Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

POSTHOSPITAL SKILLED NURSING FACILITY CARE PROVIDED TO DUALLY ELIGIBLE BENEFICIARIES IN INDIANA GENERALLY MET MEDICARE LEVEL-OF-CARE REQUIREMENTS

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Office of Inspector General

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Report in Brief
Date: April 2022
Report No. A-05-20-00005

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

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

Why OIG Did This Audit

To qualify for skilled nursing facility (SNF) services, a Medicare beneficiary must have a preceding inpatient hospital stay. Centers for Medicare & Medicaid Services (CMS) research has found that many hospital admissions of nursing home residents who are enrolled in both Medicare and Medicaid (dually eligible beneficiaries) could have been avoided because the condition could have been prevented or treated outside of an inpatient hospital setting.

Our objectives were to determine whether the posthospital SNF care provided to dually eligible beneficiaries in Indiana between October 1, 2016, and September 30, 2018 (our audit period): (1) was associated with potentially avoidable hospitalizations and (2) met Medicare level-of-care requirements.

How OIG Did This Audit

Our audit covered 20,668 SNF claims with Medicare payments totaling $119,945,529, where each payment was greater than or equal to $350 for services provided during our audit period, to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same nursing facility. We selected and reviewed a stratified random sample of 100 SNF claims totaling $667,184.

What OIG Found

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

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

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

What OIG Recommends

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

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INTRODUCTION

WHY WE DID THIS AUDIT

Skilled nursing facilities (SNFs) are specially qualified facilities that provide extended care services, such as skilled nursing care, rehabilitation services, and other services. To be eligible for Medicare coverage of SNF services, a beneficiary must have a preceding inpatient hospital stay and meet other requirements.[1] Centers for Medicare & Medicaid Services (CMS) research has found that many hospital admissions of nursing facility residents who are enrolled in both Medicare and Medicaid (dually eligible beneficiaries) could have been avoided because the condition could have either been prevented or treated outside of an inpatient hospital setting.[2]

In Federal fiscal years (FYs) 2017 and 2018 (our audit period), CMS paid $1.6 billion for more than 97,000 Medicare beneficiaries residing in Indiana to receive SNF services. Of these beneficiaries, 27,000 were dually eligible. Medicare paid $584 million for SNF services provided to those dually eligible beneficiaries.

Throughout the report, we refer to nursing facilities certified to participate in the Medicare program as SNFs.[3] We refer to nursing facilities certified to participate in the Indiana Medicaid program as NFs.[4]

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[1] Section 1861(i) of the Social Security Act (the Act).

[2] CMS, *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Program* (Aug. 2010). Available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/CostDriversTask2.pdf. Accessed Aug. 25, 2021. CMS, *Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations* (2014). Available online at https://www.cms.gov/mmrr/Downloads/MMRR2014_004_01_b01.pdf. Accessed Aug. 25, 2021.

[3] "Skilled nursing facility" is defined as an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement with one or more hospitals; and meets other requirements for a SNF (section 1819(a) of the Act).

[4] "Nursing facility" is defined as an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) that can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement with one or more hospitals; and meets other requirements for a NF (section 1919(a) of the Act).

OBJECTIVES

Our objectives were to determine whether the posthospital SNF care provided to dually eligible beneficiaries in Indiana during our audit period: (1) was associated with potentially avoidable hospitalizations and (2) met Medicare level-of-care requirements.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. CMS administers the Medicare program.

Medicare covers SNF care that includes nursing care provided by or under the supervision of a registered professional nurse; bed and board in connection with furnishing of that nursing care; physical therapy, occupational therapy, and speech-language pathology services; medical social services; drugs, biologicals, supplies, appliances, and equipment; and other services that are generally provided by (or under arrangements made by) SNFs (42 CFR § 409.20(a)). Medicare does not cover custodial care.[5]

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals, elderly individuals, and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the Medicaid program. In Indiana, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), administers the Medicaid program.

Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Indiana Medicaid covers NF care that includes nursing care provided by or under the supervision of a registered nurse, licensed practical nurse, or nurse's aide; room and board; dietary and laundry services; physical therapy, occupational therapy, respiratory therapy, and speech pathology services; medical and nonmedical supplies and equipment; durable medical

[5] Custodial care consists of any nonmedical care that can reasonably and safely be provided by nonlicensed caregivers and is care that helps with usual daily activities, such as bathing, eating, toileting, and dressing.

equipment and associated repair costs routinely required for the care of patients; and other services (Attachment 3.1A, section 4.a, to Indiana State Plan Amendment 11-025 (effective Oct. 1, 2012)). For dually eligible individuals, NFs may bill Medicare Part B for skilled rehabilitation services provided during a Medicaid-covered NF stay.[6]

Medicare Level-of-Care Requirements for Skilled Nursing Facility Services

To be covered by Medicare, SNF services must be ordered by a physician and require the skills of and be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals and be for a condition that was either previously treated at a hospital or arose while the beneficiary was receiving care in a SNF for a condition for which he or she received inpatient hospital or inpatient Critical Access Hospital (CAH) services.[7] The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF on an inpatient basis (42 CFR § 409.31).

Beneficiary Assessments

SNFs and NFs must initially and periodically conduct a comprehensive, accurate, standardized, and reproducible assessment of each beneficiary's functional capacity (42 CFR § 483.20). They are also required to develop and implement a comprehensive person-centered care plan for each beneficiary that includes measurable objectives and timetables to meet the beneficiary's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment (42 CFR § 483.21).

Some beneficiaries require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may need rehabilitation or restorative nursing services. SNF and NF personnel record a beneficiary's functional status and therapy provided, if any, during a 7-day assessment period using a data collection tool called the Minimum Data Set (MDS) to classify beneficiaries into case-mix classifiers, or Resource Utilization Groups (RUGs).[8] Medicare and Indiana Medicaid payments differ based on assigned RUGs, which represent the resource needs of each beneficiary. During our audit period, the case-mix classification system, Resource Utilization Groups, Version 4

[6] Indiana requires NFs to adjust their cost reports (which are used to calculate the Medicaid per diem rate) if such services are covered by Medicare or other health insurance providers.

[7] A CAH is a hospital that is located in a county in a rural area or is being treated as being located in a rural area, makes available 24-hour emergency care services, and provides not more than 25 acute-care inpatient beds. CAHs ensure that Medicare beneficiaries in rural areas have access to a range of hospital services (section 1820(c)(2) of the Act).

[8] The regulation at 42 CFR 424.20(a)(1)(ii) was revised at 82 Fed. Reg. 36530, 36635 (Aug. 4, 2017), effective October 1, 2017, to remove the phrase "to one of the Resource Utilization Groups designated" and add in its place the phrase "one of the case-mix classifiers that CMS designates."

(RUG-IV), used clinical data from the MDS to assign a RUG to each beneficiary that was then used to calculate SNF and NF payments.[9]

Potentially Avoidable Hospitalizations

Potentially avoidable hospitalizations are hospitalizations that could be avoided if patients' conditions could have been prevented or treated outside of an inpatient hospital setting. Two CMS-sponsored studies discussed several conditions (such as falls and trauma, dehydration, and urinary tract infections) associated with potentially avoidable hospitalizations of dually eligible nursing home residents.[10]

CMS has developed multiple programs and initiatives to improve quality of care at nursing facilities and to reduce potentially avoidable hospitalizations.[11] One of them, Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, specifically focused on dually eligible beneficiaries residing in NFs.[12]

HOW WE CONDUCTED THIS AUDIT

Our audit covered 20,668 SNF claims with Medicare payments totaling $119,945,529, where each payment was greater than or equal to $350 for services provided from October 1, 2016, through September 30, 2018, to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same nursing facility. We selected and reviewed a stratified random sample of 100 SNF claims totaling $667,184.

We contracted with an independent medical review contractor to analyze the medical records for the sampled claims to determine whether the SNF care: (1) was associated with potentially avoidable hospitalizations and (2) met the Medicare level-of-care requirements. The contractor reviewed all relevant beneficiary medical record information, including, but not limited to, the beneficiary comprehensive plans of care for the NF and SNF care, progress reports, physician orders, nursing notes, and initial and subsequent MDS assessments for the periods covering the

[9] 81 Fed. Reg. 51976 (Aug. 5, 2016), 82 Fed. Reg. 36536 (Aug. 4, 2017)), and Attachment 4.19D to Indiana State Plan Amendment 16-005 (effective July 1, 2016).

[10] Refer to footnote 2.

[11] CMS, *Nursing Home Quality Initiative*. Available online at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits. Accessed on Sept. 29, 2021.

[12] CMS, *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)*. Available online at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents. Accessed on Sept 29, 2021. The final report on the results of the Initiative was not available at the end of our fieldwork in September 2021.

