



Department of Health and Human Services

**Office of
Inspector General**

Work Plan

Health Care Financing Administration Projects

Fiscal Year 1998

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Inspector General**



Office of Inspector General

MISSION:

Under the authority of the IG Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

VISION

WE ARE GUARDIANS OF THE PUBLIC TRUST

-  Working with management, we will ensure effective and efficient HHS programs and operations.
-  Working with decision-makers, we will minimize fraud, waste and abuse in HHS programs.
-  Working with our talented and motivated staff, we will manifest the highest standards as a Federal OIG.

VALUES

WE VALUE:

-  Quality products and services that are timely and relevant.
-  A service attitude that is responsive to the needs of decision-makers.
-  Fairness, integrity, independence, objectivity, proficiency, and due care in performing our work.
-  Teamwork and open communication among OIG components.
-  A positive environment that supports our personal and professional needs and encourages us to be innovative and reach our full potential.

Department of Health and Human Services

Office of Inspector General



Work Plan for Fiscal Year 1998

INTRODUCTION

The Office of Inspector General (OIG) Work Plan is set forth in five chapters that encompass the various projects of the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General that are to be addressed during Fiscal Year (FY) 1998. The first four chapters present the full range of projects planned in each of the Department of Health and Human Services' (Department) major operating divisions: the Health Care Financing Administration, Public Health Service Agencies, the Administration for Children and Families, and the Administration on Aging. The fifth chapter embraces those projects related to issues which cut across Department programs, including State and local use of Federal funds as well as the functional areas of the Office of the Secretary.

In preparing this edition of the OIG Work Plan, we have provided a brief description of the various project areas and a projected completion date for many of the work items that we perceive as critical to the mission of the OIG and the Department. However, as the work planning process tends to be ongoing and dynamic, the focus and timing of many of these projects can evolve in response to new information, new issues, and shifting priorities of the Congress, the President and the Secretary, and may be altered over time. Given these variables, the OIG objective still remains the targeting of available resources on those projects that best identify vulnerabilities in the Department's programs and activities that have been designed to serve and protect the safety, health and welfare of the American people and promote the economy, efficiency and effectiveness of the Department's programs.

Program Audits

The Office of Audit Services (OAS) conducts comprehensive financial and performance audits of departmental programs and operations to determine whether program objectives are being achieved and which program features need to be performed in a more efficient manner. The OAS also provides overall leadership and direction in carrying out the responsibilities mandated under the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

The audit portion of the OIG Work Plan represents the most significant audit work that will be conducted in FY 1998.

Program Inspections

The Office of Evaluation and Inspections (OEI) seeks to improve the effectiveness and efficiency of departmental programs by conducting program inspections to provide timely, useful, and reliable information and advice to decision makers. These inspections are program and management evaluations that focus on specific issues of concern to the Department, the Congress, and the public. The inspections identified in this Work Plan focus on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The results of these inspections should generate accurate and up-to-date information on how well those programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

Investigative Focus Areas

The OIG's Office of Investigations (OI) conducts investigations of fraud and misconduct to safeguard the Department's programs and protect the beneficiaries of those programs from individuals and activities that would deprive them of rights and benefits.

The OIG concentrates its resources on the conduct of criminal investigations relating to the programs and operations of HHS. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses

in areas of program vulnerability that can be eliminated through corrective management actions, regulation or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

Legal Counsel Focus Areas

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of health care fraud and abuse cases, including the litigation and imposition of administrative sanctions, such as program exclusions, and civil monetary penalties and assessments; the global settlement of cases arising under the Civil False Claims Act; and the development of corporate agreements for providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry awareness of models for corporate integrity and compliance programs and monitors ongoing integrity agreements. OCIG also provides all administrative litigation services required by OIG, such as patient dumping cases and all administrative exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes, and is responsible for the development of new, and the modification of existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG counsels OIG components on personnel and operations issues, subpoenas, audit and investigative issues and other legal authorities.

Internet Address

The FY 1998 OIG Work Plan and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

<http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html>

Department of Health and Human Services



Office of Inspector General

Health Care Financing Administration Projects

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HOSPITALS

Medicare Indirect Medical Education Payments

This review will determine the initial basis for and computation of indirect medical education payments to teaching hospitals. This data will be compared to more current data on actual costs hospitals indirectly incur as a result of physician training. We will use this information to evaluate the continuing need for and amounts of such payments. Medicare made indirect medical education payments of \$5.6 billion in 1996 to compensate teaching hospitals for the higher costs they incur as a result of their overall expenses related to training physicians. The 1997 Balanced Budget Act reduces payments for indirect medical education from 7.7 percent to 5.5 percent in the year 2001 and thereafter.

OAS; W-00-98-30010; A-07-98-00000
Expected Issue Date: FY 1998

Medicare and Medicaid Payments for Graduate Medical Education

This review will determine whether there is duplication of graduate medical education reimbursements to hospitals by the Medicare and Medicaid programs. The Federal Government pays teaching hospitals for the costs they incur training medical residents through both programs. A recent GAO report identified concerns that duplication could be occurring. Our work will focus on selected States with the highest amount of total Medicare and Medicaid medical training costs.

