Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

January 2022 - February 2024 Updates

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Table of Contents

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as, give our colleagues and clients focused insights into the over 300 audits, performed by HHS OIG, over the last 12 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 12 months and sorts relevant audits into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

We review all OIG completed audits that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused completed audits, SunHawk has identified other audit items which we determined relevant to a limited number of Providers and Payers. We plan to publish a summary of these items in January 2021.

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

[1] HHS OIG's Semi-annual reports to Congress for the April 1, 2019 to March 31, 2020 periods reported 304 new Audits and Evaluations which was an increase of 111 more issued reports during the same prior year period.

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All Providers

[NEW] Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers

Medicare-certified providers are required to submit an annual cost report to their Medicare administrative contractor (MAC). Cost reports are financial documents that convey the provider's costs associated with providing services to people enrolled in Medicare. A MAC can decide to audit a provider's cost report before bringing it to final settlement. If there is an error made in the final settlement, the MAC can reopen and adjust the cost report final settlement to correct the error. OIG performed this audit to determine whether one MAC, Noridian Healthcare Solutions (Noridian), reopened and corrected cost report final settlements because of audit errors.

OIG's objectives were to determine: (1) how many audited cost reports Noridian reopened to correct the final settlements and (2) whether any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian. OIG obtained information for audited cost reports ending in fiscal years 2016 and 2017 and determined whether they had been reopened. OIG obtained workpapers, audit adjustments, and final settlement summaries. After removing cost reports that were outside of OIG's scope, OIG reviewed 12 cost reports for this audit.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG determined that Noridian reopened 141 audited cost reports to correct the final settlements. Of these, 84 cost reports were reopened based on new information or at the request of the Centers for Medicare & Medicaid Services (CMS). In addition, 45 cost reports were not related to OIG's objectives; OIG excluded these from the review. For OIG's second objective, of the remaining 12 audited cost reports that Noridian reopened and that OIG reviewed, Noridian's audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

These 12 cost reports required reopening because Noridian's auditors and supervisors required additional education on applicable criteria and audit requirements, because Noridian's procedures for multiple levels of review did not detect incorrect audit adjustments, and because of time constraints on Noridian's audits. The reopened cost reports resulted in revised final settlements to providers totaling almost $11.3 million in net overpayments.

OIG recommended that Noridian: (1) develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements; (2) develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit documents and related actions; and (3) develop and implement enhanced procedures so that supervisors and higher-level reviewers are better qualified to detect incorrect audit adjustments.

Work Plan #: A-06-22-05000 (November 2023)
Government Program: Medicare Parts A & B

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[NEW] Medicare Could Have Saved Up To $128 Million Over 5 Years if CMS Had Implemented Controls To Address Duplicate Payments for Services Provided to Individuals With Medicare and Veterans Health Administration Benefits

In 1979, the General Accounting Office (now the Government Accountability Office) issued a report that found Medicare made duplicate payments of more than $72,000 for certain medical services provided to veterans eligible for benefits from both Medicare and the Department of Veterans Affairs (VA), Veterans Health Administration (VHA). Because duplicate payments made by Medicare and VHA have been a longstanding issue, OIG conducted this audit to determine whether Medicare and VA paid duplicate claims for medical services from January 2017 through December 2021 (audit period) and to identify measures that could be taken to address duplicate payments. OIG's objective was to determine whether Medicare paid providers for medical services that were authorized and paid for by VA's community care programs.

OIG's audit covered $19.2 billion in Medicare Parts A and B payments for 36.3 million claims for individuals eligible for Medicare and VHA benefits who received services from VA's community providers during OIG's audit period. The $19.2 billion was associated with all claims related to these individuals irrespective of whether VHA authorized and paid for the claims. After obtaining claims data from VA, OIG identified paid Medicare claims from CMS data and performed a match to determine whether an enrollee had a paid claim in both the Medicare and VHA claim datasets.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare paid providers for medical services that were authorized and paid for by VA's community care programs during OIG's audit period, resulting in duplicate payments of up to $128 million. VHA is solely responsible for paying providers for medical services that it authorized.

These duplicate payments occurred because CMS did not implement controls to address duplicate payments for services provided to individuals with Medicare and VHA benefits. Specifically, CMS did not establish a data-sharing agreement with VHA for the ongoing sharing of data between the two agencies and did not develop an interagency process to include VHA enrollment, claims, and payment data in CMS's data repository. Inclusion of these data, which is required by Federal law, would have allowed CMS to compare VHA claims data with existing Medicare claims data to identify duplicate claims paid for by both Medicare and VHA. Because CMS did not develop an interagency process, CMS did not establish an internal process (such as claims processing system edits) to address duplicate payments for medical services authorized and paid for by VHA. Furthermore, CMS guidance to providers on VA's responsibility to pay for medical services did not clarify that a provider should not bill Medicare for a medical service that was authorized by VHA.

OIG recommended that CMS: (1) establish a comprehensive data-sharing agreement with VHA for the ongoing sharing of data; (2) establish an interagency process to integrate VHA enrollment, claims, and payment data into the CMS Integrated Data Repository to identify potential fraud, waste, and abuse under the Medicare program; (3) establish an internal process (such as system edits) to address duplicate payments made by Medicare for medical services authorized and paid for by VHA, which could have saved Medicare up to $128 million during OIG's audit period; and (4) issue guidance to providers on not billing Medicare for a medical service that was authorized by VHA.

Work Plan #: A-09-22-03004 (April 2023)
Government Program: Medicare Parts A & B

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Provider

[NEW] HHS's and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved

The Provider Relief Fund (PRF) provides funds to eligible hospitals and other health care providers (providers) for health-care-related expenses or lost revenue attributable to COVID-19. HHS is responsible for PRF program oversight and policy decisions, and the Health Resources and Services Administration (HRSA) within HHS provides day-to-day oversight and management of the program. Providers that received PRF payments under the Phase 1 General Distribution are subject to requirements for submission of revenue information and attestation of acceptance or rejection of payments. This audit is part of OIG's oversight of HHS's COVID-19 response and recovery efforts. OIG's objective was to determine whether HHS's and HRSA's controls related to selected PRF program requirements (i.e., those related to the requirements for submission of revenue information and attestation of rejection of payments) ensured that providers received the correct payments from the Phase 1 General Distribution.

OIG's audit covered about $48 billion in PRF payments that were disbursed to 323,498 Medicare providers from April 10 through December 17, 2020. OIG performed audit procedures, including interviewing HRSA officials and contractors and analyzing payment and attestation data. To test controls, OIG selected a random sample of 45 providers.

SunHawk Summary of OIG Audit Findings and Recommendations

In the context of unprecedented challenges from the COVID-19 national emergency, HHS and HRSA developed controls related to selected PRF program requirements designed to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. However, OIG determined that some of these controls could be improved.

OIG found that HHS and HRSA did not have certain procedures. Specifically, HHS's and HRSA's procedures did not include: (1) requesting and reviewing providers' supporting documentation to verify the estimated revenue losses in March and April 2020, (2) subtracting the automatic payments made to providers' subsidiaries when certain nonautomatic payments were calculated, and (3) specifying a deadline for providers to return rejected payments. OIG also found that HHS's and HRSA's procedures had weaknesses. Specifically: (1) HHS's and HRSA's payment thresholds for manual review of information submitted by providers were set at a level that resulted in only 2 percent of providers undergoing manual review, and (2) HRSA's process to open and view the data file containing subsidiaries' taxpayer identification numbers (subsidiary TINs) extracted from providers' applications led to an error that caused the use of incorrect subsidiary TINs when payments were calculated.

OIG understands that HHS and HRSA's operational objective at the beginning of the national emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship during the national emergency because the Coronavirus Aid, Relief, and Economic Security Act required HHS and HRSA to make payments considering "the most efficient payment systems practicable to provide emergency payment." OIG also understands that because of this statutory requirement, HHS and HRSA prioritized rapid disbursement of payments over the risk of making improper payments, because HHS and HRSA determined that activities to lower the risk would have delayed the payments. However, as HRSA fully implements post payment quality control review processes, it should consider the information and recommendations included in this report.

In addition, to prepare for a possible public health emergency in the future, HHS should use the information and recommendations included in this report when determining lessons learned from administering PRF distributions during the

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COVID-19 national emergency and look for additional ways to safeguard taxpayers' money when rapidly disbursing assistance payments to health care providers in response to future national emergencies.

OIG made five recommendations to HRSA, including that HRSA continue to perform post payment quality control reviews of selected providers, consider reviewing 189 providers that were identified for manual review, and seek repayment of any overpayments from providers. OIG also recommended that HRSA ensure that the HHS Program Support Center collects payments made to selected providers that did not return their rejected payments as of March 9, 2022. Furthermore, OIG recommended that HRSA could conduct a cost-benefit analysis for manual review of additional providers that had the potential to receive payments below existing payment thresholds and, if the benefit outweighs the cost, it could select additional providers for review. The full text of OIG's recommendations are shown in the report.

Work Plan #: A-09-21-06001 (September 2022)
Government Program: Medicare Parts A & B

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Hospital

[NEW] Medicare Generally Paid Acute-Care Hospitals for Inpatient Stays for Medicare Enrollees Diagnosed With COVID-19 in Accordance With Federal Requirements

The Coronavirus Aid, Relief, and Economic Security Act increased the payment amount that acute-care hospitals received for Medicare enrollees who were diagnosed with COVID-19 and discharged during the COVID-19 public health emergency (PHE). OIG's previous work related to pneumonia and other diagnosis codes on claims documented aberrant billing by some hospitals. In addition, acute-care hospitals may have had a financial incentive to include a COVID-19 diagnosis on claims to receive additional payments. For these reasons, OIG conducted this audit of Medicare payments to acute-care hospitals for inpatient stays with admission dates from September 1 through November 30, 2020, for enrollees diagnosed with COVID-19. OIG's objective was to determine whether Medicare paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements.

OIG's audit covered $2.7 billion in Medicare payments for 166,107 claims billed by acute-care hospitals. OIG selected a random sample of 150 claims and excluded 1 claim because the acute-care hospital did not receive the increased payment. OIG submitted the remaining 149 claims to an independent medical review contractor to determine whether the claims met coverage, medical necessity, and coding requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the 149 sampled claims for inpatient stays for enrollees diagnosed with COVID-19, 146 claims complied with Federal requirements; however, the remaining 3 claims did not comply with the requirements. As a result, Medicare improperly paid hospitals $18,911. These improper payments occurred primarily because the acute-care hospitals made clerical errors when billing claims for inpatient stays. OIG provided the Centers for Medicare & Medicaid Services (CMS) with the billing details and OIG's findings for the three improperly paid claims so that it can evaluate these claims and decide whether to recover the improper payments in accordance with the agency's policies and procedures.

At the time of OIG's audit, CMS stated that, with the recent end of the COVID-19 PHE on May 11, 2023, CMS was assessing which actions would be most useful in a future PHE, such as a natural disaster or other emergencies, to: (1) ensure a rapid response to future emergencies, both locally and nationally, or (2) address the unique needs of communities that may experience barriers to accessing health care. CMS also stated that it will use lessons learned from the COVID-19 PHE and assessments of the actions it took in response to the PHE to inform what steps it takes in responding to future emergencies, such as mitigating risk by having a policy in place to ensure that payments are made only for treatments that are reasonable and medically necessary.

This report did not have any recommendations because Medicare generally paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements, the improper payments OIG identified resulted primarily from clerical errors made by the acute-care hospitals, and Medicare no longer pays hospitals the additional amount for billing a claim for a Medicare enrollee diagnosed with COVID-19.

Work Plan #: A-09-21-03009 (December 2023)
Government Program: Medicare Parts A & B

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Provider

[NEW] Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Discharges to Postacute Care

In a 2022 report, the Trustees of the Part A Hospital Insurance Trust Fund projected a Medicare Part A deficit of $7.3 billion by 2028 and urged policymakers to take timely and effective action to address this projected deficit. OIG performed this audit because data analysis indicated that significant cost savings could be realized for the Medicare program if the Centers for Medicare & Medicaid Services (CMS) expanded the hospital transfer policy for discharges to postacute care (PAC). OIG's objective was to determine how the hospital transfer policy for discharges to PAC would financially affect Medicare and hospitals if CMS expanded the policy to include all Medicare Severity Diagnosis-Related Groups (MS-DRGs).

OIG reviewed a stratified random sample of 100 acute-care inpatient hospital claims for Medicare enrollees who were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that are not subject to the hospital transfer policy for discharges to PAC. OIG calculated the savings that the Medicare program would have realized if the hospital transfer payment policy for discharges to PAC had been expanded to include all MS-DRGs. In addition, OIG compared the payments that would have been made under an expanded transfer policy with the hospitals' calculated costs to provide care.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that an expanded hospital transfer policy for discharges to PAC would result in significant cost savings to the Medicare program, and Medicare transfer payments would exceed hospital costs to provide care for most of the claims hospitals submit to Medicare. Of the 100 claims in OIG's sample, 99 could have had transfer payments that were based on a reduced per diem rate (rather than the full payment) that would have resulted in net Medicare cost savings of $1 million. This amount represents the difference between the amount paid to the hospitals under the current policy for discharges to PAC and the amount that would have been paid if the policy had been expanded to include the MS-DRGs associated with OIG's sampled claims. This policy change might negatively impact hospitals' revenues, but the transfer payment would have exceeded hospital costs for an estimated 65 percent of all claims that hospitals submit to Medicare.

CMS officials stated that CMS had not conducted an updated analysis of claims data since 2005. This analysis could have provided updated information in support of adding MS-DRGs or expanding the hospital transfer policy to include all MS DRGs. On the basis of OIG's sample results, OIG estimated that Medicare could have saved approximately $694 million, or an average of $6,407 per claim, from 2017 through 2019 if it had expanded its hospital transfer policy to include all MS-DRGs.

OIG recommended that CMS conduct an analysis of its hospital transfer payment policy for discharges to PAC and expand the policy as necessary.

Work Plan #: A-01-21-00504 (October 2023)
Government Program: Medicare Parts A & B

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[NEW] Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy Over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period

Prior OIG audits identified over $563 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). These hospitals transferred patients to certain post acute care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home. Because compliance with the transfer policy has been an issue over a long period, OIG conducted this follow-up audit to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2019, through December 31, 2022 (audit period). OIG's objective was to determine whether Medicare properly paid acute care hospitals' inpatient claims subject to the transfer policy.

OIG's audit covered $198 million in Medicare Part A payments for 12,133 inpatient claims subject to the transfer policy. OIG first identified specific inpatient claims for OIG's audit period that had a patient discharge status code indicating a discharge to home or certain types of health care institutions. OIG used the Medicare enrollee information and service dates from those claims to identify services furnished in post-acute-care settings that began: (1) on the same date as the inpatient discharge (e.g., SNF claims) or (2) within 3 days of the inpatient discharge (i.e., home health claims).

SunHawk Summary of OIG Audit Findings and Recommendations

For OIG's audit period, they found that Medicare improperly paid $41.4 million to acute-care hospitals for inpatient claims subject to the transfer policy. These hospitals improperly billed these claims by using the incorrect discharge status codes. Specifically, they coded these claims as discharges to home (6,338 claims) or to certain types of health care institutions (5,795 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to an acute-care hospital that discharges an inpatient to home or certain types of health care institutions but pays an acute-care hospital that transfers an enrollee to post-acute care a per diem rate for each day of the enrollee's stay in the hospital. The total overpayment of $41.4 million represented the difference between the amount of the full MS-DRG payments and the amount that would have been paid if the per diem rates had been applied.

These improper payments were made because CMS's system edits were not effective in detecting inpatient claims subject to the transfer policy in October and November 2019 and from October 2020 through March 2022. However, after CMS fixed the edits in April 2022, improper payments significantly decreased through the end of the audit period (i.e., through December 2022).

OIG recommended that CMS: (1) direct the Medicare contractors to recover from acute-care hospitals the portion of the $41.4 million in identified overpayments for OIG's audit period that are within the 4-year reopening period and (2) instruct the Medicare contractors to notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule.

Work Plan #: A-09-23-03016 (September 2023)
Government Program: Medicare Parts A & B

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Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

[NEW] Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities

Medicare pays practitioners for physician services separately from the payments it makes to inpatient facilities, such as skilled nursing facilities (SNFs) and hospitals. Practitioners report a two-digit place-of-service code on a Medicare claim line that generally reflects where the practitioner furnished the service. Medicare uses the place-of-service code to determine the payment to the practitioner. OIG conducted this audit because OIG's analysis of claims indicated that practitioners may not always follow the Centers for Medicare & Medicaid (CMS) regulations and guidance when reporting the place-of-service code on a claim line, thereby increasing the risk of Medicare making an overpayment for physician services furnished to inpatients of a SNF or hospital. OIG's objective was to determine whether Medicare paid the proper rate for physician services furnished to enrollees while they were inpatients of a SNF or hospital.

For calendar years 2019 and 2020, OIG identified 2.1 million physician service claim lines at risk of overpayment because of non-compliance with the place-of-service policy. OIG conducted claims analysis and calculated the overpayments and potential overpayments. OIG also discussed coding with CMS and practitioners and reviewed a sample of medical records.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare sometimes paid higher nonfacility rates rather than lower facility rates for physician services while enrollees were Part A SNF or hospital inpatients. During the 2-year audit period, Medicare made overpayments totaling $22,463,193 for 1,130,182 claim lines by paying the nonfacility rate for services coded as furnished in a nursing facility or SNF setting without Part A coverage while enrollees were a Part A SNF inpatients. CMS did not have Common Working File (CWF) system edits to detect these coding errors. Similarly, while enrollees were Part A SNF or hospital inpatients, Medicare paid an additional $22,142,489 for 1,012,203 physician service claim lines coded as furnished in a nonfacility setting. CMS has expressed reluctance to take enforcement action for these claim lines because neither statute nor CMS's regulation specifically addresses situations in which a SNF or hospital inpatient leaves to receive a physician service in a nonfacility setting.

OIG recommended that CMS 1) direct its Medicare contractors to recover the $22.5 million in overpayments identified in OIG's audit; 2) notify the appropriate practitioners so that they can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; 3) establish and apply CWF edits to detect instances in which practitioners incorrectly use the nonfacility place-of-service code for a SNF while an enrollee is a Part A SNF inpatient; 4) take the necessary steps, including seeking legislative authority, if necessary, to revise its regulations, to ensure that Medicare appropriately pays for the physician services, which could have resulted in the Medicare program paying up to $22.1 million less; 5) consider developing a mechanism for facilities to indicate when an inpatient leaves a facility and returns the same day; and 6) provide additional education to practitioners on the appropriate use of place-of-service codes.

Work Plan #: A-04-21-04084 (May 2023)
Government Program: Medicare Parts A & B

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[NEW] Crow/Northern Cheyenne Hospital—an IHS-Operated Health Facility—Did Not Timely Conduct Required Background Checks of Staff and Supervise Certain Staff

The Indian Child Protection and Family Violence Prevention Act established requirements for Federal background investigations for individuals in contact with Indian children as well as supervision of such individuals pending completion of the background investigation. Prior OIG work in this area found that several Tribes and their health programs did not comply with Federal requirements to perform FBI fingerprint background investigations for individuals in contact with Indian children. In this audit, OIG evaluated the background investigation and supervision processes for individuals in contact with Indian children at Crow/Northern Cheyenne Hospital (the Hospital), an Indian Health Service (IHS)-operated health facility located within the IHS Billings Area Office, in Crow Agency, Montana. OIG's objective was to determine whether the Hospital met Federal requirements for conducting background investigations and supervision of staff in contact with Indian children.

OIG reviewed the background investigation and supervision processes and related documentation at the Hospital for a randomly selected sample of 50 staff in contact with Indian children during calendar year 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Hospital did not fully comply with Federal requirements for conducting background investigations of staff members in contact with Indian children. Specifically, for 44 of the 50 staff members OIG reviewed, the Hospital did not comply with Federal requirements for conducting background investigations, including failing to initiate or timely initiate and adjudicate certain investigations. Further, the Hospital could not document that it supervised certain staff members with pending background investigations (provisional staff) in accordance with Federal requirements. Specifically, for 47 of the 50 staff members OIG reviewed, the Hospital did not provide evidence documenting compliance with Federal supervision requirements while their background investigations were pending.

These deficiencies generally occurred because the Hospital did not monitor compliance with background check requirements for permanent staff or ensure background checks for temporary staff were performed in accordance with the applicable requirements. Finally, the Hospital could not document supervision in accordance with Federal requirements. As a result, Indian children faced an increased risk of harm and abuse.

OIG made a series of recommendations to the Hospital, the Billings Area Office, and IHS Headquarters, including that they work together to (1) complete and adjudicate necessary background investigations for staff members identified in OIG's report, (2) ensure provisional staff supervision is adequately documented, and (3) update standard operating procedures and establish monitoring systems for background investigations and provisional staff supervision.

Work Plan #: A-02-21-02004 (April 2023)
Government Program: Indian Health Service

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[NEW] CMS Can Use OIG Audit Reports To Improve Its Oversight of Hospital Compliance

During calendar years (CYs) 2016 through 2018, Medicare paid hospitals approximately $555.2 billion: OIG performed a series of hospital compliance audits to determine whether hospitals are billing appropriately for certain claims. OIG did this audit to determine the Centers for Medicare & Medicaid Services' (CMS's) actions taken regarding recommendations in these 12 audits. OIG also considered the results from the first and second level of appeals to determine whether identified claims errors were sustained. Finally, OIG wanted to confirm that CMS is making the best use of the reports to enhance its oversight of the Medicare program. OIG's objectives were to: (1) summarize the results, after considering the status of appeals, of OIG's hospital compliance audits covering Medicare claims paid from 2016 through 2018; (2) identify CMS's actions taken to ensure that OIG's recommendations were implemented; and (3) determine how CMS could improve program oversight using OIG's hospital compliance audits.

OIG summarized the results of the previous 12 audits, determined the appeals status of any improperly paid claims, determined what actions CMS has taken with respect to the recommendations made in these 12 audits, and identified internal controls that CMS has in place to prevent payment of high-risk Medicare claims determined to be in error in these 12 reports.

SunHawk Summary of OIG Audit Findings and Recommendations

Of the 387 improperly paid claims identified in OIG's previous 12 hospital compliance audits, 333 were inpatient claims that resulted in $5,260,147 in net overpayments, and 54 were outpatient claims that resulted in $53,729 in net overpayments. Of these 387 improperly paid claims, 229 claims were appealed at the first level, of which 22 overpayment determinations were overturned. In addition, 126 claims were appealed at the second level, of which 6 overpayment determinations were overturned. As a result, 359 overpayment determinations remained, resulting in sustained overpayments totaling $5,041,721. After considering the results of the first and second levels of appeal, OIG determined that the total overpayments received by the 12 hospitals was $82 million.

CMS has taken some actions to ensure that the recommendations in OIG's previous 12 hospital compliance audits were implemented. With respect to OIG's recommendations to repay funds, CMS provided OIG with insufficient information; therefore, OIG could not identify the actions CMS had taken to ensure that the recommendations were implemented. With respect to OIG's recommendations to follow the 60-day rule, CMS provided OIG with insufficient information; therefore, OIG could not ensure that OIG's recommendations were implemented. With respect to OIG's recommendations to strengthen internal controls, CMS acted on most of these recommendations. As a result of CMS's incomplete responses, OIG are not able to verify that some hospitals have repaid funds or implemented OIG's recommendations to follow the 60-day rule and strengthen internal controls. CMS has not used the results from OIG's 12 issued audit reports in its internal control activities. CMS could use OIG's hospital compliance audit reports to enhance its oversight of the Medicare program.

OIG recommended that CMS: (1) continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report and (2) improve tracking and responding on the status of claims identified in OIG's reports as they proceed through the appeals process. OIG made additional procedural recommendations that are included in the body of the report.

Work Plan #: A-04-21-08084 (October 2022)
Government Program: Medicare Parts A & B

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[NEW] CMS's System Edits Significantly Reduced Improper Payments to Acute-Care Hospitals After May 2019 for Outpatient Services Provided to Beneficiaries Who Were Inpatients of Other Facilities

A prior OIG audit found that Medicare inappropriately paid acute-care hospitals $51.6 million for outpatient services they provided from January 2013 through August 2016 to beneficiaries who were inpatients of long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs). The overpayments occurred because system edits were not working properly. Because of the large overpayment amount OIG identified, OIG conducted this follow-up audit to review payments to acute-care hospitals for outpatient services provided from September 2016 through December 2021 (audit period), including determining whether the Centers for Medicare & Medicaid Services (CMS) had corrected the system edits.

