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The OIG's 2010 Work Plan — What's Critical for Long-Term Care & Community-Based Providers

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The Work Plans issued by the Department of Health and Human Services, Office of the Inspector General (OIG) give providers insight into what the OIG believes are areas prone to fraud, waste and abuse. Thus, long-term care providers can utilize this information, along with other available guidance, to develop compliance plans and activities for the upcoming year.

In the last *Payment Matters* publication, we discussed the October 1, 2009 release by the OIG of its FY 2010 Work Plan [PDF] and, specifically, the provisions within the Work Plan that will affect hospital providers. We now focus on the Work Plan provisions that address perceived issues involving home health agencies, nursing homes, hospice providers, and other providers rendering services in these long-term care settings. We have divided our summary of these provisions into "new" and "continuing" initiatives based on whether the issue was previously addressed in the FY 2009 Work Plan.

Home Health Agencies

New Initiatives:

- Part B Payment for Home Health Beneficiaries: The OIG will review Part B payments made to outside suppliers for services and medical supplies that are included in the home health agency (HHA) prospective payment to determine the adequacy of established controls designed to prevent inappropriate payment.

- Home Health Agency Outlier Payments: Due to the significant increase in outlier payments for high cost episodes, the OIG will review methodology developed by the Centers for Medicare and Medicaid Services (CMS) for calculating outlier payments to HHAs to determine whether it reimburses HHAs as intended.

- Home Health Prospective Payment System Controls: Noting the substantial increase in payments to HHAs since the

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implementation of the home health Prospective Payment System (PPS) in October 2000, the OIG will review HHA compliance with the home health PPS. The OIG will also evaluate trends in HHA billing, the number of visits to beneficiaries, arrangement with other facilities, ownership information and other HHA activities.

- Home Health Agency Profitability: Noting the significant increase in HHA expenditures, the OIG will review cost report data to analyze HHA profitability trends under the home health PPS.

- Medicare Home Health Payments for Diabetes Self-Management Training Services: The OIG will review appropriateness of HHA claim submissions for diabetes self-management training services in geographic areas with high utilization of these services.

- Oversight of Home Health Agency Outcome and Assessment Information Set (OASIS) Data: The OIG will review CMS's process for ensuring that HHAs submit accurate and complete OASIS data.

Continuing Initiatives:

- Accuracy of Coding and Claims for Medicare Home Health Resource Groups: The OIG will continue to review Medicare claims submitted by HHAs to determine the accuracy of home health resource group (HHRG) billing codes and whether the HHRG billing code selected is fully supported by documentation in the medical record. The OIG will also evaluate the accuracy of HHRG assignments and look for any potential patterns of upcoding by HHAs.

- Medicare Home Health Payments for Insulin Injections: The OIG will continue to review billing patterns in geographic areas with high rates of home health visits for insulin injections to determine the appropriateness of services billed, including review of outlier payments made under the Medicare home health benefit for such services.

- Medicaid HHA Claims: The OIG will continue to review Medicaid HHA claims to determine whether providers have met the applicable criteria to provide services, including, among other things, minimum staffing levels, proper licensing, review of service plans of care, and proper authorization of services. The OIG will also evaluate whether beneficiaries meet eligibility criteria.

Nursing Homes

New Initiatives:

- Medicare Requirements for Quality of Care in Skilled Nursing Facilities: The OIG will review how Medicare skilled nursing facilities (SNFs) have: developed plans of care based on assessments of beneficiaries; used the standardized Resident Assessment Instrument (RAI) to develop plans of care; provided services in accordance with these plans of care; and planned for beneficiaries' discharges.

- Nursing Home Emergency Preparedness and Evacuation During Selected Natural Disasters: The OIG will review nursing facilities emergency plans and emergency preparedness deficiencies cited by State surveyors.

- Criminal Background Checks for Nursing Facility Employees: The OIG will review the extent to which nursing facilities have employed individuals with criminal convictions.

- Oversight of Poorly Performing Nursing Homes: The OIG will review the impact that federal and state enforcement measures have had on improving quality of care to beneficiaries residing in nursing facilities. The OIG will also review the extent to which CMS and States follow up with poorly performing nursing homes to ensure plans of correction have been implemented.

- Medicaid Nursing Home Patients Quality of Care: The OIG will identify nursing facilities that have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions.

- Medicaid Incentive Payments for Nursing Facility Quality of Care Performance Measures: The OIG will review Medicaid incentive payments to determine whether States have sufficient controls to assess nursing facilities' quality of care performance measure and determine whether States have made incentive payments in accordance with program requirements.

Continuing Initiatives:

- Transparency Within Nursing Facility Ownership: Noting that nursing homes are increasingly being purchased by private equity or other for-profit investment firms, the OIG will review the ownership structures at investor-owned nursing homes to determine which entities are benefiting from Medicaid reimbursement and study the effects of ownership changes, including potential reductions in staffing levels and other cost-cutting measures.

