Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

January 1, 2023 - December 31, 2025

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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. 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 two years, 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 sorts relevant audits into Payer and Provider 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.

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.

*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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Provider

Multiple Providers

CMS Recovered Medicare Payments to Providers Under the COVID-19 Accelerated and Advance Payments Program in Compliance With Federal Requirements

- The Centers for Medicare & Medicaid Services (CMS) disbursed more than $103 billion in COVID-19 Accelerated and Advance Payments (CAAP) Program payments to more than 46,000 providers.
- COVID-19 created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for Health and Human Services (HHS), the Office of Inspector General (OIG) oversaw HHS's COVID-19 response and recovery efforts. This audit was part of OIG's COVID-19 response strategic plan.
- This audit determined whether CAAP Program payments were recovered in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. As of the end of OIG's fieldwork, of the 100 sampled providers totaling $4.4 billion in CAAP Program payments, the Medicare Administrative Contractors completed recovery from 97 sampled providers and continued the recovery from the remaining 3 providers.

OIG concluded that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. Therefore, OIG did not have any recommendations.

Audit #: A-05-23-00005 (09/17/2024)
Government Program: CMS

Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers

- Medicare providers were required to submit to their Medicare administrative contractor (MAC) annual cost reports, which were financial documents that conveyed the provider's costs associated with providing services to Medicare enrollees. MACs used them to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (the final settlement of the cost report).
- MACs could audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the final settlement of the cost report.
- CMS's primary goal was for the MACs to arrive at correct final settlements of the cost report. If there was an error made in the final settlement, the cost report final settlement could be reopened and adjusted to correct for the error. OIG performed this audit of one MAC, Novitas Solutions, Inc. (Novitas), to determine whether Novitas reopened and corrected cost report final settlements because of obvious errors in their audits.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Novitas reopened 8 of 281 (2.8 percent) audited cost reports to correct the final settlements that contained obvious errors. These 8 audited cost reports required 10 reopenings because of human errors by Novitas.

OIG found that:

- As a result of these 10 errors, the reopened cost reports resulted in corrected final settlements to providers totaling $1.1 million in net overpayments, consisting of $1.4 million in overpayments and $285,076 in underpayments.
- Auditors and supervisors required additional education on the criteria and audit requirements applicable to certain payments and bad debts. Novitas' procedures for review by supervisors did not detect the incorrect audit adjustments.
- The risk existed that delays in the finalization of audited cost reports could have prevented some Medicare funds from being expended in the most efficient and effective ways.

OIG recommended that Novitas:

1. develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements and
2. develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments.

Audit #: A-06-23-05001 (09/11/2024)
Government Program: CMS

HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program

The Provider Relief Fund (PRF) provided funds to eligible hospitals and other health care providers (providers) for health care-related expenses or lost revenue attributable to COVID-19. The Phase 2 General Distribution went to Medicaid, the Children's Health Insurance Program (CHIP), and dental providers and assisted living facilities. From July 3, 2020, through June 21, 2021, the Health Resources and Services Administration (HRSA) distributed about $4.9 billion to more than 100,000 providers. HRSA calculated each payment based on 2 percent of the provider's patient care revenue. To receive a PRF payment, a provider had to submit an application and supporting documentation, such as a Federal income tax return, to support reported revenue. A provider also had to meet certain requirements, such as not being excluded from participating in Medicaid. This audit was part of the Office of Inspector General's (OIG's) oversight of the Department of Health and Human Services' COVID-19 response and recovery efforts.

OIG's objective was to determine whether PRF payments under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers.

The audit covered 73,449 tax-filing taxpayer identification numbers (TINs) for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider had received a total of $10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution. HRSA disbursed $4.8 billion to these providers. OIG

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selected a statistical sample of 150 providers (each represented by a TIN).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for all 150 sampled providers, HRSA made PRF payments to eligible providers. However, for 17 of the 150 sampled providers, HRSA made PRF payments that were not correctly calculated (15 sampled providers) or were not supported by appropriate documentation (2 sampled providers). Specifically, for the 15 sampled providers for which PRF payments were not correctly calculated, HRSA made payments: (1) without subtracting payments that had previously been made to providers' subsidiary organizations, (2) based on incorrectly calculated patient care revenue, (3) based on revenue information that providers incorrectly entered on PRF applications, and (4) based on revenue information for which bad debt was not subtracted. For the remaining two sampled providers, HRSA made payments based on revenue that was not supported by Federal income tax returns.

As a result, HRSA made $18.4 million in potential overpayments to the 17 sampled providers. On the basis of OIG's sample results, OIG estimated that HRSA made $159.4 million in potential overpayments to providers (3.3 percent of the total PRF payment amount that OIG audited). These potential overpayments occurred because certain HRSA procedures for processing and reviewing providers' PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and were supported by appropriate documentation. For example, HRSA's procedures did not include requiring providers to submit documentation supporting the percentage of revenue from patient care.

OIG recommended that, with respect to PRF payments that were already made to providers under the Phase 2 General Distribution, HRSA conduct a review of the 17 sampled providers OIG identified that had potential overpayments of $18.4 million and determine the amount of and seek repayment of any overpayments. Furthermore, should HRSA need to rapidly disburse similar payments to providers in response to a future national emergency, HRSA consider taking specified steps (to the extent they are applicable) to safeguard taxpayer money, such as requiring providers to submit supporting documentation for all revenue information provided on applications for payments. (The full text of OIG's recommendations is shown in the report.)

Audit #: A-09-22-06001 (03/04/2024)
Government Program: HRSA

A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data

Medicare was an essential part of the Nation's health care system, with 66 million people enrolled. The COVID-19 pandemic brought persistent disparities in health care access and outcomes to the forefront, including in the Medicare program. The Office of Inspector General (OIG) and the Centers for Medicare & Medicare Services (CMS) made advancing health equity a top priority. In order to address health disparities, it was important to assess them using accurate, complete, and comprehensive data. The results of these analyses could be used to tailor interventions aimed at improving disparities. The data could then be used to evaluate the efficacy of these interventions. Ultimately, success in advancing health equity hinged on a thorough understanding of the underlying data.

In June 2022, OIG issued a data brief, (OEI-02-21-00100), analyzing the quality of the race and ethnicity data for people enrolled in Medicare. That data brief made constructive recommendations to CMS for improving the data.

As CMS worked to implement these recommendations, improvements were expected to take several years to yield better data for health disparities research. Until then, the existing data remained a vital source for understanding one of the largest Federal programs and conducting health equity work.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the race and ethnicity data in Medicare's enrollment data had limitations, but could still be used in important health equity work if those limitations were recognized and accounted for during analysis.

Evaluation #: OEI-02-21-00101 (06/27/2023)
Government Program: CMS

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Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements

- There had been significant press about trauma care over the past decade, including allegations that hospitals were deliberately overusing trauma team activation codes and patients were being forced to pay exorbitant medical costs when the care did not seem to rise to trauma level care.
- There had also been media attention on the variability of trauma fees among hospitals and how much patients were forced to pay.
- This audit assessed whether CMS made Medicare payments to providers for trauma team activations that complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- CMS made Medicare payments to trauma centers for trauma team activations that did not comply with Federal requirements. Specifically, 107 of 125 sampled claims with trauma team activations did not meet Medicare requirements--100 sampled claims had unallowable trauma team activation charges that totaled $728,468, and 7 sampled claims had coding errors that did not have any impact on payment or charges associated with the trauma team activation.
- OIG estimated that approximately 77 percent of all claims submitted to Medicare with trauma team activations did not comply with Federal requirements. Additionally, OIG estimated that hospitals also billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements from January 1, 2020, through June 30, 2022.

OIG made four recommendations, including that CMS take the necessary steps to address the estimated $2.4 billion in unallowable trauma team activation charges reported on hospitals' cost reports and the resulting incorrect outlier payments to improve the accuracy of data used to establish future prospective payment system payment rates. In addition, OIG made procedural recommendations. The full recommendations were in the report.

CPT Codes Identified in This Audit:

- 99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

HCPCS Codes Identified in This Audit:

- G0390 - Trauma team activation with hospital critical care service

Audit #: A-01-23-00500 (09/23/2025)
Government Program: CMS

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Seventeen of Twenty-Five Selected Hospitals Did Not Comply or May Not Have Complied With the Provider Relief Fund Balance Billing Requirement

- Congress appropriated $178 billion to HHS to provide funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19 under the Provider Relief Fund (PRF) program. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Under the PRF terms and conditions, if a patient had health insurance and sought COVID-19 treatment from an out-of-network provider that received PRF payments, the provider would not seek to collect out-of-pocket payments greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. (OIG referred to this as the "balance billing requirement.")
- This audit assessed whether selected hospitals that received PRF payments complied with the balance billing requirement for COVID-19 inpatients.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 25 selected hospitals, 17 billed patients an amount that did not comply or may not have complied with the balance billing requirement. For example, one hospital billed a patient $6,000 when the patient's insurance carrier had waived all patient cost-sharing responsibility.
- Hospitals stated that they were uncertain how to comply with the requirement because HRSA did not provide sufficient guidance. If HRSA developed and provided early and detailed guidance, hospitals might not have improperly billed selected patients a total of $637,035 for services provided.

OIG made two recommendations to HRSA, including that it determine whether the selected hospitals made refunds to patients identified in this audit for billings that did not or may not have complied with the balance billing requirement and perform postpayment reviews of hospitals for compliance with the balance billing requirement as part of its ongoing program integrity procedures. The full recommendations are in the report.

Audit #: A-02-22-01018 (09/19/2025)
Government Program: HRSA

Medicare Enrollees Left Acute-Care Hospitals Against Medical Advice at Increasing Rates

After being admitted as acute-care hospital inpatients, Medicare enrollees with decision-making capacity, or their surrogates, could discharge themselves and leave against medical advice (AMA). Acute-care hospitals recorded an enrollee's discharge status using a code on the claim. For example, they used a specific code if they discharged an enrollee to their home (01) and another if they transferred the enrollee to a different acute-care hospital (02). Hospitals designated that an enrollee left AMA using code 07.

OIG's objectives were to 1) analyze rates and outcomes for Medicare enrollees at acute-care hospitals who left AMA and 2) provide the Centers for Medicare & Medicaid Services (CMS) and other stakeholders with information that could be used to improve enrollee outcomes.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- The rates at which enrollees left acute-care hospitals against medical advice (AMA) had steadily increased since 2006 across most demographics OIG analyzed and spiked during the COVID-19 public health emergency.
- Enrollees who left AMA were more likely to have had poor health outcomes than enrollees discharged to their homes.
- The rates at which enrollees had left AMA appeared inversely correlated to the quality-of-care ratings of the associated hospitals--the lower the rating, the higher the rates.
- Enrollees eligible for both Medicare and Medicaid (dual enrollees) and enrollees with a mental health diagnosis were more likely to have left AMA than Medicare-only enrollees and enrollees without a mental health diagnosis, respectively.
- This data brief may have been beneficial in the development of future guidance to address this growth, which could improve enrollee health outcomes and save taxpayer dollars.

ICD Codes Identified in This Audit:

- Z53.01 - Patient smoking
- Z53.09 - Other contraindication
- Z53.1 - Patient's decision for reasons of belief and group pressure
- Z53.20 - Patient's decision for unspecified reasons
- Z53.21 - Patient leaving prior to being seen by health care provider
- Z53.29 - Patient's decision for other reasons
- Z53.8 - Other reasons
- Z53.9 - Unspecified reason

Audit #: A-04-24-03003 (08/18/2025)
Government Program: CMS

CMS Should Take Additional Actions To Help Hospitals Prepare for a Future Emerging Infectious Disease Outbreak

- Hospitals that could not control the spread of emerging infectious diseases within their facilities risked spreading diseases to patients, staff, and the community. This was the second OIG audit of CMS controls related to hospital preparedness for emerging infectious diseases.
- OIG's prior audit assessed the design and implementation of CMS controls. This audit assessed the operating effectiveness of CMS controls related to emerging infectious disease outbreaks.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that although CMS took significant actions to help hospitals prepare for a future emerging infectious disease outbreak, there were gaps in CMS controls that could negatively affect hospital preparedness during a future event with a scope and duration similar to COVID-19. Specifically:

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- CMS did not ensure that surveyors were trained to cover key planning areas for an emerging infectious disease outbreak.
- CMS did not ensure that hospital emergency preparedness plans met the needs of all at-risk patient populations.
- CMS's guidance did not address the mental health of hospital frontline staff as part of hospital emergency preparedness planning.

OIG recommended that CMS collaborate with its emergency preparedness partners to expand surveyor training, require that hospital accreditation organization standards and survey processes cover the needs of people from all at-risk patient populations, and encourage hospitals to take into consideration the mental health of hospital frontline staff as part of emergency preparedness planning. The full recommendations appeared in the report.

Audit #: A-02-22-01019 (07/25/2025)
Government Program: CMS

Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed to Make Care Safer

- Over nearly 20 years, OIG had identified high patient harm rates nationwide in hospitals, nursing homes, and other health care settings.
- Key to improving patient safety was identifying, or capturing, patient harm events; investigating their cause; and making system-wide improvements to prevent future harm.
- For this report, OIG traced harm events identified in a 2022 report on the incidence of harm in hospitals to examine whether hospitals captured those events in their incident reporting or other surveillance systems and to understand what actions they took in response.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that hospitals did not capture all OIG-identified patient harm events, nor investigate all harm events they did capture, limiting hospitals' ability to make improvements for patient safety.

- **Hospitals did not capture half of patient harm events that occurred among hospitalized Medicare patients.** In many cases, staff did not consider these events to be harm or explained that it was not standard practice to capture them. This was often because hospitals applied narrow definitions of harm.
- **Of the patient harm events that hospitals captured, few were investigated, and even fewer led to hospitals making improvements for patient safety.** Some of the improvement actions hospitals took in response to the harm events included training staff and enhancing monitoring for similar events.

HHS led national efforts to promote patient safety. OIG's findings demonstrated that more Federal leadership was needed to drive and sustain progress. OIG recommended that AHRQ and CMS work with Federal partners and other organizations to align harm event definitions and create a taxonomy of patient harm to drive a more comprehensive capture rate of harm events. OIG also recommended that CMS ensure that surveyors prioritized the Medicare Quality Assurance and Performance Improvement (QAPI) requirement to hold hospitals accountable for patient harm. The QAPI requirement was intended to ensure that hospitals delivered safe, quality care and prevented patient harm. Finally, OIG recommended that CMS instruct Quality Improvement Organizations to use information about harm events to assist hospitals in identifying weaknesses in their incident reporting or other surveillance systems.

Evaluation #: OEI-06-18-00401 (07/24/2025)
Government Program: CMS

Hospitals Reported Few Captured Patient Harm Events to CMS and States

External reporting of patient harm was a crucial component in addressing patient safety. Hospitals were required to report certain types of harm events to meet CMS program and State legal requirements. External reporting held hospitals accountable for harm events and was intended to promote awareness and encourage learning from such events. Prior OIG work found that hospitals reported few harm events to State reporting systems. OIG revisited this issue while conducting a study on hospitals' identification and response to patient harm events. The full results of the study were described in the report *Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed to Make Care Safer* (OEI-06-18-00401), which was being issued concurrently with this memorandum report.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that there was a significant discrepancy between the events that CMS and States expected hospitals to report and the events that hospitals actually reported. Nationwide, OIG determined that 16 percent (15 of 94) of harm events that hospitals identified and captured in their incident reporting or other surveillance systems were required to be reported externally per CMS and/or State requirements. Yet, in OIG's sample, hospitals reported only 5 of 15 captured events per these requirements. For the remaining 79 events not required to be reported externally, hospitals voluntarily reported 7 of those events for learning purposes.

OIG concluded that hospitals reported few patient harm events to CMS and States, thereby limiting hospital transparency and accountability for harm that occurred in their facilities. When hospitals failed to identify and report harm events to the appropriate oversight entities, they stymied independent feedback needed to take corrective actions. The lack of such actions hampered system level improvements that could prevent future harm from occurring. OIG urged CMS, States, and other groups (e.g., accreditation organizations and other Federal agencies) to weigh these results as they developed new strategies to improve patient safety. These results also supported the recommendations made in OIG's companion report.

