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OIG 2000 work plan moves beyond billing focus

No end yet for PATH, transfer payments, and DRG payment window initiatives

The Department of Health and Human Services' Office of Inspector General (OIG) released a hefty 40-page Work Plan for FY 2000 that sets the stage for a range of new investigations for the year ahead. Compliance experts that comb the OIG's blueprint year after year say the new Work Plan, released Oct. 5, is a combination of ongoing investigations and new initiatives that shows the OIG is continuing its reach into all corners of hospital and provider operations.

"The overriding impression I had was that there is an increasing focus on quality of care, as opposed to just billing issues," says **Chris Idecker**, a partner with Ernst & Young in Atlanta. He adds that increased focus carries a risk for providers. "It is very difficult to measure because it is a lot more subjective than billing. It is also extremely difficult to monitor."

According to **Lisa Murtha**, KPMG's managing director in New York City, it is also clear that the OIG has yet to complete several ongoing investigations, notably the Physicians at Teaching Hospitals, Prospective Payment System Transfers and DRG Payment Window initiatives. "Some of these are things we have seen time and time again," she says. "The government has been able to recoup a fair amount of money in these areas, so there is really no incentive for them to stop now."

On a positive note, Idecker and Murtha both applaud the OIG for its treatments of DRG

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OIG offers five keys to unlocking advisory opinions

Over 100 providers have requested advisory opinions from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) since Congress enacted the statute two years ago. OIG Senior Counsel **Vicki Robinson** recently weighed in on the risks and benefits of requesting an advisory opinion, and a blueprint for optimizing that process.

"The bar for achieving a favorable opinion is fairly high," Robinson told attorneys at the Practising Law Institute's recent Health Care

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House Republicans seek to cut HCFA's fraud budget

Health Care Financing Administration (HCFA) Deputy Administrator **Mike Hash** told the House Ways & Means Health Subcommittee that freezing the agency's budget for the Medicare Integrity Program (MIP) would have a "devastating" impact on the agency's ability to combat fraud and abuse in the Medicare program. But Rep. **Nancy Johnson** (R-CT) lays the blame for the freeze squarely at the doorstep of the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

Hash's assertion and Johnson's response came during a sharp exchange between Republicans and Democrats at a subcommittee hearing late last month. Johnson lashed out at what she called the excesses and "egregious activities" of the OIG, but offered no specifics. At stake is an effort by a House Appropriations subcommittee to freeze expenditures for not only MIP but the OIG, as well.

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investigations. "It is a more detailed work plan that I think shows an increasing acumen on the part of the OIG," says Idecker. He specifically points to the OIG's investigation into PPS discharge transfers, which has now been broken up into four separate parts.

"I like the fact that the OIG has included some of the specific DRGs they will be looking at, such as DRG 14 for cerebrovascular disorders," adds Murtha. "They have obviously identified some misuse and are going to be looking at that, but at least folks have a heads-up."

In addition to those familiar items, Murtha says hospitals and other providers should take heed at several items that have either been added to the OIG's Work Plan or moved up on its list of priorities. Here is a rundown of several of those areas:

♦ **Cost reports.** According to Murtha, the OIG's focus on cost reports may be a byproduct of the ongoing Columbia HCA investigation or other perceived issues related to cost reports. But she notes the OIG's Work Plan covers that area in considerable detail.

"It will be interesting to see how many organizations do cost report reviews in the coming year," she says, "because most of them tend to focus more on coding, billing, and charge master reviews."

♦ **Uncollected beneficiary deductibles and coinsurance.** According to Murtha, the issue of uncollected copayments and deductibles is a growing concern for many providers because it opens the door to the issue of 'professional courtesy.' She says the root question is whether providers should offer discounts and waive copayments and deductibles to employees within a hospital or provider group.

"This is an important development and something that people should pay a lot of attention to," Murtha warns. At a minimum, she says providers should get policies and procedures in place to identify what is acceptable in terms of professional courtesy.

