Creating a Compliance Plan in the New Post-Acute World

HCCA’s 23rd Annual Compliance Institute

4.8.2019

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Considering Audit and Training Plans
- OIG Messaging
- Recent CIAs
- Work Plan Items

Identifying Internal Risk Areas
(Identify the “right” risks)

Reviewing Changing Reimbursement Models

Reviewing Changing Regulatory Requirements

Incorporating OIG Priorities

Considering Audit and Training Plans

Building Your Compliance Plan

What we will discuss today:

• Requirements of Participation
We Need to Identify the Risks

- Risks turn into areas of focus
- Focus areas turn into metrics
- Metrics turn into dashboards
Importance of Identifying the Right Risks

We all know that:

- If it isn’t documented – it didn’t happen
- If it isn’t tracked – you can’t identify improvement or increased risk
- If outcomes aren’t communicated – you don’t know where to focus resources on improvement or remediation

As a result:

- If you don’t monitor the right metrics – are you burying your head in the sand?
- How will you defend “knew or should have known”?

Roadblocks in Finding the Right Risks

- Siloed departments
- Limited collaboration
- Multiple departments looking at same risk areas with different outcomes
- Lack of coordinated corrective actions
# How do I Identify the Right Risks?

## Organizational Processes:

- Do you have **Strategic Planning Meetings**?
  - Gathering risks from Leadership in all areas

- Do you conduct a **Risk Assessment** annually?

- Does your **Compliance Committee** provide input or identify risk areas?

- Do you have **cross-organizational** or cross-department insights into risk areas?

- Do you have a **standardized method** to prioritize risks across the organization?

## Regulatory & Historical Risks

- Do you know what **regulatory changes** are happening in the coming year?
- Do you know the **areas of focus** by CMS, OIG, State agencies, payors, or surveyors related to your line of business or businesses?
- Do you know where you **missed the mark** last year?
- Do you know where you **improved** and may not need to monitor in the upcoming year?

Are your metrics reflective of these risk areas?
Changing Reimbursement Models

Compliance Issues In Light of Payment Reform

Utilization of ICD-10 coding correctly – coding of diagnosis going from low priority to high priority

UB-04 crosswalk to ICD-10 – facilities will need effective partnership with PT/OT/SLP, NP and even MD to make sound judgement calls on determining which specific primary diagnosis to use (moving away from UB-04 terminology)

Accurate tracking of group/concurrent therapy to avoid exceeding the cap (understanding potential penalties and oversight plan for this cap)

Will therapy utilization be scrutinized for “clustering” at the cap? (similar to “RUG hugging” that occurs under RUGs IV)

Scrutiny of assessment discretion: only an initial reimbursement assessment is required – additional assessments at the discretion of providers. What happens if large aggregate of reassessments are limited to outcomes increasing reimbursement?

New types of documentation needed to support traditionally neglected areas under RUGs – MDS GG, diet, swallowing, cognitive declines

Consistency between ICD-10 codes and the MDS
### SNF - PDPM Risks

#### What to look for:

<table>
<thead>
<tr>
<th>What to look for</th>
<th>CMS will continue to monitor therapy minutes – will you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate change in volume of therapy provided</td>
<td>How will you monitor for this?</td>
</tr>
<tr>
<td>25% concurrent therapy “warning”</td>
<td>How will you monitor for patterns of increase in volume of a particular condition such as depression?</td>
</tr>
<tr>
<td>Presence of conditions/services impacting payment</td>
<td>How will you monitor for volume of IPA’s and percentage resulting in increased reimbursement?</td>
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<tr>
<td>Interim Payment Assessment (IPA) – relates to significant change in condition</td>
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### Changing Requirements of Participation
RoP

Phase II
• Have you updated your Facility Assessment?
• How are you continuing to evaluate and updated staff competency based on turnover?
• How are you monitoring for changes in acuity which may impact the Facility Assessment?
• Are you monitoring for compliance with Phase II components?

Phase III:
• Have you determined who will be the Compliance Liaison in your skilled nursing facilities?
• Do you need to train your Facility Compliance Liaisons on the “basics” of compliance? Seven elements?
• How are you going to perpetuate the education for this role?

