the effectiveness of related internal controls. OIG also will continue to examine payments to Federally Facilitated Marketplace (FFM) contractors. New OIG activities for FY 2015 in this area include:

- Examining the accuracy of APTCs and CSR payments for individual enrollees;
- Looking at CMS' internal controls over APTC obligations and payments under the ACA;
- Assessing programmatic justification for CMS’ involvement in premium tax credit obligations under the ACA;
- Reviewing ACA establishment grants for state marketplaces;
- Following up on prior OIG work regarding Consumer Operated and Oriented Plan loans to verify eligibility status and use of startup and solvency loans; and
- Reviewing grant awards to navigators in FFMs or state partnership marketplaces.

With regard to eligibility and enrollment issues, OIG will continue its assessment of the inconsistencies in FFM data, but also, for the first time, in FY 2015 OIG will review ACA enrollment safeguards for state marketplaces and review the FFM’s eligibility verifications for premium tax credits.

OIG also will continue its work in FY 2015 regarding management and administration of marketplace programs, which will include reviewing efforts in implementing the FFM, reviewing acquisition planning and procurement for the FFM, and examining whether HHS exercised appropriate and adequate oversight and direction over contracts related to the FFM.

Finally, due to the sensitive nature of information stored in the FFM, security of data and the systems that house data are of paramount importance. Examples of OIG’s ongoing and planned FY 2015 work regarding security of information technology and consumer
education include reviewing CMS’ implementation of security controls over consumer information obtained in the FFM and conducting reviews of state-based marketplace system security controls.

**Medicaid and Medicare Reforms**

For FY 2015, and in light of the ACA’s significant expansion of the Medicaid program, OIG will continue conducting a wide range of reviews to examine the effectiveness and efficiency of the growing Medicaid programs. These reviews will focus on areas including prescription drugs; billing, payment, reimbursement, quality, and safety of home health services, community-based care, and other services, equipment, and supplies; state management of Medicaid programs; information system controls and security; and Medicaid managed care. New reviews directly related to specific ACA provisions include:

- CFC state plan option under the ACA;
- Payments to states under the BIP; and
- State collection of rebates for drugs dispensed to Medicaid MCO enrollees.

OIG also will continue conducting reviews related to changes to the Medicare program. A new review in this area will focus on risk assessment of CMS’ administration of the Pioneer ACO Model.

**Other Programs**

In FY 2015, OIG will continue to conduct reviews of other programs related to the ACA. Specifically, OIG will conduct two new reviews, one regarding HRSA community health
centers’ compliance with grant requirements of the ACA, and the other regarding HRSA duplicate discounts for 340B purchased drugs.

**RECOVERY ACT REVIEWS [APPENDIX B]**

Under the American Recovery and Reinvestment Act of 2009 (Recovery Act), funding was allocated to OIG for discretionary oversight of HHS programs and operations that received supplemental funding from the Recovery Act. As part of its oversight activities, OIG has planned the following reviews to assess the propriety of HHS’ use of Recovery Act funds:

- Review of Medicare and Medicaid incentive payments from 2011 to eligible health care professionals and hospitals for adoption of EHRs and CMS’ safeguards to prevent erroneous incentive payments, including CMS’ plans for oversight of those incentive payments for the duration of the program. OIG noted that as of August 2014, Medicare EHR incentive payments totaled more than $16 billion.

- Continued review of various covered entities receiving incentive payments and their business associates, including EHR cloud service providers, to determine whether the security measures in place adequately protect the electronic information created or maintained by the certified EHR technology. The review will include audits of cloud service providers and other downstream service providers to assure compliance with the regulatory and contractual obligations.

In addition, OIG will continue to evaluate allegations of improper expenditures of Recovery Act funds to identify cases in which criminal investigations should be opened and enforcement actions pursued. OIG will enforce whistleblower protections and investigate credible allegations of reprisal for whistleblowers who reasonably believed they were being retaliated against for reporting misuse of Recovery Act funds.