NF and SNF stays as well as any relevant documentation for the qualifying inpatient hospital stay preceding the SNF stay.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains a list of related OIG reports, and Appendix C contains the details of our statistical sampling methodology.

FINDINGS

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

Posthospital SNF care provided to 98 of the 100 beneficiaries met the Medicare SNF level-of-care requirements. The remaining two beneficiaries did not meet the Medicare SNF level-of-care requirements because the SNF physicians incorrectly determined that the beneficiaries required skilled nursing or skilled rehabilitation services, or both, on a daily basis.[13]

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

POSTHOSPITAL SKILLED NURSING FACILITY CARE IN INDIANA WAS GENERALLY NOT ASSOCIATED WITH POTENTIALLY AVOIDABLE HOSPITALIZATIONS

Based on the comprehensive assessment of each beneficiary, SNFs and NFs must ensure that beneficiaries receive treatment and care in accordance with professional standards of practice, comprehensive care plans, and the beneficiaries' choices. SNFs and NFs are required to develop strategies to prevent certain conditions from occurring. For example, the facility must

[13] The two beneficiaries who had potentially avoidable hospitalizations are not the same two beneficiaries whose SNF care did not comply with the Medicare level-of-care requirements.

ensure that each beneficiary receives adequate supervision and assistance devices to prevent accidents such as falls. The facility must also ensure that a beneficiary is offered sufficient fluid intake to prevent dehydration (42 CFR §483.25).

Posthospital SNF care provided to 98 of the 100 dually eligible beneficiaries in Indiana, on whose behalf the sampled SNF claims were submitted, was not associated with potentially avoidable hospitalizations; however, posthospital SNF care provided to the remaining two beneficiaries was associated with potentially avoidable hospitalizations. Our independent medical review contractor found that:

- Eighteen beneficiaries were hospitalized during their NF stays for conditions other than those that indicated potentially avoidable hospitalizations (discussed on pages 3 and 4).[14]

- Eighty beneficiaries were hospitalized during their NF stays while having one or more of the conditions that indicated potentially avoidable hospitalizations. However, the identified conditions were either not preventable or not manageable in an NF setting because of the beneficiaries' complex physical and mental conditions.

- Two beneficiaries were hospitalized during their NF stays while having one or more of the conditions that indicated potentially avoidable hospitalizations. The beneficiaries' conditions were potentially preventable and manageable at the NFs, but because the NFs did not have effective prevention strategies in place, the beneficiaries were hospitalized and later discharged to SNF care at the same facility. Figure 1 provides an example of one of the two potentially avoidable hospitalizations.

Figure 1: Example of Potentially Avoidable Hospitalization

A beneficiary had cellulitis of a lower extremity. Because the beneficiary's vital signs were stable, antibiotic management could have been initiated in the nursing facility with close monitoring of symptoms and response to treatment. There was no documentation to suggest that any interventions took place in the nursing home prior to transferring the beneficiary to the hospital emergency department. The beneficiary was treated as an inpatient at the hospital for 3 calendar days and discharged back to the nursing facility to receive SNF care.

[14] During our audit, our independent medical review contractor reviewed medical records provided by the nursing facilities and hospitals to determine whether a condition was chiefly responsible for a hospital admission.

POSTHOSPITAL SKILLED NURSING FACILITY CARE IN INDIANA GENERALLY MET THE MEDICARE LEVEL-OF-CARE REQUIREMENTS

Skilled Nursing Facility Care Met the Daily Skilled Nursing or Skilled Rehabilitation Services Requirement

To be eligible for SNF care, a beneficiary must, among other things, require skilled nursing or skilled rehabilitation services, or both, on a daily basis (42 CFR § 409.31(b)(1)). To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. A condition that does not ordinarily require skilled services may require them because of special medical complications (42 CFR § 409.32).

Posthospital SNF care provided to 98 of the 100 dually eligible beneficiaries in Indiana, on whose behalf the sampled SNF claims were submitted, met the Medicare SNF level-of-care requirements. However, posthospital SNF care for the remaining two beneficiaries did not meet the Medicare SNF level-of-care requirements because the SNF physicians incorrectly determined that the beneficiaries required skilled nursing or skilled rehabilitation services, or both, on a daily basis. Figure 2 provides an example of a SNF's improper determination that a beneficiary required skilled care on a daily basis.

