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# November 2023 OIG Work Plan Updates

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November was a very busy time for the Department of Health and Human Services Office of Inspector General (OIG) Work Plan. Fifteen new items were added during the month. Below are some of the notable items added this last month.

## INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Individuals with intellectual disabilities often stay at an Intermediate Care Facility (ICF), which is an institution that provides health and/or rehabilitation services to individuals under the Medicaid program.

These residential facilities are licensed by state survey agencies. Medicaid covers these types of services for more than 100,000 individuals. The ICFs often face challenges with emergencies such as fires, infectious disease outbreaks, and natural disasters.

The OIG states their previous audits on infection prevention and control, emergency preparedness, and life safety at nursing homes identified issues that put Medicaid enrollees at increased risk. The OIG's goal with this work plan item is to determine whether selected ICFs complied with Federal requirements for infection prevention and control, emergency preparedness, and life safety.

## AUDIT OF NURSING HOMES

Nursing homes are a focus point for the HHS OIG. In April, the Inspector General Christi Grimm spoke at the HCCA's Compliance Institute and said, "You have heard me say that nursing homes are my top priority. Improving nursing home care for those who need it is front-of-mind for the OIG team."

True to their word, the OIG has been adding Work Plan items related to nursing homes for a long time now. This newly announced audit will review the accuracy of the nurse staffing hours reported to CMS.

Nursing homes electronically submit direct care staffing information to the Centers for Medicare and Medicaid Services' (CMS) Payroll-Based Journal (PBJ) system. This is done on a quarterly basis. Direct care staff include nurses and non-nursing staff who have contact with the residents of the nursing home in the many facets of care provided.

According to the OIG, CMS and other stakeholders use the staffing information in the PBJ to:

1. Measure nursing home performance
2. Better understand the relationship between nursing home staffing levels and the quality of care that nursing homes provide.
3. Identify noncompliance with Federal nurse staffing regulations.
4. Facilitate the development of nursing home staffing measures.

The OIG plans to review the nurse staffing hours reported in the PBJ to determine whether the reported hours are accurate.

## MEDICARE PART C AUDITS

The other area Ms. Grimm mentioned at the HCCA conference as a priority for the OIG is managed care or Medicare Part C. She stated: "The expansion of managed care, especially over the last decade, has come with growing pains that have strained program integrity and highlighted compliance weaknesses. OIG's audits, evaluations, and investigations have demonstrated that risks of fraud, waste, and abuse in managed care are real and significant."

OIG plans to audit high risk codes reported by Medicare Advantage (MA) organizations. MA organizations are required to submit risk-adjustment data to CMS. Inaccurate diagnoses can cause CMS to pay MA organizations incorrect amounts. In general, MA organizations receive higher payments for enrollees with more complex diagnoses. CMS estimates that almost 10% of payments to MA organizations are improper. They report the main reason for this error rate is unsupported diagnoses submitted by MA organizations.

In recent years, the OIG has performed many audits and reviews that have identified some diagnoses are more at risk than others to be unsupported by medical record documentation. The OIG will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses in compliance with Federal requirements.

A second Medicare Part C area the OIG intends to review includes health risk assessment diagnosis codes. Payments to MA organizations are risk-adjusted based on each enrollee's health status. One tool MA organizations use to collect risk-adjusted data is the health risk assessment (HRA), which gathers information about enrollees, including health status and health risks.

For these audits, the focus will be on enrollees whose diagnoses, reported only on HRAs, mapped to a hierarchical condition category and resulted in increased risk-adjusted payments from CMS to MA organizations. OIG will determine whether these diagnosis codes complied with Federal requirements.

## CONCLUSION

These are just a few of the many areas added to the OIG's Work Plan in November. Make sure to review all the newly added items to determine if these new items apply to your organizations. compliance action as necessary.

> The expansion of managed care, especially over the last decade, has come with growing pains that have strained program integrity and highlighted compliance weaknesses.
>
> **-Inspector General Christi Grimm**

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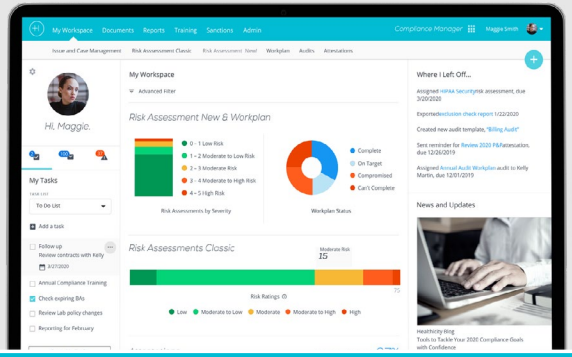


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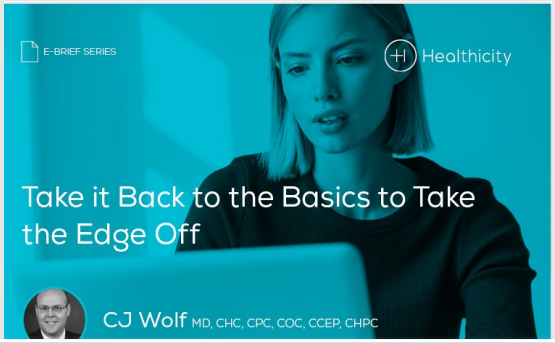


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