OIG's objective was to determine whether Medicare appropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities.

OIG's audit identified $39.3 million in Medicare Part B payments to acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of certain other facilities during OIG's audit period. OIG identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs and used the beneficiary information and service dates to identify outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims.

SunHawk Summary of OIG Audit Findings and Recommendations

During OIG's audit period, OIG found that Medicare inappropriately paid acute-care hospitals $39.3 million for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs). None of the $39.3 million should have been paid because the inpatient facilities were responsible for payment. Each type of inpatient facility covered by OIG's audit must: (1) provide directly all services furnished during an inpatient stay or (2) arrange for services to be provided on an outpatient basis by an acute-care hospital and include those outpatient services on its inpatient claims submitted to Medicare.

Before May 2019, the system edits were not working properly. However, after CMS modified the edits in May 2019, only $3.4 million (less than 9 percent of the $39.3 million in improper payments for the entire audit period) was inappropriately paid to acute-care hospitals from June 2019 through December 2021.

OIG recommended that CMS: (1) direct the Medicare contractors to recover the portion of the $39.3 million in improper payments for OIG's audit period that are within the 4-year reopening period, (2) instruct acute-care hospitals to refund beneficiaries up to $9.8 million in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, (3) direct the Medicare contractors to recover any improper payments after OIG's audit period, and (4) continue to review the system edits to determine whether any refinements are necessary to prevent overpayments to acute-care hospitals for outpatient services provided to beneficiaries who are inpatients of other facilities. The report includes one other recommendation.

Work Plan #: A-09-22-03007 (September 2022)
Government Program: Medicare Parts A & B

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[NEW] Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over $1 Million for the Same Professional Services

OIG performed survey work on calendar year 2019 Medicare Part B claims and found that Critical Access Hospitals (CAHs) were paid for professional services provided by health care practitioners that received payment for the same services provided at the CAH. Generally, Medicare should not pay both a CAH and health care practitioner for professional services. OIG's objective was to determine whether Medicare Part B payments to CAHs for professional services and payments made to health care practitioners for the same services complied with Federal requirements.

OIG's audit covered 40,026 Medicare Part B claims, 20,013 claims submitted by CAHs, and 20,013 claims submitted by health care practitioners, for the same professional services provided to the same beneficiaries on the same dates of service from March 1, 2018, through February 28, 2021 (audit period). Medicare paid CAHs $1.0 million and paid health care practitioners $872,858 for these 40,026 claims. OIG reviewed Federal requirements for reassigning professional billing rights to CAHs. To conduct the audit, OIG used data analysis techniques to identify overpayments for professional billing by both the CAH and the health care practitioner.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all Medicare Part B payments made to CAHs for professional services and payments made to health care practitioners complied with Federal requirements. For the 40,026 claims OIG audited, CAHs and health care practitioners each submitted an equal number of claims. However, for each date of service, only one of the claims complied with Federal requirements. As a result, Medicare administrative contractors (MACs) paid providers $907,438 more than they should have been paid, and beneficiaries were held responsible for $281,321 more than they should have been.

These overpayments occurred because CMS did not have claim system edits to prevent and detect duplicate professional services claims for the same date of service, beneficiary, and procedure.

OIG recommended that CMS (1) direct the MACs to recover the $331,448 from the CAHs for 12,156 claims for which the health care practitioners had not reassigned their billing rights to the CAHs and $83,412 in cost-sharing overcharges to Medicare beneficiaries that are within the 4-year reopening period and (2) direct the MACs to recover the $575,990 from health care practitioners for 7,857 claims for which the health care practitioners had reassigned their billing rights to the CAHs and $197,909 in cost-sharing overcharges to beneficiaries that are within the 4-year reopening period. See the audit report for additional recommendations.

Work Plan #: A-06-21-05003 (September 2022)
Government Program: Medicare Parts A & B

The Reduced Outlier Threshold Applied to Transfer Claims Did Not Significantly Increase Medicare Payments to Hospitals

The Medicare program pays hospitals for inpatient hospital services based on a Medicare severity diagnosis-related group (DRG) rate per discharge. To protect hospitals from excessive losses due to unusually high-cost cases, the Medicare program supplements the DRG rate payment by making outlier payments. To avoid giving hospitals an incentive to transfer

patients to another health care setting early in a patient's stay, while still receiving the full DRG rate, Congress established the transfer policy. Medicare payment for transfer claims differs from Medicare payment for discharge claims in two ways. First, under the transfer policy, CMS uses a graduated per diem rate payment (transfer rate payment), which is less than the full DRG rate payment, to pay a hospital that transfers an inpatient to another health care setting. Second, CMS decreases the outlier threshold (reduced outlier threshold) applied to determine the eligibility for, and the amount of, outlier payments for transfer claims. OIG's objective was to assess the financial impact that Medicare's transfer policy and reduced outlier threshold have on Medicare total payments for transfer claims compared with what hospitals would have been paid if the beneficiary had been discharged instead of transferred.

During fiscal years 2011 through 2017, Medicare paid approximately $776 million in outlier payments for transfer claims. OIG reviewed 5,303 transfer claims with outlier payments totaling $66 million from 30 hospitals. Specifically, using Medicare claim data and information obtained from CMS for the 7-year period, OIG calculated DRG rate amounts and outlier payment amounts without applying the transfer policy for these 5,303 transfer claims, and OIG compared the results with the actual payments that Medicare made for these transfer claims.

SunHawk Summary of OIG Audit Evaluations and Recommendations

OIG found that Medicare's reduced outlier threshold for transfer claims did not have a significant impact on the total Medicare payments to the 30 hospitals OIG audited. Of the 5,303 transfer claims, the total Medicare payments for 3,668 transfer claims were less than what Medicare would have paid the hospitals if they had discharged the beneficiaries. However, the total Medicare payments for the remaining 1,635 transfer claims were $2.9 million more than what Medicare would have paid the hospitals if they had discharged the beneficiaries. Specifically, under the transfer policy, Medicare decreased DRG rate payments by $10.8 million but, because of the reduced outlier threshold, Medicare increased outlier payments by $13.7 million, resulting in a net increase of $2.9 million in total Medicare payments compared to what hospitals would have been paid if they had discharged the beneficiaries.

The $2.9 million net increase in total Medicare payments for these 1,635 transfer claims occurred because the outlier payment increase using the reduced outlier threshold was greater than the DRG payment decrease under the transfer policy.

Medicare's reduced outlier threshold for transfer claims does not have a significant enough impact for OIG to recommend a policy change. Therefore, OIG did not have any recommendations.

Work Plan # A-05-19-00019 (July 2022)
Government Program: Medicare Parts A & B

Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 Through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services

Three Medicare Payment Advisory Commission reports to Congress and a previous Office of Inspector General (OIG) report found that hospitals were increasingly purchasing physician practices and operating them as provider-based facilities because of their higher payment rates, and that Medicare payments and beneficiary coinsurance payments were

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substantially higher for services in provider-based facilities than they were for the same services in freestanding facilities. OIG's objective was to identify the potential cost savings to both the Medicare program and its beneficiaries by comparing their payments made for certain evaluation and management (E&M) services performed at provider-based facilities in calendar years 2010 through 2017 in eight selected States with what Medicare and beneficiaries would have paid for the same type of services performed at freestanding facilities in the same eight States.

OIG's audit covered $3.95 billion that Medicare and beneficiaries paid for E&M services they received at provider-based facilities in the selected States. OIG developed a database of payments made to physicians and provider-based facilities based on outpatient and Physician Fee Schedule (PFS) claims for E&M services performed in these facilities. OIG then compared those payments to what would have been paid at freestanding facilities.

SunHawk Summary of OIG Audit Evaluations and Recommendations

OIG found that both the Medicare program and its beneficiaries could have realized significant savings for E&M services if those services had been paid as if provided at freestanding facilities. If the physicians in the selected States had been paid at the freestanding PFS nonfacility rate and hospitals paid nothing under the Outpatient Prospective Payment System for OIG's audit period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million, for combined savings totaling over $1.6 billion. In addition, beneficiaries would have been required to make only one coinsurance payment rather than two (as they are currently required to do) and the cost-sharing would generally be lower because it would be based only on the freestanding facility rate.

The Centers for Medicare & Medicaid Services (CMS) has taken some steps intended to equalize payments. If these changes had been in effect during the period covered by OIG's audit, the potential cost savings of these changes for E&M services in the selected States for OIG's audit period could have been a combined $1.4 billion for the Medicare program and its beneficiaries. However, the combined $1.4 billion in potential cost savings would still have been less than the $1.6 billion in potential cost savings if E&M services had been paid at the freestanding PFS nonfacility rate.

OIG recommended that CMS pursue legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M services.

CMS did not directly agree or disagree with OIG's recommendation; it referred to regulatory action it had taken and added that any changes to further implement OIG's recommendation "may require legislative action." OIG commended CMS for the regulatory action it has taken and note that its comments are closely aligned with OIG's findings and recommendation. OIG continued to recommend that CMS pursue legislative or regulatory changes to lower costs by equalizing payments between the two types of facilities.

Work Plan # A-07-18-02815 (June 2022)
Government Program: Medicare Parts A & B

Vanderbilt University Medical Center: Audit of Outpatient Outlier Payments

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined

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payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges. OIG selected Vanderbilt University Medical Center (VUMC) because outpatient outlier payments increased from $2.7 million in 2017 to $6.2 million in 2018. OIG's objective was to determine whether possible billing inconsistencies resulted in improper outpatient outlier payments to VUMC.

OIG's audit covered 2,362 outpatient outlier payments, totaling $6.2 million, to VUMC for services provided from January 1 through December 31, 2018. OIG selected a stratified random sample of 117 outlier payments totaling $543,684 for review. Because outlier payments are based on total charges, OIG retrieved the claim detail related to each outlier payment. OIG submitted the claims related to the 117 outlier payments to VUMC for it to review. OIG requested that VUMC verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claims data for inconsistences and claim support documentation for billing errors.

SunHawk Summary of OIG Audit Evaluations and Recommendations

OIG found that VUMC properly billed the claims for 34 of the 117 sampled outlier payments totaling $102,551. However, VUMC did not properly bill the claims related to 81 outlier payments, resulting in improper outlier payments during OIG's audit period. These 81 claims, which had outlier payments totaling $427,644, contained 110 billing errors. The billing errors primarily occurred because VUMC did not have adequately designed controls or billing system capabilities to prevent coding errors, charge errors, and billing for services not covered by Medicare Part B. VUMC billed another two claims with incorrect dates of service that caused the claims to fall outside the scope of this audit (outpatient services longer than 1 day) and so were classified as non-errors.

OIG recommended that the Vanderbilt University Medical Center refund to the Medicare contractor the portion of the $686,500 in estimated outpatient outlier net overpayments for incorrectly billed claims that are within the 4-year reopening period. OIG also recommended that VUMC improve procedures, provide education, and implement changes to its billing system to ensure that claims billed to Medicare are accurate.

Work Plan # A-06-20-04003 (May 2022)
Government Program: Medicare Parts A & B

Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018

In 2010, OIG reported the first national incidence rate of patient harm events in hospitals—27 percent of hospitalized Medicare patients experienced harm in October 2008. During that month, hospital care associated with these events cost Medicare and patients an estimated $324 million in reimbursement, coinsurance, and deductible payments. Nearly half of these events were preventable. OIG conducted a new study to update the national incidence rate of patient harm events among hospitalized Medicare patients in October 2018. This work included calculating a new rate of preventable events and updating the cost of patient harm to the Medicare program.

The Department of Health and Human Services (HHS) leads national efforts to promote quality health care and prevent patient harm. Several agencies share this responsibility, including AHRQ, which leads HHS's efforts to improve health care quality, and CMS, which is the Nation's largest health care payer and oversight entity. Although HHS agencies have reported progress during the past decade toward improving patient safety, protecting the health and safety of HHS beneficiaries

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remains one of HHS's top management and performance challenges. An increased understanding of the prevalence and nature of patient harm will further assist efforts to reduce patient harm events and the factors contributing to these events.

OIG reviewed medical records for a random sample of 770 Medicare patients who were discharged from acute-care hospitals during October 2018. OIG conducted a two-stage medical record review to estimate a national incidence rate of adverse events and temporary harm events. OIG's review included all causes of patient harm regardless of whether the harm was preventable.

Stage 1: Nurses screened the records for possible patient harm events using a "trigger tool" method. A "trigger" is a clinical clue (e.g., documentation of a fall) that may indicate harm. From the Medicare claims data, nurses also reviewed present-on-admission indicators to identify harm that developed after the patient was admitted. OIG automatically referred records to Stage 2 when patients were readmitted within 30 days of discharge, regardless of whether the nurse identified harm (these include readmissions in October and November).

Stage 2: Physicians reviewed the records flagged during Stage 1 as containing possible harm events. Physician-reviewers identified harm events and assessed the severity of events, whether events were preventable, and factors that contributed to events.

OIG calculated the potential cost incurred by Medicare and patients as a result of these events. OIG also determined whether events were on CMS's lists of hospital-acquired conditions. Finally, OIG compared the results of this report to their 2010 report and explained the limitations of this comparison.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that twenty-five percent of Medicare patients experienced patient harm during their hospital stays in October 2018. Patient harm includes adverse events and temporary harm events.

Twelve percent of patients experienced adverse events, which are events that led to longer hospital stays, permanent harm, life-saving intervention, or death. In addition to the patients who experienced adverse events, 13 percent of patients experienced temporary harm events, which required intervention but did not cause lasting harm, prolong hospital stays, or require life-sustaining measures. Temporary harm events were sometimes serious and could have caused further harm if providers had not promptly treated patients.

Categories of Harm Events. The most common type of harm event was related to medication (43 percent), such as patients experiencing delirium or other changes in mental status. The remaining events related to patient care (23 percent), such as pressure injuries; to procedures and surgeries (22 percent), such as intraoperative hypotension; and to infections (11 percent), such as hospital-acquired respiratory infections.

Preventability of Harm Events. Physician-reviewers determined that 43 percent of harm events were preventable, with preventable events commonly linked to substandard or inadequate care provided to the patient. (The overall harm rate would be 13 percent if OIG were to include only events that their physician-reviewers determined were preventable.) Reviewers determined that 56 percent of harm events were not preventable and occurred even though providers followed proper procedures. Events were determined not preventable for several reasons, including that the patients were found to be highly susceptible to the events because of their poor health status.

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CMS's Lists of Hospital-Acquired Conditions. CMS's two policies on hospital-acquired conditions (HACs) create payment incentives for harm prevention by reducing payment for certain HACs. However, because the policies use narrowly scoped lists of HACs and employ specific criteria for counting harm events, they have limited effectiveness in broadly promoting patient safety. The lists did not cover most of the harm events that patients in their study experienced. Of the harm events OIG identified, only 5 percent were on CMS's HAC Reduction Program list and only 2 percent were on CMS's Deficit Reduction Act HAC list.

Harm Events Resulting in Costs to Medicare. Nearly a quarter of Medicare patients who experienced harm events (23 percent), either preventable or nonpreventable, required treatment that led to additional Medicare costs. These events also potentially increased patient costs in the form of coinsurance and deductible payments. Costs were incurred during the sample hospital stay or for an additional hospital stay necessary to ameliorate the harm. Combined, OIG estimated the costs for all events to be in the hundreds of millions of dollars for October 2018.

Given the scale and persistence of patient harm in hospitals in the decade since OIG's last report, HHS leadership and agencies must work with urgency to reduce patient harm in hospitals. Although HHS agencies took steps to improve patient safety in hospitals, including implementing many of OIG's prior recommendations, substantial efforts are still needed.

- OIG made the following three recommendations to CMS: (1) update and broaden its lists of HACs to capture common, preventable, and high-cost harm events; (2) explore expanding the use of patient safety metrics in pilots and demonstrations for health care payment and service delivery, as appropriate; and (3) develop and release interpretive guidance to surveyors for assessing hospital compliance with requirements to track and monitor patient harm. In its response to OIG's draft report, CMS provided details about ongoing and planned efforts to improve patient safety.

- OIG made the following four recommendations to AHRQ: (1) with support from HHS leadership, coordinate agency efforts to update agency-specific Quality Strategic Plans; (2) optimize use of the Quality and Safety Review System, including assessing the feasibility of automating data capture for national measurement and to facilitate local use; (3) develop an effective model to disseminate information on national clinical practice guidelines or best practices to improve patient safety; and (4) continue efforts to identify and develop new strategies to prevent common patient harm events in hospitals. After receiving AHRQ's comments, OIG revised their first recommendation to make the recommended actions clearer and OIG revised the second recommendation to acknowledge recent progress by AHRQ regarding its event surveillance system.

Work Plan # OEI-06-18-00400 (May 2022)
Government Program: Medicare Parts A & B

Hospitals Did Not Always Meet Differing Medicare Contractor Specifications for Bariatric Surgery

Bariatric surgery helps those with morbid obesity to lose weight by making changes to their digestive system. A prior OIG audit found that a hospital's claims for bariatric surgeries performed in 2015 and 2016 did not fully meet a Medicare contractor's eligibility specifications. Because eligibility specifications varied among the Medicare contractors, OIG conducted this nationwide audit of hospitals' inpatient claims for bariatric surgeries performed from January 2018 through

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July 2019 (audit period), for which Medicare paid approximately $279 million. OIG's objective was to determine whether hospitals' inpatient claims for bariatric surgeries met Medicare national requirements and Medicare contractors' eligibility specifications.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all hospitals' inpatient claims for bariatric surgeries met Medicare national requirements or Medicare contractors' eligibility specifications. Specifically, of the 120 sampled inpatient claims, 86 met NCD requirements and applicable eligibility specifications for bariatric surgery, and 1 claim was not reviewed but treated as a non-error because it was under review by a CMS contractor. However, of the remaining 33 claims, 32 claims met the NCD requirements but not the eligibility specifications, and 1 claim did not meet the NCD requirements.

OIG also found that differing eligibility specifications for bariatric surgery contributed to differences in the number of claims that did not meet the specifications among Medicare contractor jurisdiction groups. Jurisdiction groups with more restrictive specifications had more claims that did not meet the eligibility specifications and more specifications that were not met. The Medicare contractors may have issued differing eligibility specifications because CMS's NCD requirements were not specific. On the basis of the sample results, OIG estimated that Medicare could have saved $47.8 million during the audit period if Medicare contractors had disallowed claims that did not meet Medicare national requirements or Medicare contractor specifications for bariatric surgery.

OIG recommended that CMS: (1) determine whether any eligibility specifications in the Medicare contractors' LCDs and LCAs should be added to the NCD for bariatric surgery and, if so, take the necessary steps to update the NCD; (2) work with the Medicare contractors to review the eligibility specifications in the applicable Medicare contractors' bariatric surgery LCDs and LCAs and determine which, if any, of those additional specifications should be requirements rather than guidance; and (3) educate hospitals on the NCD requirements for bariatric surgeries if the NCD has been updated in response to OIG's first recommendation.

Work Plan #: A-09-20-03007 (February 2022)
Government Program: Medicare Parts A & B

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Long Term Care

[NEW] Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes

- Nursing home residents and staff have been especially impacted by the COVID-19 pandemic. Now, it is critical to learn from what happened in nursing homes and take steps to better protect residents and staff during future infectious disease outbreaks, emergencies, or other disruptions to the health care system.

- This is the third and final report in a three-part series about the effects of the COVID-19 pandemic on nursing homes. The previous reports found that COVID-19 had a devastating impact on Medicare beneficiaries in nursing homes during 2020, as 2 in 5 residents had or likely had COVID-19 in 2020. Also, more than 1,300 nursing homes had infection rates of 75 percent or higher during surge periods.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that nursing homes faced monumental and ongoing staffing challenges, including a significant loss of staff and substantial difficulties in hiring, training, and retaining new staff. Many nursing homes used outside staffing agencies to fill gaps, which had significant downsides.

Nursing homes continued to struggle with costs, testing protocols, personal protective equipment compliance, and vaccination rates after initial challenges were resolved.

Nursing homes identified challenges with implementing effective infection control practices and opportunities for improvement.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

1. Implement and expand upon its policies and programs to strengthen the nursing home workforce.
2. Reassess nurse aide training and certification requirements.
3. Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic.
4. Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements.
5. Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care.

Work Plan #: OEI-02-20-00492 (February 2024)
Government Program: Medicare Parts A & B

[NEW] CDC Has Improved the Nursing Homes Reporting Process for COVID-19 Data in NHSN, but Challenges Remain

The Centers for Disease Control and Prevention (CDC) struggled to support nursing homes during mass enrollment into the National Healthcare Safety Network (NHSN) in 2020 and as COVID-19 reporting requirements changed throughout the pandemic. CDC has improved the nursing home reporting process and guidance, but some challenges remain. Continued improvements to NHSN user support and data quality will be important for continued reporting on vaccinations and for future public health surveillance.

NHSN has served as a critical source for monitoring the effects of the COVID-19 pandemic, and informing the Federal, State, and local pandemic response. In May 2020, the Centers for Medicare & Medicaid Services (CMS) issued a requirement for nursing homes to report COVID-19 data to NHSN. CDC has operated NHSN since 2005, but nursing home reporting had been voluntary, with participation from only a small proportion of facilities. The reporting requirement resulted in the influx of thousands of nursing homes enrolling in and reporting to NHSN in 2020, while they, and CDC, also responded to the pandemic.

This evaluation provides insights into nursing home experiences enrolling in and reporting to NHSN, and CDC efforts to facilitate reporting such as user support for facilities facing difficulties. These insights can help CDC address ongoing challenges and mitigate potential issues in future updates or expansions. OIG administered an electronic survey to a simple random sample of 197 nursing homes from a population of 15,324 facilities that have reported COVID-19 data to NHSN and interviewed a subset of facilities. OIG also interviewed CDC and CMS officials to understand CDC efforts to facilitate nursing home enrollment and reporting to NHSN. OIG based the findings on analysis of survey and interview responses.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that despite CDC efforts, both CDC and nursing homes experienced difficulties during a mass enrollment of more than 12,000 facilities into NHSN to begin reporting COVID-19 data in May 2020.

As the pandemic continued, CDC added data variables to NHSN, including fields with personally identifiable information, in response to emerging data needs and new Federal reporting requirements. Nursing homes had to upgrade their security access levels to report the sensitive data. At this time, CDC experienced a significant backlog of support requests, which also inhibited some facilities from accessing NHSN.

CDC improved the process of nursing home reporting to NHSN throughout the pandemic. Facilities acknowledged this effort and reported that CDC support improved, but some continued to experience difficulty getting assistance. Additionally, a quarter of nursing homes reported lacking confidence in the quality of NHSN data, despite the quality assurance checks CDC conducts on key variables.

After December 2024, CMS reporting requirements for some key variables will expire, but the mandate for reporting vaccination-related data will remain. CDC stated that it will continue to support voluntary reporting of COVID-19 data and other infection and quality measures and modernize NHSN reporting processes. Stakeholders and CDC expressed that having nursing home participation in NHSN is valuable for public health surveillance, and the agency is exploring opportunities to leverage the current national enrollment for reporting on other health outcomes.

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To continue improvements, OIG recommended that CDC (1) improve the user support the NHSN Help Desk provides to nursing homes, (2) take further steps to ensure the quality of nursing home reporting of COVID-19 data to NHSN, and (3) consider how quality assurance checks can be enhanced to ensure data accuracy, as appropriate.

Work Plan #: OEI-06-22-00030 (January 2024)
Government Program: Medicare Parts A & B

[NEW] The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID 19 Pandemic, but Some Found Guidance Difficult to Use

The Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) quickly distributed Provider Relief Fund (PRF) payments to nursing homes. Nursing homes reported that payments were integral to maintaining services during the COVID-19 pandemic, but that guidance from HRSA about the payments and reporting requirements was often difficult to use.

Nursing homes and their residents have been among the hardest hit by the COVID-19 pandemic, partly because of longstanding challenges with staffing and infection control. To help nursing homes and other health care providers respond to the pandemic, Congress appropriated $178 billion and designated HHS to oversee PRF and related distributions to providers. HHS made approximately $9.4 billion in targeted PRF distributions to nursing homes and skilled nursing facilities (SNFs).

