Medicare Part A and Part B

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, skilled nursing facilities (excepting custodial or long-term care), hospice care, and some home health care. Medicare Part B helps cover physicians' services and outpatient care. It also covers designated other medical services that Part A does not cover, such as some physical and occupational therapy services and home health care.

Historically, Medicare contractors that are known as fiscal intermediaries (FI) and carriers have handled Medicare's claims administration activities, with the FIs processing claims for Medicare Parts A and B for certain facilities (including hospitals and skilled nursing facilities (SNF) and the carriers processing claims for Medicare Part B (including for physicians', laboratories', and other services). The Centers for Medicare & Medicaid Services (CMS) also engages contractors that perform specific fee-for-service (FFS) business functions. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 911, CMS is implementing a Medicare contracting reform initiative that will replace FIs and carriers with Medicare Administrative Contractors (MAC) that will process both Part A and Part B claims. The reform plan includes specialty MACs that will service suppliers of durable medical equipment (DME).

Descriptions of our work in progress and planned reviews of Medicare Part A and Part B payments and services for fiscal year (FY) 2011 follow.

Hospitals

Part A Hospital Capital Payments

We will review Medicare inpatient capital payments. Capital payments reimburse a hospital's expenditures for assets such as equipment and facilities. The basic methodology for determining capital prospective rates is found in the Code of Federal Regulations (CFR) at 42 CFR § 412.308. We will determine whether capital payments to hospitals are appropriate. *(OAS; W-00-09-35300; W-00-10-35300; various reviews; expected issue date: FY 2011; work in progress)*

Provider-Based Status for Inpatient and Outpatient Facilities

We will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. Pursuant to 42 CFR § 413.65(d), Medicare may permit hospitals that own and operate multiple provider-based facilities or departments in different sites to operate as a single entity, so long as specific requirements are met. Hospitals that receive this "provider-based status" may receive higher reimbursement when they include the costs of a provider-based entity on their cost reports. Freestanding facilities may also benefit from enhanced

Medicare Part B Services During Non-Part A Nursing Home Stays: 2008 Overview

We will review the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Unlike Part B services provided during a Part A SNF stay, most of which must be billed to Medicare directly by the SNF in accordance with consolidated billing requirements, most Part B services provided during a non-Part A stay may be billed directly by suppliers and other providers. In repealing consolidated billing provisions that would have applied to non-Part A SNF stays, Congress directed OIG in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313, to monitor these services for abuse. We will also assess patterns of billing for Part B services among nursing homes and providers.

(OEI; 06-07-00580; expected issue date: FY 2011; work in progress)

Other Providers and Suppliers

Hospice Utilization in Nursing Facilities

We will review Medicare Part A hospice claims and data from the MDS to describe hospice utilization in nursing facilities. We will examine the characteristics of nursing facilities with high utilization patterns of Medicare hospice care and the characteristics of the hospices that serve them. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) created the Medicare hospice benefit for eligible beneficiaries under Medicare Part 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, which is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program, has noted that hospices and nursing facilities have incentives to admit patients likely to have long stays. We will also assess the business relationships between nursing facilities and hospices and assess the marketing practices and materials of hospices associated with high utilization patterns.

(OEI; 02-10-00070; expected issue date: FY 2011; work in progress)

Services Provided to Hospice Beneficiaries Residing in Nursing Facilities

We will review the services that hospices and nursing facilities provide to hospice beneficiaries residing in nursing facilities, including services by hospice-based home health aides. Federal regulations address Medicare CoPs for hospice at 42 CFR part 418, and SNF requirements at 42 CFR 483. We will review hospice and nursing facility medical records, including plans of care. We will determine the extent to which hospices and nursing facilities coordinate care and identify service and payment arrangements between them. We will also assess the appropriateness of hospices' general inpatient care claims.

(OEI; 02-10-00490; expected issue date: FY 2012; work in progress)

Medicare Part D
(Prescription Drug Program)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established an optional Medicare outpatient prescription drug benefit, known as Medicare Part D, which took effect on January 1, 2006. This voluntary benefit is available to all Medicare beneficiaries.

The administration of Part D depends upon extensive coordination and information sharing among Federal and State Government agencies, drug plan sponsors, contractors, health care providers, and third-party payers. CMS and drug plan sponsors share responsibility for protecting the Part D program from fraud, waste, and abuse. Payments to drug plan sponsors based on bids, risk adjustments, and reconciliations add to the complexities and challenges of the benefit.

Descriptions of our continuing and planned reviews of Medicare Part D program administration follow.

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. Pursuant to its *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 11, § 30.2, CMS publishes the hospice payment rates, which include prescription drugs (used for pain relief and symptom control) related to the beneficiary's terminal illness. Hospice providers are paid per diem amounts, which include payments for these drugs. Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), 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. Therefore, Medicare Part D drug plans should not pay for drugs that are covered under the Part A hospice benefit. We will determine whether payments under Part D are correct, are supported, and are not duplicated in hospice per diem amounts. We will also determine the extent of duplication between Part D payments and Part A hospice payments and identify controls to prevent duplicate drug payments.
(OAS; W-00-10-35307; W-00-11-35307; various reviews; expected issue date: FY 2011; work in progress)

Medicare Part D Claims Duplicated in Part A and Part B

We will review Medicare Part D claims to determine whether they were duplicated in Part A or Part B. Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), 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. Medicare Part A covers drugs for beneficiaries who are

otherwise authorized in accordance with a plan of treatment, must be provided by someone who is qualified to render such services and who is not a member of the individual's family, and must be furnished in a home or other location. The Deficit Reduction Act of 2005 (DRA), § 6087, further allowed States, beginning January 1, 2007, to pay individuals for self-directed personal assistance services for the elderly and disabled, including PCS that could be provided by a family member.
(OAS; W-00-09-31035; W-00-10-31035; W-00-11-31035; various reviews; expected issue date: FY 2011; work in progress)

Medicaid Hospice Services

We will review Medicaid payments for hospice services to determine whether the services were provided in accordance with Federal reimbursement requirements. Pursuant to the Social Security Act, § 1905(o)(1)(A), Medicaid may cover hospice services for terminally ill recipients. 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 patient's illness and death. CMS's *State Medicaid Manual*, Pub. 45, § 4305, says the individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. In FY 2009, Medicaid payments for hospice services totaled more than $2.2 billion. We will also conduct a medical review of claims for a sample of Medicaid recipients receiving hospice care to determine that services were reasonable and necessary.
(OAS; W-00-11-31385; various reviews; expected issue date: FY 2011; new start. OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicaid Adult Day Care Services for Elderly Individuals Who Have Chronic Functional Disabilities

We will review Medicaid payments to providers for adult day care services. The Social Security Act, § 1929(a)(7), allows Medicaid payments for adult day care services through home and community care for elderly individuals who have chronic functional disabilities. We will determine whether Medicaid payments to providers for adult day care health services were in compliance with Federal and State regulations.
(OAS; W-00-11-31386; various reviews; expected issue date: FY 2011; new start)

Medicaid Adult Day Health Service

We will review adult day health services reimbursed by Medicaid programs in select States. The Social Security Act, § 1915(c)(4)(B), allows Medicaid payments for adult health services through home- and community-based waiver programs. Previous Federal and State reviews of Medicaid adult day health services found problems with reimbursement systems and questionable billings. Additionally, CMS and State Medicaid programs do not receive information about the individual services provided to beneficiaries because reimbursement is based on bundled payment rates. We will describe the services provided, review the qualifications of providers, and assess the appropriateness of documentation.
(OEI; 09-07-00500; expected issue date: FY 2011; work in progress)