Report on
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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

Court Throws Out $347M FCA Verdict, Saying Deficiencies Aren't *Escobar* Material

In a biting decision that cited the landmark Supreme Court decision in the *Escobar* case, a federal court voided a $347 million False Claims Act verdict against a chain of skilled nursing facilities (SNFs) because the government paid their claims even though there allegedly were documentation problems. If the "disputed practices" alleged in the complaint against Consulate Health Care (CHC) weren't "material" enough to interrupt reimbursement, they won't pass the *Escobar* test for proving false claims under the implied certification theory, the U.S. District Court for the Middle District of Florida ruled on Jan. 11.

"*Escobar* rejects a system of traps, zaps and zingers that permits the government to retain the benefit of a substantially conforming good or service but to recover the price entirely—multiplied by three—because of some immaterial contractual or regulatory noncompliance," according to the decision by Judge Steven Merryday.

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CMS Holds Claims Under Therapy Cap, Which Now Spares Hospitals; New Codes Are in Play

Unless Congress intervenes, outpatient therapy in 2018 straddles two worlds, with a Medicare cap in place for therapy provided in virtually all settings except hospital outpatient departments. The exceptions process, which allowed providers to bill for medically necessary therapy beyond the cap, expired Dec. 31, 2017, although CMS announced on Jan. 17 that it will hold claims affected by the cap and the expiration of the exceptions process for a short time "to limit the impact on Medicare beneficiaries." CMS said it will process the claims soon if Congress doesn't come to the rescue of outpatient therapy and either lift the cap or allow exceptions.

If there's no action, providers of outpatient physical, occupational and speech therapy can no longer bill for rehab above the cap even if it's medically necessary, said Nancy Beckley, president of Nancy Beckley & Associates, at a webinar sponsored by RACMonitor.com. But the cap doesn't apply to hospital outpatient departments that are provider-based, which apparently has been a source of confusion in the hospital and therapy world. The cap was first applied to hospital outpatient departments in 2012, and it was extended, with an exceptions process, in the Medicare Access and CHIP Reauthorization Act (MACRA), but that also ended Dec. 31. "The therapy cap is per beneficiary, except that services provided at hospitals don't accrue toward the cap," she said.

Outpatient therapy providers of all stripes, meanwhile, must adapt to changes in therapy codes that took effect Jan. 1.

The annual cap for 2018 is $2,010 for physical therapy and speech-language pathology services combined, and $2,010 for occupational therapy services.

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Because of the cap on other rehab providers and the disappearance of the exceptions process, the KX modifier is meaningless, and they shouldn't append it to claims, Beckley said. "It's a firm cap with no exceptions process," she emphasized.

CMS's announcement shed little light on the therapy bind providers and beneficiaries are in, Beckley said. CMS already holds all types of claims paid electronically for 14 days, as required by law. Is that about the same amount of time it will hold claims under the cap? It said only that the claims it holds will date back to Jan. 1.

Meanwhile, the Therapy Cap Coalition, which includes therapy associations and patient groups, including the American Physical Therapy Association, is lobbying Congress for legislation to lift the cap.

In November 2017, there was bipartisan agreement on a Medicare extenders bill, which, among other things, would permanently end the therapy cap and require manual medical reviews for therapy claims over $3,000 per beneficiary. The Medicare extenders bill, which was announced by House Committee on Ways and Means Chairman Kevin Brady (R-Tex.), could be attached to whatever funding measure comes out of Congress, whether it's a stopgap bill that's enacted by midnight Jan. 19 to prevent a government shutdown or a longer term budget bill, Beckley said. If reauthorization of the Children's Health Insurance Program isn't included in the continuing resolution, the Medicare extenders bill could be included in a separate bill funding CHIP because its money runs out March 31.

If an exceptions process gets through Congress, "it will not be 100% medical review as it was in 2013 and 2014, when recovery audit contractors were assigned to reviews," she explained. CMS probably would choose the supplemental medical review contractor, which is StrategicHealthSolutions, to conduct manual medical reviews.

If not, some patients will eat through their therapy benefit quickly. "If you are at a type of facility with patients treated for stroke, getting speech and physical therapy, like an outpatient neurological center or rehab agency, those patients could reach their cap next week," she said. "Those are the patients who need therapy the most."

