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"New Start" Reviews and Activities Affecting Post-Acute Providers in OIG's 2012 Work Plan

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The Office of Inspector General recently released its work plan for fiscal year 2012, which includes a number of "new start" reviews and activities that it plans to pursue during the next 12 months and beyond with respect to U.S. Department of Health & Human Services programs affecting post-acute providers.

On October 5, 2011, the U.S. Department of Health & Human Services Office of Inspector General (OIG) issued its voluminous Work Plan for Fiscal Year 2012, which describes specific reviews and activities the OIG plans to initiate or to continue in fiscal year (FY) 2012. In this newsletter, OIG activities that will be *newly started* in FY 2012 and that affect post-acute settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTACHs), home health agencies (HHAs), hospices and dialysis facilities, will be highlighted. A "new start" review slated to begin in FY 2012 could result in reports that are published in FY 2012 or FY 2013, depending upon when the assignments are initiated during the year and the complexity and scope of the OIG's examinations.

Post-Acute Care for Medicare Beneficiaries

Focusing on three post-acute settings, SNFs, IRFs and LTACHs, the OIG will initiate a FY 2012 project to review the quality of care and safety of Medicare beneficiaries transferred from acute care hospitals to post-acute care facilities. The OIG noted the average hospital stay for Medicare beneficiaries has fallen steadily over several decades, which, in turn, has resulted in increased transfers to post-acute care facilities. Given that, and the fact that such facilities have varying capabilities to deal with patients often requiring substantial clinical care, the OIG will evaluate the transfer process and identify rates of adverse events and preventable hospital readmission from the three identified post-acute care settings. The hospital discharge planning process and the degree of communication and collaboration between acute care and post-acute care provider will be an area of review.

Nursing Home Compliance Plans and Billing Patterns

The Patient Protection and Affordable Care Act requires the U.S. Centers for Medicare & Medicaid Services (CMS) to issue regulations by 2012, and SNFs to have plans that meet those requirements on or after 2013. As a new 2012 initiative, the OIG will review Medicare and Medicaid certified nursing

homes' implementation of compliance plans, and whether the plans contain elements identified in OIG's compliance program guidance, as part of their day to day operations. In another new initiative, OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit.

Home Health Agencies

Among the new initiatives are reviews of missing or incorrect patient Outcome and Assessment (OASIS) data of HHAs. OIG will review HHAs OASIS data to identify payment for episodes for which OASIS data were not submitted, or for which the billing code on the claim is inconsistent with OASIS data. Noting that Medicare spending for HHA services has increased by 81 percent since 2000, in another new initiative the OIG will review HHA claims to identify HHAs that exhibited questionable billing in 2010 (*e.g.*, meaning claims that exhibit certain characteristics that may indicate potential fraud). The OIG will also review fraud and abuse prevention and services oversight performed by the HHA Medicare Administrative Contractor (MAC), including OIG review of the reduction of payment errors by MACs. For state Medicaid programs, the OIG will review CMS policies and practices for reviewing Medicaid state plans related to eligibility for HHA services and describe how CMS intends to enforce compliance with eligibility requirements for HHA services.

Hospice

The OIG will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care, and examine the relationship, either financial or common ownership, between the acute care hospital and the hospice provider, as well as how Medicare treats reimbursement for similar transfers from the acute care setting to other settings. Finding in a recent report that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements, and noting the alleged aggressive marketing of hospice services to nursing facility residents and hospice financial relationships with nursing facilities, the OIG will focus a new review on hospices that have a high percentage of their beneficiaries in nursing facilities.

Inpatient Rehabilitation Facilities

Where patients admitted to IRFs must undergo preadmission screening and evaluation to ensure that they are appropriate candidates for IRF care, the OIG will examine the appropriateness of admissions to,

as well as the level of therapy being provided in, IRFs, and how much concurrent and group therapy IRFs are providing.

Dialysis Facilities and Services

In two new reviews affecting renal dialysis facilities, the OIG will assess Medicare's oversight of facilities that provide outpatient maintenance dialysis services to Medicare beneficiaries with end stage renal disease (ESRD). The OIG will assess the performance of oversight functions as well as how CMS holds state survey and certification agencies and ESRD Networks accountable. In another new project, the OIG will review Medicare pricing and utilization related to renal dialysis services under the new bundled ESRD prospective payment system for renal dialysis services.