OIG conducted this evaluation in conjunction with a series of Pandemic Response Accountability Committee (PRAC) studies examining COVID-19 funding in six select locations. OIG examined how 11 nursing homes in those locations used PRF payments during 2020 and 2021 to improve their responses to the COVID-19 pandemic. OIG also examined HRSA oversight of the funds. OIG based the findings on document reviews, an analysis of PRF payment data, and 33 interviews with leadership, staff, residents, and residents' family members from the selected nursing homes. OIG also conducted two group interviews with HRSA officials. OIG collected the documents and data in early 2022 to prepare for conducting interviews from May through December concurrently with the PRAC's site visits.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that after receiving congressional appropriations in March 2020, HHS quickly worked with HRSA and other stakeholders to develop PRF and began distributing general relief payments to health care providers the following month. HHS began the first targeted distribution payments to nursing homes in May. Although leaders for the nursing homes in OIG's sample appreciated how quickly the payments were disbursed, they sometimes faced challenges with PRF distribution and attestation processes.

HRSA distributed nearly $15 million in PRF payments to the 11 nursing homes in OIG's sample in 2020 and 2021, including more than $5 million from targeted distributions to nursing homes and SNFs. Nursing home leaders reported that HRSA's broad guidance on allowable uses was initially unclear and difficult to use. As a result, some were hesitant to use the funds for fear they would use the money incorrectly and be forced to pay it back later. Regardless of the challenges, the nursing homes had used and reported about $12 million of the $15 million when OIG began site visits in May 2022. Nursing home leaders reported using the funds for expenses and lost revenue and reported that PRF payments were integral to maintaining services during the pandemic.

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HRSA required nursing homes to submit reports about PRF use. The nursing homes in this review generally complied with the reporting requirements, but some appeared to misreport data or had to resubmit information. Nursing home leaders reported that it was difficult to find time to review lengthy reporting guidance, and that completing the reports was a burden. Although HRSA reported plans to assess nursing home use of PRF, the agency had not yet begun conducting audits at the time OIG conducted the review.

OIG recommended that HRSA: (1) create a document to record lessons learned from managing PRF and submit the document to HHS leadership and (2) expedite audits of provider use of PRF payments. HRSA did not concur with the first recommendation and concurred with the second.

Work Plan #: OEI-06-22-00040 (December 2023)
Government Program: Health and Human Services

[NEW] Louisiana Should Improve Its Oversight of Nursing Homes' Compliance With Requirements That Prohibit Employment of Individuals With Disqualifying Background Checks

Background checks for employees are an important safety measure that can help protect some of the most vulnerable populations. Approximately 1.4 million beneficiaries reside in long-term care facilities (nursing homes), with more than half of them relying on Medicaid to pay for their long-term care. Oversight and management of nursing homes are crucial to the safety of long-term care residents. OIG's objective was to determine whether Louisiana ensured, for the period October 1, 2019, to June 30, 2021, that selected nursing homes in Louisiana complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds.

As of May 2021, 276 nursing homes were licensed in Louisiana. OIG selected for audit, a judgmental sample of 9 of the 276 nursing homes based on a variety of risk factors and based on the need to select nursing homes in urban and rural settings. From the 9 nursing homes, OIG reviewed background checks for 209 non-licensed employees and verified the licensure status of 77 licensed employees, for a total of 286 employees. OIG's sample size at each nursing home varied depending on the number of employees there, but generally, OIG selected for review individuals who were actively employed at some point between October 1, 2019, and June 30, 2021.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that, Louisiana ensured, for the period October 1, 2019, to June 30, 2021, that all nine selected nursing homes in the State complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds. In addition, OIG determined that 77 licensed employees whom OIG selected for review from the same 9 selected nursing homes were free from any disciplinary action against their professional license; thus, their licensure statuses were in good standing. Although Federal requirements do not specify the methods or types of information that should be considered for a background check to be regarded as having been satisfactorily completed, OIG identified potential limitations in the nursing homes' background check searches and adjudication methods for 49 of the 209 non-licensed employees OIG reviewed.

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The limitations that OIG identified occurred because Louisiana did not require the review of nursing homes' compliance with background check requirements as part of its periodic nursing home surveys unless concerns had been identified relative to inadequate staffing; issues of abuse, neglect, exploitation, or misappropriation; or both.

OIG recommended that Louisiana conduct routine monitoring of nursing homes' compliance with background check requirements. OIG made other procedural recommendations to the State in the full report.

Work Plan #: A-06-21-02000 (November 2023)
Government Program: Medicare Parts A & B

[NEW] States Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations for health care facilities to improve protections for individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. In addition, facilities were required to implement an infection control program. OIG's objective was to determine whether States ensured that selected nursing homes in selected States that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Georgia (A-04-22-08093)

OIG reported that Georgia could better ensure that nursing homes in Georgia that participate in Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at 19 of the 20 nursing homes OIG audited, totaling 155 deficiencies. Specifically, OIG found 71 deficiencies related to life safety, 66 deficiencies related to emergency preparedness, and 18 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at 19 of the 20 nursing homes are at an increased risk during a fire or other emergency or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Georgia had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Georgia does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that Georgia follow up with the 19 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions. OIG also made procedural recommendations for Georgia to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

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[NEW] New Jersey (A-02-22-01004)

OIG reported that New Jersey could better ensure that nursing homes in New Jersey that participate in Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes OIG audited, totaling 363 deficiencies. Specifically, OIG found 148 deficiencies related to life safety, 152 deficiencies related to emergency preparedness, and 63 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes are at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, New Jersey had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, New Jersey does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that New Jersey follow up with the 20 nursing homes reviewed as part of this audit to ensure that they have taken corrective actions regarding the deficiencies identified in this report and instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements. OIG also made procedural recommendations for New Jersey to work with CMS to develop and implement a plan to identify and conduct more frequent surveys at nursing homes and to develop standardized training for nursing home staff.

[NEW] Ohio (A-05-22-00019)

OIG reported that Ohio could better ensure that nursing homes in Ohio that participate in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at 18 of the 20 nursing homes that OIG audited, totaling 160 deficiencies. Specifically, OIG found 47 deficiencies related to life safety, 47 deficiencies related to emergency preparedness, and 66 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 18 nursing homes are at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Ohio had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Ohio does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that Ohio follow up with the 18 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to verify that corrective actions have been taken regarding the deficiencies identified in this report. OIG also made procedural recommendations for Ohio to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

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[NEW] Oklahoma (A-06-22-09007)

OIG reported that Oklahoma could better ensure that nursing homes in Oklahoma that participate in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes OIG audited, totaling 146 deficiencies. Specifically, OIG found 98 deficiencies related to life safety, 16 deficiencies related to emergency preparedness, and 32 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were at an increased risk during a fire or other emergency or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Oklahoma had limited resources to conduct surveys of all nursing homes as required by CMS.

OIG recommended that Oklahoma follow up with the 20 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions. OIG also made procedural recommendations for Oklahoma to work with CMS to develop an approach to identifying and conducting more frequent surveys at nursing homes.

[NEW] Pennsylvania (A-03-22-00206)

OIG reported that Pennsylvania could better ensure that nursing homes in Pennsylvania that participate in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional oversight was provided. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that OIG audited, totaling 586 deficiencies. Specifically, OIG found 220 deficiencies related to life safety, 288 deficiencies related to emergency preparedness, and 78 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes are at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, poor record keeping, combined with an inconsistent application of policies, also contributed to deficiencies. Finally, although not required by CMS, Pennsylvania does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that Pennsylvania follow up with the 20 nursing homes reviewed as part of this audit to verify that corrective actions have been taken regarding the deficiencies identified in this report. OIG also made seven additional procedural recommendations for Pennsylvania that are included in the report.

[NEW] Washington (A-09-22-02006)

OIG reported that Washington State did not ensure that selected nursing homes in Washington that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that OIG audited, totaling 525 deficiencies. Specifically, OIG found 91 deficiencies

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related to life safety, 155 deficiencies related to emergency preparedness, and 279 deficiencies related to infection control. As a result, residents, staff, and visitors at the 20 nursing homes are at an increased risk of injury, significant illness, or death during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because nursing homes lacked adequate management oversight and had frequent management turnover. In addition, although nursing home management and staff are ultimately responsible for ensuring resident safety, Washington has a role in helping nursing homes reduce the risk of resident injury, significant illness, or death through its oversight of nursing homes' compliance with Federal requirements. However, Washington did not consistently identify deficiencies related to life safety, emergency preparedness, and infection control during surveys and take enforcement action to ensure that nursing homes complied with the requirements. Furthermore, Washington did not ensure that nursing home management was educated about life safety and emergency preparedness training resources available to nursing home staff that could be used to train staff on how to comply with Federal requirements.

OIG recommended that Washington State follow up with the 20 nursing homes reviewed in this audit to ensure that these nursing homes have taken corrective actions to address the deficiencies identified. OIG also made procedural recommendations for Washington to provide training to State surveyors and educate nursing home management that training resources are available.

North Carolina (A-04-19-08070)

OIG reported that, of the 20 North Carolina nursing homes that OIG visited, 18 had deficiencies in areas related to life safety or emergency preparedness. Specifically, 18 nursing homes had 64 instances of noncompliance with life safety requirements related to building exits, smoke barriers, and smoke partitions, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment power cords. Furthermore, 14 nursing homes had 124 instances of noncompliance with emergency preparedness requirements related to written emergency plans, emergency power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training and testing.

The instances of noncompliance occurred because nursing homes had inadequate management oversight and high staff turnover. In addition, North Carolina did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 8 to 15 months, even at these higher risk nursing homes.

OIG recommended that North Carolina: (1) follow up with the 18 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies.

Illinois (A-05-18-00037)

OIG reported that Illinois did not ensure that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness. During OIG site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 15 nursing homes that OIG reviewed. Specifically, OIG found 53 instances of noncompliance with life safety requirements and 184 instances of noncompliance with emergency preparedness requirements. As a result, residents at the 15 nursing homes were at increased risk of injury or death during a fire or other emergency.

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The identified deficiencies occurred because the existing life safety training program for nursing home management could not educate all Illinois nursing home management in a timely manner, and the State did not offer an emergency preparedness training program for nursing home management. (Currently, CMS requires neither of the two training programs.) Further, Illinois performed abbreviated surveys of emergency preparedness plans and had insufficient personnel for its workload. In addition, Illinois did not determine whether carbon monoxide alarms were installed in accordance with State law.

OIG recommended that Illinois: (1) follow up with the 15 nursing homes to verify that corrective actions have been taken regarding the deficiencies that OIG identified, (2) conduct more thorough emergency preparedness reviews for the safety and protection of nursing home residents and staff, (3) work with CMS to develop emergency preparedness training and expand life safety training sessions to accommodate all nursing home management, (4) consider increasing staffing levels to address caseload thresholds for State surveyors, and (5) consider modifying its survey procedures to check for carbon monoxide alarms required by Illinois law.

Florida (A-04-18-08065)

OIG reported that all 20 nursing homes that OIG visited had deficiencies in areas related to life safety or emergency preparedness. Specifically, 19 nursing homes had 100 areas of noncompliance with life safety requirements related to building exits and smoke barriers, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment. Furthermore, 16 nursing homes had 87 areas of noncompliance with emergency preparedness requirements related to written emergency plans, emergency supplies and power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training. The instances of noncompliance occurred because of several contributing factors, specifically inadequate management oversight and staff turnover at the nursing homes. In addition, OIG reported Florida did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 12 to 15 months, even at these higher risk nursing homes.

OIG recommended Florida: (1) follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies and follow up to ensure that corrective actions have been taken.

Missouri (A-07-18-03230)

During OIG's onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes. OIG found 178 areas of noncompliance with life safety requirements related to building exits, fire detection and suppression systems, hazardous storage, smoking policies, and electrical equipment maintenance, among others. OIG also found 149 areas of noncompliance with emergency preparedness requirements related to written plans, emergency power, emergency communications, and training, among others. As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified areas of noncompliance occurred because Missouri did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, Missouri did not adequately follow up on deficiencies previously cited.

OIG recommended Missouri follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the identified deficiencies. OIG made other procedural recommendations to Missouri regarding the development

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of standardized life safety training for nursing home staff, the conducting of more frequent surveys and follow-up at nursing homes with a history of multiple high-risk deficiencies, and updates of facility-specific plans.

Texas (A-06-19-08001)

OIG reported that during OIG's onsite inspections, OIG identified deficiencies in areas related to life safety or emergency preparedness at 18 nursing homes. Specifically, OIG found 235 deficiencies with life safety requirements related to building exits and smoke partitions, fire detection and suppression systems, hazardous storage areas, fire drills and smoking policies, and electrical equipment and elevator inspection and testing. OIG found 55 deficiencies with emergency preparedness requirements related to written emergency plans, emergency supplies and power, emergency communications plans, and emergency plan training. As a result, residents at the 18 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because management oversight at nursing homes was inadequate, and nursing homes had high maintenance and administrative staff turnover. In addition, maintenance personnel at some of the nursing homes indicated that building maintenance is challenging because of the advanced age of some buildings.

OIG recommended Texas follow up with the 18 nursing homes to verify that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report.

California (A-09-18-02009)

During OIG's site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 19 nursing homes that OIG reviewed. Specifically, OIG found 137 instances of noncompliance with life safety requirements related to building exits, smoke barriers, smoke partitions, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment testing and maintenance. OIG also found 188 instances of noncompliance with emergency preparedness requirements related to written emergency plans, emergency power, plans for evacuation, sheltering in place, and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training and testing. As a result, nursing home residents at the 19 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because nursing homes lacked adequate management oversight and had high staff turnover. In addition, California did not adequately follow up on deficiencies previously cited, ensure that surveyors were consistently enforcing CMS requirements, or have a standard life safety training program for all nursing home staff (not currently required by CMS).

OIG recommended California: (1) follow up with the 19 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) conduct more frequent site surveys at nursing homes to follow up on deficiencies, (3) ensure that all surveyors consistently enforce CMS requirements, and (4) work with CMS to develop life safety training for nursing home staff.

Work Plan #: A-06-22-09007 (January 2024); A-05-22-00019 (December 2023); A-09-22-02006 (December 2023); A-03-22-00206 (November 2023); A-02-22-01004 (September 2023); A-04-22-08093 (September 2023); A-04-19-08070 (September 2020); A-05-18-00037 (September 2020); A-04-18-08065 (March 2020); A-07-18-03230 (March 2020); A-06-19-08001 (February 2020); A-09-18-02009 (November 2019)
Government Program: Medicare Parts A & B

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[NEW] Nursing Homes Reported Wide-Ranging Challenges Preparing for Public Health Emergencies and Natural Disasters

Although most nursing homes met Federal emergency preparedness requirements, an estimated 77 percent reported challenges with preparedness activities intended to ensure that resident care needs are met during an emergency. The most frequently cited concerns among nursing homes were ensuring proper staffing during emergencies and transporting residents during evacuations. OIG has identified emergency preparedness and nursing home safety as priorities. Nursing home failures to adequately plan for and respond to public health emergencies and natural disasters have led to tragic results. Although such outcomes were not typical, they point to the need to identify the source of breakdowns and to strengthen nursing home preparedness efforts.

OIG surveyed a random sample of 199 nursing homes located in geographic areas rated by the Federal Emergency Management Agency (FEMA) as having a very high or relatively high risk for natural hazards. OIG received responses from 168 nursing homes and projected the results to all nursing homes in the FEMA risk areas. Respondents rated how challenging each of 49 preparedness activities were for their facility. The activities covered seven topic areas related to emergency preparedness capabilities that are important for ensuring safety of residents during emergency events.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that, in June 2022, an estimated 77 percent of nursing homes located in areas at greater risk for natural disasters reported experiencing challenges with emergency preparedness activities. Administrators reported concerns across seven topic areas, with activities related to ensuring proper staffing during emergencies and transporting residents during evacuations being the most problematic. An estimated 62 percent of nursing homes reported at least one challenge regarding staffing and an estimated 50 percent noted at least one challenge regarding transportation. Other challenges reported by some nursing homes related to securing beds for evacuated residents and planning for infection control and quarantine during emergencies.

OIG found that even those nursing homes that meet the Federal requirements for emergency preparedness face challenges with critical aspects of emergency preparedness. Specifically, OIG found that only 24 percent of nursing homes in areas at high risk for disasters received a deficiency for not meeting emergency preparedness requirements established by the Centers for Medicare & Medicaid Services (CMS) during their most recent compliance survey—but an estimated 77 percent of nursing homes reported at least one challenge with preparedness activities.

OIG found that nursing homes reporting challenges had lower community resilience compared to other nursing homes, indicating that availability of community resources may be a factor in nursing homes' experience with preparedness activities. Further, an estimated one in five nursing homes reported difficulties coordinating preparedness activities with multiple community partners.

Work Plan #: OEI-06-22-00100 (September 2023)
Government Program: Medicare Parts A & B

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[NEW] CMS Did Not Accurately Report on Care Compare One or More Deficiencies Related to Health, Fire Safety, and Emergency Preparedness for an Estimated Two-Thirds of Nursing Homes

On behalf of the Centers for Medicare & Medicaid Services (CMS), State survey agencies perform inspections of Medicare- and Medicaid-certified nursing homes to determine whether they are in compliance with Federal health, fire safety, and emergency preparedness requirements. State survey agency surveyors cite instances of noncompliance as deficiencies and report inspection results to CMS. CMS makes the inspection results available on Care Compare, a CMS website that provides information on health care providers that consumers can use to make informed decisions about health care. OIG's objective was to determine whether CMS accurately reported on Care Compare the deficiencies related to health, fire safety, and emergency preparedness that were identified during inspections of nursing homes.

OIG selected a random sample of 100 nursing homes from among 15,377 nursing homes nationwide. For each sampled nursing home, OIG compared the deficiencies that had been reported on Care Compare as of December 10, 2020, with the deficiencies that State survey agency surveyors had documented in inspection reports from the three most recent yearly health, fire safety, and emergency preparedness inspections and the results of the most recent 3 years of complaint inspections.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for 67 of the 100 sampled nursing homes, CMS did not accurately report on Care Compare 1 or more deficiencies that surveyors identified during yearly and complaint inspections. The deficiencies consisted of health deficiencies for 34 nursing homes, fire safety deficiencies for 52 nursing homes, and emergency preparedness deficiencies for 2 nursing homes. In addition, for 42 of the 100 sampled nursing homes, CMS did not report on Care Compare the results of all yearly fire safety and emergency preparedness inspections.

On the basis of OIG's sample results, OIG estimated that 10,303 nursing homes had 1 or more deficiencies identified during inspections that were not accurately reported on Care Compare. Specifically, OIG estimated that 5,228 nursing homes had health deficiencies, 7,996 nursing homes had fire safety deficiencies, and 308 nursing homes had emergency preparedness deficiencies that were not accurately reported on Care Compare. In addition, OIG estimated that for 6,458 nursing homes CMS did not report on Care Compare the results of all yearly fire safety and emergency preparedness inspections.

OIG recommended that CMS: (1) correct the inaccurately reported deficiencies that OIG identified for the sampled nursing homes; and (2) strengthen its processes for reviewing inspection results reported on Care Compare by requiring State survey agencies to verify the deficiencies reported, providing technical assistance and additional training to State survey agencies, and verifying that nursing home inspection results are accurately reported. The report has three other procedural recommendations.

Work Plan #: A-09-20-02007 (April 2023)
Government Program: Medicare Parts A & B

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[NEW] More Than a Thousand Nursing Homes Reached Infection Rates of 75 Percent or More in the First Year of the COVID-19 Pandemic; Better Protections Are Needed for Future Emergencies

Almost every American has been affected in some way by the COVID-19 pandemic. By the end of 2020, COVID-19 had spread throughout the United States. The COVID-19 pandemic has been particularly devastating for Medicare beneficiaries in nursing homes, which is why OIG embarked on a three-part series of evaluations focusing exclusively on the nursing home experience during 2020. The first report in this series found that 2 in 5 Medicare beneficiaries in nursing homes either had or likely had COVID-19 in 2020. Some Medicare beneficiaries in nursing homes seemed to be at greater risk than others. Specifically, Black beneficiaries, Hispanic beneficiaries, and Asian beneficiaries were more likely than White beneficiaries to have or likely have COVID-19. In addition, overall mortality for Medicare beneficiaries in nursing homes increased by almost one-third in 2020 from the 2019 level.

This is the second report in the series and builds on the first OIG report by focusing on nursing homes themselves. It looks at the extent to which they had residents who were diagnosed with COVID-19 or likely COVID-19, and the characteristics of nursing homes with extremely high infection rates. The third report will feature specific challenges nursing homes faced and the strategies they used to deal with them. For the health and safety of residents, nursing homes must be prepared to face current and future health emergencies. Understanding how the COVID-19 pandemic has affected nursing homes can help the CMS, Congress, and other stakeholders learn from what has happened and inform their decisions as they strive to improve care and better protect residents.

OIG used Medicare claims data to determine the extent to which nursing homes had Medicare beneficiaries who were diagnosed with COVID-19 or likely COVID-19. OIG looked at 15,086 nursing homes nationwide and identified nursing homes with extremely high infection rates during the surges of cases during the spring and fall of 2020. These homes had three-quarters or more of their Medicare beneficiaries diagnosed with COVID-19 or likely COVID-19 during a surge period. OIG examined the characteristics of these nursing homes. OIG also examined whether these nursing homes had been cited with any infection control deficiencies and whether their reported nursing hours met minimum Medicare requirements for these hours.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that nursing homes had a surge of COVID-19 cases during the spring of 2020 and a greater surge during the fall, well after they were known to be vulnerable. More than 1,300 nursing homes had extremely high infection rates—75 percent or more of their Medicare beneficiaries—during these surges. These nursing homes were more common and geographically widespread during the second surge. Nursing homes with extremely high infection rates experienced dramatic increases in overall mortality (not limited to deaths of beneficiaries who had or likely had COVID-19). Specifically, these nursing homes experienced an average overall mortality rate approaching 20 percent during these surges—roughly double the mortality rate of other nursing homes during the same time periods. For comparison, in 2019 the average mortality rate in these same nursing homes was 6 percent.

For-profit nursing homes made up a disproportionate percentage of the nursing homes with extremely high infection rates during both surges. Other characteristics varied by surge. For example, urban nursing homes were more likely to have extremely high infection rates during the first surge, but rural nursing homes were more likely to have extremely high rates during the second surge.

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High COVID-19 transmission in a county did not always lead to nursing homes in that county reaching extremely high infection rates. In addition, the survey process did not identify any deficiencies in infection control for the majority of the nursing homes with extremely high infection rates, raising questions about how effective the survey process is in preventing and mitigating the spread of infectious disease in nursing homes. Also, the vast majority of nursing homes with extremely high infection rates reported nursing hours that met or exceeded Medicare's specific minimum requirements for these hours, which may indicate that these requirements are not adequate to keep residents safe from infectious disease.

These findings make clear that nursing homes in this country were not prepared for the sweeping health emergency that COVID-19 created, nor were they able to stem the devastation once it was evident that nursing homes were especially vulnerable. Virtually all nursing homes experienced infections, and more than 1,300 nursing homes had extreme infection rates of 75 percent or higher during a surge period and an average overall mortality rate close to 20 percent. Significant changes are needed to protect the health and safety of residents and better prepare nursing homes for current and future health emergencies.

The administration recently announced a major initiative to improve safety and quality of care in nursing homes. The findings in this report lend urgency to the administration's initiative. OIG recommended that CMS, as it supports the administration's initiative, take the following actions: (1) reexamine current nursing staff requirements and revise them as necessary; (2) improve how surveys identify infection control risks to nursing home residents and strengthen guidance on assessing the scope and severity of those risks; and (3) target nursing homes in most need of infection control intervention, and provide enhanced oversight and technical assistance to these facilities as appropriate.