Therapy Has Auditors' Attention

Outpatient rehab has already attracted scrutiny from the HHS Office of Inspector General, which has been auditing therapy practices and finding high error rates. For example, OIG said in an August 2017 audit report that 85 of 100 claims submitted by FOX Rehabilitation included services that weren't medically necessary. As a result, OIG estimated that New Jersey-based FOX improperly received $29.9 million in Medicare reimbursement.

Now Beckley thinks the new CMS medical review strategy—Targeted Probe and Educate (TPE)—will sweep in outpatient therapy. TPE, which is run by Medicare administrative contractors (MACs), replaces all other medical reviews and focuses on providers and suppliers with high billing rates or unusual billing practices *(RMC 12/18/17, p. 4)*.

She has a few problems with TPE. First of all, CMS says providers with compliant claims will escape TPE, but "that's nonsense," Beckley said. "Many times they can't determine if a claim is compliant unless the chart is pulled for review, and that is the case with therapy."

New Codes Mean Revenue Changes

Also, MACs are using data analysis to identify providers who have high claim error rates for unusual billing practices. That may put therapists in the crosshairs for the wrong reasons, she explained. For example, outpatient clinics with therapists who specialize in hand therapy will have a high rate of claims for CPT 97022. It may show up as aberrant data compared to other clinics in the MAC jurisdiction or state, but MACs can't determine whether the claims are appropriate unless they review medical records.

The 2018 Medicare Physician Fee Schedule decreased the value of 12 therapy codes and increased the value of seven therapy codes, Beckley said. These

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changes should not tempt providers to game their coding. "If you try to make rapid changes, you are a bona fide target for TPE," she cautioned.

For example, CPT code 97710 for the Wisconsin locality has decreased in reimbursement from $34.49 to $32.60 per unit, and CPT 97140 went from $31.57 to $29.32 per unit, while reimbursement for CPT 97530 rose from $36.77 to $43.04 per unit, without considering any deductions for multiple procedure payment reduction or sequestration, Beckley said.

She described some of the therapy-related changes that the American Medical Association made to the CPT codes and moves that CMS made as well. The code for reporting cognition intervention has changed: CPT code 97532, a cognitive skills, time-based code, has been deleted. In its place is 97127, which is also a cognitive skills code, but therapists report it as a service-based code. That code can only be reported once per day. CMS, however, won't use the new cognitive code, and instead created a time-based code for cognitive skills, G5015, which may be billed in units of 15 minutes, Beckley said.

In the area of orthotics and prosthetics, the CPT book deleted 97762 and revised other codes: 97760 (orthotics management and training, each 15 minutes) and 97761 (prosthetics, upper and lower extremities, each 15 minutes). They are each reported for initial encounters. There's also a new code: 97763 (orthotics/prosthetics management and training, subsequent encounter, each 15 minutes).

Time Loses Meaning

She says she's observed reviewers and therapists mistakenly thinking that time is a component of the new PT and OT tiered evaluation codes. Even some of the MACs include time as a component in their provider training on the new therapy evaluation codes, and she has seen commercial insurers deny therapy claims for evaluations because they lack the "requisite" number of minutes. That's just flat-out wrong, Beckley asserted.

Therapy will become an even hotter topic now that CMS has taken total knee replacement off the inpatient-only list, which means some of these procedures will be performed on hospital outpatients *(RMC 11/13/17, p. 1)*. Rehab is an essential part of the post-recovery process for total knee replacement, and many therapists will work with hospitals on what Beckley sees as an emerging opportunity: "prehab" to prepare patients for surgery and identify comorbidities.

Contact Beckley at nancy@nancybeckley.com. To learn more about the 2018 updates to outpatient therapy rehab, visit https://tinyurl.com/y94jd49d. View the CMS announcement about the therapy cap at https://tinyurl.com/yafh7sl5. ✧

Stark Law Complicates NPP Services and Productivity Compensation

More hospitals and medical groups both employ non-physician practitioners (NPPs) and compensate their physicians for productivity, two facts of life that together can bring trouble under the Stark Law. The irony is that NPPs, who are hired to improve efficiency and patient access, may appear to reduce the productivity of physicians who are compensated based on productivity.

The challenge for hospitals and medical groups is to compensate physicians who work with NPPs—including physician assistants (PAs) and nurse practitioners (NPs)—and stay within the four corners of the Stark Law, says attorney Bob Wade, with Barnes & Thornburg in South Bend, Ind. "When you have NPPs in the mix, you have to understand which exception you fall under and how to account for the services of the NPP," he says.