Evaluation #: OEI-06-18-00402 (07/24/2025)
Government Program: CMS

A Large Northeastern Hospital Could Improve Certain Security Controls for Preventing and Detecting Cyberattacks

- Health care's growing reliance on information technology for patient care, telemedicine, and records had heightened vulnerability to cyberattacks. HHS had an important role in guiding and supporting the adoption of cybersecurity measures to protect patients and health care delivery from cyberattacks.
- This audit examined whether a large hospital in the northeast United States (referred to as the "Entity") had implemented cybersecurity controls to (1) prevent and detect cyberattacks, (2) ensure continuity of patient care in the event of a cyberattack, and (3) protect Medicare enrollee data.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Entity implemented cybersecurity controls to ensure continuity of patient care in the event of a cyberattack and protect Medicare enrollee data. However, it could improve specific cybersecurity controls to better prevent and detect cyberattacks. OIG found:

- Among the 26 internet-accessible systems analyzed, 2 had weaknesses in their cybersecurity controls that could allow unauthorized user access.
- 13 web applications and 16 internet-accessible systems had weaknesses in their cybersecurity controls, making them susceptible to interactions and manipulations by attackers.

OIG recommended that the Entity improve its cybersecurity measures. The recommendations include enforcing configuration management policies, assessing and updating authentication controls, assessing and updating configuration management controls, conducting regular assessments of internet accessible systems for vulnerabilities, and ensuring that developers follow secure coding practices. The full recommendations are in the report.

Audit #: A-18-22-08019 (07/02/2025)
Government Program: CMS

Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System

- Congress established the Rural Flexibility Program, which created Critical Access Hospitals (CAHs), to ensure that enrollees in rural areas had access to a range of hospital services.
- CAHs provided "swing-bed" services, which were similar to services performed at a skilled nursing facility (SNF).
- Medicare reimbursed CAHs at 101 percent of their reasonable costs rather than at rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules.
- A prior Office of Inspector General report issued in 2015 recommended that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities. The recommendation remained open and unimplemented.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Swing-bed utilization for skilled nursing services at CAHs increased by 2.8 percent from CY 2015 through 2020; meanwhile, the average daily reimbursement amount increased by 16.6 percent over the same period.
- Based on OIG's sample results, it was found that 87 of 100 sampled CAHs were within a 35-mile driving distance of an alternative facility that had skilled nursing care available and estimated that 1,128 of the 1,297 CAHs in OIG's sampling frame had an alternative facility within 35 miles that could have provided care during CY 2020.
- Based on OIG's sample results and mathematical calculation, it was estimated that Medicare could have saved up to $7.7 billion over a 6-year period if payments made at CAHs were reimbursed using SNF PPS rates.

OIG recommended that CMS seek a legislative change that would allow it to reimburse CAHs at rates that aligned with those paid to alternative facilities when it determined that similar care was available at alternative facilities.

Audit #: A-05-21-00018 (12/31/2024)
Government Program: CMS

Texas Generally Claimed Medicaid Reimbursement for Fee-for-Service Inpatient Hospital Claims With Malnutrition Diagnosis Codes in Accordance with Federal and State Requirements

- A previous OIG audit found that hospitals nationwide had incorrectly billed the Medicare program by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or used no malnutrition diagnosis code at all.
- Incorrectly using malnutrition diagnosis codes can result in a higher payment for the claim.
- This audit assessed Medicaid fee-for-service (FFS) inpatient hospital claims with malnutrition diagnosis codes to determine whether Texas claimed reimbursement in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas claimed reimbursement in accordance with Federal and State requirements for 88 of 100 sampled FFS inpatient hospital claims with malnutrition diagnosis codes. However, the remaining 12 sampled claims did not comply with Federal and State requirements.

- For 10 sampled claims, the associated medical record documentation did not support the malnutrition diagnosis code; however, the use of the diagnosis code did not impact the Medicaid payment amount.
- For two sampled claims, the State agency improperly claimed $9,213 ($5,478 Federal share).

OIG concluded that this report did not contain recommendations.

ICD Codes Identified in This Audit:

- E43 - unspecified severe protein-calorie malnutrition
- E46 - unspecified protein-calorie malnutrition
- E440 - moderate protein-calorie malnutrition
- E441 - mild protein-calorie malnutrition

Audit #: A-06-22-04002 (11/26/2024)
Government Program: CMS

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Not All Selected Hospitals Complied With the Hospital Price Transparency Rule

- Health care spending was projected to account for almost 20 percent of the American economy by 2027.
- CMS believed that one reason for this upward spending trajectory was the lack of transparency in health care pricing, and that improving transparency would increase market competition and drive down the cost of health care services.
- Several media reports stated that hospitals appeared slow to comply with CMS's Hospital Price Transparency rule (HPT rule). Members of Congress expressed concern that some hospitals were either not taking any action to comply with the requirements of the HPT rule or were acting slowly.
- This audit assessed whether selected hospitals made their standard charges available to the public as required by Federal law.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all of the selected hospitals made their standard charges available to the public as required by Federal law. Of the 100 hospitals in the stratified random sample, 63 complied with the HPT rule requirements; however, 37 did not comply with 1 or both of the following HPT rule requirements:

- 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive machine-readable files.
- 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a consumer-friendly manner.

On the basis of the sample results, OIG estimated that 46 percent of the 5,879 hospitals that were required to comply with the HPT rule did not comply with the requirements to make information on their standard charges available to the public.

OIG recommended that CMS:
1. review noncompliant hospitals associated with OIG's findings and, if CMS determined that the hospitals were noncompliant, execute CMS's enforcement measures as applicable;
2. use the information in this report and consider implementing changes suggested by hospitals, including providing written guidance clarifying the definition of "shoppable services" and developing a training and compliance program that was tailored for smaller hospitals; and
3. continue to strengthen its internal controls, to include allocating sufficient resources to maintain a robust program of reviews of the hospitals and their compliance with the HPT rule.

Audit #: A-07-22-06108 (11/05/2024)
Government Program: CMS

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Medicare Improperly Paid Hospitals an Estimated $79 Million for Enrollees Who Had Received Mechanical Ventilation

Prior OIG audits found that hospitals did not fully comply with Medicare requirements for inpatient claims paid with certain Medicare Severity Diagnosis-Related Groups (MS-DRGs) that required enrollees to have received 96 or more consecutive hours (i.e., 4 days or more) of mechanical ventilation. An inpatient claim for mechanical ventilation included the date that a mechanical ventilation procedure started but did not indicate when it ended. CMS implemented an automated process to identify claims that had a mechanical ventilation start date that was 4 days or fewer before an enrollee's discharge from a hospital. Consequently, OIG conducted this audit to evaluate whether claims reporting a mechanical ventilation start date that was 5 to 10 days before the enrollee discharge date were at risk for billing errors.

OIG's objective was to determine whether Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required more than 96 consecutive hours of mechanical ventilation complied with Medicare requirements.

The audit covered $3.6 billion in payments for 83,359 inpatient claims that had dates of service from October 2015 through September 2021 (audit period), were assigned MS-DRGs 207 or 870, and had a mechanical ventilation start date from 5 to 10 days before the enrollee discharge date. OIG selected for review a stratified random sample of 250 claims with payments totaling $11 million.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required more than 96 consecutive hours of mechanical ventilation did not fully comply with Medicare requirements. For 233 of 250 sampled claims, Medicare payments to hospitals complied with requirements. However, for the 17 remaining sampled claims, Medicare payments to hospitals did not comply with requirements. Specifically, hospitals used incorrect procedure or diagnosis codes. For eight sampled claims, hospitals incorrectly used the procedure code for more than 96 hours of mechanical ventilation when enrollees had not received more than 96 hours of mechanical ventilation. For nine sampled claims, hospitals used incorrect diagnosis codes or incorrectly used a procedure code that was not related to mechanical ventilation. Consequently, the 17 sampled claims were assigned incorrectly to MS-DRGs 207 or 870, resulting in $382,032 of overpayments.

On the basis of OIG's sample results, OIG estimated that Medicare improperly paid hospitals $79.4 million for the audit period. Hospitals confirmed that they used incorrect procedure or diagnosis codes and generally attributed the improper billing to incorrectly counting the hours that enrollees had received mechanical ventilation or to clerical errors in selecting procedure or diagnosis codes.

OIG recommended that CMS: (1) direct the Medicare Administrative Contractors (MACs) to recover from hospitals the portion of the $382,032 in identified overpayments for the sampled claims during the audit period that were within the 4-year reopening period in accordance with CMS's policies and procedures; and (2) educate hospitals on correctly counting the hours of mechanical ventilation and submitting claims with correct procedure and diagnosis codes, which could have saved an estimated $79.4 million for the audit period.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

ICD Codes Identified in This Audit:

- J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
- I12.0 - Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Audit #: A-09-22-03002 (08/09/2024)
Government Program: CMS

CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays

Under CMS's two-midnight rule, implemented in fiscal year (FY) 2014, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost $2.9 billion for these stays. Given the high payment amount at risk for noncompliance identified in that report, OIG focused this audit on program safeguards for claims for short inpatient stays for calendar years 2016 through 2020 (audit period).

OIG's objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

OIG's audit covered $19.7 billion in Medicare Part A claims with dates of service during the audit period for 2.5 million short inpatient stays at 3,340 acute-care hospitals. OIG interviewed CMS officials and one Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to obtain an understanding of program safeguards for short inpatient stays and policies and procedures for reviewing claims for short inpatient stays.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for the audit period, three weaknesses were identified in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have: (1) adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule, (2) prepayment edits for claims at risk for noncompliance with the two-midnight rule, and (3) adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because, among other reasons, CMS relied primarily on post-payment reviews conducted by BFCC-QIOs to ensure compliance with the two-midnight rule. Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied $49.2 million in improper payments during the audit period, these reviews denied only 0.6 percent of the $7.8 billion in improper payments estimated by CMS's Comprehensive Error Rate Testing reviews. Without strengthening program safeguards, CMS and its contractors might not have been able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.

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Other Providers and Suppliers

OIG recommended that CMS work with its contractors to:

- add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance,
- develop a list of inpatient procedure codes associated with the outpatient procedure codes on the inpatient-only procedures list,
- implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule, and
- update policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and to focus on overpayment recoveries.

The full text of the recommendations was in the report.

ICD Codes Identified in This Audit:

- Z53 series - Persons encountering health services for specific procedures and treatments, not carried out

Audit #: A-09-21-03022 (06/11/2024)
Government Program: CMS

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 could 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 would 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.

OIG concluded that 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 paid hospitals the additional amount for billing a claim for a Medicare enrollee diagnosed with COVID-19.

ICD Codes Identified in This Audit:

- U07.1 - COVID-19 diagnosis code
- B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- J69.0 - Pneumonitis due to inhalation of food and vomit
- J96.01 - Acute respiratory failure with hypoxia

Audit #: A-09-21-03009 (12/13/2023)
Government Program: CMS

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 were 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 have resulted in significant cost savings to the Medicare program, and Medicare transfer payments would have exceeded hospital costs to provide care for most of the claims hospitals submitted to Medicare. Of the 100 claims in the 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 represented 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 the sampled claims. This policy change might have negatively impacted hospitals' revenues, but the transfer payment would have exceeded hospital costs for an estimated 65 percent of all claims that hospitals submitted 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 the 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.

Audit #: A-01-21-00504 (10/06/2023)
Government Program: CMS

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 had 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 the 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

OIG found that for the audit period, 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 made the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to an acute-care hospital that discharged an inpatient to home or certain types of health care institutions, but paid an acute-care hospital that transferred 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 the audit period that were within the 4-year reopening period and

(2) instruct the Medicare contractors to notify appropriate providers so that the providers could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule.

Audit #: A-09-23-03016 (09/08/2023)
Government Program: CMS

Targeted Provider Relief Funds Allocated to Hospitals Had Some Differences with Respect to the Ethnicity and Race of Populations Served

The COVID-19 pandemic highlighted longstanding inequities, like disparities in funding levels for health care providers by locations and populations served, as well as inequitable access to quality health care. From the beginning of the pandemic, reports indicated that people of color (e.g., Hispanic/Latino and Black Americans) and people from economically disadvantaged communities were at greater risk of COVID-19 exposure, illness, hospitalization, and death than members of predominantly Non-Hispanic White communities. In addition, the Centers for Disease Control and Prevention (CDC) considered Hispanic/Latino ethnicity and Black race to be associated with social vulnerability, along with external stressors such as poverty and poor housing conditions. This meant that communities with greater concentrations of Hispanic/Latino residents, greater concentrations of Black residents, and/or higher rates of people experiencing poverty might be at a greater risk of experiencing long-term financial hardship due to disease outbreaks.

In April 2020, the U.S. Department of Health and Human Services (HHS) began distributing Provider Relief Fund (PRF) payments through the Health Resources and Services Administration (HRSA) to support health care providers, including hospitals, on the front line of the pandemic response. To respond to the urgent need for health care funding, Congress

required HHS to make PRF payments using the most efficient payment systems practicable. HHS had to make decisions quickly about how to allocate money in accordance with statutory criteria associated with the funds.

HHS placed a priority on promoting health equity and reducing health disparities during the COVID-19 pandemic, including in the distribution of resources. While the PRF was not designed with the goal of addressing health disparities, understanding how early PRF Targeted Distributions (Targeted PRF) correlated with racial, ethnic, and economic characteristics of the communities providers served could help to inform decisions for future public health funding and the opportunities they present to advance the health equity goals of HHS.

To analyze hospital funding according to populations served, OIG took allocations to hospitals from the Targeted PRF in 2020 and translated them into estimated "PRF per person" amounts for each U.S. census tract (in this report, OIG also referred to census tracts as "communities"). To do so, OIG used Medicare data about the census tracts served by each hospital, and assigned each hospital's funding allocations to those census tracts proportionately. OIG then determined whether there were statistically significant correlations between PRF per person and the racial, ethnic, and economic composition of the census tracts. To account for other community characteristics that could help explain differences in PRF per person, OIG analyzed rural and nonrural census tracts separately. OIG conducted this analysis for the approximately $44 billion in Targeted PRF allocated to hospitals in 2020 through the four allotments designated for:

1. COVID-19 High Impact Area Hospitals
2. Safety Net Hospitals
3. Rural Hospitals
4. Indian Health Service and Tribal Hospitals.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that OIG's analysis identified some differences in PRF per person across census tracts with respect to the race and ethnicity of their residents, but not with respect to poverty rates. Specifically, when OIG analyzed all four Targeted PRF allotments combined, it was found that communities with greater concentrations of Hispanic/Latino residents were associated with less PRF per person than communities with smaller concentrations of Hispanic/Latino residents. In nonrural areas, communities with greater concentrations of Non-Hispanic Black residents were associated with more PRF per person than communities with smaller concentrations of Non-Hispanic Black residents, but this pattern did not occur in rural areas. OIG did not find a meaningful association between PRF per person and the proportion of residents experiencing poverty in the community.

When OIG analyzed the four Targeted PRF allotments individually, the most notable trends were found in the allotment targeted to rural hospitals (about $9.7 billion): Communities with greater concentrations of Hispanic/Latino residents or Non-Hispanic Black residents were associated with less PRF per person than communities with smaller concentrations of Hispanic/Latino Residents or Non-Hispanic Black residents.

OIG concluded that differences in hospital funding with respect to the characteristics of the populations hospitals serve--including race and ethnicity--could potentially have exacerbated pre-existing disparities in health outcomes. If hospitals that served populations experiencing disparate health outcomes were under-resourced, those populations might have been left with less access to high-quality care, which could have widened gaps in health outcomes. Health care funding was an important tool that could have helped HHS contribute to goals of reducing health disparities, both in the context of COVID-19 and more broadly. OIG hoped that this analysis was useful to HHS in planning for future emergency funding scenarios and identifying opportunities to support these goals, to the extent permitted by law.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

Evaluation #: OEI-05-20-00580 (07/12/2023)
Government Program: OS

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 recommended that the Hospital, the Billings Area Office, and IHS Headquarters work together to (1) complete and adjudicate necessary background investigations for staff members identified in the report, (2) ensure provisional staff supervision was adequately documented, and (3) update standard operating procedures and establish monitoring systems for background investigations and provisional staff supervision.