Work Plan #: OEI-02-20-00491 (January 2023)
Government Program: Medicare Parts A & B

[NEW] Long-Term Trends of Psychotropic Drug Use in Nursing Homes

Nursing home residents and their families rely on nursing homes to provide quality care in a safe environment, and nursing homes are statutorily required to protect residents' rights in this regard. OIG work in 2011 raised quality and safety concerns about the high use of one category of psychotropic drug—antipsychotics—by nursing home residents. CMS began monitoring nursing home residents' use of antipsychotics in 2012, and in May 2021 OIG published a report that determined that CMS's existing methods for monitoring antipsychotic use by nursing home residents did not always provide complete information. Additionally, congressional stakeholders continue to raise concerns that nursing home residents may be inappropriately prescribed other types of psychotropic drugs and that potentially inappropriate use of those drugs may be going undetected.

OIG used Minimum Data Set (MDS) assessment data from calendar year 2011 through 2019 to identify long-stay nursing home residents aged 65 and older and reviewed Medicare Part D psychotropic drug claims data for these residents. From these data, OIG identified the number of residents who received a prescription for any of these drugs. OIG then searched for patterns and characteristics in these data correlated with a higher use of psychotropic drugs in nursing homes. OIG's review did not assess the administration or medical necessity of psychotropic drugs for nursing home residents.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that from 2011 through 2019, about 80 percent of Medicare's long-stay nursing home residents were prescribed a psychotropic drug. While CMS focused its efforts to reduce the use of one category of psychotropic drug—antipsychotics—

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the use of another category of psychotropic drug—anticonvulsants—increased. This increased use of anticonvulsants contributed to the overall use of psychotropics remaining constant.

In 2019, higher use of psychotropic drugs was associated with nursing homes that have certain characteristics. Nursing homes with lower ratios of registered nurse staff to residents were associated with higher use of psychotropic drugs. Nursing homes with higher percentages of residents with low-income subsidies were also associated with higher use of psychotropic drugs. Additionally, over time the number of unsupported schizophrenia diagnoses increased and in 2019 was concentrated in relatively few nursing homes. Specifically, OIG found that from 2015 through 2019 both the reporting of residents with schizophrenia in the MDS and the number of residents who lacked a corresponding schizophrenia diagnosis in Medicare claims and encounter data increased by 194 percent. In 2019, the unsupported reporting of schizophrenia was concentrated in 99 nursing homes in which 20 percent or more of the residents had a report of schizophrenia in the MDS that was not found in the Medicare claims history.

CMS's long-stay quality measure that tracks antipsychotic use in nursing homes excludes residents who are reported as having schizophrenia in the MDS. Thus, nursing homes could misreport residents as having schizophrenia in the MDS to falsely impact CMS's quality measure.

By not collecting diagnoses on Medicare Part D claims, CMS is limited in its ability to effectively conduct oversight of psychotropic drugs. First, not having diagnoses on claims limits CMS's ability to detect patient risk and patterns of potentially inappropriate drug use. Second, the lack of diagnoses makes it difficult for CMS to systematically determine whether claims meet the payment requirement that drugs be used for medically accepted purposes.

OIG recommended that CMS should: (1) evaluate the use of psychotropic drugs among nursing home residents to determine whether additional action is needed to ensure that use among residents is appropriate, (2) use data to identify nursing homes or nursing home characteristics that are associated with a higher use of psychotropic drugs and focus oversight on nursing homes in which trends may signal inappropriate use, and (3) expand the required data elements on Medicare Part D claims to include a diagnosis code. CMS concurred with the first two recommendations and did not concur with the third recommendation in this report.

Work Plan #: OEI-07-20-00500 (November 2022)
Government Program: Medicare Parts A & B

[NEW] Certain Life Care Nursing Homes May Not Have Complied With Federal Requirements for Infection Prevention and Control and Emergency Preparedness

At the start of the pandemic, the Centers for Disease Control and Prevention indicated that individuals who are aged 65 and older or nursing home residents are at a higher risk for severe illness from COVID-19. In addition, 8 out of 10 COVID-19 deaths reported in the United States in 2020 were adults aged 65 and older. COVID 19 is especially dangerous for the more than 1.3 million residents who live in the 15,450 Medicare and Medicaid certified nursing homes nationwide.

OIG's objective was to determine whether selected Life Care Centers of America (Life Care) nursing homes complied with Federal requirements for infection prevention and control and emergency preparedness.

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OIG analyzed State survey agency (SSA) data on Medicare.gov for the most recent standard surveys and the previous 12 months of complaint surveys. OIG identified that 6,622 nursing homes had been cited for infection prevention and control program deficiencies as of February 26, 2020, and Medicare.gov indicated that 24 nursing homes were part of the Life Care nursing home chain. OIG contacted Life Care's corporate office regarding the 24 nursing homes and requested that they provide them with documentation related to infection prevention and control and emergency preparedness program policies and procedures that were in effect from January 2019 through May 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that selected Life Care nursing homes may not have complied with Federal requirements for infection prevention and control and emergency preparedness. Specifically, 23 of the 24 nursing homes selected had possible deficiencies. Actual deficiencies can only be determined following a thorough investigation by trained surveyors. At 22 nursing homes, OIG found 35 instances of possible noncompliance with infection prevention and control requirements related to annual reviews of the Infection Prevention and Control Program, training, designation of a qualified infection preventionist, and Quality Assessment and Assurance Committee meetings. OIG also found at 16 nursing homes 20 instances of possible noncompliance with emergency preparedness requirements related to the annual review of emergency preparedness plans and annual emergency preparedness risk assessments. Life Care officials attributed the possible noncompliance to: (1) leadership turnover, (2) staff turnover, (3) documentation issues (i.e., information was not documented or documentation was either lost or misplaced), (4) staff members who were unfamiliar with requirements (i.e., requirements stipulating that there is no grace period for infection preventionists to complete specialized training and that emergency preparedness plans needed to be reviewed annually), (5) qualified personnel shortage, and (6) challenges related to the COVID-19 public health emergency. OIG also believes that many of the conditions noted in the report occurred because CMS did not provide nursing homes with communication and training related to complying with the new, phase 3 infection control requirements, or clarification about the essential components to be integrated in the nursing homes' emergency plans.

OIG recommended that CMS instruct SSAs to follow up with the 23 nursing homes that OIG has identified with possible infection prevention and control and emergency preparedness deficiencies to verify that they have taken corrective actions.

Work Plan #: A-01-20-00004 (September 2022)
Government Program: Medicare Parts A & B

Certain Nursing Homes May Not Have Complied With Federal Requirements for Infection Prevention and Control and Emergency Preparedness

The Centers for Disease Control and Prevention indicate that individuals who are aged 65 and older or nursing home residents are at a higher risk for severe illness from COVID-19. In addition, 8 out of 10 COVID-19 deaths reported in the United States in 2020 were adults aged 65 years and older. COVID19 is especially dangerous for the more than 1.3 million residents who live in the 15,446 Medicare and Medicaid certified nursing homes nationwide. OIG's objective was to determine whether selected nursing homes complied with Federal requirements for infection prevention and control and emergency preparedness.

OIG analyzed State survey agency (SSA) data on Medicare.gov for the most recent standard surveys and the previous 12 months of complaint reports. OIG identified 6,830 nursing homes that were cited for infection prevention and control program deficiencies, and Medicare.gov indicated that 39 nursing homes had not provided a plan of correction for the deficiencies

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as of March 26, 2020. OIG contacted the 39 nursing homes and requested that they provide them with infection prevention and control and emergency preparedness program documents that were in effect from January 1, 2019, through May 31, 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that selected nursing homes may not have complied with Federal requirements for infection prevention and control and emergency preparedness. Specifically, 28 of the 39 nursing homes had possible deficiencies. OIG found 48 instances at 25 nursing homes of possible noncompliance with infection prevention and control requirements and 18 instances at 18 nursing homes of possible noncompliance with emergency preparedness requirements related to all-hazards risk assessments and strategies to address emerging infectious diseases. The nursing homes attributed the possible noncompliance to: (1) nursing home inadequate internal controls, (2) nursing home inadequate management oversight, (3) nursing home administrative and leadership changes, (4) inadequate communication and training from the Centers for Medicare & Medicaid Services (CMS), and (5) inconsistent and confusing regulations.

OIG recommended that CMS: (1) instruct SSAs to follow up with the 28 nursing homes that OIG identified with potential infection prevention and control and emergency preparedness deficiencies to ensure that they have taken corrective actions; (2) issue updated phase 3 interpretive guidance as soon as feasible; (3) provide training to SSAs on the updated phase 3 interpretive guidance as soon as feasible; and (4) consider updating the regulation to make clear that nursing homes must include emerging infectious diseases as a risk on their facility- and community-based all-hazards risk assessments.

CMS concurred with OIG's first three recommendations and described corrective actions it had taken or planned to take, such as ensuring that SSAs follow up with the nursing homes, issuing phase 3 interpretive guidance, and providing training related to the phase 3 interpretive guidance. CMS stated that it had intended to release the phase 3 interpretive guidance during the second quarter of 2020. However, prior to issuing the guidance, the COVID-19 public health emergency (PHE) was declared, and CMS immediately redirected resources to address patient safety needs related to the PHE. Regarding OIG's fourth recommendation, CMS stated that it would consider this recommendation in future rulemaking and that it has taken considerable steps to make clear that nursing homes should include emerging infectious diseases as an identified risk on their facility- and community-based all-hazards risk assessments.

Work Plan # A-01-20-00005 (July 2022)
Government Program: Medicare Parts A & B

Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in nursing homes. These updates expanded requirements related to sprinkler systems and smoke detector coverage. Emergency preparedness planning requirements were also expanded. As part of OIG's oversight activities, OIG is reviewing this area because many residents of nursing homes have limited or no mobility and are particularly vulnerable in the event of a fire

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or other emergency. Beginning in 2018, OIG conducted a series of audits in eight States to assess compliance with CMS's new life safety and emergency preparedness requirements. OIG's objective was to summarize the results of their previous audits of eight States' compliance with CMS's life safety and emergency preparedness requirements for nursing homes and to identify opportunities for CMS to improve resident, visitor, and staff safety.

OIG summarized the findings from the previous audits and identified opportunities and developed recommendations to help CMS address deficiencies identified during the audits and improve resident, visitor, and staff safety.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG identified a total of 2,233 areas of noncompliance with life safety and emergency preparedness requirements at 150 of the 154 nursing homes OIG visited. Specifically, OIG identified 1,094 areas of noncompliance with life safety requirements and 1,139 areas of noncompliance with emergency preparedness requirements. These deficiencies occurred because of several factors, including inadequate oversight by management, staff turnover, inadequate oversight by State survey agencies, and a lack of any requirement for mandatory participation in standardized life safety training programs. As a result, residents, visitors, and staff at the nursing homes were at increased risk of injury or death during a fire or other emergency. CMS subsequently followed up with State survey agencies to determine if they had addressed the recommendations included in OIG's prior audits and, according to CMS, the States had already taken acceptable actions to address their recommendations.

OIG identified several opportunities for CMS to expand on its life safety requirements for nursing homes to improve the safety of residents, visitors, and staff. Among other findings, CMS could propose regulations requiring nursing homes to install carbon monoxide detectors according to national standards. OIG also noted areas in which CMS could improve its support for State survey operations and nursing home training. CMS could work with State survey agencies to address issues preventing more frequent surveys of high-risk facilities and require mandatory participation in standardized nursing home staff training.

OIG made a series of recommendations to CMS to address their findings, including that it propose regulations requiring nursing homes to install carbon monoxide detectors and work with States to encourage mandatory participation in standardized training for nursing home staff. CMS generally agreed with OIG's recommendations and described steps it has taken or plans to take to address them, including working with a limited number of nursing homes with serious repeat deficiencies that pose the highest risk to residents' health and safety.

Work Plan # A-02-21-01010 (July 2022)
Government Program: Medicare Parts A & B

An Estimated 91 Percent of Nursing Home Staff Nationwide Received the Required COVID-19 Vaccine Doses, and an Estimated 56 Percent of Staff Nationwide Received a Booster Dose

The COVID-19 pandemic has hit nursing homes particularly hard. To reduce the spread of COVID-19 in nursing homes, the Centers for Medicare & Medicaid Services amended the infection control requirements for nursing homes to include a requirement for nursing homes to ensure that staff received all of the required COVID-19 vaccine doses (i.e., a single-dose vaccine or all required doses of a multidose vaccine) except for individuals granted an exemption from receiving the vaccine

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or individuals whose vaccination had to be delayed. OIG's objective was to identify the COVID 19 vaccination status of nursing home staff as of the week ended March 27, 2022.

OIG used a stratified multistage design to select a sample of nursing home staff nationwide. OIG stratified the sampling frame of 15,224 nursing homes nationwide into 10 strata based on the nursing homes' locations and randomly selected 10 nursing homes from each stratum. From each of the 100 sampled nursing homes, OIG obtained a list of staff members who were subject to the vaccination requirements and randomly selected 10 staff members. For each of the 1,000 sampled staff members, OIG reviewed documentation that nursing homes provided to determine whether the staff member had received the required vaccine doses, had received a booster dose, or had requested or had been granted an exemption from receiving the vaccine.

SunHawk Summary of OIG Audit Findings and Recommendations

As of the week ended March 27, 2022, OIG determined for the 1,000 nursing home staff members in OIG's sample that 884 had received the required vaccine doses (506 of these staff members had also received a booster dose); 78 had been granted an exemption from receiving the vaccine based on a sincerely held religious belief, practice, or observance (religious exemption); 12 were partially vaccinated; 3 had been granted an exemption from receiving the vaccine based on a medical condition (medical exemption); and 3 had applied for an exemption that was being reviewed by a nursing home. For the remaining 20 staff members in OIG's sample, the nursing homes did not provide documentation related to the staff members' vaccination status, or the documentation provided did not clearly identify the staff members' vaccination status. As a result, OIG was not able to determine the vaccination status of these staff members.

On the basis of their sample results, OIG estimated that 91 percent of staff nationwide had received the required vaccine doses, 56 percent of staff nationwide had received a booster dose, and 6 percent of staff nationwide had been granted a religious exemption. OIG did not estimate the percentages among the small number of staff members (i.e., 38) in OIG's nationwide sample results who were partially vaccinated, who were granted a medical exemption, who applied for an exemption that was being reviewed, or for whom the vaccination status could not be determined.

In addition, the estimated percentages of staff who received the required vaccine doses, staff who received a booster dose, and staff who were granted a religious exemption varied depending on the locations (i.e., Department of Health and Human Services regions) of the nursing homes in which they worked.

This report includes no recommendations. The results of this audit present a snapshot of the COVID-19 vaccination status of nursing home staff nationwide at a specific point in time.

Work Plan # A-09-22-02003 (June 2022)
Government Program: Medicare Parts A & B

Maine Implemented OIG's Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

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OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings and found that Maine did not comply with Federal and State requirements for reporting and monitoring critical incidents. The report contained seven recommendations. OIG's objective was to determine whether Maine implemented the recommendations from the prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

OIG reviewed the system that Maine had in place during their audit period (calendar year 2019) for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities. To determine whether the seven recommendations from the prior OIG report were implemented, OIG reviewed correspondence between Centers for Medicare & Medicaid Services (CMS) and Maine and supporting documentation provided by Maine. To determine whether Maine's corrective actions addressed OIG's previous findings, OIG reviewed 123 emergency room claims with service dates from October 2019 to December 2019 for 89 beneficiaries who were diagnosed with conditions that OIG determined to be indicative of high risk for suspected abuse or neglect.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Maine implemented the seven recommendations from OIG's prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. In addition, the corrective actions implemented in response to five of the seven recommendations were effective in addressing the related findings. However, Maine's corrective actions for two recommendations were not fully implemented by the conclusion of OIG's current audit period and, therefore, were only partially effective in addressing two of OIG's previous findings. OIG concluded that the corrective actions were not fully effective in addressing these findings because Maine did not ensure that all follow-up reports were completed by community-based providers within 30 days of each incident and that the Mortality Review Committee conducted a trend analysis based on completed Mortality Review Form aggregate data. As a result, Maine did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Waiver along with the State requirements incorporated under the waiver.

OIG recommended that Maine: (1) continue to work with CMS to fully implement the prior recommendation to ensure that follow up reports are submitted by community-based providers appropriately and (2) ensure that the Mortality Review Committee reviews Mortality Review Form aggregate data to identify patterns and trends and to make recommendations to improve care.

Work Plan # A-01-20-00007 (June 2022)
Government Program: Medicaid

National Background Check Program for Long-Term-Care Providers: An Interim Assessment

Background checks for employees of long-term-care facilities are an important safety measure that can help protect some of the facilities' most vulnerable populations. More than 13 million beneficiaries are served by long-term-care facilities each year, including the elderly, individuals in hospice care, and individuals with intellectual disabilities.

The National Background Check Program (Program), enacted by legislation in 2010, provides grants to States and territories (States) to assist them in developing and improving systems to conduct Federal and State background checks of prospective

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long-term-care employees. Included in this legislation is a mandate that OIG produce an evaluation of the Program within 180 days of Program completion. This report-the fifth in a series to supplement the mandated evaluation-reviews Idaho and Mississippi, the last two States that are participating in the Program. (Twenty-seven States have completed their participation in the Program.) The interim review allows for CMS to assist the States in fully implementing Program requirements during participation. In future work, OIG will assess the Program overall.

OIG reviewed grant monitoring documents and financial reports to determine the extent to which Idaho and Mississippi are working towards meeting Program requirements. Specifically, OIG evaluated the States' ability to obtain legislative authority and to coordinate between State-level agencies. Additionally, OIG evaluated States' monitoring documents.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Idaho and Mississippi lacked State legislative authority to implement some Program requirements. Further, both States encountered challenges with coordination between State-level departments responsible for seeking legislative authority.

OIG found additional concerns with Mississippi. First, Mississippi was unable to submit required data to CMS to calculate determinations of ineligibility. This is despite the fact that Mississippi conducted background checks during the first years of Program participation. Additionally, Mississippi and Idaho did not consistently report Federal and State funds on required quarterly financial reports; this made it difficult for CMS to determine the ongoing cost of Program implementation.

These report findings are consistent with findings in previous OIG reports about challenges that States experienced during Program participation. Therefore, OIG recommended that CMS continue to implement OIG's prior recommendations for it to take appropriate actions to (1) encourage States to obtain the necessary legislative authority from the State to fully implement Program requirements, and (2) require participating States to consistently submit data that allow CMS and each State to calculate determinations of ineligibility. In addition, with this report, OIG recommended that CMS ensure that participating States submit accurate quarterly reports. CMS concurred with this recommendation.

Work Plan # OEI-07-20-00181 (May 2022)
Government Program: National Background Check Program (NBCP)

Posthospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries in Indiana Generally Met Medicare Level-of-Care Requirements

To qualify for skilled nursing facility (SNF) services, a Medicare beneficiary must have a preceding inpatient hospital stay. Centers for Medicare & Medicaid Services (CMS) research has found that many hospital admissions of nursing home residents who are enrolled in both Medicare and Medicaid (dually eligible beneficiaries) could have been avoided because the condition could have been prevented or treated outside of an inpatient hospital setting. OIG's objectives were to determine whether the posthospital SNF care provided to dually eligible beneficiaries in Indiana between October 1, 2016, and September 30, 2018 (OIG's audit period): (1) was associated with potentially avoidable hospitalizations and (2) met Medicare level-of-care requirements.

OIG's audit covered 20,668 SNF claims with Medicare payments totaling $119,945,529, where each payment was greater than or equal to $350 for services provided during OIG's audit period, to dually eligible beneficiaries in Indiana who had a

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preceding Medicaid-covered stay at the same nursing facility. OIG selected and reviewed a stratified random sample of 100 SNF claims totaling $667,184.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that posthospital SNF care provided to 98 of the 100 dually eligible beneficiaries in Indiana, on whose behalf the sampled SNF claims were submitted, was not associated with potentially avoidable hospitalizations. For the remaining two beneficiaries, OIG's independent medical review contractor found that the beneficiaries' conditions were potentially preventable and manageable at the NFs, but, because the NFs did not have effective prevention strategies, the beneficiaries were hospitalized and later discharged to SNF care at the same facility.

Posthospital SNF care provided to 98 of the 100 beneficiaries met the Medicare SNF level-of-care requirements. The remaining two beneficiaries did not meet the Medicare SNF level-of-care requirements because the SNF physicians incorrectly determined that the beneficiaries required skilled nursing or skilled rehabilitation services, or both, on a daily basis.

For all 100 beneficiaries, physicians ordered SNF services. OIG noted that records from the hospitals where 33 beneficiaries had a qualifying inpatient stay did not contain a clear and definitive hospital physician discharge order for SNF care. Hospital physicians mainly discharged beneficiaries "back to nursing facility" without specifying the level of care. In these cases, SNF physicians certified the SNF level of care. The physician order not only affects level-of-care determination but also has a financial impact on the nursing facilities.

OIG's independent medical review contractor found that SNF care provided to dually eligible beneficiaries in Indiana during OIG's audit period generally: (1) was not associated with potentially avoidable hospitalizations and (2) met the Medicare level-of-care requirements. As a result, OIG did not have any recommendations. However, the quality of care in nursing facilities remains a concern for OIG. OIG will continue to monitor SNF claims, including those submitted on behalf of dually eligible beneficiaries, to determine whether services are appropriate and meet payment requirements.

Work Plan # A-05-20-00005 (April 2022)
Government Program: Medicare Parts A & B

CMS Should Take Further Action To Address States With Poor Performance in Conducting Nursing Home Surveys

CMS oversees how State survey agencies (States) conduct surveys of nursing homes to assess the homes' compliance with Federal requirements. Recent work by OIG has found problems with performance by some States, which raise questions about the effectiveness of CMS oversight of State performance in conducting nursing home surveys, and the ability of CMS to hold States accountable when problems arise. OIG analyzed CMS oversight of 52 States (including Puerto Rico and the District of Columbia) during FYs 2015-2018 to identify. OIG conducted interviews with CMS staff at the central office and 10 regional offices during February and March 2020, to learn how they work with States to address serious problems with survey performance and any challenges that States may face. OIG also collected and analyzed documents from CMS about State performance and CMS imposition of remedies and sanctions on States with poor performance.

SunHawk Summary of OIG Evaluation Findings and Recommendations

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OIG found that just over half of States - 28 of 52 - failed to meet the same performance measure or measures in three or four consecutive years during FYs 2015-2018. States most commonly missed performance measures related to survey timeliness, which CMS and States often attributed to staffing shortages. Ten percent of States' corrective action plans were missing from CMS files and many others lacked substantive detail. In addition to corrective action plans, CMS relied on other remedies, such as training and technical assistance, to help States improve performance. Although CMS sometimes imposed financial penalties when States failed to meet the timeliness requirement for surveys, it frequently offset these penalties with one-time funding adjustments. CMS rarely imposed formal sanctions and has never initiated action to terminate any of its agreements with States for conducting surveys.

OIG recommended that CMS: (1) actively monitor States' corrective action plans, (2) establish guidelines for progressive enforcement actions, (3) engage with senior State officials earlier and more frequently to address problems, and (4) revise the State Operations Manual to reflect current CMS oversight practices. OIG also recommended that CMS: (5) disseminate the results of State performance reviews more widely. In response, CMS stated that its current practices already fulfill the recommendation. OIG revised the recommendation to clarify the new and expanded dissemination of results they are recommending.

Work Plan #: OEI-06-19-00460 (January 2022)
Government Program: Medicare Parts A & B

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Home Health Service

[NEW] Home Health Agencies Rarely Furnished Services Via Telehealth Early in the COVID-19 Public Health Emergency

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) expanded telehealth benefits to limit community spread and keep vulnerable patients in their homes while maintaining access to care. In April 2020, CMS revised Medicare regulations on an interim basis to retroactively allow home health agencies (HHAs) to use telehealth services beginning March 1, 2020. In November 2020, CMS finalized changes to those regulations to permanently allow home health services to be furnished via telehealth. While Medicare makes payments for some types of telehealth services, the final regulations prohibit payments for home health services furnished via telehealth. At the start of OIG's audit, CMS did not require HHAs to report telehealth services on Medicare claims. Therefore, oversight agencies lacked the ability to effectively identify and monitor those services.

