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feature focus

Review of the OIG Work Plan FY 2008

Editor's note: The following articles review items related to hospital, home health/hospice, long-term care, health plans and Medicare Part D outlined in the U.S. Department of Health and Human Services Office of Inspector General Fiscal Year 2008 Work Plan. We thank the authors for their contributions to our Feature Focus. If you have questions you may contact the following authors by telephone:

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A review of the OIG 2008 Work Plan for Home Health & Hospice

By Deborah A. Randall, Esq.

The publication of the OIG Annual Work Plan is always a good opportunity for compliance officers and executives within the community services community to gain insight on governmental concerns. This year, there are many entries for the Home Health Agency (HHA) arena and only a few mentioning Hospice organizations directly.

HHA Work Plan entries

OIG continues to indicate concern about the accuracy of the data reported, selected, and entered in the reimbursement and assessment of HHAs. Areas under review (with year 2009 report dates) include concerns about data accuracy:

- **Homecare Compare data.** The data appearing on the CMS website "Homecare Compare" are generated from selected responses by HHAs to the patient admission status, progression, discharge health, and functional capabilities, as entered on the CMS Outcome and Assessment Information Set (OASIS) forms. These data are only as good as the accuracy and honesty of their generation. From the accumulated information, CMS ranks HHAs on the focus questions which CMS selects annually and posts for public review. Those HHAs that do not show improvements/stabilization in their patients' status over time will, most likely, fair poorly in future pay-for-performance methodologies. OIG is also concerned about what safeguards CMS has in place to ensure accuracy of the Homecare Compare data, because consumers are interested in finding information about HHA resources.
- **Home Health Resource Group (HHRG) data.** OASIS data accuracy also drives the application of the payment codes, called HHRGs that reimburse HHAs under the Medicare benefit. OIG remains concerned about the potential for up-coding by HHAs through the scoring of higher acuities, more compromised physical and functional status initially (with improvements thereafter), and higher therapy needs than the actual status or history of the patient would support.
- **Therapy actually provided.** Because the therapy levels of an HHA patient's care plan create higher levels of payment, even under the more finely tuned new Prospective Payment System (PPS) system in 2008 that has multiple rather than singular bright–lines, OIG will review the documentation of therapy actually provided, including by outside suppliers. HHAs should be on alert to any tendency by their staff or contracted therapists to shortchange the patient on the full amount of time for a therapy visit.
- **Billing accuracy for institutional care.** OIG is also going to study the accuracy of Medicaid claims paid and the reasons for any misbillings by HHAs when patients are hospitalized or cared for in other institutions, such as nursing facilities. Because of the continued growth of Medicaid payments for individuals under the home and community-based waiver programs, as well as personal care and consumer directed programs, OIG appears concerned that there are insufficient state protections against misbilled care.

OIG is focusing on the basics of entitlement for homecare services under the Medicaid program, specifically (1) the provider's criteria for perfor-

mance and credentialing of staff, and (2) the patient's initial eligibility. OIG has also indicated it will continue to study whether states are accurately ensuring that Medicaid is the last to pay for homecare services, after Medicare non-coverage has been properly ascertained and documented.

Poorly Performing HHAs

Once again, OIG is looking at the record of HHAs with poor survey performances, that continue to under-perform, but are not otherwise sanctioned. One of the problems from a surveyor enforcement standpoint is that, many years ago, CMS failed in its legislative attempt to add intermediate sanctions for HHAs like those that have existed for more than a decade for skilled nursing facilities (SNF). Currently, HHAs either are found to be performing within the conditions of participation (possibly after multiple resurveys and plans of correction), or they can be terminated from the Medicare program. It is hard to know where OIG intends to go with this Work Plan review. One outcome might be OIG recommendations for changes to the statutory framework for HHA survey. Another could be recommendations for non-renewal of certification under the 855 reapplication program for those HHAs which reappear at certain frequency in poor survey results.