♦ **Graduate Medical Education.** "Any organization that is involved in research of any kind should be paying a lot of attention to GME," cautions Murtha. She says the OIG is casting a potentially wide net over the entire issue of research compliance.

According to Murtha, one specific area that has captured the attention of many regulators is Medicare reimbursement as it relates to research grants. High on the list of potential targets are areas that are medically necessary but not related to the research grant, she says. In some cases, there may have been cases of double billing if reimbursement came through a research grant, as well as the Medicare program.

♦ **Medicare and Medicaid managed care.** Murtha says she expected to see Medicare and Medicaid managed care surface in the Work Plan, but was surprised at the level of detail included in the OIG's Work Plan. She notes that a growing number of managed care organizations are now seeking to develop and implement compliance programs around their Medicare and Medicaid business. Some are also looking to initiate specific investigations into some of the areas that the government has identified, such as physician incentive plans, the usefulness of the Medicare+Choice performance measures, and how individual companies stack up against those measures.

Murtha says the issue of outpatient prescription drugs and drug rebates also appears to be coming under more scrutiny. “Some of these so-called rebates have been interpreted to be kickbacks.” She warns that any party involved in one

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of those relationships should pay close attention to this initiative. “At a minimum, they should think about a risk assessment to identify any potential vulnerabilities.”

The OIG's Work Plan also includes a significant emphasis on nursing homes, says **Paul DeMuro** of Latham & Watkins, in Los Angeles. "I am sure the greater emphasis on skilled nursing facilities will continue to be an issue," he predicts.

According to DeMuro, the Work Plan has few surprises for physicians. He notes the plan does include examination of advanced beneficiary notices. "That has been a hot issue for the last couple years but if you look at the things set forth in the plan there really is not that much that's new," he says.

DeMuro notes that reassignment of physician benefits is probably the most noteworthy item given the OIG's crackdown on certain clinics and the use of provider numbers. "But the OIG has also been working on that with HCFA for some time.” ■

OIG work plan zeroes in on integrity agreements

While the FY 2000 Work Plan put out by the Department of Health and Human Services' Office of Inspector General (OIG) is typically viewed as a blueprint for developing compliance plans, it may actually have more value as a tool to structure corporate integrity agreements (CIA), say several experts in this area.

Relying too heavily on the OIG's Work Plan while developing a compliance program is like driving down the street looking in your rear view mirror, warns **Chris Idecker**, a partner with Ernst & Young in Atlanta. "The place I do use these work plans quite a bit is in corporate integrity agreements."

Howard Pearl, a health care attorney with Winston & Strawn in Chicago, IL, points out that the Work Plan itself emphasizes the importance of those agreements. "The thing that jumped out at me was the emphasis on corporate integrity agreements," he says. "The OIG has spent the last several years drafting, and negotiating agreements and now we are entering what I would call Phase II."

According to Pearl, Phase II will increasingly require the OIG to shift its emphasis to monitoring agreements already in place. "The critical years are the second and third and a lot of people are coming up on those," he warns. "That is when your process starts uncovering all your problems, and the government knows that.

"The new wrinkle they have started this year, and that I believe based on the Work Plan will continue into the future are site visits," he adds. "I have done one and I think that is the immediate concern for health care providers who are subject to these agreements.

"This is something they really are intent on focusing on," Pearl contends, "and because it is new, nobody has any idea what it entails."

Idecker takes a similar position. "The big danger is that these agreements are written so poorly that is it difficult to comply with them and difficult to monitor them," he says. "There is a lot of risk to companies under these agreements and a lot of misunderstandings between providers, the accounting community, and the OIG as to how these things ought to be handled."

An upcoming issue of *Compliance Hotline* will offer advice on how to minimize the risks posed by CIAs. ■

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Fraud and Abuse conference in Washington, DC. "But the significant guidance benefits outweigh the risks associated with filing a request."