OIG's objective was to determine whether home health services furnished via telehealth early in the COVID-19 PHE were provided and billed in accordance with Medicare requirements. OIG selected a stratified random sample of 200 home health claims with beginning service dates from March 1 through December 31, 2020. OIG reviewed medical records to evaluate compliance with Medicare regulations for providing and billing telehealth services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that HHAs rarely furnished services via telehealth early in the COVID-19 PHE; however, for the few claims in OIG's sample with services furnished via telehealth, HHAs did not fully comply with Medicare requirements for providing them. Of the 200 sampled claims, 4 claims had home health services furnished via telehealth, so OIG estimated that there are 127,999 claims in the sampling frame with such services. None of the four claims fully complied with Medicare requirements for home health services furnished via telehealth. The errors occurred because the HHAs were unfamiliar with the Medicare requirements for such services, which were new early in the COVID-19 PHE. Of the remaining 196 sampled claims, 194 claims did not have home health services furnished via telehealth. For the remaining two sampled claims, OIG was unable to obtain medical records, so OIG could not determine whether home health services were furnished via telehealth.

Beginning July 1, 2023, CMS now requires HHAs to report the use of telehealth services on home health claims. CMS has instructed HHAs to use one of two G-codes to report the services on claims and to list each service as a separate, dated line item. CMS stated that such reporting will allow it to analyze the characteristics of patients utilizing telehealth and give it a broader understanding of the determinants that affect who benefits most from those services. Furthermore, in their March 2022 Report to the Congress, the Medicare Payment Advisory Commission recommended tracking the use of telehealth on home health claims to improve payment accuracy.

OIG recommended that CMS monitor HHA reporting of the new G-codes to determine whether further updates to regulations or guidance are necessary.

Work Plan #: A-05-21-00026 (September 2023)
Government Program: Medicare Parts A & B

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[NEW] Home Health Agencies Failed To Report Over Half of Falls With Major Injury and Hospitalization Among Their Medicare Patients

Among Medicare home health patients hospitalized for falls with major injury, over half of the falls were not reported on patient assessments by home health agencies (HHAs) as required. These patient assessments are used by the Centers for Medicare & Medicaid Services (CMS) to monitor and provide public information about home health care quality. Due to this high rate of non reporting, Care Compare may not provide accurate information about the incidence of these falls.

Starting in 2019, HHAs were required to report that their patients experienced falls with major injury in patient Outcome and Assessment Information Set (OASIS) assessments. CMS uses this HHA-reported information to calculate major injury fall rates at the agency level. Beginning in 2022, CMS included these fall rates as one of the Care Compare website's quality measures, which provide consumers with information about HHA performance. The Office of Inspector General (OIG) and others have found problems with using provider-reported information to assess quality in the past. OIG conducted this study to determine the extent of falls reporting by HHAs and implications for the accuracy of the falls information on Care Compare.

OIG identified falls with major injury in Medicare hospital claims for home health patients. Whenever their patients are hospitalized, HHAs must submit an OASIS assessment. OIG checked whether the falls were reported in those OASIS assessments as required. OIG calculated non-reporting rates for these falls. OIG also examined whether reporting rates differed by patient or HHA characteristics, including whether HHAs had low fall rates on Care Compare.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that fifty-five percent of falls OIG identified in Medicare claims were not reported in associated OASIS assessments as required. Falls reporting on OASIS assessments was worse among younger home health patients (compared to older patients) and patients who identified as Black, Hispanic, or Asian (compared to White). Reporting was also lower among for profit HHAs as compared to nonprofit and government-owned agencies. Notably, HHAs with the lowest Care Compare major injury fall rates reported falls less often than HHAs with higher Care Compare fall rates, indicating that Care Compare does not provide the public with accurate information about how often home health patients fell. Finally, for many Medicare home health patients who fell and were hospitalized, there was no OASIS assessment at all associated with the hospitalization, which raises additional concerns about potential noncompliance with data submission requirements and its impact on the accuracy of information about falls with major injury on Care Compare.

OIG recommended that CMS (1) take steps to ensure the completeness and accuracy of the HHA reported OASIS data used to calculate the falls with major injury quality measure; (2) use data sources, in addition to OASIS assessments, to improve the accuracy of the quality measure related to falls with major injury; (3) ensure that HHAs submit required OASIS assessments when their patients are hospitalized; and (4) explore whether improvements to the quality measure related to falls can also be used to improve the accuracy of other home health measures. CMS concurred with all four recommendations.

Work Plan #: OEI-05-22-00290 (September 2023)
Government Program: Medicare Parts A & B

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[NEW] Mandated Analysis of Home Health Service Utilization From January 2016 Through March 2022

Medicare pays for home health services provided to beneficiaries who need skilled care for an illness or injury and are unable to leave their home. When providers furnish these services in rural areas, a percentage increase (rural add-on payment) is added to the standardized home health payment.

Under the Bipartisan Budget Act of 2018, Congress required the Centers for Medicare & Medicaid Services (CMS) to implement a new methodology for applying rural add-on payments beginning on January 1, 2019. Through the same legislation, Congress amended the Social Security Act to require, as a condition of payment, that all home health claims contain the code for the county (or equivalent area) where the service was furnished. Congress further required the Office of Inspector General to complete an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and make recommendations as appropriate.

OIG's audit covered $109,389,663,042 in Medicare payments to home health agencies (HHAs) for 45,417,624 claims. These claims were for home health services provided January 2016 through March 2022. OIG performed an analysis of service utilization by county and evaluated compliance with selected billing requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG determined that, during the audit period, beneficiary utilization of home health services decreased for urban counties and rural counties in the "high utilization" and "all other" categories, while utilization in the "low population density" category remained steady. OIG further determined that the number of home health episodes decreased for all urban and rural county categories. Many variables during the audit period may have affected utilization of services. Most notably, during calendar years 2020?2022, the Secretary of Health and Human Services declared a public health emergency in response to the COVID-19 pandemic. The pandemic affected utilization of services and presented staffing challenges for HHAs. Therefore, OIG could not determine the cause of any changes in utilization of services during this period.

Lawmakers designed the new rural add-on methodology to provide higher add-on percentages to rural counties in the "low population density" and "all other" categories. OIG determined that, during the audit period, the methodology shifted the distribution of add-on payments from the "high utilization" category to the "low population density" and "all other" categories. OIG originally planned to use Federal Information Processing Standards (FIPS) data to analyze utilization from January 2016 through March 2022 but were unable to do so because the FIPS data was incomplete. This occurred because providers were not always applying the FIPS codes to claims, or the FIPS codes were invalid. Also, Medicare administrative contractors (MACs) did not always return claims with missing or invalid FIPS codes to providers for correction as required.

OIG recommended that CMS take the following steps to improve FIPS code reporting: (1) update the HH Pricer logic to check for missing and invalid FIPS codes on all home health claims and work with MACs to ensure that these claims are returned to providers for correction; and (2) re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

Work Plan #: A-05-20-00031 (December 2022)
Government Program: Medicare Parts A & B

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[NEW] Home Health Agencies Used Multiple Strategies To Respond to the COVID-19 Pandemic, Although Some Challenges Persist

Home health agencies (HHAs) developed strategies to respond to challenges during the COVID-19 pandemic, including providing new incentives to maintain staff and seeking alternative sources of personal protective equipment. HHAs have also benefited from support from the Centers for Medicare & Medicaid Services (CMS), such as regulatory flexibilities and expanded telehealth allowances, but staffing challenges persist. In light of the expanded use of telehealth, more information is needed to determine its future use across different home health services.

The COVID-19 pandemic required HHAs to adapt their care to respond to COVID-19's infectious nature, as well as other circumstances from the pandemic. HHAs play an important role in caring for Medicare beneficiaries: in 2020, the first year of the COVID-19 pandemic, HHAs cared for over 3 million beneficiaries. CMS requires HHAs to prepare for and respond to emergencies and, during those emergencies, CMS can offer regulatory flexibilities and supports (which OIG refers to collectively as regulatory flexibilities) for various requirements. This report provides insights into HHAs' experiences that will help stakeholders continue managing the response to COVID-19 and prepare for future emergencies.

OIG surveyed a nationally representative sample of 400 HHAs, 396 of which participated in Medicare, in fall 2021 to ask about their experiences early in the pandemic and at the time OIG administered the survey. OIG projected the results to the 72 percent of Medicare-participating HHAs represented by OIG's sample. In addition, OIG interviewed 12 HHAs about notable challenges, strategies, or other experiences they identified in their surveys. OIG also interviewed staff at CMS about its support of—and perspectives on—HHAs' provision of care during the pandemic.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that like all health care providers, HHAs have experienced multiple challenges to providing care during the COVID-19 pandemic. HHAs have continued to experience longstanding staffing challenges as well as new ones resulting from the pandemic, such as maintaining staffing despite quarantine and isolation protocols. These staffing challenges persist for many HHAs despite efforts to address them. In addition, HHAs faced numerous and widespread infection control challenges, including accessing personal protective equipment (PPE) to limit exposure and spread, but these have mostly eased since early in the pandemic.

HHAs' own strategies to respond to the pandemic included offering paid leave to retain staff and finding PPE from nontraditional sources. HHAs have also benefited from government support—including regulatory flexibilities instituted in response to the declaration of a public health emergency—and this support has mitigated some staffing challenges. For example, by the Federal government's allowing new types of providers to certify and order home health services and complete certain patient assessments, HHAs could more efficiently provide care. Telehealth flexibilities under the public health emergency have also helped HHAs provide care while reducing COVID-19 exposure and dealing with staffing shortages. However, HHAs' challenges with telehealth raise questions about its future role in home health care, and—because of limited reporting requirements—CMS has limited insight into HHAs' telehealth use. Finally, the emergency preparedness plans required by CMS guided HHAs' responses to the pandemic but fell short of fully addressing a global emergency such as COVID-19.

CMS has an opportunity to assess how to best help HHAs prepare for and respond to future emergencies, as well as to evaluate how changes to the home health landscape can better serve patients. To that end, OIG recommended that CMS evaluate how HHAs are using telehealth-specifically, the types of services provided via telehealth and the characteristics of

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patients who benefit from these services. OIG also recommended that CMS-to inform decision-making-evaluate how the regulatory flexibilities it has offered in response to the COVID-19 public health emergency affect the quality of home health care. Finally, OIG recommended that CMS-in collaboration with the Administration for Strategic Preparedness and Response's (ASPR's) Technical Resources, Assistance Center, and Information Exchange (TRACIE)-apply lessons learned from the COVID-19 pandemic to update and/or develop emergency preparedness trainings and materials for HHAs on responding to infectious disease outbreaks. CMS concurred with all three recommendations.

Work Plan #: OEI-01-21-00110 (October 2022)
Government Program: Medicare Parts A & B

Washington State Did Not Comply With Federal and State Requirements for Claiming Enhanced Federal Reimbursement for Medicaid Managed-Care Health Home Service Expenditures

A health home is a designated provider or a team of health care providers that coordinates health care services for Medicaid beneficiaries with chronic medical conditions at a reasonable cost. States were authorized to receive Federal reimbursement at an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent (enhanced FMAP) for health home service payments they made to providers during the first eight quarters their programs were in effect. OIG's objective was to determine whether Washington State complied with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP.

OIG's audit covered the $1,957,622 ($1,770,860 Federal share) that Washington claimed as managed-care health home expenditures at the enhanced FMAP from April 1, 2017, through March 31, 2019. OIG reviewed the journal vouchers that Washington used to assign the enhanced FMAP to its managed-care health home expenditures, the managed-care encounter data that it used to support the claimed amount, and its capitation rate documentation that identified the portion of the managed-care capitation payments that was attributable to health home services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Washington did not comply with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP. Specifically, Washington improperly used fee-for-service health home reimbursement rates instead of the portion of the managed-care capitation payments that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement for its managed-care health home expenditures, totaling $1,770,860. In addition, of the $1,770,860 that Washington claimed, $374,579 was not supported by encounter data, and $29,161 was claimed for encounters that exceeded the number of encounters that managed-care organizations were allowed to report for a beneficiary. These issues occurred because Washington did not follow its State plan or Federal guidance and lacked adequate procedures and Medicaid Management Information System (MMIS) edits.

OIG recommended that Washington: (1) refund to the Federal Government $374,579 for the encounters that were no longer supported and the $29,161 that exceeded the number of allowable encounters; (2) determine the portion of the remaining $1,367,120 that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services and refund any unallowable amounts; (3) review all managed-care health home encounters from July 1,

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Home Health Service

Hospice

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Telehealth

Other Providers and Suppliers

2013, through March 31, 2017, to determine the amount that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services; (4) implement a procedure to identify whether encounters used to support journal vouchers have been removed from the encounter data; and (5) strengthen its MMIS edits to ensure that encounters comply with State reporting requirements. The full text of the recommendations is shown in the report.

Washington concurred with all of the recommendations and described corrective actions it had taken or planned to take, such as implementing MMIS edits to prevent multiple payments within a single calendar month. However, the corrective actions that Washington described did not fully address the first, second, and fifth recommendations. Therefore, OIG continues to recommend that Washington implement those recommendations.

Work Plan #: A-09-20-02008 (May 2022)
Government Program: Medicare Parts A & B

New York Verified That Medicaid Assisted Living Program Providers Met Life Safety and Emergency Planning Requirements But Did Not Always Ensure That Assisted Living Program Services Met Federal and State Requirements

A 2018 Government Accountability Office report found that improved Centers for Medicare & Medicaid Services oversight of State monitoring of Medicaid assisted living services was needed. OIG audited New York's Medicaid assisted living program (ALP) to determine whether its oversight and monitoring of ALP providers was effective because have not conducted an audit of the program since 2006. In New York, beneficiaries receiving ALP services generally require supervision and personal care to carry out basic activities of daily living. ALP providers must meet New York's life safety and emergency planning requirements. OIG's objectives were to determine whether New York verified that ALP providers met life safety and emergency planning requirements for providing Medicaid services and claimed reimbursement for ALP services in accordance with Federal and State requirements.

OIG conducted site visits at five ALP providers to review New York's monitoring and oversight of ALP providers' compliance with life safety and emergency planning requirements. OIG's audit covered 195,373 beneficiary-months of ALP services with Federal Medicaid payments totaling $244 million for calendar years 2017 through 2018 (audit period). OIG audited a random sample of 100 beneficiary-months of ALP services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New York verified life safety and emergency planning requirements were met at the five judgmentally selected ALP providers visited. However, it claimed reimbursement for some unallowable ALP services during the random sample of 100 beneficiary-months. Specifically, New York properly claimed Medicaid reimbursement for all ALP services during 91 beneficiary-months and claimed reimbursement for unallowable ALP services during the remaining 9 beneficiary-months. These deficiencies occurred because New York's monitoring was not sufficient to ensure that ALP providers complied with certain Federal and State requirements for providing, documenting, and billing services. Despite New York's efforts, some ALP providers did not comply with requirements for (1) documenting beneficiary assessments and care plans and (2) claiming reimbursement only for services in accordance with Medicaid billing requirements and beneficiary care plans.

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Telehealth

Other Providers and Suppliers

OIG estimated that New York improperly claimed at least $1.9 million in Federal Medicaid reimbursement for ALP services during the audit period. In addition, the health and safety of some Medicaid beneficiaries may have been put at risk because their assessments and care plans were not valid or were missing, and some nurse's aides' qualifications were not documented. As a result, beneficiaries may have (1) not received ALP services that they were entitled to, (2) received services that were not needed, or (3) received services from some nurse's aides that were not qualified to perform the services furnished.

OIG recommended that New York refund $1.9 million to the Federal Government. OIG also made a series of recommendations for New York to strengthen its oversight and monitoring of its ALP to ensure that providers comply with Federal and State requirements.

Work Plan #: A-02-19-01017 (February 2022)
Government Program: Medicaid

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Hospice

[NEW] National Government Services, Inc., Accurately Calculated Hospice Cap Amounts but Did Not Collect All Cap Overpayments

To ensure that hospice care does not exceed the cost of conventional care at the end of life, there are two annual limits (called caps) to payments made to hospices-the inpatient cap and the aggregate cap. The cap amounts are calculated annually, and any amount paid to a hospice above either cap amount is an overpayment and must be repaid to Medicare. The Centers for Medicare & Medicaid Services (CMS) contracts with three Medicare administrative contractors (MACs) to calculate cap amounts and recover overpayments. This audit is part of a series of audits regarding MACs' oversight of hospice cap calculations. OIG's objective was to determine whether NGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.

OIG's audit covered the cap calculation process for all 1,966 hospices in NGS's Jurisdictions 6 and K that participated in the Medicare hospice program in cap year 2019 and 3 prior cap years. For the 2019 cap calculations, NGS calculated aggregate cap overpayments totaling $186.1 million for 515 hospice providers. For the lookback calculations of 3 prior cap years, NGS calculated additional net lookback aggregate overpayments totaling $27.3 million for 673 hospice providers. For cap year 2019, NGS calculated overpayments totaling $213.4 million.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG determined that NGS accurately calculated all cap amounts and collected or attempted to collect $211.3 million of the $213.4 million in total cap overpayments in accordance with CMS requirements. However, NGS did not attempt to collect the remaining $2.1 million in net lookback overpayments because of its internal policy of not pursuing lookback cap calculation amounts that were less than a set threshold.

Additionally, against CMS requirements, NGS instructed hospices to wait to submit the overpayments calculated on their cap determination notices until the hospice received a demand letter from NGS, which took an average of more than 2 months after the due date for hospices to file the cap determination notices. Of 30 judgmentally sampled hospices, 13 reported cap overpayments, totaling $8.1 million, on their cap determination notices. Nine of those thirteen hospices did not remit their overpayments, totaling $6.1 million, when they filed their cap determination notices as required. Because of NGS's instructions, the Federal Government lost the benefit of having the overpayment funds for its use for an additional average of more than 2 months.

OIG recommended that NGS (1) collect $2.1 million in lookback overpayments and return $22,576 in lookback refunds resulting from 2019 hospice cap calculations for lookback years, (2) discontinue its internal policy of waiving certain overpayment collections related to lookback years and start collecting all hospice cap overpayments and paying refunds in accordance with CMS requirements, and (3) change its instructions on the cap determination notices to follow the CMS requirement that hospices remit overpayments at the time they submit their cap determination notice.

Work Plan #: A-06-21-08004 (November 2022)
Government Program: Medicare Parts A & B

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[NEW] Medicare Hospice Provider Compliance Audit

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of six months or less and who have elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet Medicare requirements. OIG's objective was to determine whether hospice services complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Hospice of Palm Beach County, Inc. (A-02-20-01001)

OIG found that HPBC received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in OIG's sample, 60 claims complied with Medicare requirement. However, the remaining 40 did not comply with the requirements. Specifically, the clinical record did not support the beneficiary's terminal illness prognosis (30 claims), the clinical record did not support the level of care claimed (9 claims), and services were not supported in the medical record (3 claims). The total exceeds 40 because 2 claims contained more than 1 deficiency.

Improper payment of these claims occurred because HPBC's policies and procedures were not effective in ensuring the clinical documentation it maintained supported the terminal illness prognosis, the appropriate level of care was provided, and that services were supported. On the basis of OIG's sample results, OIG estimated that HPBC received at least $42.3 million in improper Medicare reimbursement for hospice services.

OIG recommended that HPBC: (1) refund to the Federal Government the portion of the estimated $42.3 million in Medicare overpayments that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Vitas Healthcare Corporation of Florida (A-02-19-01018)

OIG found that Vitas did not comply with Medicare requirements for 89 of the 100 claims in OIG's sample. Specifically, the clinical record did not support the continuous home care (CHC) level of hospice care claimed for Medicare reimbursement (68 claims), the clinical record did not support the general inpatient level of hospice care claimed for Medicare reimbursement (28 claims), and CHC services were not documented or supported in the beneficiary's clinical record (23 claims). The total exceeds 89 because 27 claims contained more than 1 error.

These improper payments occurred because Vitas' policies and procedures were not effective to ensure that it maintained documentation to support the level of care and hospice services claimed for Medicare reimbursement. On the basis of OIG's sample results, they estimated that Vitas received at least $140 million in improper Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG made a series of recommendations to Vitas, including that it refund to the Federal Government the portion of the estimated $140 million in Medicare overpayments that are within the 4-year claims reopening period; identify, report and return any overpayments in accordance with the 60-day rule; and strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Professional Healthcare at Home, LLC (A-09-18-03028)

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OIG found that, of the 100 hospice claims in OIG's sample, 21 claims showed that the clinical record did not support the beneficiary's terminal prognosis. In addition, for 1 of these 21 claims, there was no documentation that a hospice physician or hospice nurse practitioner had a required face-to-face encounter with the beneficiary. Improper payment of these claims occurred because Professional Healthcare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. Based on OIG's sample results, OIG estimated that Professional Healthcare received at least $3.3 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Professional Healthcare: (1) refund to the Federal Government the portion of the estimated $3.3 million in Medicare overpayments that are within the 4-year claims reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Alive Hospice, Inc. (A-09-18-03016)

OIG found that, for 16 claims, the clinical record did not support the beneficiary's terminal prognosis, and for the remaining 8 claims, the clinical record did not support the level of care claimed for Medicare reimbursement. Improper payment of these claims occurred because Alive's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis and that the appropriate level of care was provided. Based on OIG's sample results, OIG estimated that Alive received at least $7.3 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Alive: (1) refund to the Federal Government the portion of the estimated $7.3 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Ambercare Hospice, Inc. (A-09-18-03017)

OIG found that, for 52 claims, the clinical record did not support the beneficiary's terminal prognosis. Improper payment of these claims occurred because Ambercare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. Based on OIG's sample results, OIG estimated that Ambercare received at least $24.6 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Ambercare: (1) refund to the Federal Government the portion of the estimated $24.6 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Suncoast Hospice (A-02-18-01001)

OIG found that, for 49 claims in the sample, Suncoast claimed Medicare reimbursement for hospice services for which the clinical record did not support the beneficiary's terminal prognosis or the level of care claimed and for services that were not provided.

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These improper payments occurred because Suncoast's policies and procedures for ensuring that claims for hospice services met Medicare requirements were not always effective. Based on OIG's sample results, OIG estimated that Suncoast received at least $47.4 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Suncoast: (1) refund to the Federal Government the portion of the estimated $47.4 million in Medicare overpayments that are within the 4-year claims reopening period; (2) exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Tidewell Hospice, Inc. (A-02-18-01024)

OIG reported that Tidewell did not comply with Medicare requirements for 18 of the 100 claims in OIG's sample. For these claims, Tidewell claimed Medicare reimbursement for hospice services for which the clinical record did not support the beneficiary's terminal illness prognosis or the level of care claimed and for services that were not eligible for Medicare reimbursement. These improper payments occurred because Tidewell's policies and procedures for ensuring that claims for hospice services met Medicare requirements were not always effective. On the basis of OIG's sample results, OIG estimated that Tidewell received at least $8.3 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Tidewell: (1) refund to the Federal Government the portion of the estimated $8.3 million in Medicare overpayments that are within the 4-year claims reopening period, (2) exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule, and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Hospice Compassus, Inc. (A-02-16-01023)

OIG reported that Compassus did not comply with Medicare requirements for 39 of the 100 claims in OIG sample. For these claims, Compassus claimed Medicare reimbursement for hospice services: (1) for which the associated beneficiary did not meet eligibility requirements, (2) that were not documented, and (3) at a reimbursement rate associated with a level of care higher than what the associated beneficiary required. These improper payments occurred because Compassus's policies and procedures for ensuring that claims for hospice service met Medicare requirements were not always effective. Based on OIG's sample results, OIG estimated that Compassus received at least $1.8 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Compassus exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and based on the results of OIG's audit, identify, report, and return any additional overpayments as having been made in accordance with OIG's recommendations. OIG also recommended that Compassus strengthen its procedures to ensure that hospice services comply with Medicare requirements.

Work Plan #: A-02-20-01001 (September 2022); A-02-19-01018 (July 2022); A-09-18-03028 (June 2021); A-09-18-03016 (May 2021); A-09-18-03017 (May 2021); A-02-18-01001 (May 2021); A-02-18-01024 (February 2021); A-02-16-01023 (November 2020)
Government Program: Medicare Parts A & B

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Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight

OIG's analysis of trends and patterns in payments for items and services provided to Medicare beneficiaries outside the Medicare hospice benefit during a hospice period of care (which OIG refers to as "nonhospice payments") demonstrate an increase in Medicare nonhospice payments for beneficiaries. Nonhospice payments for Medicare Part A services and Part B items and services totaled $6.6 billion from 2010 through 2019. If providers bill Medicare for nonhospice items and services that potentially should be covered by hospices, Medicare could pay for the same items or services twice.