Audit #: A-02-21-02004 (04/21/2023)
Government Program: IHS

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Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

ASPR Could Improve Its Oversight of the Hospital Preparedness Program To Ensure That Crisis Standards of Care Comply With Federal Nondiscrimination Laws

In 2020, during the COVID-19 pandemic, individuals with disabilities and their advocates filed complaints with HHS's Office for Civil Rights (OCR) asserting that six States had language in their Crisis Standards of Care (CSCs) that could result in individuals being denied treatment because of their disabilities.

OIG's objective was to determine whether the Administration for Strategic Preparedness and Response's (ASPR's) oversight of the Hospital Preparedness Program (HPP) could be improved with respect to recipients adopting CSCs that comply with Federal nondiscrimination laws.

OIG reviewed complaints filed by individuals with disabilities and their advocates with OCR as well as their subsequent resolutions. OIG also conducted interviews with officials from ASPR and 11 States with a focus on their development of CSC planning documents and their considerations of and compliance with Federal civil rights laws from July 2019 through June 2021. Furthermore, OIG reviewed the HPP cooperative agreements as well as Federal nondiscrimination laws and regulations. Of the States included in the interviews, six had complaints that had been filed and resolved with OCR during the COVID-19 pandemic. OIG judgmentally selected the other five States to provide input from various regions in different stages of CSC planning.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that although ASPR had taken steps to improve its oversight of the HPP by promoting the adoption of nondiscriminatory CSCs that comply with Federal nondiscrimination laws, it could take additional steps. The HPP cooperative agreement did not previously specify that States should consider Federal nondiscrimination laws when developing CSCs because prior to the COVID-19 pandemic, ASPR had not identified CSC compliance with Federal nondiscrimination laws as a high-risk area. Additionally, ASPR stated that it was not required to review CSCs for legal and regulatory compliance. CSCs that did not comply with Federal nondiscrimination laws increased the risk that individuals could be denied access to lifesaving care during a public health emergency.

OIG recommended that ASPR consider additional updates to the current HPP cooperative agreement to promote that HPP recipients adopt CSCs that comply with Federal nondiscrimination laws. OIG acknowledged that ASPR had taken steps in previous HPP updates to promote compliance with Federal nondiscrimination laws; however, OIG believed that additional steps could be taken. Such steps could have included an additional update to the HPP cooperative agreement to encourage recipients to engage with advocacy groups in decision making related to crisis care planning.

Audit #: A-01-21-01502 (01/13/2023)
Government Program: ASPR

Long Term Care

[NEW] Nine of Thirty Selected Assisted Living Facilities Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments

- Congress appropriated $178 billion to HHS to provide funds to eligible providers for health care-related expenses or lost revenues attributable to COVID-19 under the Provider Relief Fund (PRF) program. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Providers receiving PRF payments were to ensure that the payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues attributable to COVID-19; (3) not used to cover expenses or losses reimbursed by other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities.
- This audit was part of a series reviewing PRF payments to various provider types. Specifically, this audit assessed whether 30 selected assisted living facilities (ALFs) expended taxpayer funds in accordance with Federal and program requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 30 selected ALFs OIG reviewed, 7 ALFs claimed a total of $283,000 in unallowable PRF expenditures, and 2 ALFs inaccurately reported $11 million in lost revenues. These nine ALFs received a total of $25.6 million in PRF payments. The remaining ALFs used PRF funds for allowable expenditures and lost revenues.
- These deficiencies occurred because although ALFs attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the ALFs made clerical errors in their reporting of expenditures and did not always correctly interpret HRSA guidance, maintain documentation to support reported expenditures, or have procedures to verify the accuracy of lost revenue calculations.

OIG recommended that HRSA require the selected ALFs to return any unallowable expenditures and lost revenue amounts to the Federal Government or ensure that the ALFs properly accounted for these expenditures and lost revenues.

Audit #: A-02-23-01012 (12/17/2025)
Government Program: HRSA

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

[NEW] New Jersey Should Improve Its Oversight of Nursing Homes' Compliance With Background Check Requirements

- Background checks for employees were an important safety measure that could help protect some of the most vulnerable populations. Approximately 1.2 million people resided in nursing homes, with more than half of them relying on Medicare and Medicaid to pay for their long-term care. Oversight and management of nursing homes were crucial to the safety of long-term care residents.
- This audit assessed whether New Jersey ensured that selected nursing homes complied with Federal requirements that prohibited the employment of individuals with disqualifying backgrounds during calendar year 2022 (audit period). OIG reviewed 10 staff members at each of 12 nonstatistically selected nursing homes.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Jersey did not ensure that 11 of the 12 selected nursing homes complied with Federal requirements that prohibited the employment of individuals with disqualifying backgrounds during OIG's audit period. In total, these 11 nursing homes did not comply (deficiency) or did not document compliance (potential deficiency) with background check requirements for 33 of the 120 employees reviewed. Specifically:

- Nine nursing homes allowed a total of 17 staff members to provide care before completing a background check.
- Four nursing homes employed a total of six staff members without performing background checks.
- One nursing home did not provide documentation that it had performed background checks for the 10 selected staff members.

These deficiencies and potential deficiencies occurred because New Jersey's sampling of employees during its nursing home recertification surveys did not provide adequate coverage. Also, nursing homes did not have sufficient procedures to ensure that background checks were properly conducted for all staff members. This put residents at risk of abuse, neglect, exploitation, or mistreatment.

OIG recommended that New Jersey improve its procedures for monitoring nursing homes' compliance with background check requirements and provide guidance to nursing homes to implement adequate procedures for conducting background checks in accordance with Federal requirements.

Audit #: A-02-23-01011 (12/11/2025)
Government Program: CMS

[NEW] Nearly All Skilled Nursing Services Provided by Pinnacle Multicare Nursing and Rehabilitation Center Did Not Meet Medicare Payment Requirements

- In October 2019, CMS implemented a new payment system for determining Medicare Part A payments for skilled nursing facilities (SNFs) known as the Patient Driven Payment Model (PDPM).
- Prior OIG audits found that skilled nursing services were susceptible to noncompliance with Medicare requirements, resulting in improper payments to SNFs.

- This audit was the first in a series of audits of SNFs that billed for skilled nursing services under the PDPM. OIG's audit determined whether Pinnacle Multicare Nursing and Rehabilitation Center's (Pinnacle's) claims for skilled nursing services were made in accordance with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Pinnacle did not comply with Medicare requirements for 99 of 100 sampled claims, resulting in overpayments totaling $1.1 million, for skilled nursing services provided during calendar years 2020 and 2021. As a result, OIG estimated that Pinnacle received Medicare overpayments of at least $31.2 million.
- Pinnacle incorrectly billed Medicare for skilled nursing services (1) when the medical record did not support that the associated individual was assigned the correct reimbursement rate code, (2) provided to individuals who did not require skilled nursing services, and (3) that did not meet documentation requirements.
- The errors occurred because Pinnacle's clinical and billing staff did not always follow its procedures to properly assign reimbursement rate codes in accordance with Medicare requirements and provide sufficient clinical review to verify that enrollees required skilled nursing services. In addition, Pinnacle did not follow its procedures to ensure that it always complied with Medicare documentation requirements.

OIG recommended that Pinnacle refund to the Medicare program $31.2 million for skilled nursing services claims that did not meet Medicare requirements, consider conducting one or more internal audits or investigations for claims before and after OIG's audit period, and provide additional training to its clinical and billing personnel on its procedures to properly claim skilled nursing services. The full recommendations were in the report.

Audit #: A-02-22-01017 (11/14/2025)
Government Program: CMS

[NEW] CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements

- Nursing homes that did not comply with Federal requirements put resident health and safety at risk.
- The Special Focus Facility (SFF) program was the Centers for Medicare & Medicaid Services' (CMS's) flagship program to address quality problems at the nation's poorest-performing nursing homes with track records of serious noncompliance. Assessing the effectiveness of the SFF program was critical to ensure that CMS provided support and accountability for poorly performing nursing homes.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the SFF program was not working because most nursing homes that graduated from the program did not keep the improvements they made over the long term. Between 2013 and 2022, nearly two-thirds of the nursing homes that were in the SFF program improved enough to graduate but soon afterward showed the type of quality problems that put them in the SFF program in the first place. For nursing homes in the SFF program that violated Federal requirements, the SFF program relied too heavily on financial penalties that did not require changes in nursing home operations. OIG's findings pointed to ways in which CMS could make the SFF program more effective:

Staffing: CMS minimally included staffing in the SFF program, but nursing homes that graduated from the SFF program

and sustained improvements maintained higher staffing levels than those that did not sustain improvements.

Ownership: CMS did not consider ownership at all in the SFF program. However, a handful of owners stood out as owning many low-quality nursing homes, which pointed to poor management practices. Also, State agencies told OIG that owners played an important role in whether nursing homes improved quality.

States' quality improvement efforts: Some States built on the SFF program requirements with their own initiatives to support improvements in nursing homes. CMS could learn from these efforts to increase the effectiveness of the SFF program.

OIG recommended that CMS:
1. Impose more nonfinancial enforcement remedies that encourage sustained compliance
2. Assess the extent to which it took enhanced enforcement actions for SFF graduates and the effectiveness of those actions, particularly for graduates that received a deficiency for staffing
3. Incorporate nursing home ownership information into the SFF program, such as in selecting SFFs and identifying patterns of poor performance

Evaluation #: OEI-01-23-00050 (10/24/2025)
Government Program: CMS

[NEW] Special Focus Facility Program Nursing Homes, 2013–2022

Implemented by the Centers for Medicare & Medicaid Services (CMS), the Special Focus Facility (SFF) program was the nation's flagship program to facilitate quality improvements in the poorest-performing nursing homes through increased oversight. This data snapshot provided a detailed look at the nursing homes that participated in the SFF program from 2013 through 2022 and how nursing homes moved through the phases of the SFF program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- SFF served a very small number of the worst-performing nursing homes.
- SFFs generally graduated from the program, and they were primarily for-profit and nonrural nursing homes.
- Infection control was the most common deficiency category leading to selection.
- SFFs continued to receive high-level deficiencies while in the program but fewer than at selection.
- From 2013-2022, 92 percent of SFFs (591 of 645) received 6,296 total complaint surveys while in the program.
- Twenty-six percent of complaint surveys with noncompliance had a deficiency of high scope and severity.
- Over half of all remedies that SFFs received were civil money penalty (CMPs) paid by nursing homes.
- Of the 429 nursing homes that entered and exited in 10 years, 96 spent more than 2 years (24 months) in the SFF program.
- In most States, SFFs' average time to graduation was less than 2 years.
- Variation in slots impacted SFF at the State level.
- Within 3 years of graduating from the SFF program, 64 percent of nursing homes received a serious deficiency from 2013-2022.

Evaluation #: OEI-01-23-00052 (10/24/2025)
Government Program: CMS

Nursing Homes Failed To Report 43 Percent of Falls With Major Injury and Hospitalization Among Their Medicare-Enrolled Residents

- CMS's Care Compare website was intended to provide consumers with reliable information about quality of care to inform their choices. For nursing homes, the quality measures displayed on Care Compare included rates of resident falls with major injury.
- To calculate the quality measures for falls with major injury, CMS used data that nursing homes reported from Minimum Data Set (MDS) resident assessments.
- Providers may have had a disincentive to report events, such as falls, that could result in lower scores on quality measures. Previous analyses by OIG and others had identified under-reporting by providers.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that nursing homes failed to report 43 percent of falls with major injury and hospitalization among Medicare-enrolled residents, as required, in resident assessments.

- For-profit and chain nursing homes as well as larger nursing homes failed to report falls most often.
- Fall reporting varied widely by State and was worse among nonrural nursing homes.
- Nursing homes failed to report falls more often for younger residents, male residents, short-stay residents, and residents with only Medicare coverage.

  Nursing homes' failure to report falls on MDS assessments led to inaccurate fall rates on Care Compare.
- Nursing homes with the lowest fall rates on Care Compare were the least likely to report the falls OIG examined. This suggested that low fall rates for nursing homes on Care Compare were likely driven by nursing homes' failure to report falls, rather than an actual low incidence of falls.
- As a result, Care Compare did not provide the public with accurate information about how often nursing home residents fell.

  OIG released a companion data snapshot describing the falls OIG reviewed, the characteristics of the residents who fell, and the characteristics of the nursing homes where the falls occurred.

OIG recommended that:
1. CMS should have taken steps to ensure the completeness and accuracy of the nursing home-reported MDS data used to calculate the quality measures for falls with major injury.
2. CMS should have explored whether approaches to improve the quality measures related to falls could similarly have been used to improve the accuracy of other nursing home quality measures.

Evaluation #: OEI-05-24-00180 (09/15/2025)
Government Program: CMS

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Serious Falls Resulting in Hospitalization Among Medicare-Enrolled Nursing Home Residents, July 2022–June 2023

- This data snapshot was released as a companion to the report *Nursing Homes Failed To Report 43 Percent of Falls With Major Injury and Hospitalization Among Their Medicare-Enrolled Residents* (OEI-05-24-00180).
- That report found that nursing homes failed to report almost half of serious falls among Medicare-enrolled residents, as required, in resident assessments, leading to inaccurate nursing home fall rates on CMS's Care Compare website.
- Because most nursing home residents in the United States were enrolled in Medicare, analysis of falls among Medicare-enrolled residents provided insights that were broadly relevant to nursing home safety.
- Using Medicare hospital claims, OIG identified Medicare enrollees who experienced a hospitalization due to a fall with major injury during the 1-year review period from July 1, 2022, through June 30, 2023. OIG determined the subset of those enrollees who were nursing home residents at the time of the fall using Minimum Data Set (MDS) assessments.
- OIG then used the hospital claims and MDS assessments to describe the prevalence and outcomes of these serious falls; the demographic characteristics and risk factors of the residents who fell; and the characteristics of the nursing homes in which the falls occurred.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- Medicare-enrolled nursing home residents experienced **42,864 falls with major injury and hospitalization** and **1,911 residents died while hospitalized**.
- Medicare and enrollees paid more than **$800 million** for the resulting hospital care.
- **Most residents had fall risk factors** identified by nursing homes prior to their falls.
- **Female** residents, **older** residents, and residents with **short stays** had the highest fall rates.
- Nursing homes with **lower nurse staffing levels** and **lower quality ratings** had higher fall rates.

OIG concluded that more than 40,000 Medicare-enrolled nursing home residents experienced serious falls—those resulting in major injury and hospitalization—over this 1-year review period. These falls reduced residents' quality of life and were costly for the Medicare program. More robust fall prevention programs and other quality improvement initiatives can help reduce falls among nursing home residents.

Evaluation #: OEI-05-24-00181 (09/15/2025)
Government Program: CMS

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Hawaii Did Not Ensure That Selected Nursing Facilities Complied With Federal and State Background Check Requirements

- Background checks for employees were an important safety measure that could help protect some of the most vulnerable populations who received Federal health care benefits.
- As part of its oversight activities, OIG was conducting a series of audits nationwide regarding employment in nursing facilities of individuals whose criminal background checks identified information or events that should have disqualified those individuals from being hired based on Federal requirements (disqualifying backgrounds).
- This audit assessed whether two Hawaii State agencies ensured that selected nursing facilities in Hawaii complied with Federal and State requirements that prohibited employment of individuals with disqualifying backgrounds.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:
The State agencies did not ensure that selected nursing facilities in Hawaii complied with Federal requirements that prohibited employment of individuals with disqualifying backgrounds and State requirements for conducting employee background checks. Specifically, for the 10 selected nursing facilities, OIG found the following:

- Seven selected nursing facilities did not conduct background checks to ensure that employees were free from disqualifying backgrounds based on Federal regulations.
- All 10 selected nursing facilities did not conduct 1 or more State-required background checks of their employees.

OIG recommended that the two Hawaii State agencies conduct periodic reviews of nursing facilities' compliance with background check requirements.

Audit #: A-09-23-02003 (09/05/2025)
Government Program: CMS

Alabama Did Not Always Verify Selected Nursing Homes' Compliance With Background Check Requirements

- Background checks for employees in long-term care facilities (nursing homes) were an important safety measure that could help protect some of the most vulnerable populations.
- Approximately 1.4 million people resided in nursing homes, with more than half of them relying on Medicaid to pay for their long-term care.
- This audit examined whether Alabama ensured that selected nursing homes complied with Federal and State requirements that prohibited the employment of individuals with disqualifying backgrounds.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Alabama did not ensure, for the audit period of January 1, 2022, to April 8, 2024, that some of the nursing homes reviewed in OIG's sample complied with Federal and State requirements that prohibit the employment of individuals with disqualifying background checks.

