LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Highlights of the Inspector General's 2017 Work Plan Re. Nursing Home and Long-Term Care

Following are highlights of the 2017 US DHHS Office of the Inspector General (OIG) 2017 Work Plan identified by LTCCC as important to quality of care for nursing home residents and in other settings where individuals receive long-term care.

The mission of the OIG is to protect the integrity of public health programs and fight waste, fraud and abuse in Medicare, Medicaid and other programs. Over the years, the OIG has conducted numerous investigations that have been important in identifying serious problems, including significant deficiencies in the quality of care provided to nursing home residents that state and federal survey agencies too often fail to identify and address in their oversight. Examples include:

1. OIG's 2014 study, *Adverse Events in Skilled Nursing Facilities*, which found that one-in-three (33%) of people who go to a nursing home for short-term rehab are harmed within 30 days of entering a facility and that 59% of the time that harm was "clearly or likely preventable" (https://oig.hhs.gov/oei/reports/oei-06-11-00370.asp).
2. OIG's 2011 study, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, which found widespread inappropriate drugging of nursing home residents with dangerous antipsychotics, a problem that persists to this day for close to one-in-five (20%) of nursing home residents (despite the FDA's "black-box" warning against use of these drugs on elderly people with dementia). The Inspector General's statement that "Government, taxpayers, nursing home residents, as well as their families and caregivers should be outraged…" lead to the national campaign to improve dementia care and reduce antipsychotic drugging (https://oig.hhs.gov/oei/reports/oei-07-08-00150.asp).

Brief comments on the 2017 Work Plan:

1. **Nursing Home Harm**. The findings in OIG's 2014 report on adverse events among short-term residents (#1 above) were astounding and chilling. We believe that a similar study on long-term care residents is desperately needed and long overdue, given the needs and vulnerabilities of long-term residents. Unfortunately, this costly issue is, once again, not included in the OIG's annual work plan.
2. **Antipsychotic Drugging & Dementia Care**. We are very disappointed to see that the OIG has not included anything specific in its work plan related to the persistence of the antipsychotic drugging problem in our nation's nursing homes and the failure of the industry, CMS and the state agencies to adequately respond to this national scourge, which affects hundreds of thousands of nursing home residents every day. Though CMS launched a national campaign to reduce antipsychotic drugging and improve dementia care in 2012, the reduction in drugging has only been moderate while promised enforcement of standards which prohibit inappropriate drugging has never materialized. Nursing home residents, their families and the tax-payers who are footing the bill for inappropriate drugging deserve better.

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Editor's Note: The following descriptions are taken directly from the OIG's 2017 work plan, available at https://oig.hhs.gov/reports-and-publications/workplan/.

Please visit our website, www.nursinghome411.org, for information and resources on nursing home quality, oversight and advocacy, including:

- **Quality, staffing and antipsychotic drugging information for all US nursing homes;**
- **Quality improvement & advocacy tools for residents, families, LTC ombudsmen & advocates;**
- **Studies on nursing home quality and the effectiveness of state oversight;**
- **Information and tools to help improve dementia care and reduce antipsychotic drugging.**

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Nursing Homes

Nursing Home Complaint Investigation Data Brief

All nursing home complaints categorized as immediate jeopardy and actual harm must be investigated within a 2- and 10-day timeframe, respectively. A 2006 OIG report found that State agencies did not investigate some of the most serious complaints within these required timeframes. We will determine to what extent State agencies investigate the most serious nursing home complaints within the required timeframes. This work will provide an update from our previous review.

OEI: 01-16-00330 Expected issue date: FY 2017

Skilled Nursing Facilities – Unreported Incidents of Potential Abuse and Neglect

SNFs are institutions that provide skilled nursing care, including rehabilitation and various medical and nursing procedures. Ongoing OIG reviews at other settings indicate the potential for unreported instances of abuse and neglect. We will assess the incidence of abuse and neglect of Medicare beneficiaries receiving treatment in SNFs and determine whether these incidents were properly reported and investigated in accordance with applicable Federal and State requirements. We will also interview State officials to determine if each sampled incident was reported, if required, and whether each reportable incident was investigated and subsequently prosecuted by the State, if appropriate.

OAS: W-00-16-35779 Expected issue date: FY 2017

Skilled Nursing Facility Reimbursement

Some SNF patients require total assistance with their activities of daily living and have complex nursing and physical, speech, and occupational therapy needs. SNFs are required to periodically assess their patients using a tool called the Minimum Data Set that helps classify each patient into a resource utilization group for payment. Medicare payment for SNF services varies based on the activities of daily living score and the therapy minutes received by the beneficiary and reported on the Minimum Data Set. The more care and therapy the patient requires, the higher the Medicare payment. Previous OIG work found that SNFs are billing for higher levels of therapy than were provided or were reasonable or necessary. We will review the documentation at selected SNFs to determine if it meets the requirements for each particular resource utilization group.

