*Hospitals*

Oversight of hospital privileging

The OIG will determine how hospitals assess medical staff candidates before granting initial privileges,

including verification of credentials and review of the National Practitioner Databank. Hospitals that

participate in Medicare must have an organized medical staff that operates under bylaws approved

by a governing body. (42 CFR § 482.22). A hospital's governing body must ensure that the members

of the medical staff, including physicians and other licensed independent practitioners, are

accountable for the quality of care provided to patients. Robust hospital privileging programs

contribute to patient safety. (OEI; 06-13-00410; expected issue date: FY 2016).

Long-term-care hospitals—Adverse events in post-acute care for Medicare

beneficiaries (new)

The OIG will estimate the national incidence of adverse and temporary harm events for Medicare

beneficiaries receiving care in long-term-care hospitals (LTCHs). The OIG will also identify factors contributing to these events, determine the extent to which the events preventable, and estimate the associated costs to Medicare. LTCHs are inpatient hospitals that provide long-term care to clinically complex patients, such as those with multiple acute or chronic conditions. Medicare beneficiaries typically enter LTCHs following an acute-care hospital stay to receive intensive rehabilitation and medical care. LTCHs are the third most common type of post-acute care facility after SNFs and independent rehabilitation facilities (IRFs), accounting for nearly 11 percent of Medicare costs for post-acute care ($5.4 billion in FY 2011). (OEI; 06-14-00530; expected issue date: FY 2015) .

*Long Term Care*

Program for national background checks for long-term-care employees.

The OIG will review the procedures implemented by participating States for long-term-care facilities or providers to conduct background checks on prospective employees and providers who would have direct access to patients and determine the costs of conducting background checks. The OIG will determine the outcomes of the States' programs and determine whether the programs led to any unintended consequences. Section 6201 of the Patient Protection and Affordable Care Act (ACA)requires the Secretary of Health and Human Services to carry out a nationwide program for States to conduct national and State background checks for prospective direct patient access employees of nursing facilities and other long-term-care providers. The program is administered by CMS. To carry out the nationwide program, CMS has issued solicitations for grant awards. All States, the District of Columbia, and U.S. territories are eligible to be considered for a grant award. OIG is required under the ACA to submit a report to Congress evaluating this program. This mandated work is ongoing and will be issued at the program's conclusion, as required. (ACA, § 6401.) (OEI; 07-10-00420; expected issue date: FY 2015; ACA)

Home Health

Employment of individuals with criminal convictions

The OIG will determine the extent to which HHAs employed individuals with criminal convictions. The OIG will also examine the criminal convictions of selected employees with potentially disqualifying convictions. Federal law requires that HHAs comply with all applicable State and local laws and regulations. (Social Security Act, §1891(a)(5), implemented at 42 CFR § 484.12(a).) Nearly all States have laws prohibiting certain health-care-related entities from employing individuals with certain types of criminal convictions. (OEI; 07-14-00130; expected issue date: FY 2015)

*Ambulance Services*

Ambulance services—Questionable billing, medical necessity, and level

of transport. The OIG will examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports that potentially never occurred or potentially medically unnecessary transports to dialysis facilities. The OIG will also determine whether Medicare payments for ambulance services made in accordance with Medicare requirements. Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports. Medicare pays for emergency and nonemergency ambulance services when a beneficiary’s medical condition at the time of transport is such that other means of transportation are contraindicated (i.e., would endanger the beneficiary). (Social Security Act, § 1861(s)(7).) Medicare pays for different levels of ambulance service, including Basic Life Support and Advanced Life Support as specialty care transport. (42 CFR § 410.40(b).) (OEI; 09-12-00351; 09-12-00353; expected issue date: FY 2015; and OAS; W-00-11-35574; W-00-12-35574; W-00-13-35574; W-00-14-35574; various reviews; expected issue date: FY 2015)

¬ Ambulance services—Portfolio report on Medicare Part B payments

The OIG 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 and offer recommendations to improve detected vulnerabilities and minimize inappropriate payments for ambulance services. Prior OIG work identified fraud schemes and trends indicating overuse and medically unnecessary payments. The planned portfolio will offer recommendations to address the vulnerabilities that The OIG have identified and improve efficiency. Medicare does not pay for items or services that are not “reasonable and necessary.” (Social Security Act, § 1862(a)(1)(A).) Specifically, ambulance services are covered “where the use of other methods of transportation is contraindicated by the individual’s condition….” (§ 1861(s)(7).)

