OIG FY2012 Work Plan
Hospice Work Plan

PART I: Medicare Part A and Part B

Hospitals

Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care (New)
We will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care and examine the relationship, either financial or common ownership, between the acute-care hospital and the hospice provider and how Medicare treats reimbursement for similar transfers from the acute-care setting to other settings. Regulations at 42 CFR § 412.2 state that inpatient prospective payment system (IPPS) payments to hospitals for inpatient stays are payment in full for hospitals’ operating costs. Regulations state that hospice payments can be made for a general inpatient care day. (42 CFR § 318.301(b)(4).) A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. (OAS; W-00-12-35602; various reviews; expected issue date: FY 2012; new start)

Hospices

Hospice Marketing Practices and Financial Relationships with Nursing Facilities (New)
We will review hospices’ marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed their services to nursing facility residents. We will focus our review on hospices that have a high percentage of their beneficiaries in nursing facilities. (OEI; 02-10-00071; 02-10-00072; expected issue date: FY 2012; work in progress)

Medicare Hospice General Inpatient Care
We will review the use of hospice general inpatient care from 2005 to 2010. We will assess the appropriateness of hospices’ general inpatient care claims and hospice beneficiaries’ drug claims billed under Part D. Federal regulations address Medicare CoPs for hospice at 42 CFR Part 418. We will review hospice medical records to address concerns that this level of hospice care is being misused and to determine the extent to which drugs are being inappropriately billed to Part D. (OEI; 02-10-00490; expected issue date: FY 2012; work in progress)
PART II: Medicare Part C and Part D

Part D Drug Pricing and Payment-Related Reviews

Duplicate Drug Claims for Hospice Beneficiaries
We will review the appropriateness of drug claims for individuals who are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. We will determine whether payments under Part D are correct, supported, and not duplicated in hospice per diem amounts. We will also determine the extent of any duplication found and identify controls to prevent duplicate drug payments. Medicare Part D drug plans should not pay for drugs that are covered under the Part A hospice benefit. CMS publishes hospice payment rates, which include prescription drugs used for pain relief and symptom control related to the beneficiary’s terminal illness. (Medicare Claims Processing Manual, Pub. No. 100-04, ch. 11, § 30.2.) Hospice providers are paid per diem amounts, which include payments for these drugs. A drug prescribed for a Part D beneficiary shall not be considered for payment if the drug was prescribed and dispensed or administered under Part A or Part B. (Social Security Act, § 1860D-2(e)(2)(B).) (OAS; W-00-10-35307; W-00-11-35307; various reviews; expected issue date: FY 2012; work in progress)

PART III: Medicaid Reviews

Other Medicaid Services and Payments

Hospice Services: Compliance With Reimbursement Requirements
We will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients’ illness and death. An individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS’s State Medicaid Manual, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than $816 million. (OAS; W-00-11-31385; various reviews; expected issue date: FY 2012; new start, OEI; 00-00-00000; expected issue date: FY 2013; new start)