➢ State agency verification of deficiency corrections

We will determine whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys. A prior OIG review found that one State survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with Federal requirements. Federal regulations require nursing homes to submit correction plans to the State survey agency or CMS for deficiencies identified during surveys. (42 CFR § 488.402(d).) CMS requires State survey agencies to verify the correction of identified deficiencies through onsite reviews or by obtaining other evidence of correction. (*State Operations Manual*, Pub. No. 100-07, § 7300.3.) (OAS; W-00-13-35701; W-00-14-35701; various reviews; expected issue date: FY 2015)

➢ Program for national background checks for long-term-care employees

We will review the procedures implemented by participating States for long-term-care facilities or providers to conduct background checks on prospective employees and providers who would have direct access to patients and determine the costs of conducting background checks. We will determine the outcomes of the States' programs and determine whether the programs led to any unintended consequences. Section 6201 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of Health and Human Services to carry out a nationwide program for States to conduct national and State background checks for prospective direct patient access employees of nursing facilities and other long-term-care providers. The program is administered by CMS. To carry out the nationwide program, CMS has issued solicitations for grant awards. All States, the District of Columbia, and U.S. territories are eligible to be considered for a grant award. OIG is required under the ACA to submit a report to Congress evaluating this program. This mandated work is ongoing and will be issued at the program's conclusion, as required. (ACA, § 6401.) (OEI; 07-10-00420; expected issue date: FY 2015; ACA)

➢ Hospitalizations of nursing home residents for manageable and preventable conditions

We will determine the extent to which Medicare beneficiaries residing in nursing homes are hospitalized as a result of conditions thought to be manageable or preventable in the nursing home setting. A 2013 OIG review found that 25 percent of Medicare beneficiaries were hospitalized for any reason in FY 2011. Hospitalizations of nursing home residents are costly to Medicare and may indicate quality-of-care problems in nursing homes. (OEI; 06-11-00041; expected issue date: FY 2015)

Hospices

Acronyms and Abbreviations for Selected Terms:

ALF—assisted living facility
CMS—Centers for Medicare & Medicaid Services
MedPAC—Medicare Payment Advisory Commission

➢ Hospices in assisted living facilities

We will review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities (ALFs). We will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs. Pursuant to the ACA, § 3132, CMS must reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. Our work is intended to provide HHS with information relevant to these requirements. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) Hospice care may be provided to individuals and their families in various settings, including the beneficiary's place of residence, such as an ALF. ALF residents have the longest lengths of stay in hospice care. MedPAC has said that these long stays bear further monitoring and examination. (OEI; 02-14-00070; expected issue date: FY 2015; ACA)

➢ Hospice general inpatient care

We will review the use of hospice general inpatient care. We will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. We will also review hospice medical records to address concerns that this level of hospice care is being misused. Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of participation (CoP) for hospices. (42 CFR Part 418.) Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. (42 CFR § 418.28.) (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2015)

Home Health Services

Acronyms and Abbreviations for Selected Terms:

CMS—Centers for Medicare & Medicaid Services
HHA—home health agency
PPS—prospective payment system

➢ Home health prospective payment system requirements

We will review compliance with various aspects of the home health PPS, including the documentation required in support of the claims paid by Medicare. We will determine whether home health claims were paid in accordance with Federal laws and regulations. A prior OIG report found that one in four home health agencies (HHAs) had questionable billing. Further, CMS designated newly enrolling HHAs as high-risk providers, citing their record of fraud, waste, and abuse. Since 2010, nearly $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit. Home health services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. (OAS; W-00-13-35501; W-00-14-35501; various reviews; expected issue date: FY 2015)