The Phase III Requirements of Participation are likely a whole “project” but don’t leave them/off your Compliance Plan

OIG Areas of Focus
CIA Components

- Board Expectations - Participation
- Management Certifications
- Training Plan
- Risk Assessment and Internal Review Program
- IRO or Quality Monitor
- Quality CIA
  - Staffing (quantity, quality and composition)
  - Quality of Care Review Program

(As presented by OIG at AHLA conference February 2019)

Risk Areas:

- Medical Necessity
- Homebound Status
- Therapy Overutilization
- Technical signatures/dates on 485 (Care Plan)
- Inappropriate referrals
- Paying Medical Directors more than Fair Market Value for administrative services

(As presented by OIG at AHLA conference February 2019)
Hospice High Risk Areas

**Risk Areas:**

- Eligibility
- Levels of Care
  - Routine, Respite, General Inpatient (GIP), Continuous Home Care
- Lengths of Care
- Technical Requirement
- Inappropriate Referrals
- Paying Medical Directors more than Fair Market Value
- Incentive Programs

*(As presented by OIG at AHLA conference February 2019)*

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OIG – SNF “Red Flags” of quality of care concerns

**Clinical:**

- Pressure ulcers in low-risk long-stay residents
- Dehydration and urinary tract infections
- Weight loss
- Increasing percentages of residents requiring help with ADLs

**Operational:**

- Change in Ownership
- Lack of Resident and/or Family Councils
- Staff Turnover

*(As presented by OIG at AHLA conference February 2019)*
OIG – SNF Commitment to Quality

- Forum for quality issues
- Regular reports to the Board
- Active questioning
- Mission Statement
- Board member training/education
- Strategic and capital planning
- Resources for staff training and retention
- Culture of quality
- Having necessary structures and processes

OIG’s Quality and Compliance Expectations

(As presented by OIG at AHIA conference February 2019)

OIG – SNF Process Measures

- Quality data reports to the Board
- Develop Board expertise and understanding of quality data and issues
- Quality subcommittee
- Validation of data/information
- Free flow of information
- Coordinated response to quality problems
- Systemic corrective action
- Staff retention, training and competency

(As presented by OIG at AHIA conference February 2019)
OIG – SNF Outcome Measures

OIG’s Quality and Compliance Expectations

- Use of quality outcomes
  - State Surveys
  - QIs/QMs
  - Event reporting
  - Employee, resident and family surveys
  - Staff turnover
  - Complaints
- Consistent and useful tracking of quality outcomes
- Trend data and contract and compare
- Do not overwhelm with data; focus on key areas

(As presented by OIG at AHLA conference February 2019)

OIG WORK PLAN UPDATES

New Process:
- Effective June 15, 2017

Rather than annual Work Plan:

Monthly Updates:
- “to enhance transparency around OIG's continuous work planning efforts”
Audit Plans and Training Plans

Audit Plan

Consider:

- Do you know how many audits are being conducted?
- How many duplicate audits are conducted in your organization?
- Do you have a central location to track audit outcomes?
- How do you communicate audit results?
- How do you ensure corrective actions are completed based on your findings?
- What are you tracking and trending?
Consider?

• Compliance training (of course)
• Can you incorporate a “compliance message” in every training?
• Are you tracking timeliness of training completion?
• Do you have post-tests? If so, do monitor the scores or number of times it takes to pass?
• Do you have role-based training?

GET STARTED – BUILD YOUR WORK PLAN
CREATING YOUR WORK PLAN

Step 1: Carefully analyze the risks that face the organization
Step 2: Consider regulatory changes or historical areas of non-compliance
Step 3: Incorporate mandatory "areas" of monitoring (regulatory, statutory)
Step 4: Identify high risk areas published by OIG, CMS, MFCU
Step 5: Prioritize/score the risks (A whole webinar of its own)
Step 6: Determine what the “right” risks are for your organization
Step 7: Now begin building the monitoring process and dashboard

Collaboration and Communication

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risks are identified throughout the organization</td>
<td>• Regulatory Changes are communicated</td>
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<tr>
<td>• Regulatory changes are monitored by SME</td>
<td>• Education is updated</td>
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<tr>
<td>• Policy Changes are tracked</td>
<td>• Joint dashboards to monitor risk areas are created</td>
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<tr>
<td>• Metrics are shared cross-department</td>
<td>• Compliance is tracked</td>
</tr>
<tr>
<td></td>
<td>• Remediation is Completed</td>
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<td>• Process improvement is documented</td>
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Questions?