M.D.s Can Be Paid for Supervision

Hospitals that employ physicians have the Stark employment exception. To satisfy the employment exception, they have to back out NPPs from productivity compensation, Wade says. Productivity compensation usually means work relative value units (work RVUs), which capture the volume of patients treated and the effort that goes into it. The problem is, productivity compensation probably can't take into account the services rendered by NPPs incident to the physician's services in an office setting or during hospital shared visits because the Stark employment exception requires physicians to personally perform the services, Wade says, and compensation must be at fair-market value for these services. However, the physicians can be compensated for supervising the NPPs, he notes.

"It's possible a physician can't be compensated for 100% of the work RVUs because he or she didn't perform them," Wade says. "It becomes a fair-market value and possibly a commercial reasonableness issue," two cornerstones of Stark compliance. The same problem arises with shared services in the hospital setting. Medicare pays physicians 100% of their professional fees for certain evaluation and management (E/M) services provided in the hospital even though NPPs do some of the work. What if the NPP's participation pushes the E/M service from a level two to a level three? Again, the theory under Stark is the hospital can only compensate the physician for personally performed services. To use NPP services to influence the evaluation and management services, NPPs must be employed or contracted with the physician entity.

To ensure compliance, some hospitals and medical groups are going through their specialists one by one and figuring out what percentage of services are

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Checklist for Physician Arrangements

This checklist for physician arrangements, which is designed to improve compliance with fraud and abuse laws (e.g., the Stark Law and Anti-Kickback Statute), was developed by Susan Thomas, a manager at PYA, and Tynan (Olechny) Kugler, a principal at PYA. Contact Thomas at sthomas@pyapc.com and Kugler at tkugler@pyapc.com.

1. Acquire the physician's contract.	
Establish how the physician is classified – employee, independent contractor, other.	☐
Determine all of the duties the physician is providing – clinical services, medical director, professional services, on-call, administrative, teaching.	☐
Confirm that the physician and hospital/health system authority have both signed the contract in accordance with authority limits and applicable policies and procedures.	☐
Verify that hospital/health system legal counsel approves all contracts.	☐
2. Review the process and controls for payment.	
Establish that the contract describes the methodology for compensation.	☐
Determine whether a fair market value assessment has been completed for the arrangement and that it includes all sources of payment.	☐
Evaluate all types of supplemental compensation included in the contract. Loans ☐ Practice support (equipment, staffing, stipend, etc.) ☐ Sign-On Bonus ☐ Grants ☐ Relocation Expenses ☐ Miscellaneous ☐	
Determine whether a commercial reasonableness analysis (including a needs assessment) has been completed for the arrangement and documented in the file.	☐
3. Identify the physician's duties.	
Confirm that the contract defines the specific duties of the physician based on the type of arrangement, including any and/or all limitations for the provision of outside services or employment.	☐
Examine all contracts for each physician to determine whether there are duplicative duties for which the physician will be compensated.	☐
Determine whether the term of the contract is for at least one year, and whether it can be terminated without notice within one year.	☐
Review the contract for supervisory duties and the method for allocating compensation for supervised services.	☐
4. Identify a performance evaluation process.	
Verify that the contract includes an annual performance evaluation to validate the physician's professional capabilities and productivity.	☐
Determine if the contract includes functional metrics to ensure that care, treatment, and services provided through the contractual agreement are administered safely and effectively.	☐
Identify the frequency of the performance evaluation and the functional metrics review.	☐

5. Review contract documentation.	
Determine whether the contract requires the physician to provide documentation of delivered services and hours spent performing duties as applicable.	☐
Review documentation of time spent, and compare to contract and payment terms. • On-Call Coverage – Document on-call response and that the response was consistent with contract requirements. • Medical Directorship – Document time spent for required duties. Compare submitted documentation to contract and payment terms. • All Contracts – Document fair market value assessment, commercial reasonableness, and needs assessment.	☐

6. Review all forms of supplemental compensation.	
Evaluate supplemental compensation to determine if the compensation is provided within the terms of the agreement (*e.g.*, compensation terminated on the appropriate date as defined by the contract).	☐
Determine whether there is a forgiveness or repayment plan included in the contract.	☐
Evaluate the documentation utilized to track the schedule of forgiveness or repayment.	☐

7. Review the payment rate.	
Determine if payment to the physician aligns with the contract: • Review payroll information for employed physician, including hours and payments. • Review accounts payable (A/P) information for contracted physicians, including invoices, check requests, and A/P entries. • Review non-monetary compensation for all physicians, including gifts, gratuities, entertainment, meals, etc.	☐