Medicaid Homecare Services Programs. OIG is reviewing the qualifications and quality of the Medicaid homecare providers and their staff. During this past year, there have been an increasing number of state Medicaid investigations and prosecutions of homecare providers that have false or inappropriate credentials under licensure and other standards. These cases also signal the threat to quality of care for Medicaid recipients who are among the most frail and vulnerable and whose care in the home is in lieu of institutional care in many situations.

OIG plans four separate, in some cases continuing, reviews of the home and community-based services (HCBS) area of Medicaid from a programmatic standpoint, with particular focus on CMS and the states' roles in assuring the eligibility of recipients; the appropriateness, sufficiency, and quality of care; and the credentialing and acceptance of the providers themselves in these programs. Several highly critical OIG reports have been released on the alleged lack of any true safeguards in many existing HCBS programs in place.

Because of the 25% growth in numbers of recipients and services provided under the HCBS programs over three years, OIG is studying whether abuses in the programs permit expanded services and use of families and relatives to deliver care, in the qualifying of patients under the SNF equivalency-of-care needs, or in the admission of providers as HCBS participants.

Finally, OIG will specifically study the oversight function of the HCBS programs by the states, an area where previous OIG reports showed little activity. OIG will also review how the assisted living facilities which participate in the HCBS program meet the standards of eligibility and necessary care provided to residents. This area is one which OIG labels as needing greater review, because states provide limited oversight and regulation of the assisted living industry.

Hospice Work Plan entries

Once again, OIG has signaled its concern with the relationships between the hospice industry and the nursing facility industry, in particular the growing numbers of residents in SNFs who are electing hospice for end-of-life care. The single hospice entry in the OIG 2008 Work Plan recites that Medicare hospice spending doubled from 2001 to 2004, from $3.5 to $7 billion dollars, with the bulk of the growth coming from admissions of nursing facility residents to the hospice provider censuses. This is accomplished without physically moving the patient. Instead, the nursing facility decreases its responsibility for care planning and provision of services and pharmaceutical products necessary for the care, due to the terminal illness of a patient.

Because prior reviews by OIG suggested that nursing home residents received substantially less care than hospice patients seen in their own homes—a statistic strongly contested by the hospice industry—OIG is going to focus its review on the depth, length, and sufficiency of the care that hospices provide today. A potential outcome from an OIG finding of variances in the level of services provided by hospices to NF patients might be an OIG recommendation to Congress for a fourth level of hospice reimbursement by the Medicare program—a reimbursement at less than the regular routine hospice daily per diem due to lack of costs associated with such care. Alternatively, if OIG found that NF hospice patients were being underserved compared to their actual need and care plan, there might be an increased OIG enforcement effort in this area in future years.

A second area OIG identified for review is whether there are duplications or irregularities in the reimbursement of drugs under Part D for patients who are enrolled in hospice under the Medicare program. The hospice benefit under Medicare covers all drugs and supplies associated with the terminal illness, thus patients should not be seeking payment under Part D for their prescriptions that address symptoms of such diseases. On the other hand, hospices are permitted to distinguish between the illnesses which are part of the terminal diagnosis and those which are not. The concern OIG most likely wishes to address

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is whether hospices are not expending the funds they should to cover some drugs, thereby profiting excessively from the per diem hospice reimbursement. Additionally, there would be reason for concern if patients and hospices were purchasing drugs which would then be duplicative and unnecessary expenses to the program overall.

Conclusion

The sheer number of home health and homecare entries in the OIG 2008 Work Plan suggest that the rising concern about homecare is again cycling higher. The last time there was a major upheaval in the homecare fraud and abuse field was in the late 1980s and early 1990s, following Operation Restore Trust, when the coverage of homecare services was found by OIG to be under-monitored by the regulatory authorities and abused by more than a few HHAs. As the large numbers of retirees continues to swell the numbers of persons needing homecare services, OIG clearly wants to monitor potential abuse, including the Home and Community Based Services (HCBS) and credentialing areas. Although only two hospice items were directly noted in the Work Plan, OIG's identification of the strong growth in use of the benefit conveys a cautionary note, particularly for hospices seeking to grow census through admission of nursing facility patients. ■