- Oversight of Nursing Home Minimum Data Set (MDS) Data: The OIG will evaluate CMS's mechanisms for ensuring that nursing homes submit accurate and complete MDS data, which is data relating to the resident's physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. MDS-based quality performance information appears on the CMS Nursing Home Compare Website.

- Nursing Home Residents Aged 65 or Older Who Received Antipsychotic Drugs: The OIG will continue to review Medicare Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents to determine the extent to which the drugs are being used as inappropriate "chemical restraints," i.e., being prescribed in the absence of conditions approved by the Food and Drug Administration.

- Accuracy of Coding for Medicare SNF Resource Utilization Groups' (RUGs) Claims: Noting that a 2006 OIG report found that 22 percent of Medicare claims submitted by SNFs were upcoded, the OIG plans to continue evaluating a national sample of Medicare claims submitted by SNFs to determine whether the RUGs included on the claims were accurate and supported by the beneficiaries' medical charts.

- Part B Services in Nursing Homes: The OIG is continuing its review of Part B services provided in SNFs for residents whose stays are no longer covered under Part A. The OIG is evaluating the extent of Part B services provided to SNF residents in 2006 and looking for

patterns of billing by SNFs and other providers.

- Enteral Nutrition Therapy Services in Nursing Homes: The OIG will review the medical necessity, adequacy of documentation and coding accuracy of Part B claims submitted for enteral nutrition therapy provided to Medicare beneficiaries residing in nursing homes that are not covered under the Part A SNF benefit.

- Medicare Pricing for Parenteral Nutrition: The OIG is comparing Medicare's fee schedule for enteral and parenteral nutrients with prices available to other purchasers, such as nursing homes and HHAs.

- Part B Services in Nursing Homes, Mental Health and Psychotherapy Services: The OIG is continuing its review of the medical necessity, appropriateness of coding and documentation of Medicare Part B payments for psychotherapy services provided to nursing home residents during noncovered Part A stays.

- States' Administration and Use of Civil Monetary Penalty (CMP) Funds in Medicaid Nursing Homes: The OIG will review the amounts that States have received from CMP funds and the States' use of CMP funds to determine whether States are appropriately applying CMP funds to programs that protect the health and welfare of nursing home residents.

Hospice Care

No New Initiatives

Continuing Initiatives:

- Physician Billing for Medicare Hospice Beneficiaries: The OIG will continue to examine payments made for physician services provided to Medicare hospice beneficiaries. Specifically, the OIG will determine the frequency at which such services are billed under both Part A and Part B, and the total expenditures for such services. The OIG anticipates that CMS is being double-billed for hospice services under Part A and Part B.

- Trends in Medicare Hospice Utilization: Noting that the number and types of diagnoses associated with hospice utilization have increased, and that longer stays have become more common since Congress eliminated the limitation on coverage days for hospice care in 1997, the OIG will continue to examine the characteristics of hospice beneficiaries, geographic variations in utilization and differences between for-profit and non-profit hospice providers.

- Duplicate Drug Claims for Hospice Beneficiaries: The OIG will continue to examine the extent to which payments for drugs are being made under Part D while Medicare beneficiaries are covered for such drugs during a Part A SNF stay.

Miscellaneous Medicaid Providers

No New Initiatives

Continuing Initiatives:

- Community Residence Rehabilitation Services: The OIG will continue to evaluate Medicaid payments made for beneficiaries who reside in community residences for persons with mental illness to

determine whether States improperly claimed federal financial participation (FFP).

- Targeted Case Management Services: The OIG is continuing its review of Medicaid payments made for targeted case management services, which are services that assist individuals eligible under the State plan to gain access to needed medical and other services.

- Medicaid Payments for Personal Care Services: The OIG will continue to review Medicaid payments made for personal care services to determine whether States have appropriately claimed FFP. Personal care services must be authorized by a physician in accordance with a plan of treatment and is covered only for individuals who are not inpatients or residents of hospitals, nursing homes, or intermediate care facilities.

- Medicaid Payments for Medicare-Covered Home Health Services: The OIG will continue to determine the extent to which both Medicare and Medicaid have paid for the same home health care services in certain States.

- Compliance with States' Requirements for Medicaid-Funded Personal Care Service Attendants: The OIG will continue to examine whether personal care service attendants have met their State-established qualifications.

- State and Federal Oversight of Home- and Community-Based Services (HCBS) Provided in Assisted Living Facilities: The OIG will continue to review the extent to which States are complying with federal regulations for HCBS waiver programs, including assuring that necessary safeguards are in place to protect the health and welfare of recipients. The OIG will further evaluate CMS's processes for monitoring State compliance with the requirements.

- Medicaid Adult Health Service Payments for Ineligible and Absent Beneficiaries: Once again noting that prior review revealed that Adult Day Care facilities were billing Medicare for deceased patients, patients who did not require center services, and patients who attended the facility for only a fraction of the time authorized by statute, the OIG will continue to identify whether payments are being improperly made to Adult Day Care facilities on behalf of ineligible individuals.