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OIG's 2013 Work Plan - What's Critical for Long-Term Care, Hospice, Home Health Agency and Home and Community-Based Providers? [Ober|Kaler]

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The Work Plans issued annually 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. This is the second of two articles highlighting provisions in the 2013 OIG Work Plan, released by the OIG on October 2, 2012, that providers should consider addressing in their compliance plans.

This article focuses on provisions that apply to long-term care, hospice, home health agency and providers of home- and community- based services. The summary of these provisions are divided into "new" and "continuing" initiatives based on whether the issue was previously addressed in last year's Work Plan.

Nursing Homes

New Initiatives

Nursing Home Use of Atypical Antipsychotic Drugs: In an effort to deter inappropriate use of antipsychotics in nursing homes, the OIG will be looking into how antipsychotic drugs are being prescribed in nursing homes and identifying the types of nursing homes that frequently administer such drugs.

Nursing Facility Communicable Disease Care: In response to a prior audit that indicated that states are paying nursing facilities for unallowable claims related to communicable disease care, the OIG plans to review claims by nursing facilities for communicable disease care to determine whether they complied with Federal and State requirements. The OIG will also examine patient safety consequences that resulted from nursing homes' failure to comply with communicable disease requirements.

State Agency Verification of Deficiency Corrections: Noting a prior OIG review finding that state survey agencies did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with federal law, the OIG plans to examine whether state survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.

Continuing Initiatives

Adverse Events for Patients Receiving Post-Acute Care: In response to the rapid growth of Medicare expenditures for post-acute care, the OIG plans to (1) estimate the incidence of adverse events for Medicare beneficiaries receiving post-acute care in skilled nursing facilities and inpatient rehabilitation facilities; (2) identify contributing factors to those events; (3) determine the extent to which those events were preventable; and (4) estimate the associated costs to Medicare.

Medicare Requirements for Quality of Care in Skilled Nursing Facilities (SNFs): The OIG will continue to assess the extent to which SNFs have utilized the Resident Assessment Instrument (RAI) to develop plans of care and to plan for beneficiaries' discharges.

Oversight of Poorly Performing Nursing Homes: The OIG will continue to identify poorly performing nursing homes and determine the extent to which CMS and states use enforcement measures to improve nursing home performance.

Hospitalizations of Nursing Home Residents: The OIG will continue to look at the extent to which nursing home residents have been hospitalized, particularly where hospitalizations were the result of manageable or preventable conditions.

Questionable Billing Patterns During Non-Part A Nursing Home Stays: Pursuant to congressional mandate, the OIG will continue to 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.

CMS Oversight and Accuracy of Nursing Home Minimum Data Set Data: The OIG will continue to review CMS's oversight of Minimum Data Set (MDS) information submitted by nursing homes certified to participate in Medicare or Medicaid.

Home Health Agencies

New Initiatives

Home Health Face-to-Face Requirement: The OIG will look at compliance by home health agencies (HHAs) with the new Face-to-Face Requirement (the Patient Protection and Affordable Care Act mandates that physicians who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries).

HHA Employment of Home Health Aides with Criminal Convictions: The OIG plans to determine the extent to which HHAs are complying with state requirements that criminal background checks be conducted on home health aides.

Duplicate Payments by Medicare and Medicaid Home Health Payments: The OIG will examine the extent to which both Medicare and Medicaid have paid for the same home health services provided to Medicare/Medicaid dual eligibles.

Continuing Initiatives

States' Surveys and Certifications of HHAs: The OIG will continue to 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 continue to be investigated to monitor the timeliness and effectiveness of HHA surveys.

Medicare Administrative Contractors' Oversight of HHA Claims: Fraud and abuse prevention activities performed by CMS and its contractors will continue to be reviewed by the OIG.

Oversight of HHA Outcome and Assessment Information Set (OASIS): The OIG will continue to look at CMS's method for confirming that HHAs submit accurate and complete OASIS data.

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

HHA Trends in Revenues and Expenses: The OIG will continue to examine HHA cost report data to determine whether the payment methodology should be adjusted.

Health Screenings of Medicaid Home Health Care Workers: The OIG will continue to review health-screening records of Medicaid home health care workers to determine whether these individuals were screened in accordance with Federal and State requirements.

Home Health Services Claims: HHA claims under Medicaid will continue to 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.

Home Health Services Homebound Requirements: The OIG will continue to 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 plans to identify states that violate federal regulations by inappropriately restricting eligibility for home health services to homebound recipients.

Hospice Care

New Initiatives- None

Continuing Initiatives

Hospice Marketing Practices and Financial Relationships with Nursing Facilities: The OIG will continue to review hospices' marketing practices and their financial relationships with nursing facilities. The OIG will specifically focus on hospices with a high percentage of their beneficiaries in nursing facilities.

Medicare Hospice General Inpatient Care: The OIG will look at the use of hospice general inpatient care in 2011 as well as the appropriateness of claims. Previously, the OIG focused on hospice general inpatient care provided between 2005 and 2010.

Hospice Compliance with Reimbursement Requirements: Medicaid payments for hospice services will continue to be reviewed by the OIG to determine whether they complied with federal reimbursement requirements.

Other Medicaid Providers

New Initiative

Unallowable Room and Board Costs for HCBS: Noting that Medicaid covers the costs of HCBS provided under a written plan of care to individuals in need of the services but does not allow for payment of room and board costs, the OIG will examine whether payments made by states for HCBS included the cost of room and board. The OIG will also determine whether state Medicaid agencies claimed Federal reimbursement for unallowable room and board costs.

Continuing Initiatives

Home- and Community-Based Services (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.

Medicaid Waivers — Adult Day Health Care Services: The OIG will continue to examine Medicaid payments to providers for adult day care services and determine whether the payments complied with applicable Federal and State requirements. In fiscal year 2012, the OIG will be specifically looking at whether beneficiaries enrolled in adult day health care programs met eligibility requirements and whether services were provided in accordance with a plan of care.

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).