Figure 2: Example of Skilled Nursing Facility's Determination That a Beneficiary Required Skilled Care on a Daily Basis

A beneficiary was admitted to a hospital following 2 days of chest pain and shortness of breath. A nuclear stress test showed inferior wall ischemia while all other cardiac markers were negative. After the 3-day inpatient hospital stay, the beneficiary was discharged back to the nursing facility on oral iron pills for anemia. The beneficiary received SNF care, though there was no indication in the medical record of any significant change in the beneficiary's condition or medication management that would warrant skilled nursing care. Based on evaluation results by physical, occupational, and speech therapists, there was also no clear need for skilled rehabilitation services. Restorative nursing services would have been reasonable.

Physicians Ordered Skilled Nursing Facility Services

Federal regulations state that Medicare-covered skilled nursing and skilled rehabilitation services must be ordered by a physician (42 CFR § 409.31(a)(1)). Federal regulations further state that "[c]ertification and recertification statements may be signed by . . . [t]he physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case . . . ." (42 CFR § 424.20(e)(1)). While Federal regulations do not explain what is meant by "physician responsible for the case," internal communications with CMS clarified that it allows for the inclusion of any physician who is familiar with the beneficiary's case, and it could be either a hospital or SNF physician. CMS further clarified that since the initial SNF certification generally

must occur "at the time of admission,"[15] a more accurate reading of this requirement would be that the SNF certification function is to be performed by the SNF's physician as opposed to the hospital's physician.

For all 100 beneficiaries, physicians ordered SNF services. We noted that records from the hospitals where 33 beneficiaries had a qualifying inpatient stay did not contain a clear and definitive hospital physician discharge order for SNF care.[16] Hospital physicians mainly discharged beneficiaries "back to nursing facility" without specifying the level of care. In these cases, SNF physicians certified the SNF level of care. Figure 3 provides an example of contradicting hospital and SNF physicians' orders.

Figure 3: Example of Contradictory Hospital and SNF Physicians' Orders

A hospital physician determined that a beneficiary's condition at discharge was stable and recommended home or self-care. A SNF physician certified that SNF care was needed for physical and occupational therapy 5 days a week as well as for skilled nursing care.

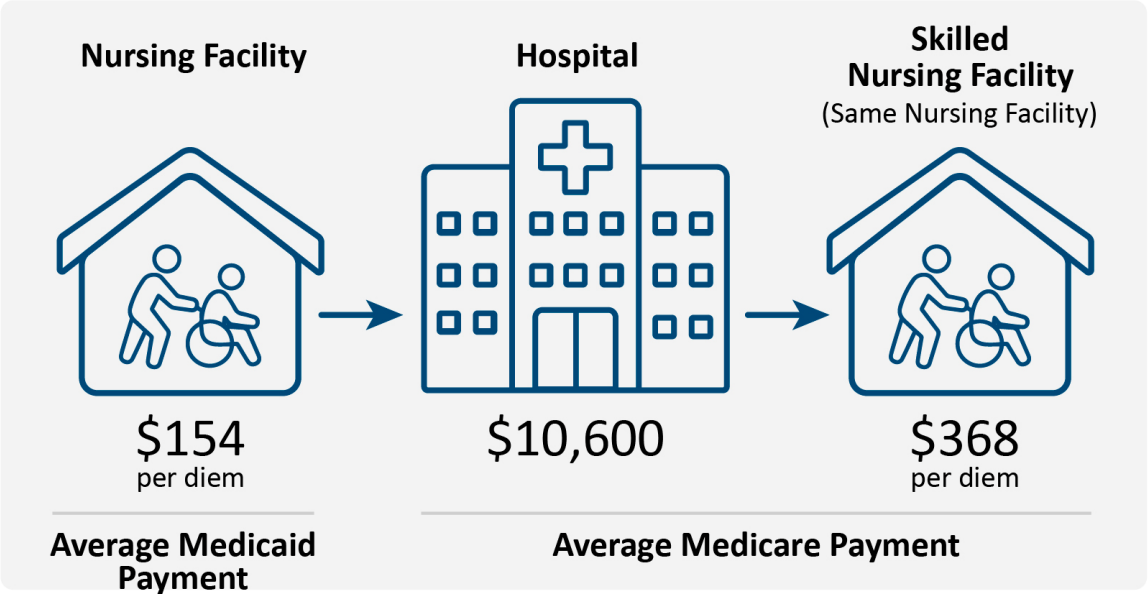
The physician order not only affects level-of-care determinations but also has a financial impact on the nursing facilities. During our audit period, as shown in Figure 4, for our sample of 100 SNF claims, the NF care in Indiana was paid by Medicaid at an average daily rate of $154, and the subsequent SNF care was paid by Medicare at an increased average daily rate of $368.[17]

[15] 42 CFR § 424.20(b)(1).