- Specifically, for the 439 nursing home employees OIG sampled, OIG found that for 139, the nursing homes either did not meet Federal requirements by having a background check completed before beginning work, did not meet

State requirements by querying the Alabama Elderly and Adult in Need of Protective Services Abuse Registry (the Registry) before the employee began work, or a combination of both.

OIG recommended that Alabama:

- develop a process for verifying that nursing homes complete a background check and a Registry query before employees begin work,
- educate nursing homes on the importance of conducting timely background checks and Registry queries,
- require nursing homes to develop policies and procedures to conduct Registry queries before employees begin work, and
- conduct a review of nursing homes' compliance with background checks and Registry check requirements.

Audit #: A-04-24-08104 (08/12/2025)
Government Program: CMS

Oklahoma Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

- CMS required intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- Oklahoma conducted surveys of ICF/IIDs to determine whether they complied with Federal requirements.
- This audit was part of a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 426 deficiencies related to life safety, emergency preparedness, and infection control were identified at the 42 ICF/IIDs operated in Oklahoma that they reviewed. These deficiencies put residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

OIG recommended that Oklahoma:
1. follow up with the 42 ICF/IIDs to verify that they had taken corrective actions on the life safety, emergency preparedness, and infection control deficiencies identified during the audit;
2. conduct surveys at ICF/IIDs at least every 15 months as required by CMS; and
3. work with CMS to develop standardized life safety training for ICF/IID staff.

Audit #: A-06-24-09002 (07/15/2025)
Government Program: CMS

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Maine Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Maine, the State's Department of Health and Human Services (State agency) conducted surveys of ICF/IIDs for compliance with Federal requirements.
- This audit was part of a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that there were 121 deficiencies related to life safety, emergency preparedness, and infection control at the 16 ICF/IIDs in Maine. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency or in the event of an infectious disease outbreak.

OIG recommended that the State agency:
1. Follow up with the 16 ICF/IIDs to verify that they had taken corrective actions on the life safety, emergency preparedness, and infection control deficiencies identified during the audit.
2. Conduct surveys at ICF/IIDs at least every 15 months as required by CMS.
3. Work with CMS to develop standardized life safety training for ICF/IID staff.

Audit #: A-01-24-00004 (06/12/2025)
Government Program: CMS

CMS Use of Staffing Data To Inform State Oversight of Nursing Homes

- Nursing home residents and families depended on nursing homes to maintain sufficient staffing to meet their needs. To that end, the Centers for Medicare & Medicaid Services (CMS) had long required nursing homes to meet minimum staffing requirements, which included at least 8 hours of registered nurse (RN) services each day.
- This evaluation assessed the early experiences of States in leveraging new data and guidance provided by CMS to identify staffing deficiencies.
- Previously, CMS had implemented the Payroll Based Journal (PBJ) to provide consumers with more accurate information about nursing home staffing. The PBJ was a system where nursing homes submitted auditable information about the hours worked each day by different types of staff. Then in response to OIG recommendations, CMS began providing certain PBJ data to State survey agencies (States) along with guidance for using the data during nursing home inspections.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that although States reported that the PBJ data had been useful, CMS did not provide States with all the information they needed to effectively oversee the minimum requirement to provide 8 RN hours every day, as well as the broader requirement to provide sufficient staffing to meet residents' needs.

- CMS did not identify all nursing homes with fewer than 8 RN hours. Instead, CMS targeted nursing homes with zero RN hours. States could have better targeted their oversight if CMS had identified all nursing homes that had more than zero but fewer than 8 hours of RN coverage.
- CMS did not explain to States which aspect(s) of staffing posed a risk for insufficient staffing, when it identified nursing homes with a one-star staffing rating (the lowest rating on Care Compare, the public website for consumers). For example, States OIG reviewed wanted to know specifically whether low staffing of nurse aides contributed to the potential insufficient staffing in nursing homes identified by CMS.

OIG recommended that:

1. CMS should have informed States of nursing homes that appeared from PBJ data to violate the required number of daily RN staffing hours.
2. CMS should have provided States additional nursing home staffing analysis and guidance to identify potential insufficient staffing.

Evaluation #: OEI-04-22-00550 (06/04/2025)
Government Program: CMS

State Survey Agencies Need Additional Guidance to Assess Nursing Home Emergency Preparedness Programs

- Nursing home failures, such as resident deaths during Hurricane Ida, demonstrated continued challenges in nursing home emergency preparedness. These failures raised questions about how effective the survey process was in overseeing nursing home emergency preparedness.
- State survey agencies, contracted and overseen by the Centers for Medicare and Medicaid Services (CMS), were responsible for determining whether nursing homes complied with Medicare and Medicaid Requirements for Participation, including rules regarding emergency preparedness.
- Though CMS led the oversight of nursing homes' compliance with Medicare and Medicaid program rules, the Administration for Strategic Preparedness and Response (ASPR), and the Centers for Disease Control and Prevention (CDC) funded efforts at State and local levels that supported the emergency preparedness of health care facilities and health care systems, including nursing homes.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that a quarter of State survey agencies reported that surveyors typically lacked emergency preparedness expertise when hired, and building and retaining this expertise was challenging. CMS program guidance was more focused on documents to collect to demonstrate compliance with emergency preparedness rules than on assessing the content of those documents. Nearly one-half of State survey agencies reported successes that went beyond CMS guidance, including (1) information sharing with emergency preparedness partners and (2) additional tools and

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resources to enhance CMS guidance.

OIG recommended that to improve the survey process and support survey staff with limited expertise in the area, CMS:
1. Provide surveyors with instructions for *how* to assess the contents of nursing home emergency preparedness documentation as a part of the survey process.
2. Issue guidance that encourages State survey agencies to collaborate and share information.

Evaluation #: OEI-04-23-00030 (03/11/2025)
Government Program: CMS

Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs

- Most of the approximately 15,000 nursing homes in this country were certified by Medicare to serve as skilled nursing facilities (SNFs). As of FY 2023, about 1.2 million people resided in nursing homes.
- SNFs filed cost reports with Medicare. Accurate cost reports were important because cost reports provided the Medicare program with transparency about the costs SNFs incurred in providing care for residents and with critical information that CMS used to update SNF payment rates.
- SNFs and other Medicare providers regularly obtained services, facilities, or supplies (e.g., therapy services for SNF residents) from parties related to the provider (related parties).
- SNFs and other providers had to report related parties and related-party costs on their cost reports. Compliance with Medicare cost reporting requirements ensured that SNFs were not reporting related-party costs in excess of what was allowable.
- For Medicare cost reporting periods ending during FYs 2015 through 2020, SNFs reported receiving a total of $160.4 billion in Medicare payments and paying a total of $65.4 billion to related parties.
- This audit examined whether selected SNFs reported related parties as required and whether their related-party costs complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 14 SNFs in the nonstatistical sample, 3 SNFs did not properly disclose 1 or more related parties on their Medicare cost reports. In addition, 7 of the 14 SNFs did not properly adjust some of their related-party costs to Medicare-allowable costs as required, which resulted in more than $1.7 million in overstated costs.
- Medicare administrative contractors (MACs) did not review, as part of their oversight activities, the disclosure or reporting of related parties and their costs, and CMS did not provide sufficient guidance to SNFs that explained how to determine Medicare-allowable related-party costs.

OIG recommended that CMS:
1. require the MACs to include, as part of the normal desk review or audit process, a review of reporting and disclosure of related-party costs;
2. develop and implement guidance for SNFs on the appropriate methods for providers to determine their allowable related-party costs; and
3. provide guidance to reeducate MACs on the need to review, grant, and document requests from SNFs for exceptions

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to cost reporting requirements in compliance with 42 CFR SS 413.17(d).

Audit #: A-07-21-02836 (12/18/2024)
Government Program: CMS

Nonprofit and Government-Owned Nursing Homes Generally Complied With Federal Requirements Regarding the Infection Preventionist Position

- More than 1.3 million people live in nursing homes nationwide. These individuals are susceptible to a high number of health care-associated infections.
- Prior OIG audits found that nursing homes did not always comply with Federal regulations regarding designating an infection preventionist (IP) who met Federal requirements for that position.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that three nonprofit and two Government-owned nursing homes may not have complied with the requirement that the IPs complete specialized infection prevention and control training prior to assuming the IP role. On the basis of OIG's sample results, OIG estimated that 117 nursing homes nationwide (99 of 3,294 nonprofit and 18 of 922 Government-owned) may not have complied with Federal regulations pertaining to IPs during the audit period. As a result, there may have been increased health and safety risks for the residents and staff of these nursing homes.

OIG recommended that the Centers for Medicare & Medicaid Services instruct the State survey agencies to follow up with the five nursing homes (three nonprofit and two Government-owned) that may not have complied with Federal requirements to verify that they had taken corrective actions.

Audit #: A-01-24-00002 (12/02/2024)
Government Program: CMS

National Background Check Program for Long-Term Care Providers: A Final Assessment

- As many as 70 percent of seniors may need care in long-term care settings at some point in their lives. In 2023, nearly 16 percent of residents living in long-term care settings reported experiencing abuse.
- In 2010, the Patient Protection and Affordable Care Act (the Act) established a National Background Check Program, which provided Federal financial assistance for States to develop or enhance systems for long-term care settings to conduct background checks on prospective employees.
- Twenty-nine States participated in the program at various times from 2010 to 2024. The last two States ended participation on May 31, 2024.
- The Act included a mandate for OIG to produce an evaluation of this program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the National Background Check Program successfully established a program to help States identify efficient, effective, and economical procedures for conducting background checks on prospective long-term care employees. The National Background Check Program helped States successfully build systems to disqualify employees with concerning criminal convictions from working in long-term care settings. States reported two procedures that were appropriate, efficient, and effective for conducting background checks: having an automated system for conducting background checks and having the ability to monitor status changes to a person's background check after the initial background check has been completed. States rarely reported that conducting background checks resulted in any unintended consequences, such as a reduction in workforce. The most common challenges that States encountered while in the program were a lack of State legislative authority and difficulty coordinating between State-level departments. States spent more than $100 million in combined Federal and State funds to develop or enhance systems to conduct background checks of potential employees of long-term care providers.

OIG concluded that OIG issued recommendations during the program that aided the outcomes in this final assessment. OIG did not have further recommendations for CMS.

Evaluation #: OEI-07-24-00100 (11/04/2024)
Government Program: CMS

Massachusetts Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

- Nursing homes that participated in Medicare and Medicaid were required by CMS to comply with requirements intended to protect residents, including requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Massachusetts, the State's Department of Public Health conducted surveys of nursing homes to ensure compliance with Federal requirements.
- This audit was one in a series of audits that assessed compliance with Federal requirements for life safety, emergency preparedness, and infection control.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 236 deficiencies related to life safety, emergency preparedness, or infection control were identified at the 20 nursing homes in Massachusetts that they reviewed. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency, or in the event of an infectious disease outbreak.

OIG recommended that Massachusetts improve the health and safety of residents, staff, and visitors at nursing homes by following up with the 20 nursing homes where OIG identified deficiencies to ensure that they had taken corrective actions. Additionally, OIG recommended that Massachusetts work with CMS to identify nursing homes requiring frequent inspections. The full recommendations were in the report.

Audit #: A-01-23-00003 (10/04/2024)
Government Program: CMS

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Certain For-Profit Nursing Homes May Not Have Complied With Federal Requirements Regarding the Infection Preventionist Position

- More than 1.3 million people lived in nursing homes nationwide. These individuals were susceptible to a high number of health care-associated infections.
- Prior OIG audits found that nursing homes did not always comply with Federal regulations regarding designating an infection preventionist (IP) who met Federal requirements for that position.
- This audit examined whether for-profit nursing homes nationwide complied with Federal requirements pertaining to IPs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all for-profit nursing homes that OIG reviewed met Federal requirements. Seventy-six of the 100 for-profit nursing homes in OIG's sample complied with Federal requirements pertaining to IPs. However:

- 17 potentially did not comply with the requirement that the IP complete specialized infection prevention and control training prior to assuming the role and
- 7 potentially did not comply with the requirement to designate an IP.

On the basis of OIG's sample results, OIG estimated that 2,568 for-profit nursing homes nationwide (approximately 1 in 4) may not have complied with Federal requirements pertaining to IPs during the audit period. As a result, there may have been increased health and safety risks for the residents and staff of these nursing homes.

OIG recommended that the Centers for Medicare & Medicaid Services:
1. instruct the State survey agencies to follow up with the 24 nursing homes that may not have complied with Federal requirements to verify that they had taken corrective actions, and
2. share the results of this audit with the State survey agencies and encourage them to focus their oversight on verifying that nursing homes designated an IP and that the IPs completed specialized training prior to filling that position.

Audit #: A-01-22-00001 (08/19/2024)
Government Program: CMS

Florida Ensured That Nursing Homes Complied with Federal Background Check Requirements

Background checks for employees in long-term care facilities (nursing homes) were an important safety measure that could help protect some of the most vulnerable populations. Approximately 1.4 million Medicare recipients resided in nursing homes, with more than half of them relying on Medicaid to pay for their long-term care. Oversight and management of nursing homes were crucial to the safety of long-term care residents.

OIG's objective was to determine whether the Florida Agency for Health Care Administration (State agency) ensured, for the period of January 1, 2021, to June 1, 2023, that selected nursing homes in Florida complied with Federal requirements that prohibited the employment of individuals with disqualifying backgrounds.

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As of April 11, 2023, 676 nursing homes in Florida were certified by Medicaid. From this group, OIG selected 30, based on their geographic location and a variety of risk factors.

At each of the selected nursing homes, OIG reviewed background checks for 30 randomly selected employees per nursing home, for a total of 900. In addition, OIG judgmentally selected an additional 119 employees for review based on OIG's review of incident reports during the audit period. The total sample size was 1,019 employees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the State agency complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds as defined at 42 CFR SS 483.12(a)(3). Specifically, for the 1,019 nursing home employees OIG sampled, all of them had completed a background check by the State agency through the Clearinghouse before working at a nursing home. In addition, the sampled employees who were required to have a license because of their occupation had a current license (as of the time of their employment) and did not have any actions taken against their license related to disqualifying offenses. Finally, none of the sampled employees were listed on the OIG List of Excluded Providers and Entities, which would have precluded them from working in a healthcare setting.

OIG attributed this compliance with Federal requirements to the State agency's internal controls over the background check screening process for nursing home employees.

Audit #: A-04-23-08100 (04/26/2024)
Government Program: CMS

Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes

- Facility-initiated discharges that did not follow Federal regulations could be unsafe and traumatic, leading to resident harm.
- CMS and State Long-Term Care Ombudsmen had raised concerns about the extent to which nursing homes followed Federal requirements for these discharges.
- This review provided insights into a sample of facility-initiated discharges from nursing homes and the extent to which these discharges followed Federal requirements.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that in most (107 out of 126) of the facility-initiated discharge cases in the review, nursing homes discharged residents for allowable reasons; however, the review raised concerns about nursing homes' understanding of and compliance with notice and documentation requirements for facility-initiated discharges.

- **Nursing homes sometimes fell short in providing required documentation**, such as documentation that the receiving facility could provide services that met residents' needs.
- **Nursing homes often failed to notify residents of their discharges and frequently omitted required information in notices**, which may have compromised residents' rights and abilities to plan for safe transitions.
- **Even when nursing homes provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required**, potentially impeding the Ombudsman's ability to

effectively advocate for residents.

OIG also found that nursing homes struggled to identify facility-initiated discharges, which may have presented CMS and State survey agencies with challenges in overseeing these discharges during the survey process.

OIG concluded that:

1. CMS provided a standard notice template to help nursing homes provide complete and accurate information to residents facing discharge and Ombudsmen.
2. CMS required nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight.