8. Identify and prioritize physician compensation risks, including, but not limited to:	
Stacked agreements – one physician with multiple agreements that provide compensation	☐
Unsigned contracts or contracts that do not define accountability for monitoring the terms and conditions	☐
Contracts for services that are performed by another physician or employee	☐
Any implication the physician is compensated for volume or value of referrals	☐
Longstanding evergreen contracts	☐
Compensation rates which may be inconsistent with fair market value	☐
Agreements that do not include an assessment of fair market value	☐
Questionable timesheets – *e.g.*, multiple timesheets completed and provided on the same date, timesheets with the same work performed during the same hours each month	☐
Missing physician signature and executive approval on timesheets	☐
Hours worked less than or greater than the terms of the contract	☐
Duties submitted for compensation not included in the contract	☐

performed by the physician vs. the NPP, he says. "If you're compliant, you have to take into account the value of services performed by the NPP and back that out of the productivity compensation," Wade says.

Another twist: There's growing compliance concern around independent physicians' use of NPPs employed by hospitals, Wade says. A hospital client recently sent a notice to its independent physicians informing them the hospital now employs NPPs to help provide services, but advising the physicians against their using the NPPs to enable the physicians to code a higher level of service otherwise performed by the physician. Hospitals generally should take this to heart, he says. "If the hospital pays for the NPPs and the doctor uses their services to increase their coding levels, then the doctors are technically receiving free services, and that is a violation of Stark and possibly the Anti-Kickback Statute," Wade says.

Because risks mutate and hospitals typically have dozens or hundreds of physician agreements, they need a predictable process for contract management and oversight, says Susan Thomas, a manager with PYA. "We see quite a lot of risky behavior."

Stacking Is a Risk

When she was a compliance officer, there was often a "perceived dire need to complete the physician arrangement." It's better to slow down and do it right, with "early compliance involvement," Thomas says (see checklist, p. 4). "It saves a lot of headaches down the road."

Hospitals also have to guard against stacking, says Shannon Sumner, consulting principal with PYA. They may pay a physician fair-market value for each service, such as medical directorships and on-call coverage, but if hospitals have multiple agreements with the same physician, "they may be outside the bounds of fair-market value and commercial reasonableness," she notes.

Even when arrangements hit all the right compliance notes, sometimes there's a "breakdown in the execution of the arrangements," Sumner says. That's why physician arrangements should be on a hospital's audit work plan, with oversight by the board's audit committee. She also recommends a charter that anchors the contract management process. "It would describe the hospital's philosophy of entering physician compensation arrangements and give guidance for day-to-day execution of the compensation plan," Sumner explains. For example, it might state that the physician compensation committee reviews all payment terms in contracts where physicians are paid less than the 75th percentile, but above that, contracts will be elevated to the board.

When conducting reviews of physician arrangements, Thomas suggests pulling 1099 tax forms at the end of the year by physician name and then isolating them by type of payment. "Reconcile the payments going out to determine whether you have corresponding contracts to support the payments," she says.

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Court Throws Out $347M Verdict

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He took swipes at the whistleblower's case, saying, "The defendants argue persuasively that the relator failed to offer evidence of materiality, defined unambiguously and required emphatically by *Universal Health Services, Inc. v. Escobar, 136 S. Ct. 1989 (2016)*...The record fatally wants for evidence of materiality and scienter."

A spokesperson for the whistleblower's attorney tells *RMC* they plan to appeal Merryday's decision. "We believe the jury's verdict correctly reflected the evidence at trial and the law, and that the judge's opinion overturning that verdict is in error."

Despite this decision, continued payment by Medicare, Medicaid or TRICARE isn't the same as giving questionable practices a green light, says former federal prosecutor Robert Trusiak. "Compliance officers struggle with the incantation by staff that Medicare has always paid the claim and therefore it must be OK," he says. *Escobar* offers no relief to "misrepresenting providers" if there's a lack of supporting documentation for a level-five evaluation and management service, or medical necessity for hospital admissions, procedures and drugs, says Trusiak, who is now in private practice.

The false claims complaint was filed in 2011 against five entities of CHC, which operates 53 SNFs in Florida, and includes Salus Rehabilitation. The whistleblower, Angela Ruckh, alleged the defendants upcoded Medicare resource utilization groups (RUGs), which are the SNF units of payment, and failed to create and maintain Medicaid plans of care. "The relator argued at trial that certain Consulate facilities had committed fraud by allegedly billing certain patient claims to Medicare and the Florida Medicaid program without sufficient supporting documentation," according to a statement from Skadden Arps, CHC's law firm. The Department of Justice did not intervene in the lawsuit.

