Hospice-Specific OIG Work Plan Projects

Hospice in assisted living facilities (new)

**Policies and Practices.** 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. Context—Pursuant to the Affordable Care Act, § 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. The Medicare Payment Advisory Commission has said that these long stays bear further monitoring and examination. (OEI; 02-14-00070; expected issue date: FY 2014; work in progress; Affordable Care Act)

Hospice general inpatient care

**Quality of Care and Safety.** 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. Context—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 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 2014; work in progress)

Hospice Topics from Previous OIG Work Plans with no Published Reports

**FY2013**

Hospitals

Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care
We will determine the extent to which acute care hospitals discharge beneficiaries after a short stay to hospice facilities. Analysis of Medicare claims data demonstrates significant occurrences of a discharge from an acute care hospital after a short stay that is immediately followed by hospice care. Medicare pays a full PPS rate to hospitals that discharge beneficiaries for hospice care (42 CFR § 412.4(e). In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital or, for certain DRGs, to postacute care settings, such as a skilled nursing facility. (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged “early” and then admitted for additional care in other clinical settings. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to hospice facilities. *(OAS; W-00-12-35602; various reviews; expected issue date: FY 2013; work in progress)*

**Hospices**

**Hospices—Marketing Practices and Financial Relationships with Nursing Facilities**

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 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 2013; work in progress)*

**Part III**

**Medicaid Reviews**

**Hospice Services—Compliance with Reimbursement Requirements**

We will determine whether Medicaid payments by States 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, may 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; W-00-12-31385; various reviews; expected issue date: FY 2013; work in progress)*