OAS: W-00-16-35784 Expected issue date: FY 2017

Skilled Nursing Facility Adverse Event Screening Tool

OIG developed the SNF adverse event trigger tool as part of its study, “Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries” (OEI-06-11-00370), released in February 2014. The tool was developed with assistance from clinicians at the Institute for Healthcare Improvement (IHI), which also published the tool for industry use. This product will describe the purpose, use, and benefits of the SNF adverse event trigger tool and the guidance document released by IHI, including the methodology for developing the instrument and the instrument’s use in developing the February 2014 report findings. The product will also describe the contributions of OIG

and IHI. The goal of this product is to disseminate practical information about the tool for use by those involved with the skilled nursing industry.

OEI: 06-16-00370 Expected issue date: FY 2017

Skilled Nursing Facility Prospective Payment System Requirements

Medicare requires a beneficiary to be an inpatient of a hospital for at least 3 consecutive days before being discharged from the hospital to be eligible for SNF services (SSA § 1861(i)). If the beneficiary is subsequently admitted to an SNF, the beneficiary is required to be admitted either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. Prior OIG reviews found that Medicare payments for SNF services were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of an SNF admission.

We will review compliance with the SNF prospective payment system requirement related to a 3-day qualifying inpatient hospital stay.

OAS: W-00-16-30014 Expected issue date: FY 2017

Potentially Avoidable Hospitalizations of Medicare - and Medicaid-Eligible Nursing Facility Residents

High occurrences of patient transfers from nursing facilities to hospitals for potentially preventable conditions could indicate poor quality of care. Prior OIG work identified a nursing facility with a high rate of Medicaid recipient transfers to hospitals for a urinary tract infection (UTI), a condition that is often preventable and treatable in the nursing facility setting without requiring hospitalization. The audit disclosed that the nursing facility often did not provide UTI prevention and detection services in accordance with its residents' care plans, increasing the residents' risk for infection and hospitalization.

We will review nursing homes with high rates of patient transfers to hospitals for potentially preventable conditions and determine whether the nursing homes provided services to residents in accordance with their care plans (42 CFR § 483.25(d)).

OAS: W-00-17-35792 Expected issue date: FY 2017

State Agency Verification of Deficiency Corrections

Federal regulations require nursing homes to submit correction plans to the State survey agency or CMS for deficiencies identified during surveys (42 CFR § 488.402(d)).

CMS requires State survey agencies to verify the correction of identified deficiencies through on-site reviews or by obtaining other evidence of correction (State Operations Manual, Pub. No. 100-07, § 7300.3).

A previous OIG review found that one State survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with Federal requirements. We will determine whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.

OAS: W-00-17-31502; various reviews Expected issue date: FY 2017

Medicaid Beneficiary Transfers from Group Homes and Nursing Facilities to Hospital Emergency Rooms

High occurrences of emergency transfers could indicate poor quality of care. Previous OIG work examined transfers to hospital emergency departments, raising concerns about the quality of care provided in some nursing facilities. We will review the rate of and reasons for transfer from group homes or nursing facilities to hospital emergency departments.

OAS: W-00-16-31040; various reviews Expected issue date: FY 2017

Hospice

Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio

The Medicare hospice program is an important benefit for beneficiaries and their families at the end of life. However, OIG and others have identified vulnerabilities in payment, compliance, and oversight as well as quality-of-care concerns, which can have significant consequences both for beneficiaries and for the program. We will summarize OIG evaluations, audits, and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

OEI: 02-16-00570 Expected issue date: FY 2017

Review of Hospices' Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

OAS: W-00-16-35783; various reviews Expected issue date: FY 2017

Hospice Home Care —Frequency of Nurse On-Site Visits to Assess Quality of Care and Services

In 2013, more than 1.3 million Medicare beneficiaries received hospice services from more than 3,900 hospice providers, and Medicare hospice expenditures totaled $15.1 billion. Hospices are required to comply with all Federal, State, and local laws and regulations related to the health and safety of patients (42 CFR § 418.116). Medicare requires that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs (42 CFR § 418.76(h)(1)(i)). We will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

OAS: W-00-16-35777 Expected issue date: FY 2017

HCBS

Data Brief on Fraud in Medicaid Personal Care Services

OIG has conducted numerous audits, evaluations, and investigative work involving PCS. Much of this work is summarized in a November 2012 portfolio report to CMS entitled "Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement" (OIG-12-12-01). The portfolio report summarized the observations and findings of previous OIG evaluation and audit reports on Medicaid PCS and offered recommendations for improving program oversight. We will issue a data brief that provides, through data collected from the 50 State Medicaid Fraud Control Units (MFCUs, or Units) and OIG's Office of Investigations, an overview of PCS statistical data collected since the portfolio was issued in 2012. The data brief will provide information on State and Federal investigations, indictments, convictions, and recoveries involving fraud and patient abuse or neglect in Medicaid PCS. The data presented in this brief are intended to illustrate the prevalence and magnitude of fraud and patient abuse or neglect involving PCS. These data will be especially important for OIG's future work with CMS to combat these issues.