Thank you for joining us!

4.8.2019

Barbara J. Duffy
Shareholder

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Chief Compliance Officer

OIG Recent OIG Updates

For your Reference
**Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid**

Medicare Home Health Agency (HHA) coverage requirements state that an HHA is responsible for providing all services either directly or under arrangement while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare pays a single HHA overseeing that plan. “Dual eligible beneficiaries” generally describes beneficiaries eligible for both Medicare and Medicaid. Medicare pays covered medical services first for dual eligible beneficiaries because Medicare is generally the payer of last resort. We will determine whether states made Medicaid payments for home health services for dual eligible beneficiaries who are also covered under Medicare.

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<th>Expected Issue Date (FY)</th>
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<td>January 2019</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid</td>
<td>Office of Audit Services</td>
<td>W-00-19-31141</td>
<td>2020</td>
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**CMS Oversight of Nursing Facility Staffing Levels**

Staffing levels in nursing facilities can impact residents’ quality of care. Nursing facilities that receive Medicare and Medicaid payments must provide sufficient licensed nursing services 24 hours a day, including a registered nurse for at least 8 consecutive hours every day. CMS uses auditable daily staffing data, called the Payroll-Based Journal, to analyze staffing patterns and populate the staffing component of the Nursing Home Compare website - a site that enables the public to compare the results of health and safety inspections, the quality of care provided at nursing facilities, and staffing at nursing facilities. We will examine nursing staffing levels reported by facilities to the Payroll-Based Journal and CMS’s efforts to ensure data accuracy and improve resident quality of care by both enforcing minimum requirements and incentivizing high quality staffing above minimum requirements.

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<tr>
<td>August 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>CMS Oversight of Nursing Facility Staffing Levels</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-04-18-00459</td>
<td>2020</td>
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</table>
Review of Home Health Claims for Services With 5 to 10 Skilled Visits

If a home health agency (HHA) provides four or fewer visits from a skilled service provider that are included under home health coverage (excluding visits providing only services listed in 42 CFR §409.40) in an episode, the HHA will be paid a standardized per-visit payment based on visit type. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPA). Once a fifth visit is provided, an HHA will instead receive a full 60-day payment based on episode of care. Since OIG has not reviewed payments for LUPA, we will review supporting documentation to determine whether home health claims with 5 to 10 skilled visits in a payment episode in which the beneficiary was discharged home met the conditions for coverage and were adequately supported as required by Federal guidance.

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<td>June 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Review of Home Health Claims for Services With 5 to 10 Skilled Visits</td>
<td>Office of Audit Services</td>
<td>W-00-18-335813</td>
<td>2019</td>
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Medicare Payments Made Outside of the Hospice Benefit

According to 42 CFR 418.24(f), in general, a hospice beneficiary waives all rights to Medicare payments for any services that are related to the treatment of the terminal condition for which hospice care was elected. The hospice agency assumes responsibility for medical care related to the beneficiary’s terminal illness and related conditions. Medicare continues to pay for covered medical services that are not related to the terminal illness. Prior OIG reviews have identified separate payments that should have been covered under the per diem payments made to hospice organizations. We will produce summary data on all Medicare payments made outside the hospice benefit, without determining the appropriateness of such payments, for beneficiaries who are under hospice care. In addition, we will conduct separate reviews of selected individual categories of services (e.g., durable medical equipment, prosthetics, orthotics and supplies, physician services, outpatient) to determine whether payments made outside of the hospice benefit complied with Federal requirements.

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<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicare Payments Made Outside of the Hospice Benefit</td>
<td>Office of Audit Services</td>
<td>W-00-17-35797, W-00-18-35797</td>
<td>2019</td>
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Medicaid Nursing Home Supplemental Payments

CMS approved a nursing home supplemental payment program in certain States that pays the difference between Medicare and Medicaid rates for nursing home services. In some of these programs, local governments fund the States’ share of the supplemental payments through intergovernmental transfers. Prior OIG and Government Accountability Office audits have found that Federal supplemental payments often benefit the State and local governments more than the nursing homes. We will review the nursing home supplemental payment program’s flow of funding and determine how the funds are being used.