OAS; W-00-98-30010; A-07-98-00000; A-02-98-00000
Expected Issue Date: FY 1998

Observational Stays Billed to Medicare

This study will determine the financial impact on the Medicare program and its beneficiaries of miscoded hospital outpatient observational stays. Observation services are furnished by a hospital on an outpatient basis and may include the use of a bed and periodic monitoring. Medicare reimburses for these services on a cost basis. The Prospective Payment Assessment Commission identified this as a problem area in

1994, because many of these observational stays should have been coded as inpatient admissions to the hospital. HCFA has subsequently changed its policy to deny coverage for observation stays longer than 2 days.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Diagnosis-Related Group Coding

This review will determine the extent to which hospitals are incorrectly coding hospital discharges for Medicare payment. The basis for payments to hospitals is the diagnosis-related group (DRG) code for each discharge under the prospective payment system. This review will develop an approach to identify facilities possibly engaged in inappropriate coding for more thorough review and proper remedial action. Approaches may include the use of changes in case-mix or commercial software currently used to detect billing irregularities.

OEI; 01-97-00010

Expected Issue Date: FY 1998

Revenue Codes Billed By Hospitals

This study will determine the extent to which hospitals are inappropriately billing Medicare for non-covered items through the use of general revenue codes. Revenue codes are billing codes which identify accommodation and/or ancillary charges covered by Medicare. Revenue codes are used when providers use a cost report, as opposed to billing on a prospective basis. However, in instances when a beneficiary's Part A inpatient coverage runs out, revenue codes are used to bill Part B for covered services. Likewise, if a beneficiary is having a procedure performed in a hospital on an outpatient basis, revenue codes are also used to bill Part B.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Hospital Services Billed Under Arrangement

This study will determine the extent to which hospitals purchase services under arrangement and identify the services that hospitals purchase most frequently. It will also assess the fiscal effects of these arrangements. Previous work conducted by the OIG has concluded that Medicare pays substantially more when nursing homes purchasing services “under arrangement” from ancillary service providers such as therapy/rehabilitation agencies and portable x-ray suppliers. “Under arrangement,” means that a facility purchases ancillary services from a service provider who bills the facility rather than a Medicare contractor. The facility then includes those services as costs on the claims they submit to the fiscal intermediary, marking them up as much as 250 percent for overhead and administrative expenses. This study will determine if similar problems occur at hospitals.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Short-Stay Discharges At Non-Prospective Payment System Providers

This review will: (1) identify the extent of “short stay” discharges from a prospective payment system (PPS) hospital and to a hospital unit that is not part of the prospective payment system; (2) assess whether such stays were warranted; and (3) determine whether Medicare reimbursement should be adjusted if the beneficiaries were subsequently readmitted to the same PPS hospital that made the original referral. Examples of non-PPS providers include rehabilitative and psychiatric hospitals, or such units, within hospitals.

Acute care PPS providers have a financial incentive to discharge patients to non-PPS providers in order to reduce lengths of stay and at the same time receive payment at the full diagnosis-related group amount. Increased discharges could enable non-PPS providers to qualify for higher Medicare reimbursement through increases to their allowable operating cost target amount.

OAS; W-00-98-30010; A-01-98-00000

Expected Issue Date: FY 1998

Outpatient Psychiatric Services

This review will determine whether psychiatric services rendered on an outpatient basis are billed for and reimbursed in accordance with Medicare regulations. Medicare regulations require that payments be limited to covered services that are supported by medical records. We have indications from one fiscal intermediary that services rendered in outpatient hospital settings were not documented, not ordered by a physician, nor were covered services. We will determine if this is also a problem at other fiscal intermediaries.

OAS; W-00-98-30010

Expected Issue Date: FY 1998

Partial Hospitalization Services

We will review partial hospitalization services, i.e., specialized outpatient mental health services, to identify services that do not meet the Medicare reimbursement requirements. Medicare covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of a beneficiary's mental condition. The OIG reviews will focus on uncovered services and those provided to beneficiaries who do not meet eligibility requirements. The reviews will be conducted in three modalities: a joint project with HCFA; individual providers; and a nationwide review.

OAS; W-00-98-30010; A-04-98-00000

Expected Issue Date: FY 1998

Experimental Drug Trials

We will conduct two reviews to determine whether hospitals and other providers are inappropriately billing Medicare for items or services provided to beneficiaries as part of research grants and experimental drug trials. Many research projects are funded by the Public Health Service and private foundations, whereas experimental drug trials are usually paid by pharmaceutical companies. We will determine if claims for these projects are also being paid by Medicare.

OAS; W-00-98-30010; A-06-98-00000

Expected Issue Date: FY 1998

Organ Transplant Costs

This review will evaluate the financial and nonfinancial consequences of modifying the method used to pay for organs. The current system involves reimbursement of certified transplant centers and organ procurement organizations. The charge paid to the procurement organization by the transplant center is included in the transplant center's cost report and overhead is applied to this amount and reimbursed by Medicare. This overhead allocation adds 25 percent to the cost of organs procured and reimbursed by the Medicare program.