Assuming that all regulatory requirements for submitting a request are satisfied, Robinson says the OIG's framework for analyzing an arrangement under the antikickback statute is generally broken down into several parts. She says providers should focus on five key areas — fact, reimbursement, risk, safeguards, and benefits — to maximize the value of advisory opinions.

I. Facts. According to Robinson, two factual aspects — possible referrals and possible remuneration — dominate the OIG's analysis of advisory opinions. The bottom line is that requesters must provide detailed and specific factual descriptions of

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their arrangements, she says. "We want to know what is really going on," she warns. "Our opinions turn on very specific factual issues."

She adds that most requesters are asked for additional information, but says those questions often enable providers to restructure their arrangements and develop additional safeguards. "If you hear our concerns, you may be able to improve what you are doing," she explains. "You should not take that as a sign that you have done a bad job in submitting your request."

II. Reimbursement. Understanding the ever-changing federal program reimbursement is often key to identifying the financial incentives that may be driving a deal. "Reimbursement is an aspect of kickback analysis that parties sometimes overlook when they are advocating for their arrangements in advisory opinion requests," she warns.

Robinson points to the advent of prospective payment systems that are rapidly altering financial incentives, as well as items and services that are separately reimbursable under a global or consolidated rate as two prime examples.

She advises potential requesters to look at several recent opinions — 99-2, 99-3, and 99-6 — as examples that demonstrate the importance of reimbursement as an issue in kickback analysis. "We do consult with HCFA in appropriate circumstances," she adds.

III & IV. Risks and safeguards. Risks and benefits many times can be viewed in tandem, according to Robinson. "We identify the possible risks of a particular arrangement and look to see if the arrangement contains sufficient safeguards to protect against those risks," she explains.

When considering risks, she says the OIG often begins with its own prior guidance, and potential requesters should do the same. She also recommends that potential requesters review the preamble to the safe harbor regulations.

According to Robinson, the OIG zeroes in on four key risk areas — increased utilization, increased program costs, inappropriate steering of patients, and unfair competition.

Having assessed the risks, her office looks to see what safeguards are present that might minimize those risks, she says. "Here, there is a good opportunity for good and thoughtful lawyering," she contends. "Safeguards should be specific, not vague generalizations and they are best if they are clear, enforceable, objective, and verifiable."

Many opinions deal with the issue of safeguards, says Robinson. But she tells potential requesters to begin with 90-75, 98-10, and 98-96.

V. Benefits. The OIG's final consideration is benefits, Robinson says. "If taking into account all of the risks and safeguards, [and] the arrangement poses relatively little risk of harm, then we look at the benefits such as increased access to care and expanded patient choice," she says. "But again, we are looking for evidence of real benefits, not speculative and theoretical ones.

"There is one element missing from this list and that is intent," concludes Robinson. "We do not make determinations of intent for the purposes of an advisory opinion." As a result, a negative opinion is not a determination of an actual violation, but rather a determination that there "may be a violation if the requisite intent is present." ■

Budget freeze

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA) dedicated $630 million to fund MIP in FY 2000. Instead, Republican appropriators are trying to cap it at the current level of $560 million. Notably, HIPAA also authorized $100 million for the past two years for Medicare+Choice consumer education. But Republican appropriators want to drop that number from the current $95 million to $15 million.

Those reductions, which are included in a House Appropriations mark, may or may not see the light of day, House Appropriations staff admit. The latest proposal in the Senate would increase spending for MIP and Medicare+Choice to the $630 million and $95 million called for by HIPAA. For its part, the White House is renewing efforts to boost Medicare+Choice education dollars to $150 million.

"Ordinarily, none of this would have to go through the appropriations process because it was dedicated funding," says a HCFA spokesperson. "The fact that it showed up in the bill at all was a little unusual, but doing it that way lets them try to cut $70 million from MIP." ■