Lawyer: A Case of Too Big to Fail

CHC went on trial in January 2017, and the whistleblower won the case, with the jury finding the defendants submitted false Medicare and Medicaid claims and hitting them with $115 million in damages. A judge trebled that amount to $347 million, but Merryday has thrown out the verdict, relying on the June 16, 2016, decision in *Escobar*, which supported the theory of

implied certification as a basis for a false claims case *(RMC 6/20/16, p. 1)*. *Escobar* allows liability to attach "when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant's noncompliance with a statutory, regulatory, or contractual requirement," the nation's highest court ruled, if the noncompliance is "material" to the government's payment decision.

Escobar was not the only factor in overturning the CHC verdict. "The defendants were too big to fail," Trusiak says. After the $347 million verdict came down, the federal court issued a stay pending appeal based on CHC's argument that paying the fines would cause the collapse of SNFs in 17 states, he says. "Money, profits, cash calls and defaults are all irrelevant to the *Escobar* materiality analysis; however, the court's opinion vacating the judgment of the jury expressly noted the 'slim profit margin' of nursing home providers. Too big to fail was successfully used in 2008 during the financial crisis. [The CHC case] demonstrates it remains a viable defense strategy today."

'Charlatans' Are a Different Thing Altogether

The unanimous decision in *Escobar* came down in an appeal of a ruling from the U.S. Court of Appeals for the First Circuit, which held that Universal Health Services had violated Massachusetts Medicaid regulations on licensing and certification of mental health workers that "clearly impose conditions of payment" even though the conditions were not expressly stated. Julio Escobar had sued Universal Health Services under the False Claims Act over treatment his teenage daughter, Yarushka, received at Arbour Counseling Services, a satellite mental health facility in Lawrence, Mass., owned by a subsidiary of Universal Health Services. "In May 2009, Yarushka had an adverse reaction to a medication that a purported doctor at Arbour prescribed after diagnosing her with bipolar disorder. Her condition worsened; she suffered a seizure that required hospitalization. In October 2009, she suffered another seizure and died. She was 17 years old," the decision states. It turned out that "of the five professionals who had treated Yarushka, only one was properly licensed." Arbour billed Mass. Medicaid using payment codes that identified the therapy and counseling services provided. "By using payment and other codes that conveyed [information about the services and the staff qualifications to perform such services] without disclosing Arbour's many violations of basic staff and licensing requirements for mental health facilities, Universal Health's claims constituted misrepresentations," the court said.

Merryday saw distinctions between the allegations in the CHC/Salus Rehabilitation and Universal Health Services cases. "The fraud in *Escobar*—unqualified mental health providers and substandard mental health care—profoundly and manifestly affects a government's willingness to pay, a fact undoubtedly obvious to the provider," the judge said. "With predictable and sound reciprocity, the law charges the charlatans and quacks with knowledge of their own disrepute, that is, with knowledge that the information they have designed to misrepresent, hide, and distort would, to say the least, materially influence the decision of the party deciding whether to pay."

But in the CHC/Salus case, Merryday found the evidence lacking under the "rigorous and demanding" standard that *Escobar* set for evaluating materiality. "The evidence shows not a single threat of nonpayment, not a single complaint or demand and not a single resort to an administrative remedy or other sanction for the same practices that result in the enormous verdict at issue."

Like other decisions that have come down since the Supreme Court ruling, Merryday's opinion is more evidence that "you don't have an *Escobar* case" if the government continues to pay for services even when it's aware of potential noncompliance, says Washington, D.C., attorney Elizabeth Carder-Thompson, with Reed Smith LLP. But not all noncompliance is the same; most courts of appeal are looking at whether defendants "affirmatively mislead the government about compliance requirements that they knew were material," she says.