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<td>April 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicaid Nursing Home Supplemental Payments</td>
<td>Office of Audit Services</td>
<td>W-00-18-31530</td>
<td>2019</td>
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Hospitals' Compliance with Medicare's Transfer Policy With the Resumption of Home Health Services and the Use of Condition Codes

Medicare payments to acute care hospitals for inpatient stays under Medicare Part A are made on the basis of prospective rates. Normally, Medicare pays a hospital discharging a beneficiary the full amount for the corresponding diagnosis-related group (DRG). In contrast, a hospital that transfers a beneficiary to another facility or to home health services is paid a graduated per diem rate, not to exceed the full DRG payment. When transferring a patient to home health services, the hospital can apply specific condition codes to the claim and receive the full DRG payment. The hospital is responsible for coding the full on the basis of its discharge plan for the patient or adjusting the claim if it finds out that the patient received postacute care after the discharge. We will determine whether Medicare appropriately paid hospitals’ inpatient claims subject to the postacute care transfer policy when (1) patients resumed home health services after discharge or (2) hospitals applied condition codes to claims to receive a full DRG payment.

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<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Hospitals’ Compliance with Medicare’s Transfer Policy With the Resumption of Home Health Services and the Use of Condition Codes</td>
<td>Office of Audit Services</td>
<td>W-00-18-3050</td>
<td>2019</td>
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</table>
RECENT OIG UPDATES

Skilled Nursing Facility Prospective Payment System Requirements

Medicare requires a beneficiary to be an inpatient of a hospital for at least 3 consecutive days before being discharged from the hospital to be eligible for skilled nursing facility (SNF) services (21 U.S.C. & 1861(f)). If the beneficiary is subsequently admitted to an SNF, the beneficiary is required to be admitted either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. Prior OIG reviews found that Medicare payments for SNF services were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of an SNF admission. We will review compliance with the SNF prospective payment system requirement related to a 3-day qualifying inpatient hospital stay.

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<td>October 2017</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Skilled Nursing Facility Prospective Payment System Requirements</td>
<td>Office of Audit Services</td>
<td>W-00-16-30014</td>
<td>2019</td>
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Home Health Compliance with Medicare Requirements

The Medicare home health benefit covers intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational services, medical social worker services, and home health aide services. For CY 2014, Medicare paid home health agencies (HHAs) about $18 billion for home health services. Centers for Medicare & Medicaid Services' Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was 11.4 percent, or about $2 billion. Recent OIG reports have similarly disclosed high error rates at individual HHAs. Improper payments identified in these OIG reports consisted primarily of beneficiaries who were not homebound or who did not require skilled services. We will review compliance with various aspects of the home health prospective payment system and include medical review of the documentation required in support of the claims paid by Medicare. We will determine whether home health claims were paid in accordance with Federal requirements.

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<td>October 2017</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Home Health Compliance with Medicare Requirements</td>
<td>Office of Audit Services</td>
<td>W-00-10-35712, W-00-16-35500, W-00-17-35712, various revisions</td>
<td>2019</td>
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</table>
Physical Therapists – High Use of Outpatient Physical Therapy Services

Previous OIG work found that claims for therapy services provided by independent physical therapists were not reasonable, were not properly documented, or the therapy services were not medically necessary. Medicare will not pay for items or services that are not “reasonable and necessary” (SSA § 1862(a)(1)(A)). We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Documentation requirements for therapy services can be found in Centers for Medicare & Medicaid Services’s Medicare Benefit Policy Manual, Pub. No. 100-00, Ch. 15, §120.1.

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<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Physical Therapists - High Use of Outpatient Physical Therapy Services</td>
<td>Office of Audit Services</td>
<td>A-95-14-00961; A-02-18-01066; 16-00-16-35226; various reviews</td>
<td>2018</td>
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Skilled Nursing Facilities – Unreported Incidents of Potential Abuse and Neglect

Skilled nursing facilities (SNFs) are institutions that provide skilled nursing care, including rehabilitation and various medical and nursing procedures. Ongoing OIG reviews at other settings indicate the potential for unreported instances of abuse and neglect. We will assess the incidence of abuse and neglect of Medicare beneficiaries receiving treatment in SNFs and determine whether these incidences were properly reported and investigated in accordance with applicable Federal and State requirements. We will also interview State officials to determine if each sampled incident was reported, if required, and whether each reportable incident was investigated and subsequently prosecuted by the State, if appropriate.

