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OIG's 2011 Work Plan – What Can Long-Term Care and Community-Based Providers Expect to See in the Coming Year?

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Providers can look to the Work Plan issued each year by the Department of Health and Human Services, Office of the Inspector General (OIG) in order to gain insight into enforcement priorities for the coming year. In the last issue we discussed the provisions of the 2011 Work Plan that affect hospitals and physicians.

This article focuses on the elements of the OIG Work Plan that apply to Long-Term Care facilities, hospices, and providers of home- and community-based services (HCBS). We have divided the discussion into "new" and "continuing" initiatives, based on whether the OIG identified a topic for enforcement priority in the 2010 Work Plan.

Home Health Agencies

New Initiative

Medicare HHA Enrollment: The OIG will review the program integrity efforts of CMS, its contractors and States and determine whether these efforts successfully identify questionable HHA applicants.

Continuing 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.

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.

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

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.

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.

Nursing Facilities

New Initiatives

Hospitalizations of Nursing Home Residents: Having noted that a substantial percentage of hospitalizations during a skilled nursing facility stay may be caused by poor quality of care, the OIG will review hospitalizations of nursing home residents. The OIG will also assess CMS's oversight of nursing homes whose residents are hospitalized at a high rate.

National and State Background Checks for Long-Term Care Employees: The healthcare reform legislation provides for HHS to develop a nationwide program to establish procedures for conducting background checks on potential long term care employees. The OIG will assess the program, including a review of the procedures implemented by participating States and facilities.

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.

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.

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 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.

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.

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.

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 2008 and looking for patterns of billing by SNFs and other providers.

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.

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.

Hospice Care

New Initiative

Services Provided to Hospice Beneficiaries Residing in Nursing Facilities: The OIG will review services the hospice services provided to nursing facility residents and determine the extent to which the hospice and nursing facility coordinate the care of such beneficiaries. In addition, the OIG will review hospices' general inpatient care claims and assess their appropriateness.

No Continuing Initiatives

Miscellaneous Medicaid Providers

New Initiatives

Medicaid Hospice Services: The OIG will review Medicaid payments for hospice services, and determine whether the services were provided in a manner consistent with federal requirements. The OIG will also review a sample of hospice beneficiaries in order to confirm that services provided were reasonable and necessary.

Medicaid Adult Day Care Services for Elderly Individuals Who Have Chronic Functional Disabilities: The OIG will review Medicaid payments to providers for adult day care health services and determine whether the providers were in compliance with Federal and State regulations.

Appropriateness of Level of Care Determinations for Home- and Community-Based Services Waiver Recipients: The OIG has noted an increase in the enrollment of Medicaid beneficiaries who qualify for nursing home care, but instead opt to receive home- and community-based services (HCBS) via a waiver. Under the Medicaid regulations, States must review HBCS waiver applicants in order to determine the applicants' appropriate level of care. The OIG will review State assessment of HCBS care recipients and determine whether the States are following Federal guidelines for assessing level of care.

Health Screenings of Medicaid Home Health Care Workers: The OIG will determine whether HHA workers have undergone health screenings in a manner consistent with State and Federal requirements.

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).

Medicaid Adult Day Health Service: Noting that prior review revealed problems with billing by Adult Day Care facilities, the OIG will continue to identify whether

payments are being improperly made to Adult Day Care facilities on behalf of ineligible individuals.

State and Federal Oversight of HCBS: 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.