The Medicare Benefit Policy Manual, § 10.2.1, more specifically states that Medicare covers

ambulance transports when a beneficiary’s medical condition at the time of the transport is such

that using other means of transportation would endanger the beneficiary’s health. Coverage

requirements and requirements for ambulance suppliers are in 42 CFR §§ 410.40 and 41. (OIG; OIG-12-14-02; expected issue date: FY 2016)

*Provider Eligibility*

¬ Enhanced enrollment screening process for Medicare providers

The OIG will determine the extent to which and the way in which CMS and its contractors have

implemented enhanced screening procedures for Medicare providers pursuant to the ACA, § 6401.

The OIG will also collect data on and report the number of initial enrollments and enrollment

revalidations approved and denied by CMS before and after the implementation of the enhanced

screening procedures. As part of an effort to prevent fraud, waste, and abuse resulting from

vulnerabilities in the Medicare enrollment process, CMS is implementing new authorities that

include site visits, fingerprinting, and background checks, an automated provider screening process. (OEI; 03-13-00050; expected issue date: FY 2015; ACA.)

*Quality of Care and Safety of Beneficiaries*

¬ Home health services—Screenings of health care workers

The OIG will review health-screening records of Medicaid home health agency (HHA) health care workers to determine whether they screened in accordance with Federal and State requirements.

Health screenings for home health care workers include vaccinations, such as those for hepatitis and influenza. HHAs provide health care services to Medicaid beneficiaries while the home health care workers are visiting beneficiaries’ homes. HHAs must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with accepted standards that apply to personnel providing services within such an agency. (Social Security Act, § 1891(a)(5).) The Federal requirements for home health services are found at 42 CFR §§ 440.70, 441.15, and 441.16 and at 42 CFR Part 484. Other applicable requirements are found in State and local regulations. (OAS; W-00-11-31387; various reviews; expected issue date: FY 2015).

**State terminations of providers terminated by Medicare or by other States**

**The OIG will review States’ compliance with a new requirement that they terminate their Medicaid program providers that have been terminated under Medicare or by another State Medicaid program. The OIG will determine whether such providers are terminated by all State Medicaid programs in which they are enrolled, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify obstacles States face in complying with the termination requirement. The new requirement became effective January 1, 2011. (Social Security Act, § 1902(a)(39), as amended by the ACA, § 6501.) (OEI; 06-12-00030; expected issue date: FY 2015; ACA)**

**State and CMS collection and verification of provider ownership information**

**The OIG will determine the extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. The OIG will also review States’ and CMS’s practices for collecting and verifying provider ownership information and determine whether States and CMS had comparable provider ownership information for providers enrolled in Medicaid and/or Medicare. Federal regulations require Medicaid and Medicare providers to disclose ownership information, such as the name, address, and date of birth of each person with an** **ownership or controlling interest in the provider entity. (42 CFR § 455.104.) (OEI; 04-11-00590,**

**04-11-00591, 04-11-00592; expected issue date: FY 2015)**

**¬ States' experiences with enhanced provider screening**

The OIG will review States’ use of enhanced screenings that assess risk for fraud, waste, and abuse for moderate- and high-risk enrolling and revalidating Medicaid providers and suppliers. The OIG will also determine the results of States’ efforts to prevent risky providers and suppliers from participating in Medicaid before and after the implementation of enhanced screenings. The ACA, § 6402, requires enhanced screening for providers and suppliers seeking initial enrollment, re-enrollment, or revalidation in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). States are responsible for employing screening and revalidation procedures for their Medicaid and CHIP providers. (OEI; 05-13-00520; expected issue date: FY 2015; ACA)

**¬ Provider payment suspensions during pending investigations of credible fraud**

**allegations**

The OIG will review payments to providers with allegations of fraud deemed credible by States. The OIG will also review States’ processes for suspending payments. FFP in Medicaid is not available for items or services furnished by an individual or entity when the State has failed to suspend payments during a period when there is a credible allegation of fraud. (Social Security Act, § 1903(i)(2), as amended by the ACA, § 6402(h)(2).) Upon determinations that allegations of fraud are credible, States must suspend all Medicaid payments to the providers, unless the States have good cause to not suspend payments or to suspend payment only in part. (42 CFR § 455.23(a).) States are required to make fraud referrals to Medicaid Fraud Control Units (MFCUs) or to appropriate law enforcement agencies in States with no certified MFCUs. (42 CFR § 455.23(d).) The OIG will determine whether select Medicaid State agencies are in compliance with these provisions. (OAS; W-00-14-31473; various reviews; expected issue date: FY 2015; and OEI; 09-14-00020; expected issue date: FY 2015; ACA)