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<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Skilled Nursing Facilities - Unreported Incidents of Potential Abuse and Neglect</td>
<td>Office of Audit Services</td>
<td>W-00-16-35779</td>
<td>2019</td>
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**Medicaid Health Home Services for Beneficiaries with Chronic Conditions**

Section 1945 of the Social Security Act created an optional Medicaid State Plan benefit for States to establish “health homes” to coordinate care for people with Medicaid who have chronic medical conditions. States receive a 90-percent enhanced Federal Medical Assistance Percentage (FMAP) for health home services valid through the first eight quarters of the program. The State option to provide health home services to eligible Medicaid beneficiaries became effective on January 1, 2011. As of May 2017, CMS has approved Medicaid State plan amendments for 21 States and the District of Columbia for health home programs. More than 1 million Medicaid beneficiaries have been enrolled in these programs. We will review Medicaid health home programs for compliance with relevant Federal and State requirements.

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<td>September 2017</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicaid Health Home Services for Beneficiaries with Chronic Conditions</td>
<td>Office of Audit Services</td>
<td>W-00-17-31534; A-02-17-00000</td>
<td>2019</td>
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**Medicaid Nursing Home Life Safety Reviews**

CMS recently updated its health care facilities’ life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in LTC facilities. These updates include requirements that facilities install expanded sprinkler and smoke detector systems to protect residents from the hazards of fire and develop an emergency preparedness plan that facilities must review, test, update, and train residents on annually. The plan must include provisions for sheltering in place and evacuation. OIG is reviewing this area because residents of LTC facilities are particularly vulnerable to the risk of fires, since many of these residents have limited or no mobility. Our objective is to determine if LTC facilities that received Medicare or Medicaid funds complied with new Federal requirements for life safety and emergency preparedness for the period May 4, 2016, through November 15, 2017.

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<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicaid Nursing Home Life Safety Reviews</td>
<td>Office of Audit Services</td>
<td>W-00-17-31535; A-02-17-00000</td>
<td>2019</td>
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</table>
Trends in Hospice Deficiencies and Complaints

The Medicare hospice program is an important benefit for beneficiaries and their families at the end of life. Surveys and complaint investigations are critical oversight mechanisms that address the care provided to beneficiaries by hospices. The Centers for Medicare & Medicaid Services (CMS) contracts with State survey agencies to conduct onsite surveys of hospices for certification and in response to complaints. National accreditation organizations, approved by CMS, may also conduct onsite surveys. These surveys assess the extent to which hospices meet Federal health and safety standards and require that surveyors cite hospices with deficiencies if they fail to meet the standards. Previous OIG reports identified numerous vulnerabilities and raised concerns about the limited enforcement actions against poorly performing hospices. As part of OIG’s ongoing commitment to address quality of care, we will determine the extent and nature of hospice deficiencies and complaints and identify trends.

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<td>Jun-17</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Trends in Hospice Deficiencies and Complaints</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-02-17-0020</td>
<td>2019</td>
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Involuntary Transfer and Discharge in Nursing Homes

The involuntary transfer or discharge of a resident of a nursing home can be unsafe and a traumatic experience for the resident and his or her family. To address these concerns, Congress passed the Nursing Home Reform Act of 1987 to protect residents against involuntary transfer and discharge. However, data from the National Ombudsman Reporting System show that from 2011 through 2016, the Long-Term Care Ombudsman Program, established to advocate for older Americans by the Older Americans Act of 1965, cited complaints related to "discharge/eviction" more frequently than any other concern. In addition, the media has recently highlighted the rise in nursing home evictions. CMS estimates that as many as one-third of all residents in long-term care facilities are involuntarily discharged. We will determine the extent to which State long-term care ombudsmen address involuntary transfers and discharges from nursing homes and the extent to which State survey agencies investigated and took enforcement actions against nursing homes for inappropriate involuntary transfers and discharges. We will also examine the extent to which nursing homes meet CMS requirements for involuntary transfers and discharges.

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<tr>
<td>November 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Involuntary Transfer and Discharge in Nursing Homes</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-01-18-00250</td>
<td>2019</td>
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