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*Editors: [Leslie Demaree Goldsmith](#) and [Carel T. Hedlund](#)*

## OIG's 2012 Work Plan – What Can Long-Term Care and Community-Based Providers Expect in the Coming Year?

By: [John S. Linehan](#)

Providers may refer to the Work Plan issued each year by the Department of Health and Human Services, Office of the Inspector General (OIG) to obtain guidance into enforcement priorities for the coming year. In the last issue we summarized provisions of the 2012 Work Plan that relate to hospitals and physicians.

This article focuses on both the Medicare and Medicaid provisions in the [2012 OIG Work Plan \[PDF\]](#) that apply to long-term care facilities, hospices, and providers of home- and community- based services (HCBS). The discussion is organized into “new” and “continuing” initiatives, based on whether the OIG identified a topic as an enforcement priority in the [2011 Work Plan \[PDF\]](#).

### Home Health Agencies

#### New Initiatives

*States' Survey and Certification of HHAs:* The OIG will review HHA standard and complaint surveys conducted by the State Survey Agencies and Accreditation Organizations, the outcomes of those surveys, and the nature and follow-up of complaints against HHAs. CMS oversight activities will also be investigated to monitor the timeliness and effectiveness of HHA surveys.

*HHA Billing Characteristics:* Noting that Medicare spending has increased 81 percent for HHA services since 2000, the OIG will investigate HHA claims to identify HHAs that exhibited questionable billing in 2010 in order to unearth potential fraud.

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*Medicare Administrative Contractors' Oversight of HHA Claims:* The OIG will review fraud and abuse prevention and services performed by home health benefit MACs and the reduction of payment errors by MACs.

*Wage Indexes Used to Calculate Home Health Payments:* Medicare home health payments will be assessed to determine whether they were calculated using incorrect wage indexes and to evaluate the adequacy of controls to prevent such inaccuracies.

*Home Health Services Homebound Requirements:* The OIG will review CMS practices for reviewing the sections of Medicaid state plans related to eligibility for home health services and describe how CMS intends to enforce compliance with home health services eligibility requirements. The OIG will seek to identify states that violate federal regulations by inappropriately restricting eligibility for home health services to homebound recipients.

#### **Continuing Initiatives**

*Oversight of HHA Outcome and Assessment Information Set (OASIS):* The OIG will review CMS's method for confirming that HHAs submit accurate and complete OASIS data. In addition, the agency will review HHA OASIS data to identify payments for episodes for which OASIS data were not provided or for which the claim billing code is inconsistent with OASIS data.

*HHA Claims' Compliance with Coverage and Coding Requirements:* The OIG will review Medicare claims submitted by HHAs to determine the extent to which the claims meet Medicare coverage requirements and to assess the accuracy of resource group codes submitted for Medicare home health claims in 2008.

*Home Health Prospective Payment System (PPS) Requirements:* The OIG will continue to review compliance with various aspects of the home health PPS, including the documentation required to support claims paid by Medicare.

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*HHA Trends in Revenues and Expenses:* Since the implementation of home health PPS in October 2000, HHA expenditures have increased substantially.

Accordingly, cost report data will be analyzed for HHA revenue and expense trends under the home health PPS to determine whether payment methodology should be adjusted. The OIG will examine various Medicare and overall revenue and expense trends for freestanding and hospital-based HHAs.

*Home Health Services Claims:* HHA claims under Medicaid will be reviewed to determine whether beneficiaries have met eligibility criteria and whether providers have satisfied applicable criteria to provide services, such as minimum number of professional staff, proper licensing and certification, review of service plans of care, and proper authorization and documentation of provided services.

*Health Screenings of Medicaid Home Health Care Workers:* HHAs must operate in compliance with applicable federal, state, and local laws and regulations and with accepted standards that apply to personnel providing services within such an agency. The OIG will determine whether Medicaid HHA workers have undergone health screenings in a manner consistent with these requirements.

## **Nursing Homes**

### **New Initiatives**

*Safety and Quality of Post-Acute Care for Medicare Beneficiaries:* The OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to post-acute care. With a focus on three post-acute settings—skilled nurse facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals—the OIG will evaluate the transfer process and identify rates of adverse events and preventable hospital readmissions from post-acute care settings.

