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2013 OIG Work Plan: Key Issues for Skilled Nursing Facilities/Nursing Facilities [Ober|Kaler]

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The Office of Inspector General, U.S. Department of Health and Human Services (OIG) Work Plan is one of the core source documents for the establishment and updating of any health care provider corporate compliance plan. In addition to the Work Plan's general guidance about the authority and priority of this law enforcement agency, each provider community is well-advised to focus on both continuing and newly identified areas of interest, investigation and prosecution. The following discussion highlights the Work Plan areas most relevant for Medicare-certified skilled nursing facilities (SNFs) and Medicaid-certified nursing facilities (NFs) (collectively "Facilities").

Nursing Home Issues

Nursing Homes—Adverse Events in Post-Acute Care for Medicare Beneficiaries

The OIG intends to estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care in SNFs and inpatient rehabilitation facilities (IRFs). It will identify contributing factors to these events, determine the extent to which the events were preventable, and estimate the associated costs to Medicare. The OIG has noted in particular the growth in Medicare's SNF spending.

Nursing Homes—Medicare Requirements for Quality of Care in Skilled Nursing Facilities

The OIG continues to focus on how SNFs have addressed certain federal requirements related to quality of care, using the Residential Assessment Instruments (RAI) to develop care plans to provide services to beneficiaries in accordance with the plans of care and to plan for beneficiaries' discharges. It is acting based on reports indicating that approximately one-fourth of residents' needs for care, as identified through RAIs, were not reflected in care plans and that nursing home residents did not receive all the psychosocial services identified in care plans.

Nursing Homes—State Agency Verification of Deficiency Corrections

A newly identified priority by the OIG is to determine whether state survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.

Nursing Homes—Oversight of Poorly Performing Facilities

The OIG intends to identify poorly performing nursing homes and determine the extent to which the Centers for Medicare and Medicaid Services (CMS) and state survey agencies improve nursing home performance using enforcement tools. This will include review of CMS and states' follow-up actions to ensure that poorly performing nursing homes implement corrective actions. This includes examination of enforcement decisions by CMS and states resulting from surveys and complaint allegations.

Nursing Homes—Use of Atypical Antipsychotic Drugs

A new area of interest for the OIG includes Facilities' administration of atypical antipsychotic drugs, including the percentage of residents receiving these drugs and the types of drugs most commonly received. The OIG

plans to describe the characteristics associated with nursing homes that frequently administer atypical antipsychotic drugs.

Nursing Homes—Hospitalizations of Nursing Home Residents

The OIG is interested in studying the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized, including the extent to which hospitalizations were a result of manageable or preventable conditions or were the result of poor quality of care or unnecessary fragmentation of services.

Nursing Homes—Questionable Billing Patterns for Part B Services During Nursing Home Stays

The OIG is maintaining its interest in questionable billing patterns associated with Facilities and Medicare providers for Part B services provided to nursing home residents, where the Part B services must be billed directly by suppliers and other providers.

Nursing Homes—Oversight of the Minimum Data Set Submitted by Long-Term-Care Facilities

Another new area of interest for the OIG is whether and the extent to which CMS and the States oversee the accuracy and completeness of Minimum Data Set (MDS) data submitted by nursing facilities.

Nursing Facility Services—Communicable Disease Care

In a new initiative, the OIG plans to review NF claims for communicable disease care to determine whether they complied with federal and state requirements, including patient safety consequences associated with nursing homes' failure to comply with related communicable disease requirements. A prior audit indicated that states are paying nursing facilities for unallowable claims related to communicable disease care.

Hospice/SNF and NF Relationships

Facilities' relationships with other providers will be scrutinized, including, for example, marketing and financial relationships with hospices. The OIG referred to a recent report in which it found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements, and noted that MedPAC has found that hospices and nursing facilities may be involved in inappropriate enrollment and compensation and that there have been hospices aggressively marketed services to nursing facility residents.

Program Integrity Issues

The OIG identified a number of new areas involving provider enrollment and related program integrity issues of importance to facilities.

Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New)

The OIG now plans to determine how often onsite visits occur as part of the Medicare enrollment or reenrollment process. CMS reserves the right, when deemed necessary, to perform onsite inspections, announced and unannounced, of a provider or supplier to verify enrollment information submitted to CMS. Provider and supplier types can be identified as moderate risk or high risk.

Program Integrity—Medical Review of Part A and Part B Claims Submitted by Top Error-Prone Providers

The OIG will review Medicare Part A and Part B claims submitted by error-prone providers to determine their validity, project the results to each provider's population of claims, and recommend that CMS request refunds on projected overpayments. Previous OIG work illustrated a methodology for identifying error-prone providers using CMS's Comprehensive Error Rate Testing (CERT) Program data. The OIG will select the top error-prone

providers on the basis of expected dollar error amounts and match the selected providers against the National Claims History file to determine the total dollar amount of claims paid, after which it will perform a medical review on a sample of claims.

Program Integrity—Payments to Providers Subject to Debt Collection

The OIG is adopting a new initiative to review providers and suppliers that received Medicare payments after CMS referred them to the Department of the Treasury (Treasury) for failure to refund overpayments. It will determine the extent to which they ceased billing under one Medicare provider number but billed Medicare under a different number after being referred to Treasury. CMS may deny a provider's or supplier's enrollment in the Medicare program if the current owner, physician, or nonphysician practitioner has an existing overpayment at the time of filing an enrollment application. Federal law requires CMS to seek the recovery of all identified overpayments. According to the work plan, the Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer eligible delinquent debt to Treasury for appropriate action.

State Procedures for Identifying and Collecting Third-Party Liability Payments

The OIG will review states' procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries, such as where Medicaid beneficiaries may have additional health insurance through third-party sources, such as employer-sponsored health insurance.

State Collection and Verification of Provider Ownership Information

The OIG plans to review how State Medicaid agencies and CMS collect and verify required ownership information for enrolled providers.

Medicaid Overpayments—Credit Balances in Medicaid Patient Accounts

There will be a review of Facilities' patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances since Medicaid is the payer of last resort and providers are to identify and refund overpayments received.

Nursing Home Minimum Data Set—Accuracy and CMS Oversight

There will be an OIG review CMS's oversight of MDS data submitted by SNFs and NFs.

Medicaid Home and Community-based Services

Facilities may be interested to know that the OIG plans to review the quality of care provided through Medicaid waiver programs. It will determine the extent to which Medicaid home and community-based services (HCBS) beneficiaries have service plans, receive the services in their plans, and receive services from qualified providers. The OIG noted that states offering HCBS waiver programs must provide adequate planning for services and provide those services through qualified providers, as well as ensure the health and welfare of beneficiaries.