Supreme Court May Take Another FCA Case

Whether a recent case "bucks the trend" may be decided by the Supreme Court this term, Carder-Thompson notes. On Dec. 26, 2017, Gilead Sciences, a pharmaceutical manufacturer, petitioned the high court to hear its defense of a FCA lawsuit. The

CMS Transmittals

Jan. 11–18

Live links to the following documents are included on *RMC's* subscriber-only webpage at hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-02, Medicare Benefit Policy Manual

- Internet Only Manual (IOM) Update to Pub. 100-02, Chapter 11 - End Stage Renal Disease (ESRD), Section 100, Trans. 240 (Jan. 19, 2018)

Pub. 100-20, One-Time Notification

- ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs), Trans. 2005 (Jan. 18, 2017)

whistleblower alleged Gilead violated the FCA by seeking Medicare payment for FDA-approved drugs that had been manufactured using chemicals from non-FDA-approved Chinese facilities, Carder-Thompson says. The case seemed to be going nowhere, but then the U.S. Court of Appeals for the Ninth Circuit "resurrected it," she says, rejecting "the argument that the FDA's continued approval and ongoing government reimbursement for Gilead's drugs meant that any violations were not material under the FCA."

The Gilead and CHC cases may not be comparable, Carder-Thompson says. While the whistleblower alleges Gilead "affirmatively misled the government," there wasn't evidence to that effect in the CHC case, "and that may be the critical distinction," she explains.

But Trusiak found some of the findings in the CHC/Salus decision out of step with regulatory imperatives. The court characterized the SNFs' failure to sign, date and complete comprehensive care plans as "administrative noncompliance" or a "recordkeeping deficiency." That flies in the face of the clinical "mantra" that if it's not documented, it didn't happen, he says. "CMS has defined comprehensive care plans as the essential communication tool to be used by the interdisciplinary team to provide coordinated services," Trusiak notes. "The compliance takeaway should be that the mantra continues unabated. Complete documentation of care, prepared in accordance with state and federal rules, will always be the best means to mitigate risk."

Trusiak also is concerned about the emphasis on continued payment and its link to materiality. As the judge wrote, "the evidence and the history of this action establish that the federal and state governments regard the disputed practices with leniency or tolerance or indifference or perhaps with resignation to the colossal difficulty of precise, pervasive, ponderous, and permanent record-keeping in the pertinent clinical environment."

Patient Harm May Be a Factor

That's a simplification of how CMS uses its enforcement powers, Trusiak says. CMS has to move cautiously before suspending payments. For example, would nursing home patients be put in harm's way if CMS shut off the SNF payments? "The [CHC] decision would force the government to make the Hobson's choice of suspending payments now and creating immediate jeopardy for residents to preserve the ability to litigate a false claims case months or years from trial," he says. "The law does not require this Hobson's choice."

In addition to throwing out the verdict and closing the case, Merryday issued a second, "conditional" decision granting a new trial, says Washington, D.C., attorney Kelly Hibbert, also with Reed Smith. Practically speaking, it provides the defendants with an opportunity for a new trial if an appellate court determines that judgment for the defendants was unwarranted, she explains.

Contact Trusiak at robert@trusiaklaw.com, Carder-Thompson at ecarder@reedsmith.com and Hibbert at khibbert@reedsmith.com. The decision is *United States ex. rel. Ruckh v. CMC II, LLC, No. 8:11-cv-1303-T-23 (M.D. Fla. Jan. 11, 2018).* ✧

NEWS BRIEFS

◆ **Hospitals should expect regulatory relief in the Medicare Conditions of Participation (COP), CMS Administrator Seema Verma said on a Jan. 18 American Hospital Association "Town Hall Interactive" webcast with AHA President Rick Pollack.** Verma said when CMS reached out for feedback from providers on the "most onerous regulations," they pointed to the COP. "A lot are not necessarily in the payment rules. They are in the Conditions of Participation," Verma said. "We will put out new regulations that are intended to be deregulatory." If a requirement comes from Congress, however, CMS can't mess with it. "But if we can change it, how can we change it?" CMS also will assemble an interagency group, with the Department of Justice and Office of Inspector General, to look at the Stark Law and its regulations, which are ripe for an update. In terms of rural providers, Verma said, "We will look at every policy we put out through a rural lens." Some policies may not make sense for a rural provider, or maybe they need "more time or technical assistance." Visit http://windrosemedia.com/windstream/aha/011718/ to watch the video.

◆ **The HHS Office of Inspector General has posted an update to its Work Plan, which is a road map of audits, evaluations and investigations.** There are six new items. They include potential abuse and neglect of Medicare beneficiaries, which appears to be a sweeping review; an OIG toolkit to identify patients at risk of opioid abuse; and "the financial impact of health risk assessments and chart reviews on risk scores in Medicare Advantage." Visit https://go.usa.gov/xnv46.