*Nursing Home Compliance Plans:* The OIG will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their customary operations and whether the plans contain elements mentioned in the OIG's compliance program guidance. Among other things, the agency will assess

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whether CMS has incorporated compliance requirements into Requirements of Participation.

*Questionable Billing Patterns During Non-Part A Nursing Home Stays:* Pursuant to congressional mandate, the 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 reimbursed under Medicare's Part A SNF benefit.

#### **Continuing Initiatives**

*Medicare Requirements for Quality of Care in Skilled Nursing Facilities:* The OIG will continue to assess the extent to which SNFs have: (1) developed plans of care based on assessments of beneficiaries; (2) utilized the Resident Assessment Instrument (RAI) to develop plans of care; (3) provided services in accordance with these plans of care; and (4) planned for beneficiaries' discharges.

*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 Evacuations During Selected Natural Disasters:* Federal regulations require that Medicare- and Medicaid-certified nursing homes have plans and procedures to meet all potential emergencies and train all employees in emergency procedures. The OIG will review nursing facilities emergency plans and emergency preparedness deficiencies cited by state surveyors.

*Medicare Part A Payments to Skilled Nursing Facilities:* Citing a report that estimated \$542 million in potential overpayments for FY 2002, the OIG will assess the extent to which payments to SNFs meet Medicare coverage requirements and will conduct a medical review to determine whether claims were medically

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necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009.

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

*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 measures and determine whether states made incentive payments in accordance with program requirements.

*CMS Oversight and Accuracy of Nursing Home Minimum Data Set Data:* The OIG will review CMS's oversight of Minimum Data Set (MDS) information submitted by nursing homes certified to participate in Medicare or Medicaid. CMS's processes will be reviewed to ensure that nursing homes report accurate MDS data.

## **Hospice Care**

### **New Initiative**

*Hospice Marketing Practices and Financial Relationships with Nursing Facilities:* Citing a recent report that found that 82 percent of hospice claims for beneficiaries in nursing facilities failed to meet Medicare coverage requirements, the OIG will review hospices' marketing practices and their financial relationships with nursing facilities; the review will focus on hospices with a high percentage of their beneficiaries in nursing facilities.

### **Continuing Initiatives**

*Medicare Hospice General Inpatient Care:* The OIG will review the use of hospice general inpatient care from 2005 to 2010, and will assess the appropriateness of

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hospices' general inpatient care claims and hospice beneficiaries' drug claims billed under Part D.

*Hospice Services: Compliance with Reimbursement Requirements:* Noting that Medicaid payments for hospice services topped more than \$816 million in FY 2010, the OIG will continue to review Medicaid payments for hospice services to determine whether they complied with federal reimbursement requirements.

## **Miscellaneous Medicaid Providers**

### **New Initiative**

*Home- and Community-Based Services (HCBS): Vulnerabilities in Providing Services:* The OIG will determine whether and to what extent HCBS waiver participants have plans of care, receive the services in their plans, and receive services from qualified providers. The agency will identify recipient concerns about the quality of care they receive.

### **Continuing Initiatives**

*HCBS: Federal and States Oversight of Quality of Care:* The OIG will continue to review CMS and state oversight of HCBS waiver programs to determine the extent to which CMS oversees states' efforts to ensure the quality of care provided under such waiver programs. The OIG will further determine the extent to which states monitor the quality of care given to participants in HCBS waiver programs for the aged and disabled.

*HCBS: Federal and State Oversight of Assisted-Living Facilities:* Federal regulations mandate that states confirm that sufficient safeguards have been taken to protect the health and welfare of HCBS recipients. The OIG will assess the extent to which assisted-living facilities (ALFs) provide HCBS to their Medicaid-eligible residents and will determine how states and CMS ensure that ALFs are meeting provider standards, following plans of care, and meeting other federal requirements for HCBS services.

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*HCBS: Waiver Program Administrative Costs:* The HCBS waiver program authorizes states to provide services that help Medicaid beneficiaries avoid institutionalization. The OIG will weigh the reasonableness of Medicaid HCBS waiver program administrative costs and will determine whether states' contractual arrangements with nonprofit entities for administration of HCBS waiver programs are economical.

*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 are in compliance with federal and state regulations.

*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).

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