The Inside Scoop for Nursing Homes: What the OIG Is Looking For in 2012

The 2012 Office of Inspector General (OIG) Work Plan offers providers a helpful overview of Medicare enforcement priorities. With respect to skilled nursing facilities (nursing homes or "SNF's), the Work Plan contains five "carryovers" from 2011 and three new areas of inquiry. The plan is a helpful guide of priority areas in need of improvement and those coming under imminent scrutiny. In general, the common theme is monitoring quality of care while simultaneously cracking down on fraud and abuse.

A. Carryover Work Plan Items

1) Medicare requirements for quality of care in SNF's

OIG will review how SNF's have addressed federal requirements related to quality of care. The focus will be on the extent to which SNF's have 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. The review will also cover the SNFs' use of Resident Assessment Instruments (RAI) to develop nursing home residents' plans of care.[1] It is essential for facilities to ensure their compliance related to these areas.

2) Oversight of poorly performing nursing homes

OIG will review CMS's and States' use of enforcement measures and their impact on improving the quality of care beneficiaries received in poorly performing nursing homes. The review will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement correction plans.[2] Facilities with a history of poor performance should take note that persistent underperformance is not going to be tolerated to the same extent it may have been in the past.

3) 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. The review will highlight 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.[3] It is critical for staff to be trained in facility disaster and emergency procedures.

4) Medicare Part A payments to SNF's

OIG will review the extent to which payments to SNF's meet Medicare coverage requirements by conducting a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during 2009.[4] Medicare regulators believe that some facilities are accepting patients for Part A stays that do not qualify under a rigorous application of coverage requirements.

5) 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. The review will assess CMS's oversight of nursing homes whose residents have high rates of hospitalization.[5]

B. New Work Plan Items

The following three areas are new to the OIG's Work Plan for nursing homes. Undoubtedly, the Affordable Care Act and the new culture of accountability in healthcare is shaping these new areas of scrutiny.

1) Nursing home compliance plans

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. The review will also 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 in 2012 and SNF's to have already established plans that meet such requirements on or after 2013. OIG has already published compliance program guidance at 65 Fed. Reg. 14289 and 73 Fed. Reg. 56832.

2) Safety and quality of post acute care for Medicare beneficiaries

OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to postacute care. They will evaluate the transfer process and also identify rates of adverse events and preventable hospital readmissions from post-acute-care settings. Primarily, the OIG will focus on these 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 postacute-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 collaboration between acute-care and postacute-care providers also affect a beneficiary's experience and the ability of providers to ensure a smooth and safe transition.

3) Questionable billing patterns during a non-Part A nursing home stays

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 specifically directed OIG to monitor these services for abuse.

While skilled nursing facilities should certainly not limit their compliance efforts to the OIG's Work Plan items alone, they should take note of the new and carryover topics in refining and expanding those efforts. By self-auditing on these issues, facilities can take proactive and preventative steps to prevent regulatory problems before they result in government action.

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[1] The RAI review was included after previous reports revealed that about 25% of residents' needs for care, as identified through RAI's, 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 RAI's to assess each resident's strengths and needs. [2] 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. [3] 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. [4] The amount paid to SNF's 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% of claims had RUGs that were not supported by patients' medical records. The percentage represented $542 million in potential overpayments for that year. [5] Hospitalizations and rehospitalizations of nursing home residents are costly to Medicare and may indicate quality-of-care problems at nursing homes. One study showed that 35% of hospitalizations during a SNF stay were caused by poor quality of care or unnecessary fragmentation of services.