Evaluation #: OEI-01-18-00251 (03/29/2024)
Government Program: CMS

Nursing Home Residents With Endangering Behaviors and Mental Health Disorders May Be Vulnerable to Facility-Initiated Discharges

- Facility-initiated discharges that did not follow Federal regulations could be unsafe and traumatic, leading to resident harm.
- CMS and State Long-Term Care Ombudsmen had raised concerns about the extent to which nursing homes followed Federal requirements for these discharges.
- This review provided insights into a sample of facility-initiated discharges from nursing homes, including the reasons cited for discharges, shared characteristics among discharged residents, and the locations to which residents were discharged.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that nursing homes discharged 72 of the 126 residents in OIG's review because of behaviors that endangered them or others in a facility. In most cases, the residents exhibited aggressive or violent behaviors. Prior to discharging these residents, nursing homes most commonly tried changing medications and counseling. Residents discharged due to behaviors shared some characteristics such as a mental health disorder and admission for long-term versus short-term care. Nursing homes also initiated discharges for residents who failed to pay for a stay (33 of 126) or residents whose health improved and no longer needed facility services (13 of 126). Lastly, most residents in OIG's review were discharged to acute-care hospitals, and 10 residents were discharged to an unknown location, a nonspecific location, or a hotel.

OIG concluded that the findings highlighted the challenges that nursing homes faced in caring for residents with mental health disorders as well as raised questions about nursing homes' admissions of and capacities to care for these residents. More research was needed into how to provide safe and effective long-term care for residents with mental health disorders and behaviors, especially as the demand for such care grew. To that end, the new Center for Excellence for Behavioral Health in Nursing Facilities, established by the Substance Abuse and Mental Health Services Administration in partnership with CMS, held promise.

Evaluation #: OEI-01-18-00252 (03/29/2024)
Government Program: CMS

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

- Nursing home residents and staff had 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 was 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.

Evaluation #: OEI-02-20-00492 (02/26/2024)
Government Program: CMS

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Colorado 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 related to health care facilities to improve protections for all 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. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Colorado ensured that selected nursing homes in Colorado that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 219 nursing homes in Colorado that participated in the Medicare or Medicaid programs, OIG selected a non-statistical sample of 20 nursing homes for the audit based on location and certain risk factors, including multiple high-risk deficiencies that Colorado reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from September through November 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Colorado could better ensure that nursing homes in Colorado that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control. During OIG's onsite visits, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that were audited, totaling 556 deficiencies. Specifically, OIG identified 165 deficiencies related to life safety requirements, 210 deficiencies related to emergency preparedness requirements, and 181 deficiencies related to infection control requirements. 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 inadequate oversight by Colorado and by nursing home management, frequent management and staff turnover at the nursing homes, inadequate oversight by the State survey agency, and frequent State survey agency staff turnover. In addition, the State survey agency had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than was required by CMS. Finally, although not required by CMS, Colorado did 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.

OIG recommended that Colorado follow up with the 20 nursing homes reviewed in this audit to ensure that corrective actions had been taken regarding the life safety, emergency preparedness, and infection control deficiencies OIG identified; work with CMS to develop a risk-based approach to identify nursing homes at which surveys would be conducted more frequently, such as those with a history of multiple high-risk deficiencies or frequent management turnover; and work with CMS to develop standardized life safety training for nursing home staff.

Audit #: A-07-22-07009 (02/02/2024)
Government Program: CMS

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

NHSN had 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 had 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 provided 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 had 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 its 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 conducted 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.

To continue improvements, OIG recommended that CDC (1) improve the user support the NHSN Help Desk provided 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 could be enhanced to ensure data accuracy, as appropriate.

Evaluation #: OEI-06-22-00030 (01/08/2024)
Government Program: CDC

Oklahoma Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, 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 develop an infection control program.

OIG's objective was to determine whether Oklahoma ensured that selected nursing homes in Oklahoma that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 296 nursing homes in Oklahoma that participated in Medicare or Medicaid, OIG selected a non-statistical sample of 20 nursing homes for the audit based on certain risk factors, including the number of deficiencies Oklahoma reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from October 2022 through January 2023. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Oklahoma could better ensure that nursing homes in Oklahoma that participated in the Medicare or Medicaid programs complied 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 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 had 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.

Audit #: A-06-22-09007 (01/04/2024)
Government Program: CMS

Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, CMS updated its life safety and emergency preparedness regulations for health care facilities to improve protections for all Medicare and Medicaid enrollees, 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. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Ohio ensured that selected nursing homes in Ohio that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 949 nursing homes in Ohio that participated in Medicare or Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Ohio reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from August through November 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Ohio could have better ensured that nursing homes in Ohio that participated in the Medicare or Medicaid programs complied 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 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, Ohio had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Ohio did 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 had 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.

HCPCS Codes Identified in This Audit:

- K354 - Sprinkler System - Out of Service: There are no procedures for "Sprinkler System - Out of Service"
- K325 - Alcohol Based Hand Rub Dispenser: Empty hand sanitizer dispensers
- K372 - Penetrations in smoke/fire barrier: Several ceiling tiles have water damage

Audit #: A-05-22-00019 (12/20/2023)
Government Program: CMS

Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all 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. Additionally, facilities were required to develop an infection control program.

OIG's objective was to determine whether Washington State ensured 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.

Of the 200 nursing homes in Washington State that participated in Medicare or Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies that Washington reported to CMS.

OIG conducted unannounced site visits at each of the 20 nursing homes from September through November 2022. During each site visit, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found 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 onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that were audited, totaling 525 deficiencies. Specifically, OIG found 91 deficiencies 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 were 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 were ultimately responsible for ensuring resident safety, Washington had 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 had 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 were available.

Audit #: A-09-22-02006 (12/08/2023)
Government Program: CMS

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 resided 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 were 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 the 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. The 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 found 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 did 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.

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 its full report.

Audit #: A-06-21-02000 (11/29/2023)
Government Program: CMS

Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all Medicare and Medicaid enrollees, 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. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Pennsylvania ensured that selected nursing homes in Pennsylvania that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 701 nursing homes in Pennsylvania that participated in Medicare and Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Pennsylvania reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from July through October 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Pennsylvania could better ensure that nursing homes in Pennsylvania that participated in the Medicare or Medicaid programs complied 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 were 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 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, poor record keeping, combined with an inconsistent application of policies, also contributed to deficiencies. Finally, although not required by CMS, Pennsylvania

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

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Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

did 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 had been taken regarding the deficiencies identified in this report. OIG also made seven additional procedural recommendations for Pennsylvania that were included in the report.

Audit #: A-03-22-00206 (11/08/2023)
Government Program: CMS

New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all Medicare and Medicaid enrollees, 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. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether New Jersey ensured that selected nursing homes in New Jersey that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 356 nursing homes in New Jersey that participated in Medicare and Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies New Jersey reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from March through May 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies based on requirements listed on CMS surveyor checklists.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that New Jersey could better ensure that nursing homes in New Jersey that participated in Medicare or Medicaid programs complied 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 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 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, 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 did 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 had 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.

Audit #: A-02-22-01004 (09/29/2023)
Government Program: CMS

Georgia 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 Georgia ensured that selected nursing homes in Georgia that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 358 nursing homes in Georgia that participated in Medicare and Medicaid, OIG selected a non-statistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Georgia reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from June through September 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Georgia could better ensure that nursing homes in Georgia that participated in Medicare or Medicaid programs complied 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 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 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, Georgia had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Georgia did 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 had 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.

Audit #: A-04-22-08093 (09/06/2023)
Government Program: CMS

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

OIG had 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 had led to tragic results. Although such outcomes were not typical, they pointed 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 met the Federal requirements for emergency preparedness faced 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 have been 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.

Evaluation #: OEI-06-22-00100 (09/01/2023)
Government Program: CMS

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 performed inspections of Medicare- and Medicaid-certified nursing homes to determine whether they were in compliance with Federal health, fire safety, and emergency preparedness requirements. State survey agency surveyors cited instances of noncompliance as deficiencies and reported inspection results to CMS. CMS made 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 were accurately reported. The report had three other procedural recommendations.

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Provider

Multiple Providers

Hospital

Long Term Care

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Other Providers and Suppliers

Audit #: A-09-20-02007 (04/10/2023)
Government Program: CMS

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 had 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 had been particularly devastating for Medicare beneficiaries in nursing homes, which was 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 was the second report in the series and built on the first OIG report by focusing on nursing homes themselves. It looked 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 had affected nursing homes can help the CMS, Congress, and other stakeholders learn from what had 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 found 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.

OIG found that 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.

OIG found that 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 was 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 were not adequate to keep residents safe from infectious disease.

OIG concluded that these findings made 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 were 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 lent urgency to the administration's initiative. OIG recommended that CMS, as it supported the administration's initiative, take the following actions:
(1) reexamine current nursing staff requirements and revise them as necessary;
(2) improve how surveys identified 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.

ICD Codes Identified in This Evaluation:

- U07.1 - Confirmed COVID-19 test result
- B97.29 - Other coronaviruses as the cause of diseases
- Z20.828 - Contact with or suspected exposure to other viral communicable diseases

Evaluation #: OEI-02-20-00491 (01/12/2023)
Government Program: CMS

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Provider

Home Health Service

[NEW] Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether Guardian Home Care, LLC, complied with Medicare requirements for billing home health services provided to enrollees from July 1, 2021, through June 30, 2023 (audit period).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Guardian Home Care complied with Medicare billing requirements for 97 of the 100 home health claims OIG reviewed. For the remaining three claims, Guardian Home Care incorrectly billed Medicare for claims with unsupported codes or for a skilled service that did not meet a plan of care requirement.

- Two claims did not meet billing and coding requirements, resulting in overpayments totaling $123.
- One claim did not meet a plan of care requirement, resulting in an overpayment of $1,567.

Guardian Home Care received overpayments totaling $1,690 for the claims in the sample.

OIG recommended that Guardian Home Care: (1) refund the $1,690 in overpayments to the Medicare program and (2) consider conducting one or more internal audits or investigations for claims after OIG's audit period, based on the risks identified by this audit, to identify any similar overpayments that Guardian Home Care might have received and return any identified overpayments to the Medicare program.

Audit #: A-07-24-05146 (12/15/2025)
Government Program: CMS

[NEW] Medicare Home Health Agency Provider Compliance Audit: VNA Care Network

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether VNA Care Network complied with Medicare requirements.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that VNA Care Network complied with Medicare billing requirements for 85 of the 100 home health claims reviewed. For the remaining 15 claims, VNA Care Network had incorrectly billed Medicare for claims with unsupported codes, services that did not meet plan of care requirements, invalid face-to-face encounters, skilled services that did not meet medical necessity requirements, and services that did not meet comprehensive assessment requirements.

VNA Care Network received overpayments totaling $6,171 for the claims in the sample.

OIG recommended that VNA Care Network take the following actions: refund the $6,171 in overpayments to the Medicare program, consider conducting additional audits or investigations to identify any similar overpayments and return any identified overpayments to the Medicare program, and strengthen its review processes for identification of inaccuracies in medical record documentation to improve compliance with Medicare billing requirements.

Audit #: A-05-22-00016 (10/23/2025)
Government Program: CMS

Medicare Home Health Agency Provider Compliance Audit: Sunflower Home Health

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether Sunflower Home Health complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Sunflower Home Health complied with Medicare billing requirements for all 100 of the home health claims that OIG reviewed.

OIG concluded that because Sunflower Home Health complied with Medicare billing requirements for all 100 claims that OIG reviewed, this report contained no recommendations.

Audit #: A-05-23-00002 (07/09/2025)
Government Program: CMS

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

Medicare Home Health Agency Provider Compliance Audit: HRS Home Health

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether HRS Home Health complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that HRS Home Health complied with Medicare billing requirements for 80 of the 100 home health claims reviewed. For the remaining 20 claims, HRS Home Health incorrectly billed Medicare for claims with unsupported codes and for skilled services that did not meet requirements, including plan of care requirements.

- Fifteen claims did not meet billing and coding requirements, resulting in overpayments totaling $2,291.
- Four claims did not meet plan of care requirements but did not result in an overpayment.
- One claim did not meet skilled need requirements but did not result in an overpayment.

Based on OIG's sample results, it was estimated that HRS Home Health received overpayments of at least $100,696 for the audit period.

OIG recommended that HRS Home Health: (1) refund the $100,696 in estimated overpayments to the Medicare program; (2) consider conducting one or more internal audits or investigations for claims after OIG's audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program; and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

Audit #: A-05-22-00017 (06/30/2025)
Government Program: CMS

Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, the first of a nationwide series of home health audits, examined whether Bridge Home Health complied with Medicare requirements.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Bridge Home Health complied with Medicare billing requirements for 90 of the 100 home health claims OIG reviewed. For the remaining 10 claims, Bridge Home Health incorrectly billed Medicare for claims with unsupported codes, invalid face-to-face encounters, and skilled services that did not meet requirements.

- Six claims did not meet billing and coding requirements, resulting in a net underpayment totaling $291.
- Three claims did not meet face-to-face requirements, resulting in overpayments totaling $6,337.
- One claim did not meet skilled need requirements but did not result in an overpayment.

Bridge Home Health received net overpayments totaling $6,046 for the claims in the sample.

OIG recommended that Bridge Home Health: (1) refund the $6,046 in overpayments to the Medicare program; (2) identify similar instances of noncompliance that occurred before, during, and after the audit period and determine the impact and return any overpayments to the Federal Government; and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

Audit #: A-05-23-00017 (12/19/2024)
Government Program: CMS

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 made payments for some types of telehealth services, the final regulations prohibited payments for home health services furnished via telehealth. At the start of the 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 the 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 it was estimated that there were 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, medical records were unable to be obtained, so it could not be determined 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 were necessary.

HCPCS Codes Identified in This Audit:

- G0320 - Home health services furnished using synchronous telemedicine rendered via a real-time, two-way audio and video telecommunications system
- G0321 - Home health services furnished using synchronous telemedicine rendered via telephone or other real-time, interactive, audio-only telecommunications system

Audit #: A-05-21-00026 (09/25/2023)
Government Program: CMS

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

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 used 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 provided consumers with information about HHA performance. The Office of Inspector General (OIG) and others had 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 were hospitalized, HHAs had to 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 did 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 raised 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 were hospitalized; and (4) explore whether improvements to the quality measure related to falls could also be used to improve the accuracy of other home health measures.

Evaluation #: OEI-05-22-00290 (09/05/2023)
Government Program: CMS

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Provider

- Multiple Providers
- Hospital
- Long Term Care
- Home Health Service
- **Hospice**
- Medical Equipment and Supplies
- Behavioral Health
- Laboratory
- Telehealth
- Other Providers and Suppliers

Hospice

Texas Did Not Calculate or Collect Hospice Cap Overpayments Totaling $10.5 Million

- In States for which hospice services were covered under Medicaid, two annual limits (called caps) could apply to hospice providers. In these States, hospices were required to repay Medicaid for payments received that exceeded applicable caps (i.e., overpayments).
- OIG's audit determined whether Texas correctly calculated and collected hospice cap overpayments and refunded the Federal share of those overpayments to the Federal Government.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas overpaid $10.5 million ($6.9 million Federal share) to 174 hospices (36 percent of hospices that received payments) for services provided during Federal fiscal years 2020 through 2022 because it did not have any policies and procedures related to calculating and collecting the hospice cap overpayments. Texas did not calculate these cap overpayments; therefore, it did not collect them or return the related Federal share.

OIG recommended that Texas:
1. collect the hospice cap overpayments totaling $10.5 million and refund the Federal share of $6.9 million to the Federal Government and
2. develop and implement policies and procedures related to calculating and collecting hospice cap overpayments.

Audit #: A-06-24-09001 (09/17/2025)
Government Program: CMS

CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020

- Payments made to hospices were limited by inpatient cap and aggregate cap amounts that represented the maximum amount of Medicare payments a hospice could have received for a cap year. The cap amounts were calculated annually, and any amount paid to a hospice above either cap amount was an overpayment and had to be repaid to Medicare.
- Medicare administrative contractors (MACs) completed the hospice cap calculations for the inpatient and aggregate cap after the end of the cap year. Cap calculations were subject to CMS reopening regulations, which allowed reopening for up to 3 years from the date of the cap calculation.
- OIG's audit determined whether CGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.
- This audit was part of a series that reviewed MAC calculations and collections of hospice aggregate and inpatient cap overpayments.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- CGS accurately calculated the initial 2020 cap amounts for all 805 hospices that operated in its jurisdiction and collected or attempted to collect the $9.1 million in cap overpayments it identified. However, for 45 selected hospices, CGS did not reopen and recalculate most hospice caps for prior cap years (i.e., 2017, 2018, and 2019), which limited CGS's overpayment identification and collection for those prior years.
- Because CGS missed cap reopening deadlines and failed to revisit prior years' cap calculations for hospices with Unified Program Integrity Contractor (UPIC) recoupments, it did not calculate and collect additional overpayments totaling $201,873 for prior cap years.