OIG's prior work on Medicare Part D drugs and durable medical equipment, prosthetics, orthotics, and supplies provided to hospice beneficiaries demonstrated that these duplicate payments are, in fact, occurring. In three prior reports, OIG made several recommendations to CMS to establish oversight and scrutiny of Medicare nonhospice payments. Implementing the recommendations from those reports and considering the information in this data brief may help the Centers for Medicare & Medicaid Services (CMS) further evaluate the need to potentially restructure the hospice payment system to reduce duplicate payments for items and services that should be included in the hospice per diem payment. The information in this data brief may also help CMS determine whether the hospice benefit is operating consistent with its longstanding position that services unrelated to a hospice beneficiary's terminal illness and related conditions should be exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit.

SunHawk Summary of OIG Audit Findings and Recommendations

The results of OIG's data analysis demonstrate an increase in Medicare nonhospice payments for beneficiaries during a hospice period of care. Nonhospice payments for Medicare Part A services and Part B items and services totaled $6.6 billion from 2010 through 2019, and the majority of payments were for Part B items and services. In addition, the percentage of hospice beneficiaries who received nonhospice items and services remained at an average of 44 percent over the 10-year audit period, which indicates that a potential inappropriate "unbundling" of items and services from the hospice benefit still exists. If providers bill Medicare for nonhospice items and services that potentially should be covered by hospices, Medicare could pay for the same items or services twice. OIG's prior work on Medicare Part D drugs and DMEPOS items provided to hospice beneficiaries demonstrated that these duplicate payments are, in fact, occurring.

This report contains no recommendations.

Work Plan #: A-09-20-03015 (February 2022)
Government Program: Medicare Parts A & B

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Medical Equipment & Supplies

[NEW] Report to Congress on the Reported Impact of Discarded-Drug Refunds on Biosimilar Biological Products

The Infrastructure Investment and Jobs Act amended section 1847 of the Social Security Act (the Act). The Act requires manufacturers of certain single-dose container or single-use package drugs payable under Part B of the Medicare program to provide refunds for discarded amounts of such drugs. The Act also requires OIG, after consultation with the Centers for Medicare & Medicaid Services (CMS) and the Food & Drug Administration (FDA), to submit to certain Congressional committees, not later than 3 years after the date of enactment, a report on any impact the discarded-drug refund is reported to have or may have on the licensure, market entry, market retention, or marketing of biosimilar biological products (biosimilars). OIG's objective was to determine what impact requiring refunds from manufacturers of certain single-dose products payable under Medicare Part B is reported to have on the licensure, market entry, market retention, or marketing of biosimilars.

OIG consulted with CMS, FDA, selected biosimilar drug manufacturers, and a relevant trade association to determine what effect(s), if any, this Act has had or may have on the licensure, market entry, market retention, or marketing of biosimilars, and how it may affect availability of biosimilars under Medicare Part B. On the basis of OIG's consultation with CMS, FDA, selected manufacturers of biosimilars, and a relevant trade association, OIG concluded that currently there is no known or expected impact on the licensure, market entry, market retention, or marketing of biosimilars as a result of legislation requiring refunds from manufacturers of certain single-dose container or single-use package drugs payable under Medicare Part B.

SunHawk Summary of OIG Audit Findings and Recommendations

This report contains no recommendations.

Work Plan #: A-06-23-04003 (February 2024)
Government Program: Medicare Parts A & B

[NEW] Medicare Paid $30 Million for Accumulated Repair Costs That Exceeded the Federally Recommended Cost Limit for Wheelchairs During Their 5-Year Reasonable Useful Lifetime

From January 2016 through December 2021 (audit period), Medicare paid $91.1 million to durable medical equipment (DME) suppliers nationwide for repairs made to capped-rental wheelchairs (wheelchairs) that were within their 5-year reasonable useful lifetime (RUL) and owned by Medicare enrollees. Two prior OIG reviews found that Medicare paid DME suppliers for repairs made to capped-rental DME items after the accumulated costs of repairs had exceeded 60 percent of the cost to replace the items (federally recommended cost limit), which may have resulted in unallowable payments. Therefore, OIG conducted this nationwide audit to determine the extent to which the issue identified in the prior OIG reviews occurred for wheelchairs during OIG's audit period. OIG's objective was to determine whether the accumulated costs of

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repairs paid by Medicare for enrollee-owned wheelchairs that were within their 5-year RUL exceeded the federally recommended cost limit.

OIG's audit covered Medicare Part B claim lines, totaling $91.1 million, for repairs made to 77,774 enrollee-owned wheelchairs during OIG's audit period that were within their 5-year RUL and were purchased during the same period. OIG analyzed claims data to determine the amount paid for repairing each enrollee's wheelchair and the portion of the accumulated costs of repairs that exceeded the federally recommended cost limit.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that the accumulated costs of repairs paid by Medicare for some enrollee-owned wheelchairs that were within their 5-year RUL exceeded the federally recommended cost limit. For 504,794 of the 688,948 repairs (73 percent) that OIG reviewed, Medicare paid suppliers before the accumulated costs of repairing 77,200 wheelchairs had exceeded the federally recommended cost limit. However, the remaining 184,154 repairs (27 percent) were paid after the accumulated costs of repairing 16,962 wheelchairs had exceeded the federally recommended cost limit, resulting in $30.1 million in potentially unallowable Medicare payments. Enrollee coinsurance associated with the potentially unallowable payments totaled $7.6 million. Suppliers' billing of these wheelchair repairs may reflect noncompliance with Medicare requirements.

OIG recommended that CMS work with the DME Medicare administrative contractors (DME MACs) to: (1) strengthen Medicare requirements to ensure that DME MACs review accumulated costs of repairs made to wheelchairs during their 5-year RUL that exceed a certain cost limit and use this cost limit as a basis for determining when wheelchairs furnished by suppliers will not remain serviceable for their entire RUL, (2) implement system edits to identify for review claims for repairs made to wheelchairs during their 5-year RUL when the accumulated costs of repairs have exceeded a certain cost limit, and (3) take appropriate action for suppliers that consistently bill for repairs made to wheelchairs during their 5-year RUL that exceed the federally recommended cost limit or the cost limit used as the basis for determining when wheelchairs furnished by suppliers will not remain serviceable for their entire RUL (e.g., by educating suppliers on proper billing and recovering improper payments). The report contains one other recommendation.

Work Plan #: A-09-22-03003 (July 2023)
Government Program: Medicare Parts A & B

[NEW] HHS Did Not Fully Comply With Federal Requirements and HHS Policies and Procedures When Awarding and Monitoring Contracts for Ventilators

HHS is one of the largest contracting agencies in the Federal Government. In fiscal year 2020, HHS awarded over $14 billion in contracts in response to the COVID-19 pandemic. Of these contracts, HHS's Administration for Strategic Preparedness and Response (ASPR) awarded 10 contracts between March 30, 2020, and May 28, 2020, totaling nearly $2.9 billion to supply approximately 198,000 ventilators for the Strategic National Stockpile (SNS) by the end of 2020. OIG's objective was to determine whether ASPR awarded and monitored contracts for the production of ventilators in accordance with Federal requirements and HHS policies and procedures.

OIG audited the five highest-dollar value contracts that ASPR awarded for the production of ventilators, totaling approximately $2.4 billion. OIG reviewed these firm-fixed price contracts and associated modifications, invoices, delivery documentation, and other documentation maintained by ASPR.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that ASPR did not consistently award and monitor contracts for ventilators for use in responding to the COVID-19 pandemic in accordance with Federal requirements and HHS policies and procedures. Specifically, ASPR did not establish roles and responsibilities for communication with other emergency response teams, did not always accurately report contract data, and did not always properly monitor contractor performance.

As a result, ASPR could not ensure compliance with applicable Federal requirements or that each contract's terms were economically and efficiently achieved; therefore, ASPR could not determine whether the use of taxpayer funds was reasonable. In addition, the Federal Government may have used inaccurate contract data supplied by ASPR to measure and assess the impact of Federal procurements on Coronavirus Aid, Relief and Economic Security (CARES) Act spending. Finally, ASPR potentially hindered the SNS's ability to meet anticipated ventilator demand in support of the Federal Government's COVID-19 pandemic response.

OIG made a series of recommendations to ASPR, including that it establish written policies and procedures for communicating with federally established emergency response team lead agencies, accurately report contract data, and strengthen its policies and procedures to ensure proper monitoring of contractor performance.

Work Plan #: A-02-20-02002 (September 2022)
Government Program: Health and Human Services

Medicare Improperly Paid Durable Medical Equipment Suppliers an Estimated $8 Million of the $40 Million Paid for Power Mobility Device Repairs

From October 1, 2018, through September 30, 2019 (audit period), Medicare Part B paid approximately $40.1 million for Power Mobility Device (PMD) repairs for Medicare beneficiaries nationwide. For 2006 through 2008, a prior OIG review of claims for capped rental durable medical equipment (DME), which includes certain PMDs, found that Medicare paid DME suppliers (suppliers) approximately $26.8 million for DME repair claims that did not meet Medicare requirements. OIG conducted this nationwide audit of PMD repairs to determine whether the issues identified in the prior OIG report were still occurring during the audit period. OIG's objective was to determine whether suppliers complied with Medicare requirements when billing for PMD repairs.

OIG's audit covered Medicare Part B paid claims for 37,013 beneficiaries for whom suppliers submitted charges for 244,667 claim lines, totaling $40.1 million, for PMD repairs provided during the audit period. The beneficiary coinsurance associated with these PMD repairs totaled $10.4 million. (A claim line represented one PMD repair for a beneficiary on a single date of service.) OIG selected a stratified random sample of 100 beneficiaries, for whom 52 suppliers submitted charges for 922 PMD repairs totaling $170,776.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all suppliers complied with Medicare requirements when billing for PMD repairs. For 637 of the 922 PMD repairs associated with the 100 sampled beneficiaries, suppliers complied with those requirements. However, for 261 PMD repairs, suppliers submitted PMD repair charges that did not comply with those requirements. (OIG did not review the remaining 24 PMD repairs but treated them as non-errors because they were under contractor review.) Specifically, documentation did not adequately support the charges for PMD repairs, the labor time associated with PMD repairs was

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not documented, or PMD repair charges were not reasonable and necessary, resulting in $41,137 in improper Medicare payments and $10,494 in associated beneficiary coinsurance payments. OIG also identified questionable charges for 183 PMD repairs associated with 19 sampled beneficiaries. Although the billing of these PMD repairs did not reflect noncompliance with Medicare requirements, suppliers did not meet documentation standards established by guidance or submitted charges that may not have been reasonable and necessary, resulting in $20,692 in questionable Medicare payments and $5,278 in associated beneficiary coinsurance payments.

On the basis of the sample results, OIG estimated that $7.9 million of the $40.1 million paid for PMD repairs was improperly paid. OIG also estimated that Medicare could have saved as much as an additional $3.7 million for questionably paid PMD repairs. In addition, OIG estimated that Medicare beneficiaries could have saved as much as $3 million in coinsurance for the improperly and questionably paid PMD repairs.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) instruct the DME Medicare contractors to: (1) recover $41,137 in overpayments for PMD repairs; (2) notify suppliers to refund $10,494 in coinsurance; and (3) based upon the results of this audit, notify appropriate suppliers so that they can exercise reasonable diligence to identify, report, and return any overpayments. OIG also made four procedural recommendations. The full text of OIG's recommendations is shown in the report.

CMS concurred with five of the seven recommendations, including two procedural recommendations. However, CMS did not concur with one procedural recommendation and did not concur with one part of another procedural recommendation. After reviewing CMS's comments, OIG maintained that the recommendations are valid.

Work Plan #: A-09-20-03016 (May 2022)
Government Program: Medicare Parts A & B

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Behavioral Health

[NEW] Medicare Improperly Paid Providers for Some Psychotherapy Services, Including Those Provided via Telehealth, During the First Year of the COVID-19 Public Health Emergency

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) temporarily expanded access to health services provided via telehealth. From March 2020 through February 2021 (audit period), Medicare Part B paid $1 billion for psychotherapy services, including telehealth services, provided to Medicare enrollees nationwide. Prior Office of Inspector General (OIG) audits of four psychotherapy providers identified high improper payment rates for psychotherapy services furnished before the PHE. OIG conducted this nationwide audit to determine whether compliance issues identified in the prior audits occurred during their audit period. To understand the challenges that providers faced when furnishing telehealth services, OIG also surveyed providers on their experience with providing those services to people enrolled in Medicare. OIG's objective was to determine whether providers met Medicare requirements and guidance when billing for psychotherapy services, including services provided via telehealth.

OIG's audit covered approximately $1 billion in Part B payments for more than 13.5 million psychotherapy services provided during their audit period. OIG selected two stratified random samples of psychotherapy services: one sample consisted of 111 enrollee days for telehealth services, and the other consisted of 105 enrollee days for non-telehealth services (i.e., provided in person).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Providers did not meet Medicare requirements and guidance when billing for some psychotherapy services, including services provided via telehealth. For 84 of the 216 sampled enrollee days, providers met Medicare requirements. However, for 128 sampled enrollee days, providers did not meet these requirements (e.g., psychotherapy time was not documented). In addition, for 54 sampled enrollee days, providers did not meet Medicare guidance (e.g., providers' signatures were missing). (OIG did not review 4 sampled enrollee days and treated them as non-errors because they were already part of other OIG reviews.) Based on OIG's sample results, OIG estimated that of the $1 billion that Medicare paid for psychotherapy services, providers received $580 million in improper payments for services that did not comply with Medicare requirements, consisting of $348 million for telehealth services and $232 million for non-telehealth services.

OIG also presented the information obtained on providers' experience with providing telehealth services during the PHE for the sampled enrollee days. CMS may be able to use this information when making decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future. OIG found that some providers reported challenges in furnishing telehealth services and most providers used approved communication technology to provide those services.

OIG recommended that CMS: (1) work with Medicare contractors to recover $35,560 in improper payments for the sampled enrollee days, (2) implement system edits for psychotherapy services to prevent payments for incorrectly billed services, and (3) strengthen educational efforts to make providers aware of educational materials on meeting requirements and guidance for psychotherapy services. The report contains three other recommendations.

Work Plan #: A-09-21-03021 (May 2023)
Government Program: Medicare Parts A & B

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Montana Claimed Federal Medicaid Reimbursement for More Than $5 Million in Targeted Case Management Services That Did Not Comply With Federal and State Requirements

Targeted Case Management (TCM) services assist specific State-designated Medicaid groups in gaining access to medical, social, educational, and other types of services. Previous Office of Inspector General (OIG) audits found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements. OIG's objective was to determine whether Montana claimed Federal Medicaid reimbursement for TCM services during Federal fiscal years (FYs) 2018 through 2020 in accordance with Federal and State requirements.

OIG's audit covered $42.1 million ($27.5 million Federal share) in Medicaid payments for TCM services provided and paid for in Montana during FYs 2018 through 2020 (October 1, 2017, through September 30, 2020). OIG reviewed documentation for a stratified random sample of 150 unique TCM grouped line items (sample items) from the 4 largest target groups in the State to determine whether the services provided were allowable, case managers providing services were qualified, and recipients receiving services were eligible. OIG reviewed payment rates to determine whether they matched the approved rates for the period. OIG compared TCM documentation provided by Montana to applicable Federal regulations and the State plan supplements governing Montana's TCM program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Montana did not always claim Federal Medicaid reimbursement for TCM services during FYs 2018 through 2020 in accordance with Federal and State requirements. Of the 150 randomly sampled grouped line items, 43 sample items were at least partially unallowable because they had at least 1 error related to case managers lacking required experience or qualifications, unsupported services, unallowable services, or an ineligible recipient.

Montana had policies and procedures in place for the administration of TCM services that, if followed, would have ensured compliance with Federal and State requirements. Based on OIG's sample results, OIG estimated that Montana claimed at least $7.7 million (more than $5 million Federal share) in unallowable Medicaid reimbursement for these services.

OIG recommended that Montana refund to the Federal Government the more than $5 million (Federal share) in overpayments. OIG also make procedural recommendations that Montana always follows its established policies and procedures regarding: (1) TCM providers' case manager hiring practices, (2) verification that billed services were allowable and properly documented, and (3) verification that all individuals receiving services were eligible. Furthermore, OIG made procedural recommendations that Montana require TCM providers to comply with established policies and procedures.

OIG's draft report had identified 45 sample items with errors. Montana did not concur with 10 of the 45 sample items that OIG had identified as unallowable, said that these were allowable claims that were consistent with Federal and State law and policy, and gave OIG additional documentation. Montana neither agreed nor disagreed with OIG's procedural recommendations but described corrective actions that it had taken or planned to take.

After reviewing Montana's comments and the additional documentation provided, OIG revised, for this final report, the number of errors that were identified from 45 to 43 sample items. Accordingly, OIG revised the statistical estimate and the dollar amount conveyed in their first recommendation. OIG maintains that the findings and recommendations, as revised, are valid.

Work Plan #: A-07-21-03246 (August 2022)
Government Program: Medicaid

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Psychotherapy Services Billed by a New York City Provider Did Not Comply With Medicare Requirements

Medicare paid approximately $1 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar year 2019. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services. After analyzing Medicare claims data for Part B psychotherapy services provided during 2019, OIG identified a New York City provider that was among the highest reimbursed individual providers in the Nation. OIG's objective was to determine whether a New York City provider complied with Medicare requirements when billing for psychotherapy services

OIG's audit covered 15,559 beneficiary days for psychotherapy services for which a New York City provider received Medicare reimbursement totaling $1.1 million during the period April 1,2018, through August 31, 2020 (audit period). OIG reviewed a simple random sample of 100 beneficiary days. OIG did not determine whether the services were medically necessary.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the New York City provider did not comply with Medicare requirements when billing for psychotherapy services for all 100 sampled beneficiary days. Specifically, beneficiaries' treatment plans associated with these services were not provided or did not contain required elements (e.g., frequency or duration of services). This heightens the risk that treatments were inappropriate or unnecessary and could have a significant effect on the beneficiaries' quality of care received. OIG also found that services billed to Medicare did not meet incident-to requirements or were conducted by a therapist that was not licensed or registered in New York State. Also, time spent on psychotherapy services was not documented and treatment notes were not maintained to support the services billed. In addition, for psychotherapy services provided during 96 sampled beneficiary days, there was no evidence that beneficiaries' treatment plans were signed by the treating physician.

On the basis of OIG's sample results, OIG estimated that the New York City provider received $1.1 million in Medicare overpayments for psychotherapy services. These deficiencies occurred because the provider did not develop policies and procedures or provide training to its therapists to ensure that psychotherapy services were appropriately billed to Medicare.

OIG recommended that the New York City provider (1) refund to the Medicare program the estimated $1.1 million overpayment and (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommended that the provider develop policies and procedures and provide training to its therapists to ensure that psychotherapy services comply with Medicare requirements.

Work Plan #: A-02-21-01006 (March 2022)
Government Program: Medicare Parts A & B

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Laboratory

[NEW] Medicare Part B Spending on Clinical Diagnostic Laboratory Tests in 2022

In 2022, Medicare Part B spending on clinical diagnostic laboratory tests (lab tests) decreased by 10 percent from lab test spending in 2021. Medicare Part B spending on lab tests has experienced an upward trend since 2014, the first year OIG began this series of annual analysis required by the Protecting Access to Medicare Act of 2014 (PAMA). Because payment rates for individual lab tests did not change in 2021 and 2022, changes in spending were primarily driven by changes in the volume of tests. Decreases in spending and volume occurred for most, but not all, individual lab tests and for each category of lab tests—COVID-19 tests; genetic tests; and chemistry and other tests.

To help control lab test spending, PAMA required that Medicare Part B payment rates align with rates paid by private payors. From 2018 through 2020, the Centers for Medicare and Medicaid Services (CMS) implemented new Medicare Part B lab test payment rates. From 2021 through 2023, changes in legislation have delayed any rate changes; the next payment rate changes are scheduled for January 1, 2026. Since 2014, OIG has been reporting on lab test spending in Medicare Part B as mandated by PAMA.

In this report, OIG analyzed Medicare Part B claims data for lab tests paid for by CMS under the Clinical Laboratory Fee Schedule in 2022. OIG identified key statistics and trends for total Medicare spending on lab tests, including the top 25 lab tests on the basis of total spending.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG's data snapshot contained no recommendations.

Work Plan #: OEI-09-23-00350 (December 2023)
Government Program: Medicare Parts A & B

[NEW] CMS's Oversight of Medicare Payments for the Highest Paid Molecular Pathology Genetic Test Was Not Adequate To Reduce the Risk of up to $888 Million in Improper Payments

Prior OIG work identified increased spending on Medicare Part B genetic testing, as well as fraudulent billing of genetic tests. Although there may be legitimate reasons for the increased spending, the increases indicate the potential for improper payments. OIG's prior analysis showed that, for 2016 through 2019, Current Procedural Terminology (CPT) code 81408 was the genetic-testing procedure code with the second highest total Part B payments and was the molecular pathology procedure (a type of genetic test) with the highest Medicare payment amount ($2,000). This CPT code may be billed when testing for multiple genes associated with rare diseases. Because these diseases generally manifest in childhood, the genes associated with them would not generally be tested for in the Medicare population, which is predominantly 65 years of age and older. Therefore, there is a risk of Medicare improper payments for this CPT code.

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OIG's objective was to determine whether the Centers for Medicare & Medicaid Services' (CMS's) oversight of Medicare payments for CPT code 81408 was adequate to reduce the risk of improper payments.

To determine whether there was a risk of improper payments, OIG analyzed the Medicare Part B claims associated with payments of $888.2 million for more than 450,000 genetic tests billed under CPT code 81408 that had dates of service from 2018 through 2021 (audit period). OIG also interviewed CMS and Medicare contractor officials.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS and the Medicare Administrative Contractors' (MACs') oversight of Medicare payments for CPT code 81408 did not: (1) ensure that all Medicare enrollees had established relationships with ordering providers; (2) ensure that Medicare payments for CPT code 81408 were related to diseases associated with genes that would generally be tested and billed under that CPT code; and (3) include adequate monitoring of the number of tests billed under CPT code 81408, a Tier 2 molecular pathology procedure (MPP) code, to determine whether that number exceeded the number of tests billed under Tier 1 MPP codes. (Tier 2 MPPs are generally performed in lower volumes than Tier 1 MPPs because the diseases being tested for are rare.) In addition, not all MACs could identify the specific gene tested by laboratories billing CPT code 81408. Finally, although five of the seven MACs had Local Coverage Article guidance that prohibited or limited use of CPT code 81408, two MACs' Local Coverage Articles did not limit its use.

Although CMS officials stated that CMS conducts data analysis (e.g., to identify high-risk providers), CMS did not ensure that the MACs provided sufficient oversight over billing of and payments for CPT code 81408. Two of the MACs' payments made up 97 percent of the total payments for CPT code 81408 for OIG's audit period. Because there were no longer payments for this CPT code by the end of the audit period (December 31, 2021), OIG considers the issues identified by this audit corrected. However, based on the results of OIG's audit, up to $888.2 million in Medicare payments made for CPT code 81408 claims that OIG identified for the audit period was at risk of improper payment.

OIG recommended that CMS direct the appropriate Medicare contractors to: (1) review claims billed under CPT code 81408 for OIG's audit period to determine whether they complied with Medicare requirements; and (2) determine the amount of improper payments for the claims that did not comply with Medicare requirements and, for those that are within the 4-year claim-reopening period, in accordance with CMS's policies and procedures, recover up to $888.2 million for claims that were at risk of improper payment during OIG's audit period. The report contains one other recommendation.

Work Plan #: A-09-22-03010 (June 2023)
Government Program: Medicare Parts A & B

[NEW] Medicare Part B Spending on Lab Tests Increased in 2021, Driven By Higher Volume of COVID-19 Tests, Genetic Tests, and Chemistry Tests

Medicare Part B spent $9.3 billion on laboratory (lab) tests in 2021, a 17-percent increase from 2020. The spending increase resulted from increased volume for three types of tests: COVID-19 tests, genetic tests, and chemistry tests. Genetic tests exceeded pre-pandemic spending levels, while chemistry test spending increased from 2020 but did not fully return to pre-pandemic levels.