[16] During our audit period, hospitals were required to provide a discharge planning evaluation to the patient upon the request of the patient or the physician (42 CFR § 482.43 (b)). Effective November 29, 2019 (after our audit period), the discharge planning regulation for hospitals was amended to state that the hospital must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

[17] Our calculations were based on the audited sample of 100 SNF claims and associated NF and hospital stays.

Figure 4: Average Payments for Our Sample



Improving the quality of care at NFs could lead to the reduction of potentially avoidable and costly (1) hospital care averaging $10,600 and (2) upon discharge from the hospital, subsequent SNF care at the same nursing facility with an increased daily rate of $368.

CONCLUSION

Our independent medical review contractor found that SNF care provided to dually eligible beneficiaries in Indiana during our audit period was generally not associated with potentially avoidable hospitalizations. As a result, we do not have any recommendations. However, prior OIG audits and studies identified a number of issues with the quality of care in nursing facilities.[18] These problems pose risks to beneficiaries and increase Medicare costs in the form of potentially avoidable hospitalizations and subsequent SNF care.

In addition, our independent medical review contractor found that SNF care generally met the Medicare level-of-care requirements. However, we noted that contradicting hospital and SNF physician orders might call into question the medical necessity of SNF care. The physician order affects whether Medicare or Medicaid will pay a nursing facility for care.

Identifying nursing facility quality-of-care issues as well as waste, fraud, and abuse are significant challenges that require focused and sustained efforts using a variety of methods. The quality of care in nursing facilities remains a concern for OIG. OIG will continue to monitor SNF claims, including those submitted on behalf of dually eligible beneficiaries, to determine whether services are appropriate and meet payment requirements.

[18] Refer to Appendix B for the list of the related OIG reports.

We provided CMS with a draft report for review. CMS elected not to provide formal comments; however, it provided technical comments, which we addressed as appropriate.

OTHER MATTERS

Federal regulations (42 CFR § 409.30(a)(1)) state that to be eligible for SNF care, a Medicare beneficiary must be hospitalized in a hospital or CAH for medically necessary inpatient hospital or inpatient CAH care for at least 3 consecutive calendar days, not counting the date of discharge.

One beneficiary required and received SNF care.[19] However, the SNF claim submitted on behalf of this beneficiary did not meet the 3-day qualifying hospital stay requirement and did not qualify for Medicare payment because the coverage requirement was not met.[20] We determined that the beneficiary spent several days at the hospital as an outpatient (prior to the inpatient admission).[21] The SNF erroneously used a combination of inpatient and outpatient hospital stay days to determine whether the 3-day qualifying hospital stay requirement was met.

[19] This beneficiary was one of the 98 beneficiaries who met the Medicare SNF level-of-care requirements.

[20] OIG discussed the issue of SNFs not complying with the 3-day inpatient hospital stay requirement in its report *CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met* (A-05-16-00043), issued Feb. 14, 2019.

[21] OIG raised a concern about beneficiaries in outpatient stays having limited access to SNF services in its report *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* (OEI-02-15-00020), issued Dec. 19, 2016.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 20,668 SNF claims with Medicare payments totaling $119,945,529, where each payment was greater than or equal to $350 for services provided from October 1, 2016, through September 30, 2018, to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same NF. We selected and reviewed a stratified random sample of 100 SNF claims totaling $667,184.

We established reasonable assurance of the authenticity and accuracy of the data obtained from the NCH and T-MSIS, but we did not assess the overall completeness of the file.

We did not perform an overall assessment of the internal control structure of CMS and nursing facilities. Rather, we limited our review of internal controls to those applicable to our audit objective. Specifically, we reviewed CMS's requirements and guidance provided to the nursing facilities in Indiana as well as nursing facilities' policies and procedures related to the level-of-care determinations.