OIG recommended that CGS:
1. discontinue its practices that limited the reopening of prior years' cap calculations and start reopening all prior years' cap calculations,
2. revise policies and procedures so that it met the reopening deadlines established in the Federal requirements, and
3. conduct the prior years' hospice cap calculations for the five hospices with UPIC recoupments and collect any additional overpayments.

Audit #: A-06-23-09003 (11/27/2024)
Government Program: CMS

Seven of Thirty Hospices Reviewed Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments

- The Provider Relief Fund (PRF), a $178 billion program, provided funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Providers receiving PRF payments were to ensure that the payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues attributable to COVID-19; (3) not used to cover expenses or losses reimbursed by other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities.
- This audit was part of a series reviewing PRF payments to various provider types. Specifically, this audit assessed whether 30 selected hospices expended taxpayer funds in accordance with Federal and program requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- The selected hospices reported that they had used $80.2 million of their PRF payments to offset lost revenues, $89.8 million for general and administrative expenses, and $34.8 million for health care-related expenses.
- Of the 30 selected hospices, 23 hospices had used PRF funds for allowable expenditures and lost revenues attributable to COVID-19; however, 7 hospices did not comply with or may not have complied with Federal requirements. Of these seven hospices, which received $98.1 million in PRF payments, six hospices had claimed a

total of $8.3 million of unallowable PRF expenditures and inaccurately reported $1.5 million of lost revenues, and one hospice had claimed $4 million in expenditures that may not have been allowable.

- These deficiencies occurred because although HRSA provided the PRF terms and conditions and updated its guidance to PRF recipients, the hospices did not always maintain documentation for expenses claimed, correctly interpret HRSA guidance, have procedures to verify the accuracy of lost revenue calculations, or track expenses funded by PRF payments.

OIG recommended that HRSA require the selected hospices to return any unallowable expenditures to the Federal Government or ensure that the hospices properly accounted for these expenditures.

Audit #: A-02-22-01014 (11/08/2024)
Government Program: HRSA

Medical Equipment and Supplies

[NEW] Medicare Payments for Continuous Glucose Monitors and Supplies Exceeded Supplier Costs and Retail Market Prices, Indicating Medicare Can Save At Least Tens of Millions of Dollars in One Year

- Continuous glucose monitors (CGMs) were a wearable technology that could help patients manage diabetes by tracking glucose levels every few minutes. Low blood glucose levels could impact an individual's ability to think and function. High levels could damage organs over time.
- Medicare Part B payments for CGMs and supplies rose from $109 million in 2018 to $1.3 billion in 2023.
- This review compared Medicare payments for CGMs and associated supplies to the costs incurred by suppliers and retail prices to assess the potential for Medicare cost savings. Previous OIG work determined that Medicare was paying more than other payors for other types of durable medical equipment, other than CGMs, inflating Medicare's overall expenses and the enrollee copayments.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that comparing Medicare payments to CGM suppliers' acquisition costs, their total estimated costs, and, for supplies, retail prices indicated that there were potential cost savings for Medicare and enrollees.

From July 2022 to June 2023, Medicare payments for CGMs and supplies exceeded suppliers' acquisition costs and suppliers' estimated total costs. Medicare payments for CGMs and supplies exceeded suppliers' acquisition costs by $377 million (or 69 percent) in a year, and their total estimated costs by $70 million (or 8 percent) in one year.

CGM supplies--the most common CGM-related Medicare billing--represented the largest potential number of dollars saved. Medicare payments exceeded suppliers' acquisition costs by $359 million and their total estimated costs by $61 million. Medicare payments for CGM supplies also exceeded retail market prices by $290 million in one year.

Suppliers received $7 million in potential overpayments based on improper coding of CGMs and supplies. Suppliers billed Medicare for CGMs and supplies that had higher payment rates but provided CGMs and supplies that should have had lower payment rates.

1. OIG stated that CMS should pursue reductions to Medicare's payment rates for CGMs and supplies.

2. OIG stated that CMS should take action to prevent overpayments caused by suppliers' improper use of billing codes for CGMs and supplies to achieve potentially millions of dollars of cost savings for Medicare and enrollees.

Evaluation #: OEI-04-23-00430 (11/25/2025)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

[NEW] Medicare Improperly Paid Suppliers $22.7 Million Over 7 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Enrollees During Inpatient Stays

- A prior OIG audit found that Medicare improperly paid suppliers $34 million for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items provided to enrollees during inpatient stays from 2015 through 2017.
- Generally, Medicare should not pay a supplier for DMEPOS items provided to an enrollee during an inpatient stay. Instead, all items must be provided directly by the inpatient facility or under arrangements between the facility and the supplier.
- Because of the large overpayment amount identified in OIG's prior audit, OIG conducted this followup audit to determine whether Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays from 2018 through 2024 complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Medicare payments to suppliers for DMEPOS items provided to enrollees during inpatient stays did not comply with Medicare requirements. None of the $22.7 million in payments for DMEPOS items covered by this audit should have been paid. In addition, suppliers might have incorrectly collected up to $5.9 million in deductible and coinsurance amounts from enrollees or from someone on their behalf.
- Prior to January 2020, the system edits were not working properly. However, after CMS modified the edits in January 2020, improper payments substantially decreased. From January 2020 through December 2024, $4.5 million was improperly paid (about 20 percent of the $22.7 million). Because improper payments continued to be made, further review of the edits might have been necessary to determine whether refinements were needed.

OIG recommended that CMS direct the DME Medicare contractors to recover from suppliers up to $22.7 million in identified improper payments and recommend that the suppliers refund to enrollees up to $5.9 million in deductible and coinsurance amounts. OIG also recommended that CMS review its system edits to determine whether any refinements were necessary to prevent improper payments to suppliers for DMEPOS items provided to enrollees during inpatient stays. The full recommendations were in the report.

Audit #: OAS-24-09-005 (10/24/2025)
Government Program: CMS

Medicare Improperly Paid Suppliers for Intermittent Urinary Catheters

- From 2014 through 2021, CMS identified high improper payments for urological supplies, which included intermittent urinary catheters (catheters).
- Because of the ongoing risk of improper payments, OIG conducted this nationwide audit to determine whether Medicare paid suppliers for catheters in accordance with Medicare requirements for catheters provided to enrollees from July 2021 through June 2022 (audit period).

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not make some payments to suppliers for catheters in accordance with Medicare requirements:

- Payments for 88 of 105 sample items met requirements. (OIG did not review 2 of 105 sample items and treated them as non-errors because after OIG had selected the sample, it was determined that Medicare contractors had denied the claims.)
- Payments for the remaining 15 sample items did not meet requirements. Specifically, medical records did not support Medicare enrollees' eligibility for curved-tip catheters or sterile catheter kits (kits), or suppliers did not meet Medicare requirements for catheter refills, proof of delivery, or a standard written order.

  On the basis of the sample results, OIG estimated that of the $303.3 million Medicare paid for catheters and kits for the audit period, approximately $35.1 million was improperly paid. In addition, OIG estimated that enrollees were responsible for approximately $8.8 million in associated coinsurance.

  In addition, OIG's analysis of Medicare claims submitted after the audit period showed that suppliers billed 125,426 claims for curved-tip catheters provided to female enrollees in 2023, compared with 2,753 claims for the audit period. This large increase in claims billed may have been an indication of improper claims. OIG shared the analysis, identifying suppliers with questionable billing patterns, with CMS so that it could take action as needed. In comments on the draft report, CMS informed OIG that it had already taken corrective action on 15 suppliers.

OIG recommended that CMS instruct Medicare contractors to recover $11,399 in overpayments made to suppliers for the 15 sample items that did not meet Medicare requirements; perform additional medical reviews of claims for catheters and kits, which could have saved Medicare an estimated $35.1 million for the audit period; and provide additional education to suppliers on documenting eligibility for curved-tip catheters and kits and on documenting refills of catheters and kits. The full recommendations were in the report.

HCPCS Codes Identified in This Audit:

- A4351 - Straight-tip catheter
- A4352 - Curved-tip catheter (also called a Coude-tip catheter)
- A4353 - Sterile catheter kit, which includes a straight-tip or curved-tip catheter with all necessary insertion supplies.

Audit #: A-09-22-03019 (02/04/2025)
Government Program: CMS

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

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Other Providers and Suppliers

Medicare Remains Vulnerable to Fraud, Waste, and Abuse Related to Off-the-Shelf Orthotic Braces, Which May Result in Improper Payments and Impact the Health of Enrollees

From calendar years (CYs) 2014 through 2020, Medicare paid approximately $5.3 billion for orthotic braces provided to Medicare enrollees. The Centers for Medicare & Medicaid Services (CMS) found that orthotic braces were consistently among the top 20 items of durable medical equipment, prosthetics, orthotics, and supplies with the highest improper payment rates. Adequate CMS oversight was critical in ensuring that Medicare enrollees continued to have access to and receive medically necessary braces.

This portfolio provided an overview of vulnerabilities identified in prior Office of Inspector General (OIG) audits, evaluations, and investigations and issues identified in OIG's analysis of Medicare claims data related to off-the-shelf (OTS) orthotic braces from CYs 2018 through 2020.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that, based on OIG's review of the vulnerabilities identified in OIG's prior work and OIG's analysis of Medicare claims data, OIG identified issues related to CMS's oversight of OTS braces, including the following: (1) providers ordered braces for enrollees for whom there was no history of a treating relationship, (2) new suppliers were located in geographic areas with known Medicare fraud, (3) Medicare paid more than private payers for OTS braces, and (4) suppliers used prohibited solicitation to contact enrollees.

These issues continued to put Medicare and its enrollees at risk and demonstrated the need for CMS to strengthen its oversight related to supplier billing requirements, ordering provider requirements, supplier enrollment and monitoring, Medicare allowable amounts for OTS braces, telemarketing to Medicare enrollees, and fraud related to OTS braces. If not addressed, these issues could result in improper payments, potential enrollee harm, and Medicare paying more than non-Medicare payers, such as private insurance companies, for OTS braces.

OIG recommended that CMS strengthen its oversight of Medicare billing for OTS braces by:
(1) taking steps to prevent payments for claims for replacement OTS braces billed without required modifiers;
(2) identifying providers who ordered OTS braces for enrollees with whom they had no treating relationships, and using that information to determine whether to provide additional education to or take administrative or legal action against the ordering providers or associated suppliers;
(3) analyzing supplier billing patterns to determine whether to conduct additional prepayment or postpayment reviews of suppliers;
(4) ensuring that Medicare allowable amounts were reasonably comparable with payments made by non-Medicare payers;
(5) educating suppliers and enrollees on telemarketing practices for OTS braces; and
(6) using predictive data analysis and information from other Federal agencies and from State agencies to identify emerging fraud schemes related to OTS braces, and using CMS's authority to prevent further losses to the Medicare program.

HCPCS Codes Identified in This Audit:

- L1832 - Off-the-shelf knee brace

Audit #: A-09-21-03019 (05/24/2024)
Government Program: CMS

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 the audit period.

The objective was to determine whether the accumulated costs of repairs paid by Medicare for enrollee-owned wheelchairs that were within their 5-year RUL exceeded the federally recommended cost limit.

The audit covered Medicare Part B claim lines, totaling $91.1 million, for repairs made to 77,774 enrollee-owned wheelchairs during the 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 found 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 have reflected noncompliance with Medicare requirements. Specifically, the excessive costs for repairing these wheelchairs may have indicated that the repairs were not reasonable or that enrollees were furnished substandard wheelchairs that would not remain serviceable for their entire 5-year RUL.

OIG recommended that CMS work with the DME Medicare administrative contractors (DME MACs) to:

- strengthen Medicare requirements to ensure that DME MACs review accumulated costs of repairs made to wheelchairs during their 5-year RUL that exceeded a certain cost limit and use this cost limit as a basis for determining when wheelchairs furnished by suppliers would not remain serviceable for their entire RUL,

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- implement system edits to identify for review claims for repairs made to wheelchairs during their 5-year RUL when the accumulated costs of repairs had exceeded a certain cost limit, and
- take appropriate action for suppliers that consistently billed for repairs made to wheelchairs during their 5-year RUL that exceeded the federally recommended cost limit or the cost limit used as the basis for determining when wheelchairs furnished by suppliers would not remain serviceable for their entire RUL (e.g., by educating suppliers on proper billing and recovering improper payments).

The report contained one other recommendation.

HCPCS Codes Identified in This Audit:

- K0739 - Labor for repair of patient-owned durable medical equipment other than oxygen equipment, per 15 minutes.

Audit #: A-09-22-03003 (07/31/2023)
Government Program: CMS

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Behavioral Health

[NEW] Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers

- Medicare and Medicaid played significant roles in ensuring access to care for millions of enrollees with behavioral health conditions, which included mental health disorders and substance use disorders.
- Most Medicare and Medicaid enrollees' behavioral health care was covered by managed care plans. As a result, enrollees' access to providers was largely determined by the network of providers contracted by each plan.
- Plans had to provide enrollees with a list of all providers in their network, i.e., a network directory. This review assessed the extent to which selected plan networks were limited and whether the providers listed in each directory were actively providing services to the plan's enrollees.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- Many Medicare Advantage and Medicaid managed care plans had limited networks of behavioral health providers.
- These provider networks were further limited by including inactive providers who did not provide any services to enrollees.
- Most of these inactive providers should not have been listed as network providers by the plan. For example, these providers no longer worked at any of the locations listed by the plan or they indicated they would not see patients enrolled in the plan.
  - These inactive providers were sometimes referred to as "ghost" providers and could make the networks appear larger than they were.
- Providers cited administrative burden and low payment rates as factors affecting their willingness to work with managed care plans.

OIG recommended that:
1. Use data to monitor provider networks and take additional steps to improve the accuracy of network directories in Medicare Advantage.
2. Work with States to improve the accuracy of network directories in Medicaid managed care.
3. Continue exploring how a nationwide directory could reduce inaccuracies and increase administrative efficiencies for providers and patients.

Evaluation #: OEI-02-23-00540 (10/02/2025)
Government Program: CMS

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Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid

- Medicare and Medicaid played a significant role in providing access to care for millions of enrollees seeking behavioral health services for serious mental health challenges and substance use disorders.
- This review was part of a three-part series about access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care that OIG was conducting, in part, because of congressional interest in ensuring access to care. The first report in this series found that, overall, there were few behavioral health providers to treat Medicare and Medicaid enrollees in 2021.
- This review assessed whether providers who actively served Medicare and Medicaid patients could make new patient appointments for enrollees in 2023. Without enough actively participating behavioral health providers willing to treat new patients in Medicare and Medicaid, enrollees might have experienced delays in care and even forgone treatment altogether.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that Medicare and Medicaid enrollee access to needed behavioral health care was hampered not only by a lack of providers actively serving Medicare and Medicaid enrollees, but also by the inability of active providers to treat new patients. Forty-five percent of surveyed behavioral health providers reported that they were not available to treat new patients enrolled in traditional Medicare, Medicare Advantage, and Medicaid managed care. About three-quarters of behavioral health providers who were unavailable for new Medicare or Medicaid patients reported that they could not take on any new patients, many citing full caseloads. Among the behavioral health providers who were available to treat new patients enrolled in Medicare or Medicaid, about a quarter reported wait times of more than 30 days for an appointment.

OIG concluded that the findings of this report reiterated the importance of OIG's previous recommendations that were made in the first report of this series. Those recommendations could help address behavioral health provider shortages in Medicare and Medicaid, improve new patients' access to behavioral health care, and reduce wait times for new patient appointments.

Evaluation #: OEI-09-21-00410 (06/23/2025)
Government Program: CMS

Mental Health Center of Florida Generally Met Medicare Billing Requirements for Some Psychotherapy Services

- During calendar year 2019, Medicare Part B paid approximately $1 billion for psychotherapy services.
- Prior Office of Inspector General (OIG) audits of psychotherapy providers identified a high number of improper payments and found that providers did not always comply with Medicare billing requirements.
- This audit examined whether Mental Health Center of Florida (MHCF) complied with Medicare requirements when billing for psychotherapy services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- For 1 of 100 sampled claim lines, MHCF billed an incorrect Current Procedural Terminology (CPT) code. The error occurred because the provider inadvertently billed the incorrect CPT code.
- Since the audit period ended, MHCF stated that it updated its internal controls, including additional quality assurance steps, to increase compliance with Medicare requirements.