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The Protecting Access to Medicare Act of 2014 (PAMA) changed the way the Medicare program sets payment rates for lab tests by aligning Medicare payment rates with rates paid by private payers. The Centers for Medicare & Medicaid Services (CMS) calculated new rates that took effect in 2018, lowering Medicare payment rates for many tests. As part of PAMA, Congress also mandated that the Office of Inspector General (OIG) publicly release an annual analysis of the top 25 tests based on Medicare spending and that it conduct analyses that OIG determines appropriate. OIG issued the first report in 2015, analyzing Medicare Part B payments for lab tests in 2014. This data brief provides an analysis of Medicare payments for lab tests in 2021.

OIG analyzed claims data for lab tests performed in 2021 that CMS paid for under the Clinical Laboratory Fee Schedule (CLFS). These tests are covered under Medicare Part B and do not include tests that Medicare paid for under other payment systems, such as the payment system for critical access hospitals or the Hospital Outpatient Prospective Payment System. OIG identified the top 25 lab tests based on Medicare spending for tests performed in 2021. OIG also identified key statistics and emerging trends, including Medicare spending by procedure code and test category.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that Medicare Part B spending on lab tests increased by $1.3 billion in 2021, from $8.0 billion in 2020 to $9.3 billion in 2021. The 17-percent increase was the biggest change in spending since OIG began monitoring payments in 2014.

In 2021, Medicare Part B spent $2.0 billion on COVID-19 tests, a 29-percent increase from 2020. Medicare Part B paid for 26 different procedure codes for COVID-19 tests, including code U0005, a new code that incentivized faster test turnaround times. More than 10 million enrollees received at least 1 COVID-19 test paid for by Medicare Part B.

Medicare Part B spending on non-COVID-19 tests also increased. Total spending on four categories of high-priced genetic tests increased by 56 percent, from $1.2 billion in 2020 to $1.9 billion in 2021, exceeding pre-pandemic spending levels. Spending on chemistry tests—the largest category of tests by both spending and volume—increased from $1.9 billion in 2020 to $2.1 billion, but remained below pre-pandemic levels.

Medicare Part B spent $5.5 billion in 2021 on the top 25 tests, which accounted for 59 percent of total test spending. The factors that affected overall spending also contributed to the increase in spending on the top 25 tests. These factors were the increased volume for COVID-19 tests, the continued growth of high-priced genetic tests, and the increased volume for panel and chemistry tests.

The COVID-19 pandemic continued to have an impact on Medicare Part B spending on lab tests. Spending on COVID-19 tests increased in 2021, driven by more people receiving more tests. However, the decline between pre-pandemic levels for chemistry tests and the 2020 and 2021 levels could indicate that people are not seeking the routine or preventive care appointments where these tests are ordered. The second year in a row of low volume for chemistry tests raises questions about the pandemic's long-term impact on Medicare enrollee health.

Work Plan #: OEI-09-22-00400 (December 2022)
Government Program: Medicare Parts A & B

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Provider

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Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment & Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

[NEW] Labs With Questionably High Billing for Additional Tests Alongside COVID-19 Tests Warrant Further Scrutiny

Medicare Part B spending on COVID-19 lab tests increased steadily between spring 2020—when Medicare first started paying for these tests—and the end of that year. Preliminary analysis of Medicare Part B claims data indicated that some diagnostic testing laboratories billed for other diagnostic tests—such as individual respiratory tests (IRTs), respiratory pathogen panels (RPPs), genetic tests, and allergy tests—along with COVID-19 tests. OIG refers to these four types of tests billed with COVID-19 tests as add-on tests. Although it is not unusual for labs to bill for COVID-19 tests and other diagnostic tests on the same claim, certain billing patterns—such as a high volume of or high payments for add-on tests—raise concerns of potential waste or fraud.

OIG performed outlier analysis to identify labs that billed for add-on tests at questionably high levels compared to other labs that billed for COVID-19 tests. OIG identified two kinds of outlier labs: (1) those for which add-on tests constituted a high proportion of each lab's total number of tests, and (2) those for which add-on tests constituted a high proportion of each lab's total payments for tests.

OIG examined all Medicare Part B claims paid for COVID-19 tests during 2020, and for the following types of add-on tests: IRTs, RPPs, genetic tests, and allergy tests.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 378 labs billed Medicare Part B for add-on tests at questionably high levels—in volume, payment amount, or both—compared to the 19,199 other labs. This includes 276 labs that billed for high volumes of add-on tests on claims for COVID-19 tests, and 263 labs that billed for high payment amounts from add-on tests on claims for COVID-19 tests. Further, 161 of these labs billed for both high volumes of add-ons and high payment amounts from add ons on claims for COVID-19 tests. OIG also found a small number of labs that had at least 10 claims where 2 labs had billed for the same enrollee for the same tests on the same day, which may be an indication of a fraud scheme involving the sharing of enrollee information.

On their claims for COVID-19 tests, some of the 378 labs billed for add-on tests in combinations that had little if any variation across patients. This may indicate that these tests were not specific to individual patients' needs. The add-on tests significantly increased the per-claim amounts that Medicare Part B paid to these labs. For example, one outlier lab regularly billed for a combination of five add-on respiratory tests on almost all of its claims for COVID-19 tests. As a result, the average per-claim Medicare payment to this outlier lab was $666, covering both COVID-19 and add-on tests, compared to an average payment of $89 to all other labs that billed for COVID-19 tests and any add-on tests. Although billing for add-on tests was generally allowable, and Medicare Part B pays for these tests when they are medically appropriate, these patterns of questionably high billing raise concerns that some tests may have been wasteful or potentially fraudulent.

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Government Program: Medicare Parts A & B

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[NEW] The Number of Beneficiaries Who Received Medicare Part B Clinical Laboratory Tests Decreased During the First 10 Months of the COVID-19 Pandemic

Clinical laboratory (lab) tests, when used appropriately, are important because they provide health care providers with information to prevent, detect, diagnose, treat, and manage disease (including managing chronic medical conditions). These conditions have health impacts and economic costs, and prevention can reduce costs. To help contain the spread of COVID-19, Federal, State, Tribal, and local government agencies implemented community mitigation activities, including some issuing orders or advisories to residents to stay at home. These and other factors may have contributed to Medicare beneficiaries receiving fewer clinical services, including lab tests. OIG's preliminary analysis of lab tests billed to and paid by Medicare Part B found decreases in the number of beneficiaries who received lab tests when compared with a similar period before the pandemic.

OIG's objective was to identify changes in the number of beneficiaries who received Medicare Part B lab tests during the first 10 months of the COVID-19 pandemic-specifically, the number of beneficiaries who received: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries.

OIG's audit covered Part B claims for lab tests provided from March through December 2019 ("pre-pandemic period") and from March through December 2020 ("pandemic period").

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that, during the pandemic period, the number of beneficiaries who received Medicare Part B lab tests decreased for: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries. From March through December in 2016, 2017, and 2018 and for the pre-pandemic period (in 2019), the number of beneficiaries who received lab tests paid for by Medicare decreased by 1 percent or less in each year. However, for the pandemic period (in 2020), the number of beneficiaries who received lab tests decreased by about 9 percent compared with the pre-pandemic period.

OIG's comparison of the numbers of beneficiaries who received lab tests during the pandemic and pre-pandemic periods identified the following trends: (1) The number of beneficiaries who received lab tests had the highest percentage decreases during the first 3 months of the pandemic period when compared with the same months during the pre-pandemic period; (2) for almost 90 percent of lab tests for which the number of tests performed had decreased during the pandemic period, the number of beneficiaries who received those tests decreased by more than 10 percent; (3) for the gender and residential location (i.e., rural or urban) demographics, during the pandemic period the number of beneficiaries who received lab tests had similar percentage decreases for each category within the corresponding demographic (e.g., the female and male genders had similar percentage decreases); (4) for the race or ethnicity group demographic, during the pandemic period there was more variation in the percentage decreases in the number of beneficiaries who received lab tests for each category (e.g., the Hispanic or Latino category had a higher percentage decrease than the White category); and (5) the number of beneficiaries with diabetes, kidney disease, and heart disease who received common lab tests for those conditions decreased during the pandemic period. The results of OIG's data analysis suggest that the COVID-19 pandemic contributed to these decreases. Lab tests are important for beneficiaries with chronic medical conditions, which are associated with hospitalizations, billions of dollars in Medicare costs, and deaths.

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The information in this report is provided for informational purposes only and therefore the report does not contain any recommendations. The Centers for Medicare & Medicaid Services elected not to provide comments on OIG's draft report.

Work Plan #: A-09-21-03004 (November 2022)
Government Program: Medicare Parts A & B

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Telehealth

[NEW] Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements

In response to the COVID-19 public health emergency (PHE), CMS temporarily expanded access to health services provided via telehealth. From March 2020 through November 2020 (audit period), Medicare Part B paid approximately $10.3 billion for Evaluation and Management (E/M) services, including telehealth services, provided to Medicare enrollees nationwide. The telehealth expansion increased the risk of inappropriate payments in the Medicare program due to the extent and speed of the changes. Therefore, CMS's oversight of the telehealth expansion becomes increasingly important to ensure that enrollees receive the appropriate quality of care both during and after the PHE, while protecting the Medicare program from fraud, waste, and abuse. OIG's objective was to determine whether physicians and other practitioners that provided E/M services via telehealth complied with Medicare requirements.

OIG's audit covered $1.4 billion in Medicare Part B payments for more than 19 million E/M claim line services that were billed with place of service codes or modifiers indicating telehealth was used to provide the service OIG's audit period. OIG selected a stratified random sample containing three strata of E/M services provided via telehealth during the audit period. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that, physicians and other practitioners that provided E/M services via telehealth generally complied with Medicare requirements. For 105 of the 110 sampled E/M services provided via telehealth, providers complied with Medicare requirements. However, for the remaining five sampled E/M services, providers did not comply with Medicare requirements. Medicare paid $446 for the five sampled E/M services for which providers did not document or insufficiently documented the services. OIG also identified potential documentation issues in the medical records used to support the sampled E/M services that OIG discussed in the Other Matters section of this report.

This report does not have recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments OIG identified resulted primarily from clerical errors or the inability to access records.

Work Plan #: A-01-21-00501 (February 2024)
Government Program: Medicare Parts A & B

Provider

[NEW] Telehealth During 2020 Helped Ensure End-Stage Renal Disease Patients Received Care, But Limited Information Related to Telehealth Was Documented

In response to the COVID-19 public health emergency (PHE) and pursuant to section 1135 of the Social Security Act, the Secretary of Health and Human Services (HHS) authorized the Centers for Medicare & Medicaid Services (CMS) to temporarily implement waivers and modifications to Medicare program requirements, retroactive to March 2020. From March through December 2020 (audit period), Medicare claims data shows that payments for end-stage renal disease (ESRD)-related telehealth services increased almost 10,000 percent from 2019. Oversight of telehealth expansion is increasingly important to ensure that Medicare enrollees receive the appropriate care while protecting the program from fraud, waste, and abuse. OIG conducted this audit of ESRD-related telehealth services provided during the first year of the PHE to verify whether providers complied with Medicare requirements, determine what telehealth-related information was documented in the medical records, and further inform policymakers and other stakeholders as they consider permanent changes to telehealth policies. OIG's objectives were to determine, for ESRD-related telehealth services provided during the PHE: (1) what information related to the telehealth services was documented in the medical records and (2) whether the claims met certain Medicare requirements.

OIG's audit covered approximately $38 million in Medicare Part B payments for 179,952 ESRD-related telehealth services provided during the audit period. OIG selected a stratified random sample: one stratum included 75 claim lines for telehealth services provided to in-center dialysis patients, and the other included 25 claim lines for telehealth services provided to at-home dialysis patients.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that providers documented limited information related to telehealth services in the medical records, but the ESRD-related telehealth service claim lines generally met certain Medicare requirements. Most medical records for sampled claim lines included documentation identifying that the service was provided via telehealth but did not include documentation that would allow us to determine whether the services were provided using 1) audiovisual interactive technology and 2) technology that was non-public-facing.

CMS does not oversee or enforce whether the telecommunications systems used to provide telehealth services are non-public-facing; the Health and Human Service's Office for Civil Rights (OCR) has responsibility for oversight of this requirement. Any information in this report regarding non-public-facing telecommunications systems used is for informational purposes only.

Although OIG did not make any recommendations, OIG believed it would be beneficial for the medical records to document the type of telecommunications system used to perform the telehealth visit. This information may be beneficial to CMS and OCR when considering future oversight mechanisms or changes regarding remote communication products.

Work Plan #: A-05-22-00015 (August 2023)
Government Program: Medicare Parts A & B

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Provider

[NEW] Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic

As part of the Pandemic Response Accountability Committee (PRAC) Health Care Subgroup, the Department of Health and Human Services' Office of Inspector General (OIG) led a group of OIGs in producing this PRAC-issued report focusing on telehealth across selected health care programs in six Federal agencies during the first year of the COVID-19 pandemic.

The pandemic changed many aspects of our lives, including how we visit the doctor and other health care providers. Reliance on telehealth services—that is, health care services that are provided remotely using technology between a provider and a patient—skyrocketed during the first year of the pandemic, especially among Federal health care programs.

The PRAC's Health Care Subgroup developed this report to provide policymakers and stakeholders—such as Congress; Federal and State agencies; and health care organizations—with information about the nature of telehealth and its use across selected health care programs in six Federal agencies during the first year of the pandemic. The report also provides insights into the program integrity risks associated with telehealth and safeguards that could strengthen oversight in these programs.

The PRAC Health Care Subgroup comprises six OIGs responsible for the oversight of agencies that provide or are involved with the provision of health care services. For this review, the six OIGs selected programs or components within their agencies for which they could obtain data on the use of telehealth during the first year of the pandemic. These programs were Medicare (Department of Health and Human Services); TRICARE (Department of Defense); the Federal Employees Health Benefits Program (Office of Personnel Management); the Veterans Health Administration (Department of Veterans Affairs); the Office of Workers' Compensation Programs (Department of Labor); and the Federal Bureau of Prisons and U.S. Marshals Service (Department of Justice).

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- The selected programs in six Federal agencies took steps to make telehealth available during the COVID-19 pandemic and provided relatively similar coverage of telehealth services.
- All selected programs experienced dramatic increases in the use of telehealth during the first year of the pandemic. During this time, approximately 37 million individuals used telehealth across the selected programs in six Federal agencies, 13 times the number who used telehealth the prior year.
- OIGs identified several program integrity risks associated with billing for telehealth services that were similar across multiple health care programs, such as risks involving inappropriate billing for the highest, most expensive level of telehealth services and risks related to duplicate claims and high-volume billing.
- OIGs found limited information about the impact of telehealth on quality of care, which has implications for the care provided to individuals and program integrity.
- OIGs found that programs lack some data necessary for oversight of telehealth services.

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- The selected health care programs have some safeguards in place to oversee telehealth services, but additional safeguards could strengthen program integrity. For example:
    - Programs could conduct additional monitoring of telehealth services.
    - Programs could develop additional billing controls to prevent inappropriate payments for telehealth services.
    - Programs could conduct efforts to educate providers and individuals about telehealth services.
    - Programs could collect additional data related to telehealth services.
    - Programs could collect and review information about the impact of telehealth services on quality of care.
- Together, these insights demonstrate the importance of ensuring the benefits of telehealth are realized while minimizing the risk in an effective and efficient manner.

This report contained no recommendations.

Work Plan #: OEI-02-22-00150 (November 2022)
Government Program: Medicare Parts A & B

[NEW] The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls

In response to the COVID-19 pandemic, health care providers increasingly deliver care using telehealth technologies. These technologies improve access to care, increase patient convenience, and increase service-delivery efficiency. OIG's objective was to determine whether the Indian Health Service (IHS) implemented select cybersecurity controls to protect its telehealth system.

OIG reviewed applicable IHS and HHS policies and procedures for telehealth technologies, interviewed staff, and reviewed system security documentation to determine whether IHS telehealth technologies was secure. OIG focused on determining whether IHS designed and implemented cybersecurity controls that are essential to securing IHS telehealth systems components before deployment.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that although IHS deployed a national telehealth system, which increased the availability of health care services during the pandemic, it did not complete select IT controls as required prior to deploying its telehealth system nationally. Specifically, IHS did not complete the contingency plan, risk assessment, finalized authorization to operate (ATO), and system security plan. Additionally, after deployment of the telehealth system, IHS did not remediate known vulnerabilities on some telehealth system devices in a timely manner.

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OIG recommended that the Indian Health Service develop a strategy for identifying, implementing, and testing cybersecurity controls for new information systems that are deployed in an expedited fashion to meet an urgent, mission-critical need. The strategy should define the minimum set of critical controls that must be implemented and tested before the system is deployed, noting the acceptance of risk for not implementing all required controls and stipulate that the full ATO process will be completed within a specific time period. OIG also recommended that the Indian Health Service ensure that adequate policies, procedures, and training are implemented to ensure that known telehealth vulnerabilities are remediated in a timely manner.

Work Plan #: A-18-21-03100 (September 2022)
Government Program: Indian Health Service

[NEW] Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries access health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and from the beneficiary's home. In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million—about 2 in 5—Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expands on that analysis and examines the characteristics of beneficiaries who used telehealth during the first year of the pandemic. This information sheds light on how the temporary expansion of telehealth affected different groups of beneficiaries. This information will help CMS, HHS, Congress, and other stakeholders understand who benefited from the expansion and make decisions about whether some of the temporary changes should become permanent. It can also inform efforts aimed at ensuring that all beneficiaries have appropriate access to telehealth. This data brief includes beneficiaries in Medicare fee-for-service and Medicare Advantage. This report is part of a series that examines the use of telehealth in Medicare and identifies program integrity concerns related to telehealth during the pandemic.

This analysis focuses on Medicare beneficiaries who used telehealth services during the first year of the pandemic, from March 1, 2020, to February 28, 2021. OIG based this analysis on Medicare fee-for-service claims data, Medicare Advantage encounter data, and data from the Medicare Enrollment Database.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that beneficiaries in urban areas were more likely than those in rural areas to use telehealth during the first year of the pandemic. Beneficiaries in Massachusetts, Delaware, and California were more likely than beneficiaries in some other States to use telehealth. Dually eligible beneficiaries (i.e., those eligible for both Medicare and Medicaid), Hispanic beneficiaries, younger beneficiaries, and female beneficiaries were also more likely than others to use telehealth. In addition, beneficiaries almost always used telehealth from home or other non-health-care settings. Furthermore, almost one-fifth of beneficiaries used certain audio-only telehealth services, with the vast majority of these beneficiaries using these audio-

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only services exclusively. Older beneficiaries were more likely to use these audio-only services, as were dually eligible and Hispanic beneficiaries.

As CMS, HHS, Congress, and other stakeholders consider permanent changes to Medicare telehealth services, it is important that they balance concerns about issues such as access, quality of care, health equity, and program integrity. Doing so will ensure that the benefits of telehealth are realized while minimizing risk. The data presented in this report demonstrate how the temporary expansions improved access to telehealth for Medicare beneficiaries, particularly for those who are medically underserved. Understanding who benefited from increased access and how different groups used telehealth can inform policymakers and stakeholders as they make decisions about telehealth.

Accordingly, OIG recommended that CMS: (1) take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home, (2) temporarily extend the use of audio-only telehealth services and evaluate their impact, (3) require a modifier to identify all audio-only telehealth services provided in Medicare, and (4) use telehealth to advance health care equity.

Work Plan #: OEI-02-20-00522 (September 2022)
Government Program: Medicare Parts A & B

[NEW] Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries access health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. In addition, CMS temporarily paused several program integrity activities, including medical reviews of claims. In a related report, the OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million Medicare beneficiaries—about 2 in 5—used telehealth services that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

The changes to Medicare telehealth policies, along with the dramatic increase in the use of telehealth, underscore the importance of determining whether providers are billing for telehealth services appropriately and how to best protect Medicare and beneficiaries against fraud, waste, and abuse. This data brief describes providers' billing for telehealth services and identifies ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. This information can help CMS, Congress, and other stakeholders determine what safeguards may be needed as they consider permanent changes to telehealth policies in Medicare. This report is part of a series that examines the use of telehealth in Medicare and the characteristics of beneficiaries who used telehealth during the pandemic.

This data brief is based on an analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic from March 1, 2020, to February 28, 2021. OIG focused the analysis on the approximately 742,000 providers who billed for a telehealth service. Using input from OIG investigators, OIG developed seven measures that focus on different types of billing for telehealth services that may indicate fraud, waste, or abuse. For each of these measures, OIG set very high thresholds to identify providers whose billing poses a high risk to Medicare. Because this data

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brief focuses on specific measures with very high thresholds, it does not capture all concerning billing related to telehealth services that may be occurring in Medicare. Additionally, this report does not confirm that any particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

Further, a Medicare billing practice-known as "incident to" billing—creates challenges for oversight because it allows services provided by clinical staff who are directly supervised by a practitioner to be billed under the supervising practitioner's identification number. It is critical for program integrity efforts to identify the individual who delivered the telehealth service that is billed to Medicare. To address these limitations in the data, OIG developed measures for this report that aim to minimize the effect of "incident to" billing on the results of the claims analysis.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG identified 1,714 providers whose billing for telehealth services during the first year of the pandemic poses a high risk to Medicare. These providers billed for telehealth services for about half a million beneficiaries. They received a total of $127.7 million in Medicare fee-for-service payments. Each of these 1,714 providers had concerning billing on at least 1 of 7 measures OIG developed that may indicate fraud, waste, or abuse of telehealth services. All of these providers warrant further scrutiny. For example, they may be billing for telehealth services that are not medically necessary or were never provided.

In addition, more than half of the high-risk providers OIG identified are a part of a medical practice with at least one other provider whose billing poses a high risk to Medicare. This may indicate that certain practices are encouraging such billing among their associated providers. Further, 41 providers whose billing poses a high risk appear to be associated with telehealth companies; however, there is currently no systematic way to identify these companies in the Medicare data.

Although these high-risk providers represent a small proportion of all providers who billed for a telehealth service, these findings demonstrate the importance of strong, targeted oversight of telehealth services. The findings also offer insight on how Medicare and others can protect beneficiaries against fraud, waste, and abuse. Conducting targeted oversight of telehealth will help ensure the benefits of telehealth are realized while minimizing risk in an effective and efficient manner. Accordingly, OIG recommended that CMS: (1) strengthen monitoring and targeted oversight of telehealth services, (2) provide additional education to providers on appropriate billing for telehealth services, (3) improve the transparency of "incident to" services when clinical staff primarily delivered the telehealth service, (4) identify telehealth companies that bill Medicare, and (5) follow up on the providers identified in this report.

Work Plan #: OEI-02-20-00720 (September 2022)
Government Program: Medicare Parts A & B

Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services; it also allowed beneficiaries to use telehealth in different locations, including in urban areas and from the beneficiary's home.

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Telehealth

Other Providers and Suppliers

This data brief provides insight into the use of telehealth in both Medicare fee-for-service and Medicare Advantage during the first year of the COVID-19 pandemic, from March 2020 through February 2021. It is a companion to a report that examines the characteristics of beneficiaries who used telehealth during the pandemic. Another report in this series identifies program integrity concerns related to telehealth during the pandemic. Understanding the use of telehealth during the first year of the pandemic can shed light on how the temporary expansion of telehealth affected where and how beneficiaries accessed their health care. This information can help CMS, Congress, and other stakeholders make decisions about how telehealth can be best used to meet the needs of beneficiaries in the future.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that over 28 million Medicare beneficiaries used telehealth during the first year of the pandemic. This was more than 2 in 5 Medicare beneficiaries. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they used in the prior year. Beneficiaries' use of telehealth peaked in April 2020 and remained high through early 2021. Overall, beneficiaries used telehealth to receive 12 percent of their services during the first year of the pandemic. Beneficiaries most commonly used telehealth for office visits, which accounted for just under half of all telehealth services used during the first year of the pandemic. However, beneficiaries' use of telehealth for behavioral health services stands out. Beneficiaries used telehealth for a larger share of their behavioral health services compared to their use of telehealth for other services. Specifically, beneficiaries used telehealth for 43 percent of behavioral health services, whereas they used telehealth for 13 percent of office visits.