OEI: 12-16-00500 Expected issue date: FY 2017

Oversight and Effectiveness of Medicaid Waivers

More States are using waivers to alter their Medicaid program in significant ways. Oversight of State waiver programs present challenges to ensure that payments made under the waivers are consistent with regards to efficiency, economy, and quality of care and do not inflate Federal costs. We will determine the extent to which selected States made use of Medicaid waivers and if costs associated with the waivers are efficient, economic, and do not inflate Federal costs. We will also look at CMS's oversight of State Medicaid waivers.

OAS: W-00-17-31513 Expected issue date: FY 2018

Room-and-Board Costs Associated with HCBS Waiver Program Payments

Medicaid covers the cost of home- and community-based services (HCBS) provided under a written plan of care to individuals in need of such services, but does not allow for payment of room-and-board costs (42 CFR §§ 441.301(b) and 441.310(a)). States may use various methods to pay for such services, such as a settlement process that is based on annual cost reports or prospective rates with rate adjustments that are based on cost report data and cost-trending factors. We will determine whether selected States claimed Federal reimbursement for unallowable room-and-board costs associated with services provided under the terms and conditions of HCBS waiver programs. We will determine whether HCBS payments included the costs of room and board and identify the methods the States used to determine the amounts paid.

OAS: W-00-17-31465; various reviews Expected issue date: FY2017

Community First Choice State Plan Option Under the Affordable Care Act

Section 2401 of the ACA added section 1915(k) to the SSA, a new Medicaid State plan option that allows States to provide statewide home and community-based attendant services and support to

individuals who would otherwise require an institutional level of care. States taking up the option will receive a 6-percent increase in their FMAP for Community First Choice (CFC) services. To be eligible for CFC services, beneficiaries must otherwise require an institutional level of care and meet financial eligibility criteria. We will review CFC payments to determine whether the payments are proper and allowable.

OAS: W-00-17-31495 Expected issue date: FY 2017

Payments to States Under the Balancing Incentive Program

Under the Balancing Incentive Program (BIP), eligible States can receive either a 2-percent or 5-percent increase in their FMAP for eligible Medicaid long-term services and support (LTSS) expenditures. Funding to States under the BIP cannot exceed $3 billion over the program's 4-year period (i.e., October 1, 2011, through September 30, 2015). To receive payments, participating States agree to make structural changes to increase access to noninstitutional LTSS. The States must also use the additional Federal funding for the purposes of providing new or expanded offerings of noninstitutional LTSS. We will review expenditures that States claimed under the BIP to ensure that they were for eligible Medicaid LTSS and determine whether the States used the additional enhanced Federal match in accordance with § 10202 of the ACA.

OAS: W-00-17-31482; various reviews Expected issue date: FY 2017

Healthcare Fraud

Health Care Fraud Strike Force Teams and Other Collaborations

OIG devotes significant resources to investigating Medicare and Medicaid fraud. We conduct investigations in conjunction with other law enforcement entities, such as the FBI, Drug Enforcement Administration, MFCUs, and other Federal and State law enforcement partners.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and DOJ to strengthen programs and invest in resources and technologies to prevent and combat health care fraud, waste, and abuse. Using a collaborative model, Health Care Fraud Strike Force teams coordinate law enforcement operations among Federal, State, and local law enforcement entities. These teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud.

Strike Force teams are operating in nine major cities. The effectiveness of the Strike Force model is enhanced by interagency collaboration within HHS. For example, we refer credible allegations of fraud to CMS so it can suspend payments as appropriate. During Strike Force operations, OIG and CMS work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets. In support of Strike Force operations, OIG:

- investigates individuals, facilities, or entities that, for example, bill or are alleged to have billed Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes to inflate reimbursement amounts, and false claims submitted to obtain program funds;

- investigates business arrangements that allegedly violate the Federal health care anti-kickback statute and the statutory limitation on self-referrals by physicians; and

- examines quality-of-care and failure-of-care issues in nursing facilities, institutions, community-based settings, and other care settings and instances in which Federal programs may have been billed for services that were medically unnecessary, were not rendered, or were not rendered as prescribed or in which the care was so deficient that it constituted “worthless services.”

Other areas of investigation include Medicare and Medicaid drug benefit issues and assisting CMS in identifying program vulnerabilities and schemes, such as prescription shorting (when a pharmacy dispenses fewer doses of a drug than prescribed, but charges the full amount).

Working with law enforcement partners at the Federal, State, and local levels, we investigate schemes that illegally market, obtain, and distribute prescription drugs. In doing so, we seek to protect Medicare and Medicaid from making improper payments, deter the illegal use of prescription drugs, and curb the danger associated with street distribution of highly addictive medications. We assist MFCUs in investigating allegations of false claims submitted to Medicaid and will continue to strengthen coordination between OIG and organizations such as the National Association of Medicaid Fraud Control Units and the National Association for Medicaid Program Integrity. Highlights of recent enforcement actions to which OIG has contributed are posted to OIG’s website at http://oig.hhs.gov/fraud/enforcement/criminal/.