OIG recommended that Mental Health Center of Florida monitor and evaluate the effectiveness of its quality assurance program updates to ensure that documenting of time spent on psychotherapy services met Medicare requirements.

CPT Codes Identified in This Audit:

- 90837 - Psychotherapy for 60 minutes
- 90834 - Psychotherapy for 45 minutes
- 90832 - Psychotherapy for 30 minutes
- 90833 - Psychotherapy for 30 minutes with E&M;
- 90836 - Psychotherapy for 45 minutes with E&M;
- 90838 - Psychotherapy for 60 minutes with E&M;
- 90853 - Group Psychotherapy
- 90785 - Interactive Complexity

Audit #: A-04-21-06251 (02/19/2025)
Government Program: CMS

A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care

- Almost half of all Americans will experience a behavioral health condition--which includes mental health disorders and substance use disorders--in their lifetime.
- Without enough behavioral health providers willing to participate in Medicare and Medicaid, enrollees may have experienced difficulty accessing providers or delays in care and may even have forgone treatment altogether.
- The Office of Inspector General (OIG) conducted this review, in part, because of congressional interest in ensuring that enrollees had access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care (hereafter referred to as 'Medicaid').

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees. These providers represented about one-third of the total behavioral health workforce in the counties. Despite unprecedented demand for behavioral health services, treatment rates in all three programs remained relatively low. Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them.

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

1. Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.

2. Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.

3. Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.

4. Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

CPT Codes Identified in This Evaluation:

- 90839 - Psychotherapy for crisis; first 60 minutes
- 90840 - Psychotherapy for crisis; each additional 30 minutes

Evaluation #: OEI-02-22-00050 (03/29/2024)
Government Program: CMS

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 the 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 the 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).

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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 the 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 contained three other recommendations.

CPT Codes Identified in This Audit:

- 90837 - 60 minutes of psychotherapy
- 90834 - 45 minutes of psychotherapy
- 90832 - 30 minutes of psychotherapy
- 90833 - 30 minutes of psychotherapy with an E&M; service
- 90836 - 45 minutes of psychotherapy with an E&M; service
- 90838 - 60 minutes of psychotherapy with an E&M; service
- 90785 - interactive complexity add-on service

Audit #: A-09-21-03021 (05/02/2023)
Government Program: CMS

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By Requiring Emergency Preparedness Plans for Independent Labs, CMS Could Better Ensure That Medicare Enrollees Have Access to Infectious-Disease Diagnostic Testing During a Public Health Emergency

- A report published by the Pandemic Response Accountability Committee identified that Medicare paid more than $551 million for almost 8 million diagnostic tests for an emerging infectious disease at the beginning of a public health emergency (PHE) from February through August 2020. Almost 50 percent of these tests were performed at independent laboratories (labs). The report stated that various issues affected Medicare enrollees' access to this diagnostic testing, including availability of tests and shortages in medical supplies used to administer tests.
- CMS established national emergency preparedness requirements for certain provider types to ensure adequate planning for natural and human-caused disasters, facility emergencies, and emerging infectious diseases. Independent labs are not one of these provider types.
- This audit assessed whether CMS should require independent labs to have emergency preparedness plans to ensure that diagnostic tests related to the cause of a PHE are available to enrollees.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- By requiring emergency preparedness plans for independent labs, CMS could better ensure that enrollees had access to diagnostic testing related to an emerging infectious disease or a biological toxin that was the cause of a PHE.
- During the first 3 years of the PHE, independent labs performed the majority of enrollees' diagnostic tests related to the emerging infectious disease, and some independent labs experienced testing process and staffing issues that may have affected enrollees' access to tests.
- CMS did not have an emergency preparedness plan requirement for independent labs but had such a requirement for certain provider types that participated in Medicare.

OIG recommended that CMS consider requiring independent labs that participated in Medicare to have emergency preparedness plans to better ensure that Medicare enrollees had access to diagnostic testing related to an emerging infectious disease or a biological toxin in the event of a future PHE.

Audit #: A-09-23-03003 (09/04/2025)
Government Program: CMS

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Total Medicare Part B Spending on Lab Tests Decreased in 2023, Driven in Part by Less Spending on COVID-19 Tests

This review was part of an effort to help control Medicare lab test spending. The Protecting Access to Medicare Act of 2014 required that Medicare Part B payment rates align with rates paid by private payors. To provide oversight that these efforts were helping to control lab test spending, Congress also mandated that OIG publicly release an annual analysis of the top 25 tests based on Medicare spending and conduct analyses that OIG determined appropriate. This data snapshot provided an analysis of Medicare Part B payments for lab tests in 2023, including an analysis of the top 25 tests. From 2018 through 2020, CMS implemented new Medicare Part B lab test payment rates. In 2021, new payment rates were to go into effect; however, changes in legislation delayed any rate changes. The next payment rate changes were scheduled for January 1, 2027.

OIG analyzed Medicare Part B claims data for lab tests paid for under the Medicare Clinical Laboratory Fee Schedule in 2023. OIG identified key statistics and trends for total Medicare Part B 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 found that:

- In 2023, total Medicare Part B spending on clinical diagnostic laboratory tests (lab tests) decreased by 5.4 percent from total lab test spending in 2022.
- Spending on COVID-19 tests decreased significantly in 2023 due to several factors, including the widespread availability of over-the-counter COVID-19 tests.
- Medicare Part B spending on genetic tests has steadily increased over the last 10 years.

OIG concluded that this data snapshot contained no recommendations.

CPT Codes Identified in This Evaluation:

- 81528 - Genetic test: Gene analysis (colorectal cancer)
- 87798 - Detection test by nucleic acid for organism, amplified probe technique
- 85025 - Complete blood cell count (red cells, white blood cells, platelets), automated
- 82306 - Vitamin D-3 level
- 83036 - Hemoglobin A1C level
- 81455 - Genetic test: Test for detecting genes associated with cancer
- 80307 - Testing for presence of drug, by chemistry analyzers
- 0242U - Genetic test: Gene analysis of 55-74 genes associated with solid organ cancer in cell-free
- 87637 - COVID-19 test: Detection test by multiplex amplified probe technique for severe acute
- 83970 - Parathormone (parathyroid hormone) level
- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 82607 - Cyanocobalamin (vitamin B-12) level
- 0241U - COVID-19 test: Respiratory infectious agent detection by RNA for severe acute respiratory
- 80048 - Blood test, basic group of blood chemicals (calcium, total)
- 87635 - COVID-19 test: Amplified DNA or RNA probe detection of severe acute respiratory syndrome
- 84153 - PSA (prostate specific antigen) measurement, total
- 81542 - Genetic test: mRNA gene expression analysis of 22 genes in prostate tumor tissue

- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids (cholesterol and triglycerides)
- 84443 - Blood test, thyroid stimulating hormone (TSH).

HCPCS Codes Identified in This Evaluation:

- G0483 - Drug test(s), definitive, 22 or more drug class(es)
- U0003 - COVID-19 test: Infectious agent detection by nucleic acid (DNA or RNA); severe acute
- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- G0481 - Drug test(s), definitive, 8-14 drug class(es).

Evaluation #: OEI-09-24-00350 (12/20/2024)
Government Program: CMS

Potential Vulnerabilities in CMS Oversight of Medicare Add-on Payments for COVID-19 Tests Show That Oversight of Incentive Payments Could Be Improved

OIG understood that CMS had to quickly: (1) establish the payment rates for laboratories to bill for COVID-19 testing and create an add-on payment to incentivize laboratories to promptly complete COVID-19 tests and (2) establish documentation requirements to support the add-on payment. However, OIG believed that it was important for CMS and MACs to provide oversight of add-on payments to prevent fraud, waste, and abuse in the Medicare program. For incentive payments in general, it was important that CMS issue specific guidance on documentation that was expected to be maintained to support incentive payments and provide oversight to ensure that these payments were supported, especially in the event of a future public health emergency.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Centers for Medicare & Medicaid Services (CMS) established an add-on payment to incentivize laboratories to promptly complete COVID-19 tests (i.e., within 2 calendar days or less). Based on OIG's analysis of $339.4 million in Medicare add-on payments made to 9,380 laboratories for COVID-19 diagnostic tests provided to more than 4 million enrollees during the audit period (January 1, 2021, through June 30, 2022), OIG determined that more than two-thirds of laboratories that billed Medicare at least once for the add-on payment during the audit period billed for that payment with all of their COVID-19 tests. OIG also identified the following potential vulnerabilities related to CMS and the Medicare Administrators' (MACs') oversight of add-on payments for COVID-19 tests: (1) CMS requirements related to supporting documentation for add-on payments were vague, and documentation from the laboratories was inconsistent; and (2) CMS and the MACs did not perform adequate reviews of claims for add-on payments. To determine whether the incentive payment achieved the intended result of laboratories' prompt completion of COVID-19 tests, CMS would have had to perform manual reviews of supporting documentation, which could be difficult and costly to perform in the event of an audit or a medical review.

HCPCS Codes Identified in This Audit:

- U0005 - Add-on payment for COVID-19 tests completed within 2 calendar days or less from the date the specimen was collected
- U0003 - COVID-19 diagnostic test using a specific technique
- U0004 - COVID-19 diagnostic test using any technique

Audit #: A-09-22-03015 (05/08/2024)
Government Program: CMS

CMS Could Improve Its Procedures for Setting Medicare Clinical Diagnostic Laboratory Test Rates Under the Clinical Laboratory Fee Schedule for Future Public Health Emergencies

On March 13, 2020, the White House declared the COVID-19 outbreak a national emergency. This emergency posed unprecedented challenges to the delivery of health care including the establishment of sufficient lab testing capacity to help combat COVID-19. In response to the public health emergency (PHE) and these challenges, CMS had to quickly establish billing codes for new clinical diagnostic laboratory tests (CDLTs) and payment rates that would be adequate to cover labs' costs for conducting the tests. OIG's objective was to determine whether CMS's procedures for CDLT rate setting could be improved for future PHEs.

OIG reviewed applicable laws and regulations effective as of January 2018 related to CMS setting rates for new CDLTs. OIG reviewed those principles in the *Standards for Internal Controls in the Federal Government* (Green Book) that were determined to be relevant to the audit objective. OIG also conducted interviews with CMS and Medicare administrative contractor's (MAC's) pricing coordinators to obtain an understanding of the rate setting process that occurred from February 2020 through January 2021. OIG conducted interviews with officials from two laboratory associations to obtain an understanding of the communication they had with CMS and MACs during the PHE rate setting process.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS's procedures for CDLT rate setting could have been improved for future PHEs. Specifically, CMS could have improved its: (1) communication with laboratory associations and the MACs' pricing coordinators, and (2) procedures to provide the MACs with additional flexibility when they set interim CDLT rates to respond to a PHE. Neither the Clinical Laboratory Fee Schedule statute (CLFS) nor its implementing regulations specifically addressed how pricing coordinators could quickly set rates for new CDLTs before the lengthy public consultation rate setting process. Normally, CMS filled that delay by using its longstanding MAC interim rate setting policy. Accordingly, in March 2020, MACs set rates for new COVID-19 viral tests through CMS's interim MAC rate setting policy. However, CMS had to take additional action beyond its standard rate setting procedures to set and adjust rates for CDLTs.

As a result, CMS's standard rate setting procedures did not allow the MACs to set rates that were adequate to cover the cost of conducting COVID-19 viral tests for all laboratories during a time when CMS was working to increase testing capacity. CMS may have missed opportunities to obtain important information that could have improved its response to the COVID-19 pandemic from laboratory associations and the MACs' pricing coordinators when it made decisions about the new CDLT rates.

OIG recommended that CMS: (1) establish procedures to improve communication among all stakeholders involved in setting new CDLT rates during a PHE; and (2) improve its procedures, which may have required seeking legislative authority, for setting and adjusting rates for new CDLTs during a PHE.

CPT Codes Identified in This Audit:

- 87635 - COVID-19 tests involving infectious agent detection by nucleic acid

HCPCS Codes Identified in This Audit:

- U0002 - Non-CDC COVID-19 tests
- U0003 - COVID-19 tests involving infectious agent detection by nucleic acid using high-throughput technologies
- U0004 - Non-CDC COVID-19 tests using high-throughput technologies
- U0005 - Add-on payment for high-throughput COVID-19 tests completed within 2 days of specimen collection

Audit #: A-01-21-00506 (04/03/2024)
Government Program: CMS

Medicare Part B Spending on Clinical Diagnostic Laboratory Tests in 2022

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 delayed any rate changes; the next payment rate changes were scheduled for January 1, 2026. Since 2014, OIG had 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 found that 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 had 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. OIG's data snapshot contained no recommendations.

CPT Codes Identified in This Evaluation:

- 87798 - Detection test by nucleic acid for organism
- 83036 - Hemoglobin A1C level
- 83970 - Parathormone (parathyroid hormone) level
- 80307 - Testing for presence of drug, by chemistry analyzers
- 87635 - COVID-19 test: Amplified DNA or RNA probe detection of severe acute respiratory syndrome
- 87426 - COVID-19 test: Detection test by immunoassay technique for severe acute respiratory syndrome

- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 81455 - Genetic test: Test for detecting genes associated with cancer
- 82607 - Cyanocobalamin (vitamin B-12) level
- 80048 - Blood test, basic group of blood chemicals (Calcium, total)
- 84153 - PSA (prostate specific antigen) measurement, total.

HCPCS Codes Identified in This Evaluation:

- U0005 - COVID-19 test: Infectious agent detection by nucleic acid (DNA or RNA); severe acute
- U0004 - COVID-19 test: Any technique, high-throughput technologies
- G0483 - Drug test(s), definitive, 22 or more drug class(es)
- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- 0241U - COVID-19 test: Respiratory infectious agent detection by RNA for severe acute respiratory
- 0242U - Genetic test: Gene analysis of 55-74 genes associated with solid organ cancer in cell-free

Evaluation #: OEI-09-23-00350 (12/19/2023)
Government Program: CMS

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 have been legitimate reasons for the increased spending, the increases indicated 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 have been billed when testing for multiple genes associated with rare diseases. Because these diseases generally manifested in childhood, the genes associated with them would not generally have been tested for in the Medicare population, which was predominantly 65 years of age and older. Therefore, there was a risk of Medicare improper payments for this CPT code.

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.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found 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 conducted 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 the audit period. Because there were no longer payments for this CPT code by the end of the audit period (December 31, 2021), OIG considered the issues identified by this audit corrected. However, based on the results of the audit, up to $888.2 million in Medicare payments made for CPT code 81408 claims that OIG identified for the audit period were at risk of improper payment.

OIG recommended that CMS direct the appropriate Medicare contractors to:

- review claims billed under CPT code 81408 for the audit period to determine whether they complied with Medicare requirements; and
- determine the amount of improper payments for the claims that did not comply with Medicare requirements and, for those that were 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 the audit period.

The report contained one other recommendation.

CPT Codes Identified in This Audit:

- 81400 - Level 1 Molecular Pathology Procedure (least complex)
- 81408 - Level 9 Molecular Pathology Procedure (most complex)

ICD Codes Identified in This Audit:

- E7800 - Pure hypercholesterolemia, unspecified
- Z1509 - Genetic susceptibility to other malignant neoplasm
- Z8546 - Personal history of malignant neoplasm of prostate
- E785 - Hyperlipidemia, unspecified
- I429 - Cardiomyopathy, unspecified
- I2510 - Atherosclerotic heart disease of native coronary artery without angina pectoris

Audit #: A-09-22-03010 (06/21/2023)
Government Program: CMS

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Medicare Could Have Saved up to $216 Million Over 5 Years if Program Safeguards Had Prevented At-Risk Payments for Definitive Drug Testing Services

Drug testing was generally used to detect the presence or absence of drugs in patients undergoing treatment for pain management or substance use disorders. Medicare payments for definitive drug testing services increased based on the number of drug classes tested. The Centers for Medicare & Medicaid Services (CMS) identified overpayments for the definitive drug testing service with the highest reimbursement amount (procedure code G0483, definitive drug testing for 22 or more drug classes) due to noncompliance with Medicare requirements. In addition, a prior OIG report on drug testing services identified that payments for G0483 were at risk for overpayments.