OIG concluded that telehealth was critical for providing services to Medicare beneficiaries during the first year of the pandemic. Beneficiaries' use of telehealth during the pandemic also demonstrates the long-term potential of telehealth to increase access to health care for beneficiaries. Further, it shows that beneficiaries particularly benefited from the ability to use telehealth for certain services, such as behavioral health services. These findings are important for CMS, Congress, and other stakeholders to take into account as they consider making changes to telehealth in Medicare. For example, CMS could use these findings to inform changes to the services that are allowed via telehealth on a permanent basis.

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Government Program: Medicare Parts A & B

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Other Providers and Suppliers

[NEW] Medicare Paid Independent Organ Procurement Organizations Over Half a Million Dollars for Professional and Public Education Overhead Costs That Did Not Meet Medicare Requirements

Organ procurement organizations (OPOs) perform or coordinate the procurement and preservation of organs, such as kidneys, as well as transportation of organs to hospitals for transplantation into patients on a waiting list to receive a transplant. Prior OIG audits found that two independent OPOs in California did not comply with Medicare requirements for reporting overhead costs as well as administrative and general costs. Specifically, professional and public education overhead costs accounted for 44 percent and 65 percent of the total amount questioned in each report, respectively. OIG conducted this nationwide audit to determine whether the issues identified in the two prior OIG audits were occurring at independent OPOs nationwide. OIG's objective was to determine whether independent OPOs' professional and public education overhead costs met Medicare requirements.

OIG's audit covered $101.6 million of professional and public education overhead costs (with Medicare payments of $50.9 million) reported in the 50 independent OPOs' most recently finalized Medicare cost reports with FY end dates from May 31, 2015, through June 30, 2019 (audit period). OIG's audit covered costs from only 1 FY for each OPO. OIG randomly sampled for review 30 professional and public education overhead costs from each of the 10 randomly selected OPOs (300 sampled costs totaling $294,692).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all professional and public education overhead costs reported by independent OPOs met Medicare requirements. Of the 300 sampled professional and public education overhead costs, 264 costs met Medicare requirements. The remaining 36 costs, totaling $15,852 (with Medicare payments of $6,423), did not meet Medicare requirements and were therefore unallowable. Furthermore, while reconciling the OPOs' general ledgers with the OPOs' Medicare cost reports, OIG determined that OPOs reported an additional $132,898 of unallowable professional and public education overhead costs (with Medicare payments of $65,785).

On the basis of OIG's sample results and additional findings OIG identified during their reconciliation, OIG estimated that $664,295 (consisting of an estimated $598,510 based on the sample results and $65,785 for the reconciliation findings) of the $50.9 million paid for professional and public education overhead costs was unallowable. The OPOs reported unallowable costs because: (1) they misunderstood Medicare requirements and (2) their staff made administrative errors or were not aware that costs did not meet Medicare requirements.

OIG recommended that CMS: (1) instruct the Medicare administrative contractor (MAC) to recover $72,208 in unallowable Medicare payments by adjusting the applicable OPOs' Medicare cost reports to correct the $148,750 of unallowable professional and public education overhead costs reported, consistent with relevant laws and the agency's policies and procedures; and (2) update applicable Medicare requirements to clarify which types of professional and public education overhead costs are unallowable, which could have saved Medicare an estimated $664,295 for professional and public education overhead costs during OIG's audit period.

Work Plan #: A-09-21-03020 (August 2023)
Government Program: Medicare Parts A & B

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[NEW] Noridian Healthcare Solutions, LLC, Made $8.8 Million in Improper Monthly Capitation Payments to Physicians and Qualified Nonphysician Practitioners in Jurisdiction E for Certain Services Related to End-Stage Renal Disease

Medicare makes monthly capitation payments (MCPs) to physicians and qualified nonphysician practitioners managing patients in a dialysis center. The MCP covers most outpatient dialysis-related physician services furnished to enrollees with end-stage renal disease (ESRD). In FY 2016, the Centers for Medicare & Medicaid Services estimated that there was $107 million in overpayments for ESRD-related services billed for enrollees 20 years of age and older who had four or more face-to-face visits by a physician or qualified nonphysician practitioner per month, which corresponded to an improper payment rate of 21 percent. OIG's objective was to determine whether Noridian Healthcare Solutions, LLC (Noridian), made MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance.

OIG's audit covered Medicare Part B payments of $46.7 million for certain ESRD-related services, which OIG grouped into 189,683 enrollee-months with dates of service from April 1 through December 31, 2020 (audit period). OIG selected a random sample of 100 enrollee-months. An enrollee-month consisted of all Part B claim lines for an enrollee who received ESRD-related services and was 20 years of age or older with four or more visits by a physician or qualified nonphysician practitioner in that month.

SunHawk Summary OIG Audit Findings and Recommendations

OIG found that Noridian did not make some MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance. Of the sampled 100 enrollee-months, 74 met the requirements; however, the remaining 26 enrollee-months did not meet 1 or more of the requirements. As a result, Noridian made improper MCPs of $4,663 to physicians and qualified nonphysician practitioners. Enrollees were responsible for $1,162 in coinsurance related to the improper payments. These improper payments occurred because Noridian's oversight was not sufficient to ensure that physicians and qualified nonphysician practitioners met Medicare billing requirements for ESRD-related services. On the basis of OIG's sample results, OIG estimated that for their audit period Noridian made approximately $8.8 million in improper MCPs to physicians and qualified nonphysician practitioners for ESRD-related services. OIG also estimated that Medicare enrollees paid approximately $2.2 million in coinsurance for the improperly paid ESRD-related services.

OIGs recommended that Noridian: (1) recover $4,663 in improper payments made to physicians and qualified nonphysician practitioners for the 26 sampled enrollee-months; (2) notify the physicians and qualified nonphysician practitioners to refund $1,162 in coinsurance that was collected for the 26 sampled enrollee-months; and (3) update the educational material on its website as well as any previously provided webinars to include all Medicare requirements and guidance for billing and documenting ESRD-related services and continue to perform medical record reviews as part of the Targeted Probe and Educate program, which could have saved the Medicare program an estimated $8.8 million and could have saved Medicare enrollees up to an estimated $2.2 million for OIG's audit period. The report contains one other recommendation.

Work Plan #: A-09-21-03016 (June 2023)
Government Program: Medicare Parts A & B

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[NEW] Seventeen of Thirty Selected Health Centers Did Not Use or May Not Have Used Their HRSA COVID-19 Supplemental Grant Funding in Accordance With Federal Requirements

In response to the unprecedented crisis of COVID-19, Congress appropriated approximately $2 billion for supplemental grant funding to the Health Resources and Services Administration (HRSA) Health Center Program. HRSA awarded this supplemental grant funding to health centers and made the funds immediately available to help vulnerable populations and underserved communities detect, prevent, diagnose, and treat COVID-19. This audit is part of the OIG's COVID-19 response strategic plan. OIG's objective was to determine whether selected health centers used their COVID-19 supplemental grant funding in accordance with Federal requirements and grant terms.

OIG's audit covered COVID-19 supplemental grant funding totaling $70,305,389 awarded during fiscal year 2020 to 30 selected health centers. OIG judgmentally selected these health centers for audit based on their geographic location, financial risk level, and grant award amounts. For each of the sampled health centers, OIG interviewed financial and program officials and reviewed financial documentation and other records.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that seventeen of the 30 selected health centers did not use or may not have used a portion of their COVID-19 supplemental grant funding in accordance with Federal requirements and grant terms. Specifically, 10 health centers charged unallowable costs totaling $787,152 and 13 health centers may not have properly allocated salary and fringe benefits costs totaling $15,056,835 to their COVID-19 supplemental grant funding. (The total exceeds 17 because 6 health centers had more than 1 deficiency.) These funds could have been used to support health centers' activities related to COVID-19 response, including providing essential testing services to monitor and suppress COVID- 19.

These deficiencies occurred because health centers did not always follow HRSA's guidance for financial management systems and internal controls to ensure that only allowable, allocable, and documented costs were charged to their COVID-19 supplemental grant funding.

OIG made a series of recommendations to HRSA, including that it require health centers in OIG's sample to refund unallowable and improperly allocated costs to the Federal Government. In addition, OIG recommended that HRSA assist the 17 health centers to implement HRSA's guidance for developing and maintaining financial management systems and internal controls that ensure only allowable, allocable, and documented costs to their HRSA supplemental grant funding.

Work Plan #: A-02-21-02005 (May 2023)
Government Program: Health Resources and Services Administration

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[NEW] Medicare Improperly Paid Physicians an Estimated $30 Million for Spinal Facet-Joint Interventions

Medicare covers pain management procedures, such as facet-joint interventions, to treat neck or back pain resulting from arthritis in or injury to the spinal facet joints. A prior OIG audit found that for 51 of 100 sampled sessions, a Medicare contractor did not pay physicians in 1 jurisdiction for facet-joint injections in accordance with Medicare requirements. Another

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OIG audit found that Medicare improperly paid for facet-joint denervation sessions. Because facet-joint interventions are at risk for overutilization and prior audits have found improper payments for these services, OIG conducted this audit to determine whether Medicare improperly paid for these interventions from August 1 through October 31, 2021 (audit period). OIG's objective was to determine whether Medicare paid physicians for spinal facet-joint interventions in accordance with Medicare requirements and guidance.

OIG's audit covered Medicare Part B payments of $62.2 million for 425,843 claim lines for facet-joint interventions, which OIG grouped into 218,421 sessions, with dates of service during their audit period. OIG selected a statistical sample of 120 sessions. For each session, OIG reviewed beneficiaries' medical records to evaluate compliance with Medicare billing requirements and guidance but did not use medical review to determine whether interventions were medically necessary.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not pay physicians for some spinal facet-joint interventions in accordance with Medicare requirements and guidance. Of the 120 sampled sessions, 54 complied with Medicare requirements; however, the remaining 66 sessions did not comply with 1 or more of the requirements. As a result, Medicare made improper payments to physicians of $18,084. On the basis of OIG's sample results, OIG estimated that Medicare improperly paid physicians $29.6 million for facet-joint interventions for their audit period.

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least 1 therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic instead of therapeutic facet-joint injections. This improper billing did not result in improper payments because Medicare pays the same amount for diagnostic and therapeutic facet-joint injections. The Medicare Administrative Contractors' (MACs') education of physicians and their billing staff varied across their jurisdictions and was not always sufficient to ensure compliance with Medicare requirements and guidance.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) direct the MACs to recover $18,084 in improper payments made to physicians for the 66 sampled sessions. OIG also recommended that CMS encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions and that are specific to Medicare requirements for facet-joint interventions, which could have saved an estimated $29.6 million for OIG's audit period; and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education or updating guidance on how each type of injection should be billed. The report contains one other recommendation.

Work Plan #: A-09-22-03006 (March 2023)
Government Program: Medicare Parts A & B

[NEW] Medicare Improperly Paid Physicians for Epidural Steroid Injection Sessions

To address inappropriate billing for and overuse of epidural steroid injections, 10 of the 12 Medicare Administrative Contractors' (MACs') jurisdictions developed coverage limitations, through Local Coverage Determinations (LCDs), for epidural steroid injection sessions. These coverage limitations allow for physicians to be reimbursed for a maximum number of epidural steroid injection sessions in a 6-month or a 12-month period. Prior Office of Inspector General audits found that

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Medicare did not always pay physicians for spinal facet-joint denervation and injection sessions in accordance with Federal requirements. OIG's objective was to determine whether Medicare paid physicians for epidural steroid injection sessions in accordance with Medicare requirements.

During OIG's audit period (January 1, 2019, to December 31, 2020), the MACs paid physicians $52.8 million for 303,408 epidural steroid injection sessions. OIG analyzed the 303,408 sessions and identified 80,419 sessions totaling $13.8 million that exceeded the coverage limitation for the respective MAC jurisdiction.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not always pay physicians for epidural steroid injection sessions in accordance with Medicare requirements. For OIG's audit period, Medicare improperly paid physicians $3.6 million on behalf of beneficiaries who received more epidural steroid injection sessions than were permitted by the coverage limitations in the applicable LCDs. These improper payments occurred because neither the Centers for Medicare & Medicaid Services's (CMS's) oversight nor the MACs' oversight was adequate to prevent or detect improper payments for epidural steroid injection sessions. After OIG's audit period, all 12 MAC jurisdictions updated their LCDs with revised coverage limitations that were specific to epidural steroid injections.

OIG recommended that CMS: (1) direct the MACs to recover the $3.6 million in improper payments made to physicians for epidural steroid injection sessions; (2) instruct the MACs to, based on the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) assess the effectiveness of oversight mechanisms, put in place after OIG's audit period, that are specific to preventing or detecting improper payments to physicians for more than the allowed number of epidural steroid injection sessions, and modify the oversight mechanisms, if necessary, based on that assessment; and (4) direct the MACs (or other designated entities) to review a sample of claims for injection sessions administered after OIG's audit period but before the revised coverage limitations became effective to identify and recover any improper payments.

Work Plan #: A-07-21-00618 (March 2023)
Government Program: Medicare Parts A & B

[NEW] Providers Did Not Always Comply With Federal Requirements When Claiming Medicare Bad Debts

Providers sought reimbursement of nearly $10 billion for Medicare bad debts on their cost reports with cost reporting periods ending during Federal fiscal years 2016 through 2018. Federal regulations state that Medicare is to reimburse providers 65 percent of deductible and coinsurance amounts for Medicare beneficiaries that remain unpaid (1) after the provider has made a reasonable effort to collect, (2) the debt was uncollectible, and (3) there was no likelihood of future recovery based on sound business judgment ("Medicare bad debts"). OIG's objectives were to determine whether (1) providers complied with Federal requirements when claiming Medicare reimbursement for Medicare bad debts and (2) providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements.

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OIG randomly selected 67 cost reports in which providers claimed Medicare bad debts. OIG selected a nonstatistical sample of 148 bad debts and reviewed the providers' documentation of the collection efforts performed. OIG reviewed the sampled providers' policies and procedures for collecting Medicare bad debts to ensure that the policies and procedures included reasonable collection efforts.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Providers did not always comply with Federal requirements when claiming Medicare reimbursement for Medicare bad debts. Of the 148 Medicare bad debts in OIG's nonstatistical sample, 86 were associated with beneficiaries whom providers had deemed indigent and for whom, therefore, no reasonable collection efforts were required. Providers did not comply with Federal requirements when claiming 18 of the remaining 62 Medicare bad debts. OIG identified four additional bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries. These 22 bad debts resulted in a total of $29,787 in unallowable Medicare reimbursement. The Centers for Medicare & Medicaid Services (CMS) inappropriately reimbursed these amounts because the Medicare administrative contractors (MACs) did not concentrate on reviewing bad debts when performing audits of cost reports during OIG's audit period.

For OIG's second objective, the 67 selected providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. These policies and procedures were similar to the providers' policies and procedures for collecting non-Medicare bad debts.

OIG recommended that CMS consider issuing instructions or guidance to the MACs that require or encourage more review of Medicare bad debts claimed on cost reports, such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directs the MACs to revise their cost report audit work plans accordingly.

Work Plan #: A-07-20-02825 (December 2022)
Government Program: Medicare Parts A & B

[NEW] Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals and patients to discuss their wishes if they become unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services. Payments for ACP provided from 2016 through 2019 totaled more than $340 million. Payments for services provided in an office setting represented 61 percent of all payments. OIG's objective was to determine whether Medicare providers who received payments for ACP services in an office setting complied with Federal requirements.

OIG's audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of $70.1 million. OIG selected for review a stratified random sample of 125 beneficiaries. OIG reviewed all 691 paid ACP services for the 125 beneficiaries selected for their sample.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare providers that billed for ACP services in an office setting did not always comply with Federal requirements. Specifically, of the 691 ACP services associated with OIG's sample, Medicare providers complied with Federal requirements for 225 services totaling $15,874. However, providers did not comply with Federal requirements for 466 services totaling $33,332.

On the basis of OIG's sample results, OIG estimated that Medicare providers in an office setting were paid approximately $42.3 million for ACP services that did not comply with Federal requirements. These payments occurred because the providers did not understand the Federal requirements for billing ACP services.

OIG also identified questionable claims associated with 12 sampled beneficiaries for whom 15 or more ACP services were received. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings do not align with guidance contained in CMS's Frequently Asked Questions.

OIG recommended that CMS educate providers on documentation and time requirements for ACP services to comply with Federal requirements. Had the requirements been followed, Medicare could have saved an estimated $42.3 million during OIG's audit period. In addition, CMS should instruct the MACs to recoup $33,332 for ACP services paid in error for claims in OIG's sample. Also, CMS should instruct the MACs to notify appropriate providers so that they can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule. Finally, CMS should establish Medicare requirements that address when it is appropriate to provide multiple ACP services for a single beneficiary and how these services should be documented when required to support the need for multiple ACP services.

Work Plan #: A-06-20-04008 (November 2022)
Government Program: Medicare Parts A & B

[NEW] Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers

Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) makes a reduced payment to physicians who work together as co-surgeons to perform a surgical procedure on the same patient during the same operative session. OIG conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier. OIG's objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

OIG's audit covered $15.4 million in Medicare Part B payments for services performed during calendar years 2017 through 2019 (audit period) in which two different providers separately billed an identical procedure code for the same beneficiary and on the same day. OIG selected a stratified random sample of 100 services for review that were billed by one of the providers from OIG's sampling frame without a co-surgery or assistant-at-surgery modifier. OIG also identified and reviewed 127 corresponding services that were billed by providers with the same procedure code for the same beneficiary on the same day as OIG's sampled services.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that from 100 statistically sampled services, they found that 69 did not comply with Federal requirements. Specifically, these statistically sampled services included 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. These statistically sampled service errors resulted in overpayments of $31,545. Based on the results of OIG's statistical sample, OIG estimated that Medicare made $4.9 million in improper payments for physician surgical services during OIG's audit period. In addition to the statistically sampled services, based on OIG's review of the 127 corresponding services, OIG further found that 62 of these corresponding services did not comply with Federal requirements. These corresponding service errors resulted in overpayments of $24,471. Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to identify and prevent such payments.

OIG recommended that CMS: (1) recover the portion of the $56,016 in Medicare Part B overpayments that are within the 4-year claim reopening period; (2) instruct the Medicare contractors to, based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services-which could have saved approximately $4.9 million during OIG's audit period; and (4) update Medicare requirements and corresponding educational material to improve providers' understanding of the Part B billing requirements for co-surgery procedures.

Work Plan #: A-01-20-00503 (November 2022)
Government Program: Medicare Parts A & B

[NEW] Medicare Dialysis Services Provider Compliance Audit - Dialysis Clinic, Inc.

Medicare Part B covers dialysis services for beneficiaries with end-stage renal disease (ESRD). Prior OIG reviews identified inappropriate Medicare payments made for ESRD dialysis services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements. OIG selected Dialysis Clinic, Inc. (DCI), because it ranked among the highest paid providers of dialysis services in the United States, and Medicare surveyors identified various health and safety issues. OIG's objective was to determine whether dialysis services provided by DCI complied with Medicare requirements.

OIG's audit covered 112,192 claims for dialysis services provided during the audit period (calendar year 2018) for which DCI received Medicare reimbursement totaling $276,427,841. OIG reviewed a random sample of 100 claims. OIG evaluated the services for compliance with Medicare requirements and submitted them to independent medical review.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that DCI claimed reimbursement for dialysis services that did not comply with Medicare requirements for 70 of the 100 sampled claims. Specifically, DCI submitted claims for which: (1) comprehensive assessments or plans of care did not meet Medicare requirements, (2) dialysis treatments were not completed, (3) dialysis services were not documented, (4) beneficiaries' height or weight measurements did not comply with Medicare requirements, and (5) the medical record did not have a monthly progress note by a physician or other qualified professional.

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While DCI had established corporate-wide internal controls to monitor and maintain complete, accurate, and accessible medical records at all its facilities, these controls were not always effective in ensuring that DCI's claims for dialysis services complied with Medicare requirements.

OIG estimated that DCI received unallowable Medicare payments of at least $14,193,677 for dialysis services that did not comply with Medicare requirements. Many of the errors OIG identified did not affect DCI's Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have a significant impact on the quality of care provided to Medicare beneficiaries and could result in the provision of inappropriate or unnecessary dialysis services.

OIG recommended that DCI refund an estimated $14,193,677 to the Medicare program. OIG also made a series of recommendations to strengthen DCI's internal controls to ensure that dialysis services comply with Medicare requirements.

Work Plan #: A-05-20-00010 (September 2022)
Government Program: Medicare Parts A & B

More Than 90 Percent of the New Hampshire Managed Care Organization and Fee-for-Service Claims for Opioid Treatment Program Services Did Not Comply With Medicaid Requirements

The Medicaid program pays for opioid treatment program (OTP) services. Prior Office of Inspector General (OIG) audit reports have identified OTP services as vulnerable to fraud, waste, and abuse. OIG's objective was to determine whether New Hampshire claimed Medicaid reimbursement for OTP services in accordance with Federal and State requirements.

OIG reviewed New Hampshire's monitoring and oversight of the OTP providers (providers), including compliance with Federal and State requirements, to determine whether: (1) counseling hour and toxicology testing requirements were met, (2) initial treatment plans were prepared, (3) treatment plans were reviewed as required, and (4) the OTP service was provided. OIG reviewed 100 randomly sampled claim lines of service from the 1,458,896 lines of service between July 1, 2016, to June 30, 2019, for which New Hampshire paid $16.2 million.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Hampshire claimed Medicaid reimbursement for OTP services that did not comply with Federal and State requirements. Of the 100 OTP services OIG sampled, 6 complied with Federal and State requirements, but 94 did not meet applicable Federal and State requirements. These deficiencies occurred because New Hampshire did not have the resources to oversee providers and enforce the OTP requirements. Providers said high personnel turnover, difficulty attracting and retaining personnel, and difficulty keeping patients engaged in counseling services contributed to the lack of adherence to State requirements. Furthermore, New Hampshire did not always provide guidance regarding State OTP requirements.

On the basis of their sample results, OIG estimated that New Hampshire improperly claimed at least $7.9 million in Federal Medicaid reimbursement for OTP services during their audit period.

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Other Providers and Suppliers

OIG made several recommendations to the New Hampshire Department of Health and Human Services, including that it: (1) refund $7.9 million to the Federal Government, (2) take steps to ensure that providers comply with Federal and State requirements for providing and claiming Medicaid reimbursement for OTP services, and (3) improve communication with providers regarding the State requirements for opioid use disorder treatment and provide written confirmation about whether offsite counseling may be included as a required counseling service.

Work Plan # A-01-20-00006 (June 2022)
Government Agency: Medicaid

Selected Dialysis Companies Implemented Additional Infection Control Policies and Procedures To Protect Beneficiaries and Employees During the COVID-19 Pandemic

End-stage renal disease (ESRD) is a medical condition in which a person's kidneys permanently cease functioning, leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. The Centers for Disease Control and Prevention (CDC) found that beneficiaries with serious underlying medical conditions, such as ESRD, are at a higher risk for severe illness from COVID-19. Health care personnel are also some of the most at-risk essential workers. OIG's objective was to determine whether selected dialysis companies implemented additional infection control policies and procedures in accordance with Centers for Medicare & Medicaid Services (CMS) and certain CDC guidance to protect high-risk ESRD beneficiaries during the COVID-19 pandemic.

OIG's audit covered 9 dialysis companies that owned 6,451 facilities (83 percent) of the 7,813 ESRD facilities that had a Medicare or Medicaid certification at any point during 2020 in 50 States, the District of Columbia, Guam, and Puerto Rico. OIG's findings are based on responses to a questionnaire and follow up interviews that they conducted with nine dialysis companies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the nine selected dialysis companies surveyed (representing 83 percent of the ESRD facilities that had a Medicare or Medicaid certification at any point during 2020) implemented additional infection control policies and procedures in accordance with CMS and CDC recommendations to protect high-risk ESRD beneficiaries and employees during the COVID-19 pandemic. OIG found all nine companies had infection control policies and procedures in place to protect beneficiaries and employees, and when recommended by CMS and CDC, the companies implemented additional policies and procedures. However, while two companies provided education about the importance of hand hygiene, they did not emphasize the importance of hand hygiene immediately before and after any contact with a facemask or cloth face covering, as recommended by CDC.

Because the nine selected companies implemented additional infection control policies and procedures as recommended by CMS and CDC, this report contains no recommendations.

Work Plan # A-05-20-00052 (May 2022)
Government Agency: Medicare Parts A & B

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