We performed our audit work from November 2019 through January 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and other requirements related to the Medicaid NF and Medicare SNF level-of-care requirements;

- interviewed CMS officials to obtain an understanding of the Medicare SNF level-of-care requirements and issues related to the potentially avoidable hospitalizations;

- interviewed State agency officials to obtain an understanding of the Indiana Medicaid NF care requirements;

- interviewed the Medicare Administrative Contractor for the State of Indiana — Wisconsin Physicians Service Government Health Administrators — to obtain an understanding of the Medicare SNF level-of-care requirements specific to Indiana providers;

- extracted from the NCH 20,668 SNF claims with Medicare payments greater than or equal to $350 each, totaling $119,945,529, for services provided from October 1, 2016, through September 30, 2018, to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same nursing facility;

- selected a stratified random sample of 100 SNF claims totaling $667,184 (Appendix C);

- reviewed available data from CMS's Common Working File for the SNF claims to determine whether the claims had been canceled or adjusted;

- obtained medical records documentation from nursing facilities and associated hospitals for the 100 SNF claims;

- provided the medical records documentation for the 100 SNF claims to an independent medical review contractor to determine whether the SNF care: (1) was associated with potentially avoidable hospitalizations and (2) met Medicare level-of-care requirements; and

- discussed the results of our audit with CMS officials.

We provided CMS with a draft report on February 23, 2022, for review. CMS elected not to provide formal comments; however, it provided technical comments, which we addressed as appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Princeton Place Did Not Always Comply With Care Plans for Residents Who Were Diagnosed With Urinary Tract Infections	A-06-17-02002	6/4/2019
CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	A-05-16-00043	2/14/2019
West Carroll Care Center Did Not Always Follow Care Plans for Residents Who Were Later Hospitalized With Potentially Avoidable Urinary Tract Infections	A-06-14-00073	6/13/2016
Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries	OEI-06-11-00370	2/27/2014
Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring	OEI-06-11-00040	11/18/2013

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 20,668 SNF claims totaling $119,945,529 in Medicare payments, where each payment was greater than or equal to $350 for services provided from October 1, 2016, through September 30, 2018,[22] to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same nursing facility (NF).[23] The SNF claims in the sampling frame: (1) were for beneficiaries whose Medicaid-covered NF stay was within 30 days of the SNF admission,[24] (2) were part of the same SNF stay,[25] and (3) were submitted by SNFs that are not under investigation by the OIG or a CMS Recovery Audit Contractor.

SAMPLE UNIT

The sample unit was a SNF claim paid from the Medicare trust fund.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into three strata, as shown in Table 1:

[22] Because our target population for this audit was SNF stays that followed NF stays, we matched SNF claims with dates of service during our audit period to NF claims with the dates of service from August 1, 2016, through September 30, 2018.

[23] The National Provider Identifier (NPI) was the same on both the NF and the SNF claim for each beneficiary. The NPI is a unique identification number for health care providers.

[24] There were no Medicare or Medicaid claims of nursing facilities with different NPIs between the date of discharge from the NF and the date of admission to the SNF.

[25] If more than one SNF claim for the same beneficiary were within 30 days of each other, we considered the claims to be for the same SNF stay. If a break in SNF care lasts more than 30 days, a new 3-day qualifying inpatient hospital stay is required for Medicare to cover subsequent SNF care (CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 8, § 20.2.1).

Table 1: Stratum Description

Stratum	Description of Stratum
1	7,755 SNF claims with at least one RUG[26] for ultra high or very high therapy with Medicare payments ranging from $353 to less than $8,263 (totaling $34,528,182).
2	5,158 SNF claims with at least one RUG for ultra high or very high therapy with Medicare payments ranging from $8,263 to $51,183 (totaling $57,629,643).
3	7,755 SNF claims with other RUGs with Medicare payments ranging from $350 to $27,332 (totaling $27,787,704)

SAMPLE SIZE

We selected a sample of 100 beneficiaries, as shown in Table 2:

Table 2: Sample Stratum Size and Value

Stratum	Sample Size	Sample Value
1	35	$161,331
2	35	397,565
3	30	108,288
Total	**100**	**$667,184**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims in each stratum in the sampling frame. After generating the random numbers, we selected the corresponding claims in that stratum.

ESTIMATION METHODOLOGY

OIG has chosen not to report any estimates due to the low error rate found in the sample results.

[26] SNF claims include RUG codes that identify whether a beneficiary received therapy and the range of therapy minutes provided. For example, SNF claims with a RUG that begins with "RU" or "RV" indicate that an ultra high or very high level of therapy was provided and that during a 7-day period, the beneficiary received 720 minutes or more, or 500 to 719 minutes of therapy, respectively. The higher the volume of therapy services provided, the higher the Medicare payment.