OIG's objective was to identify Medicare Part B payments for definitive drug testing services that were at risk for noncompliance with Medicare requirements.

OIG's audit covered $3 billion in Medicare Part B payments for definitive drug testing services with dates of service from January 2016 through December 2020 (audit period). These payments were made to 1,062 "at-risk providers," which routinely billed procedure code G0483 (for 75 percent or more of their definitive drug testing services), and 4,227 "other providers," which did not routinely bill this service. OIG compared characteristics of the at-risk providers and other providers.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for the 5-year audit period, Medicare paid $704.2 million for definitive drug testing services that were at risk for noncompliance with Medicare requirements. Specifically, these payments were for the definitive drug testing service with the highest reimbursement amount (procedure code G0483). These payments were made to 1,062 at-risk providers that routinely billed this procedure code and may not have been reasonable and necessary. OIG determined that presumptive drug testing preceded most definitive drug testing services billed by both the at-risk and other providers. However, the at-risk providers may not have always used presumptive testing to determine the number of drug classes that needed to be tested using definitive drug testing, because they routinely billed for testing 22 or more drug classes using G0483 and the other providers did not. Although the at-risk providers billed a significantly higher percentage of definitive drug testing services using G0483 than the other providers, the at-risk and other providers had similar characteristics (such as the types of patients they tested and the frequency of testing). This suggested that the at-risk providers may have been able to bill for definitive drug testing services using primarily procedure codes with lower reimbursement amounts, as the other providers did.

If CMS's program safeguards had focused on at-risk payments to at-risk providers for procedure code G0483, Medicare could have saved up to $215.8 million for the audit period.

OIG recommended that CMS:

(1) expand program safeguards to prevent and detect at-risk payments to at-risk providers for procedure code G0483;
(2) review at-risk payments made to at-risk providers during and after the audit period and recover any overpayments;
(3) notify appropriate providers to exercise reasonable diligence to identify, report, and return any overpayments; and
(4) educate providers that received payments that did not comply with Medicare requirements.

CPT Codes Identified in This Audit:

- 80305 - Presumptive drug test, low complexity
- 80306 - Presumptive drug test, moderate complexity
- 80307 - Presumptive drug test, high complexity

HCPCS Codes Identified in This Audit:

- G0480 - Definitive drug test, 1-7 drug classes
- G0481 - Definitive drug test, 8-14 drug classes
- G0482 - Definitive drug test, 15-21 drug classes
- G0483 - Definitive drug test, 22+ drug classes
- G0659 - Simple definitive drug test for all classes

ICD Codes Identified in This Audit:

- Z79.891 - Long term (current) use of opiate analgesic

Audit #: A-09-21-03006 (02/27/2023)
Government Program: CMS

Telehealth

Additional Oversight of Remote Patient Monitoring in Medicare Is Needed

- Medicare broadly covered remote patient monitoring of health data for any chronic or acute condition.
- The use of remote patient monitoring had the potential to greatly expand in the Medicare population.
- As a result, there was an increasing need to know how remote patient monitoring was being used, including who was receiving it and for what conditions, as well as a need to identify any vulnerabilities that might limit the oversight of these services.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- The use of remote patient monitoring in Medicare increased dramatically from 2019 to 2022.
- About 43 percent of enrollees who received remote patient monitoring did not receive all 3 components of it, raising questions about whether the monitoring was being used as intended.
- OIG and CMS had raised concerns about fraud related to remote patient monitoring.
- Medicare lacked key information for oversight, including who ordered the monitoring for the enrollee.

  Taken together, OIG's findings demonstrated the need for additional oversight to ensure that remote patient monitoring was being used and billed appropriately.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) take the following steps to strengthen oversight of remote patient monitoring:

1. Implement additional safeguards to ensure that remote patient monitoring was used and billed appropriately in Medicare.
2. Require that remote patient monitoring be ordered and that information about the ordering provider be included on claims and encounter data for remote patient monitoring.
3. Develop methods to identify what health data were being monitored.
4. Conduct provider education about billing of remote patient monitoring.
5. Identify and monitor companies that billed for remote patient monitoring.

CPT Codes Identified in This Evaluation:

- 99091 - Treatment management service that includes time for providers to communicate with patients about their data and related treatment decisions
- 99453 - Education and setup of remote patient monitoring
- 99454 - Device supply for remote patient monitoring
- 99457 - Remote patient monitoring treatment management services
- 99458 - Additional treatment management services for remote patient monitoring

Evaluation #: OEI-02-23-00260 (09/19/2024)
Government Program: CMS

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Other Providers and Suppliers

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 became increasingly important to ensure that enrollees received 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 during the 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 did 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.

CMS elected not to provide comments on OIG's draft report.

CPT Codes Identified in This Audit:

- 99213 - Established patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
- 99214 - Established patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

- 99215 - Established patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
- 99201 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- 99202 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 99203 - New patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 99204 - New patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 99205 - New patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
- 99211 - Established patient office or other outpatient visit. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- 99212 - Established patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family

Audit #: A-01-21-00501 (02/13/2024)
Government Program: CMS

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 showed that payments for end-stage renal disease (ESRD)-related telehealth services increased almost 10,000 percent from 2019. Oversight of telehealth expansion was increasingly important to ensure that Medicare enrollees received 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 considered 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 OIG to determine whether the services were provided using 1) audiovisual interactive technology and 2) technology that was non-public-facing.

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

OIG concluded that 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.

CPT Codes Identified in This Audit:

- 90951 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90962 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90963 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90966 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90967 - Age-specific and based on the number of visits for less than a month of service, billed per day
- 90970 - Age-specific and based on the number of visits for less than a month of service, billed per day

Audit #: A-05-22-00015 (08/01/2023)
Government Program: CMS

Other Providers and Suppliers

[NEW] Florida Retina Institute Generally Met Medicare Requirements for Ophthalmology Services Provided on the Same Day as Eye Injections

- Prior OIG work found that Medicare inappropriately paid for services that were billed as being unrelated to, distinct from, or significant and separately identifiable from injections of drugs into the eye (i.e., intravitreal injections) or other services provided on the same day.
- OIG's analysis showed that the Florida Retina Institute (FRI) frequently billed for ophthalmology services provided on the same day as intravitreal injections, and its billing patterns were similar to those found in previous OIG audits that identified improper billing for ophthalmology services.
- This audit assessed whether FRI complied with Medicare requirements when billing for ophthalmology services provided on the same day as an intravitreal injection during calendar years 2020 and 2021.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- FRI generally complied with Medicare requirements when billing for ophthalmology services provided on the same day as intravitreal injections. For 92 of the 100 sampled patient days, FRI complied with Medicare requirements for all services billed; for 8 sampled patient days it did not. Specifically, FRI incorrectly billed Medicare for services that were not medically necessary and not separately identifiable from the intravitreal injection.
- OIG estimated that Medicare made overpayments totaling at least $42,295 to FRI for ophthalmology services that did not comply with Medicare requirements.
- The overpayments in OIG's sample occurred because FRI did not fully implement its policy of monitoring its claims process to promptly identify deficiencies that would affect the accuracy of its claims.

OIG recommended FRI refund the $42,295 in Medicare overpayments.

CPT Codes Identified in This Audit:

- 67028 - Intravitreal injection, a procedure where medication is injected into the eye to treat diseases like wet age-related macular degeneration.

Audit #: A-04-22-04086 (12/02/2025)
Government Program: CMS

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[NEW] Four of Thirty Selected Dental Providers Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments

- Congress had appropriated $178 billion to HHS to provide funds to eligible providers for health care-related expenses or lost revenues attributable to COVID-19 under the Provider Relief Fund (PRF) program. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Providers receiving PRF payments were to ensure that the payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues attributable to COVID-19; (3) not used to cover expenses or losses reimbursed by other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities.
- This audit was part of a series reviewing PRF payments to various provider types. Specifically, this audit assessed whether 30 selected dental providers expended taxpayer funds in accordance with Federal and program requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 30 selected dental providers OIG reviewed, 4 dental providers inaccurately calculated and reported $3.4 million of lost revenues. These four dental providers received a total of $14.8 million in PRF payments. The remaining dental providers used PRF payments for allowable expenses and accurately calculated lost revenues.
- These deficiencies occurred because although dental providers attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, some dental providers misinterpreted HRSA's guidance on calculating patient care lost revenues and used incorrect revenue amounts in their lost revenue calculations.

OIG recommended that HRSA require the selected dental providers to return to the Federal Government any PRF payments used to offset inaccurately calculated lost revenue amounts or properly account for these lost revenues.

Audit #: A-02-23-01013 (11/25/2025)
Government Program: HRSA

Massachusetts Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Emergency Preparedness

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Massachusetts, the State's Department of Public Health (State agency) conducted surveys of ICF/IIDs for compliance with Federal requirements.
- This audit was the first in a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the State agency generally ensured that the ICF/IIDs complied with Federal requirements for infection control. However, OIG identified 44 deficiencies related to life safety and emergency preparedness at the 2 ICF/IIDs operated by Massachusetts. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

OIG recommended that the State agency:
1. Follow up with the two ICF/IIDs to verify that they had taken corrective actions on the life safety and emergency preparedness deficiencies identified during the audit.
2. Work with CMS to develop standardized life safety training for ICF/IID staff.

Audit #: A-01-24-00001 (10/23/2024)
Government Program: CMS

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 were required to submit an annual cost report to their Medicare administrative contractor (MAC). Cost reports were financial documents that conveyed the provider's costs associated with providing services to people enrolled in Medicare. A MAC could decide to audit a provider's cost report before bringing it to final settlement. If there was an error made in the final settlement, the MAC could 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 found 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 the 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.

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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 were better qualified to detect incorrect audit adjustments.

Audit #: A-06-22-05000 (11/01/2023)
Government Program: CMS

FDA Could Take Stronger Enforcement Action Against Tobacco Retailers With Histories of Sales to Youth and Other Violations

Youth tobacco use in the United States remained a high public health concern. FDA's Tobacco Retailer Compliance Check Inspection Program was a critical part of its approach to prevent youth access to tobacco. Through that program, FDA inspected tobacco retailers to determine whether they were in violation of tobacco law or regulation. If FDA found a violation, it might issue an advisory action, such as a warning letter, or an enforcement action, such as a civil money penalty. When FDA issued an enforcement action, it had to consider mitigating factors including the nature, circumstances, extent, and gravity of the violation and, with respect to the violator, ability to pay, effect on ability to continue to do business, any history of prior such violations, and the degree of culpability.

OIG analyzed data from FDA on retailer inspections; violations; and advisory and enforcement actions from 2010 through 2019. OIG also analyzed retailer inspection and violation histories for a random sample of retailers that were subject to enforcement actions. To determine whether FDA inspection, advisory, or enforcement actions varied by neighborhood socioeconomic characteristics, OIG compared FDA inspection data to the Area Deprivation Index. OIG also interviewed FDA officials about the agency's direction and management of the retailer compliance check inspection program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that FDA conducted more than one million inspections from 2010 through 2019, by inspecting, at least once, 74 percent of tobacco retailers that were in business nationwide as of 2020. FDA almost always returned to inspect retailers where it found violations within 12 months. In some States, inspection activities were correlated with neighborhoods' socioeconomic conditions, raising questions about how FDA and its contractors selected retailers to inspect. Overall, FDA's actions against retailers that violated tobacco laws and regulations were in accord with its policies.

However, retailers with histories of violations were often not subject to the strongest enforcement actions. FDA collected the full amount for only 9 percent of the civil money penalties (CMPs) it issued to retailers with histories of violations

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compared to 60 percent of CMPs it issued to retailers with fewer violations. Also, retailers in the sample that could have been subject to a no-tobacco-sale order usually did not receive one. However, OIG did not determine the extent to which FDA's consideration of mitigating factors or actions by Administrative Law Judges played a role in these outcomes.

OIG recommended that FDA (1) give greater weight to retailers' past noncompliance when taking enforcement actions against retailers with histories of violations and (2) determine whether variation in inspection activity on the basis of neighborhoods' socioeconomic status was appropriate and the extent to which it was meeting FDA's objective for protecting vulnerable populations.

Evaluation #: OEI-01-20-00240 (09/18/2023)
Government Program: FDA

Novitas Solutions, Inc., Claimed Some Unallowable Medicare Nonqualified Plan Costs Through Its Incurred Cost Proposals

The Centers for Medicare & Medicaid Services (CMS) reimbursed a portion of its contractors' nonqualified plan costs.

The Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services, Region VII pension audit team reviewed the cost elements related to qualified defined-benefit, postretirement benefit, and any other pension-related cost elements claimed by Medicare contractors through Incurred Cost Proposals (ICPs).

Previous OIG audits found that Medicare contractors did not always correctly identify and claim nonqualified plan costs.

OIG's objective was to determine whether the calendar years (CYs) 2016 through 2018 nonqualified plan costs that Novitas Solutions, Inc. (Novitas), claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

OIG reviewed $1.9 million of Medicare nonqualified costs that Novitas reported on its ICPs for CYs 2016 through 2018.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Novitas claimed Medicare nonqualified costs of $1.9 million for Medicare reimbursement, through its ICPs, for CYs 2016 through 2018. However, OIG determined that the allowable costs during this period were $1.8 million. The difference, $84,291, represented unallowable nonqualified costs that Novitas should not have claimed on its ICPs for CYs 2016 through 2018. This overstatement occurred primarily because Novitas based its claims for Medicare reimbursement on incorrectly calculated Cost Accounting Standards-based nonqualified costs.

OIG recommended that Novitas work with CMS to ensure that its final settlement of contract costs reflected a decrease in Medicare nonqualified costs of $84,291 for CYs 2016 through 2018.

Audit #: A-07-23-00633 (09/12/2023)
Government Program: CMS

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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) performed or coordinated 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.

The objective was to determine whether independent OPOs' professional and public education overhead costs met Medicare requirements.

The 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). The 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 the sample results and additional findings OIG identified during the 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.

Audit #: A-09-21-03020 (08/09/2023)
Government Program: CMS

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 made monthly capitation payments (MCPs) to physicians and qualified nonphysician practitioners managing patients in a dialysis center. The MCP covered 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 of 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 the 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.

OIG 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
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 the audit period.

The report contained one other recommendation.

CPT Codes Identified in This Audit:

- 90960 - ESRD-related services for an enrollee with four or more face-to-face visits during the sampled enrollee-month.

Audit #: A-09-21-03016 (06/27/2023)
Government Program: CMS

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

Medicare covered 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 OIG audit found that Medicare improperly paid for facet-joint denervation sessions. Because facet-joint interventions were at risk for overutilization and prior audits had 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 the 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 one 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 the audit period.

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least one 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 were specific to Medicare requirements for facet-joint interventions, which could have saved an estimated $29.6 million for the 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 contained one other recommendation.

CPT Codes Identified in This Audit:

- 64633 - Denervation of a single facet joint in the cervical/thoracic spine
- 64635 - Denervation of a single facet joint in the lumbar/sacral spine
- 64634 - Denervation of each additional facet joint in the cervical/thoracic spine
- 64636 - Denervation of each additional facet joint in the lumbar/sacral spine
- 64490 - Injection to a single facet-joint level in the cervical/thoracic spine
- 64493 - Injection to a single facet-joint level in the lumbar/sacral spine
- 64491 - Injection to the second facet-joint level in the cervical/thoracic spine
- 64492 - Injection to the third and any additional facet-joint levels in the cervical/thoracic spine
- 64494 - Injection to the second facet-joint level in the lumbar/sacral spine
- 64495 - Injection to the third and any additional facet-joint levels in the lumbar/sacral spine

Audit #: A-09-22-03006 (03/22/2023)
Government Program: CMS

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 allowed 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 Medicare did not always pay physicians for spinal facet-joint denervation and injection sessions in accordance with Federal requirements.

The objective was to determine whether Medicare paid physicians for epidural steroid injection sessions in accordance with Medicare requirements.

During the 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.

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Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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 the 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 the 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 determined this audit constituted credible information of potential overpayments) so that the physicians could 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 were 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.

CPT Codes Identified in This Audit:

- 62320 - 62321
- 62325 - Injection of anesthetic and/or steroid drug into the cervical or thoracic spinal region with imaging guidance and contrast
- 64479 - 64480
- 64483 - 64484

Audit #: A-07-21-00618 (03/10/2023)
Government Program: CMS