HHS Office of Inspector General
FY2017 Work Plan

Hospice-Specific Work Plan Issues

On November 10, 2016, the HHS Office of Inspector General (OIG) issued its FY2017 Work Plan. Among the projects listed for FY2017 are several hospice-specific issues that will be reviewed, as well as a review of Medicare’s Chronic Care Management Program.

Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio

The Medicare hospice program is an important benefit for beneficiaries and their families at the end of life. However, OIG and others have identified vulnerabilities in payment, compliance, and oversight as well as quality-of-care concerns, which can have significant consequences both for beneficiaries and for the program. We will summarize OIG evaluations, audits, and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

OEI: 02-16-00570 Expected Issue Date: FY2017

Review of Hospices’ Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. 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 and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

OAS: W-00-16-35783; various reviews. Expected Issue Date: FY2017

Hospice Home Care – Frequency of Nurse On-Site Visits to Assess Quality of Care and Services

In 2013, more than 1.3 million Medicare beneficiaries received hospice services from more than 3,900 hospice providers, and Medicare hospice expenditures totaled $15.1 billion. Hospices are required to comply with all Federal, State, and local laws and regulations related to the health and safety of patients (42 CFR 418.116) Medicare requires that a registered nurse make an on-site visit to the patient’s home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient’s needs (42 CFR 418.76(h)(1)(i)). We will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

OAS: W-00-16-35777 Expected Issue Date: FY2017
Medicare Payments for Chronic Care Management

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions (Alzheimer’s disease, arthritis, cancer, diabetes, et.) that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These significant chronic conditions are expected to last at least 12 months or until the death of the patient. CCM cannot be billed during the same service period as transitional care management, home health care supervision/hospice care, or certain end-stage renal disease services. Beginning January 1, 2015, Medicare paid separately for CCM under the Medicare Physician Fee Schedule and under the American Medical Association Current Procedural Terminology. We will determine whether payments for CCM services were in accordance with Medicare requirements.

OAS: W-00-17-35785  Expected Issue Date: FY2017

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