

The Office of Inspector General (OIG) Releases Its Work Plan for 2012

Reviewing Medicare Part A payments to skilled nursing facilities (SNFs) and addressing Medicare requirements for quality of care in skilled nursing facilities will be among the various projects the Office of Inspector General (OIG) will undertake in fiscal year (FY) 2012. On October 5, 2011, the Department of Health and Human Services' (HHS) OIG released its annual *Work Plan for FY 2012* (Work Plan). The Work Plan details hundreds of investigations planned for each of the major entities of the HHS, including the Centers for Medicare & Medicaid Services (CMS).

Under the authority of the Inspector General Act, the OIG improves HHS programs and operations by conducting independent and objective audits, evaluations, and investigations. They seek to provide timely, useful, and reliable information and advice to department officials, the administration, the Congress, and the public. Each year, the OIG issues a Work Plan that briefly describes each of the various project areas that would meet these goals.

Although the OIG is known for its investigative function, the Office of Evaluations and Inspection (OEI) conducts program and management evaluations that seek to generate accurate and up-to-date information on how well those programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness. This year, the OIG will conduct more than 100 studies involving CMS. These projects include: Medicare requirements for quality of care in SNFs, safety and quality of post-acute care for Medicare beneficiaries, nursing home compliance plans, oversight of poorly performing nursing homes, nursing home emergency preparedness and evacuations during selected natural disasters, Medicare Part A payments to SNFs, hospitalizations and rehospitalizations of nursing home residents, questionable billing patterns during non-Part A nursing home stays, and CMS oversight and accuracy of nursing home minimum data set data.

Medicare Requirements for Quality of Care in Skilled Nursing Facilities

The OIG will review how SNFs have addressed certain federal requirements related to quality of care. OIG will determine the extent to which SNFs developed plans of care based on assessments of beneficiaries, provided services to beneficiaries in accordance with the plans of care, and planned for beneficiaries' discharges. OIG also will review SNFs' use of Resident Assessment Instruments (RAI) to develop nursing home residents' plans of care. Prior OIG reports revealed that about a quarter 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. Federal laws require nursing homes participating in Medicare or Medicaid to use RAIs to assess each nursing home resident's strengths and needs. This is an ongoing project that also was in OIG's 2010 and 2011 Work Plans. In May 2011, AMDA provided OIG with the white paper entitled the *Role of the Attending Physician in the Nursing Home*, which discusses the attending physician's role in assessment and care planning to assist staff in their efforts to develop plans of care based on a physician's assessment of beneficiaries. A report on this study is expected to be released by Spring 2012.

Safety and Quality of Post-Acute Care for Medicare Beneficiaries (New Study)

OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to post-acute care. OIG will evaluate the transfer process and also identify rates of adverse events and preventable hospital readmissions from post-acute-care settings. OIG will focus on three post-acute settings: SNFs, IRFs and long-term care hospitals. Average hospital stays for Medicare beneficiaries have fallen steadily over several decades, resulting in increased transfers to post-acute care facilities. Patients recovering in these facilities often require substantial clinical care, and the capabilities of the facilities to care for residents vary by facility type and access to appropriate equipment and staffing. The hospital discharge planning process and the degree of communication and

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collaboration between acute care and post-acute care providers also affect a beneficiary's experience and the ability of providers to ensure a smooth and safe transition.

Nursing Home Compliance Plans (New Study)

OIG will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in OIG's compliance program guidance. OIG also will assess whether CMS has incorporated compliance requirements into Requirements of Participation and oversees provider implementation of plans. Section 6102 of the Affordable Care Act requires nursing homes to operate a compliance and ethics program, containing at least 8 components, to prevent and detect criminal, civil, and administrative violations and promote quality of care. The Affordable Care Act requires CMS to issue regulations by 2012 and SNFs to have plans that meet such requirements on or after 2013. OIG's compliance program guidance is at 65 Fed. Reg. 14289 and 73 Fed. Reg. 56832.

Oversight of Poorly Performing Nursing Homes

OIG will review CMS's and states' use of enforcement measures to determine their impact on improving the quality of care that beneficiaries received in poorly performing nursing homes and evaluate the performance of these nursing homes. OIG also will determine the extent to which CMS and states follow up to ensure that poorly performing nursing homes implement correction plans. Federal requirements include a survey and certification process, including an enforcement process, to ensure that nursing homes meet federal standards for participation in Medicare and Medicaid. OIG will examine enforcement decisions resulting from inspections and other oversight by CMS and states. This is an ongoing project that also was in OIG's 2010 and 2011 Work Plans.

Nursing Home Emergency Preparedness and Evacuations during Selected Natural Disasters

OIG will review nursing homes' emergency plans and emergency preparedness deficiencies cited by state surveyors to determine the sufficiency of the nursing homes' plans and their implementation of the plans. OIG also will describe the experiences of selected nursing homes, including challenges, successes, and lessons learned, when they implemented their plans during recent disasters, such as hurricanes, floods, and wildfires. 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. In 2006, OIG reported that nursing homes in certain Gulf States had plans that lacked a number of features suggested by emergency preparedness experts and that staff members did not always follow plans during emergencies. This is an ongoing project that also was included in the 2010 and 2011 OIG Work Plans.

Medicare Part A Payments to Skilled Nursing Facilities

OIG will review the extent to which payments to SNFs meet Medicare coverage requirements. OIG will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009. The amount paid to SNFs for all covered services is established by the Social Security Act, § 1888(e). Medicare pays Part A SNF stays using a system that categorizes each beneficiary into a group according to care and resource needs. The groups are referred to as Resource Utilization Groups (RUG). In a prior report, OIG found that 26 percent of claims had RUGs that were not supported by patients' medical records. The percentage represented \$542 million in potential overpayments for FY 2002. This is an ongoing project that was also included in the 2011 OIG Work Plan.

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Hospitalizations and Rehospitalizations of Nursing Home Residents

OIG will review the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized and rehospitalized. OIG also will assess CMS's oversight of nursing homes whose residents have high rates of hospitalization. Hospitalizations and rehospitalizations of nursing home residents are costly to Medicare and may indicate quality-of-care problems at nursing homes. A 2007 OIG study found that 35 percent of hospitalizations during a SNF stay were caused by poor quality of care or unnecessary fragmentation of services. This is an ongoing project that was included in the OIG's 2011 Work Plan. The regional OIG office in Dallas currently is drafting the design of the study and hope to begin their work soon. In May 2011, AMDA provided the OIG with AMDA's *Acute Change of Condition in the Long-Term Care Setting* clinical practice guideline (CPG) to use as an educational resource in the study in order to gain a better understanding on classifying avoidable versus unavoidable re-hospitalizations.

Questionable Billing Patterns During Non-Part A Nursing Home Stays (New Study)

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. Part B services provided during a non-Part A stay must be billed directly by suppliers and other providers. Congress directed OIG to monitor these services for abuse. A series of studies will examine podiatry, ambulance, laboratory, and imaging services.

CMS Oversight and Accuracy of Nursing Home Minimum Data Set Data

OIG will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. OIG also will review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. Nursing homes must conduct accurate comprehensive assessments for residents using an instrument that includes the MDS. (Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act.) Federal regulations specify the requirements of the assessment instrument. CMS implemented a skilled nursing facility prospective payment system based on MDS data in July 1998 and began posting MDS-based quality performance information on its Nursing Home Compare Web site in 2002. About half of the states base their Medicaid payment systems on MDS data.

To view the complete 2012 OIG Work Plan, click [here](#).