OAS; W-00-98-30001; A-04-98-00000
Expected Issue Date: FY 1998

Private Hospital Accreditation

We will assess HCFA's oversight of private accreditation and State certification activities as well as the role of private accreditation and State licensure. In order for hospitals to receive Medicare payments, they must be certified by Medicare (through federally reimbursed State surveys) or they must be accredited. Of the 6,200 hospitals currently participating in the Medicare program, over 70 percent are accredited: about 4,700 through the Joint Commission on the Accreditation of Health Care Organizations and 144 through the American Osteopathic Association.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Prospective Payment System Transfers

We will continue to support the Department of Justice's assistance to the Department in seeking recovery of Medicare overpayments to Prospective Payment System (PPS) hospitals that incorrectly reported PPS transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between PPS hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay while the hospital receiving the transferred patient is to be paid a diagnosis related group

payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount.

OAS; W-00-98-30010; A-06-97-00006

Expected Issue Date: FY 1998

Prospective Payment System Transfers During Hospital Mergers

We will review transfers from acquired Prospective Payment System (PPS) hospitals to the acquiring PPS hospital to identify situations where Medicare paid the acquired hospital under the PPS transfer payment policy (per diem based payments) and the acquiring hospital the full diagnosis related group payment without the patient leaving the hospital bed. The PPS was designed to pay a hospital for all care a Medicare beneficiary needed for discharge. Where a PPS hospital is acquired, the patient does not leave the hospital bed, and the new owner receives a new provider number only one payment should be made by Medicare. We have noted a number of situations in which Medicare contractors paid both the acquired and the acquiring hospitals.

OAS; W-00-98-30010; A-06-98-00000

Expected Issue Date: FY 1998

Hospital Reporting of Patients Who “Left Against Medical Advice”

We will identify Prospective Payment System (PPS) hospitals that routinely report Medicare patients leaving the hospital against medical advice as a possible indicator of facilities trying to circumvent the PPS transfer payment policy. This policy exempts situations in which the patient left the first PPS hospital against medical advice (self-discharged). A significant increase in the reporting of “left against medical advice” transfers occurred since the OIG’s first PPS transfer recovery project (January 1986 through November 1991).

OAS; W-00-98-30010; A-06-97-00059

Expected Issue Date: FY 1998

Duplicate Billing of Outpatient Hospital Services

We will compare the billing practices of hospital-based outpatient clinics and physicians who bill for similar services in the clinics. Services rendered in a hospital-based outpatient clinic are billed under Medicare Part B but through a fiscal intermediary. The physicians providing services in these clinics may be billing for the same services under Part B, but submitting their claims to the carrier. If both are billing for and receiving reimbursement for the same services, then duplicate payments result. These types of duplicate payments would be hard to routinely detect because bills are sent to different contractors.

OAS: W-00-98-30010; A-03-98-00000
Expected Issue Date: FY 1999

Hospital Closure: 1996

This will be the tenth in a series of reports on hospital closure, examining the extent, characteristics, reasons for and impact of closures in 1996. In the mid to late 1980s, closure of general, acute care hospitals had generated considerable public and congressional interest. Our first report on closures in 1987 showed that the problem was not as severe as generally believed. Few hospitals had closed; most were small and had low occupancy; few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there is continuing interest in this phenomenon and our annual reports have become a standard reference on it.

OEI; 04-97-00110
Expected Issue Date: FY 1998

Hospital Ownership of Physician Practices

This study will examine the prevalence and characteristics of hospital-owned physician practices. In recent years, integration in the health care marketplace has included hospital purchases of physician practices. This study will be the first in a series of reports aimed at determining what vulnerabilities to Medicare result from this growing trend. The report will describe: the number and types of physician practices owned by

hospitals, physician compensation arrangements, and hospitals' business objectives in pursuing physician practices.

OEI; 04-97-00090

Expected Issue Date: FY 1998

HOME HEALTH

Hospital Ownership of Home Health Agencies

This study is a follow-up to an OIG review entitled, "Hospital Discharge Planning" and will determine more precisely how and to what extent hospital ownership of home health agencies impacts on the referral to these agencies. This study will focus on discharges involving specific DRGs with co-morbidities and will analyze a number of factors including referral rates; length and cost of initial hospitalization; and length, cost, intensity and different types of home health agency services provided.

OEI; 02-94-00321

Expected Issue Date: FY 1998

General and Administrative Costs

Because of the large increase in home health expenditures during the last several years, we will conduct a series of reviews to determine the allowability of general and administrative (G&A) costs incurred in "chain" organizations and being billed to the Medicare program. Data indicates that some providers' costs (cost per visit) are significantly higher than their peers. We will concentrate our review on salaries and fringe benefits and similar G&A costs to determine whether they are reasonable and related to patient care. We will also incorporate the results of our financial statement audit work into future general and administrative cost reviews.

OAS; W-00-98-30009; Various CINs

Expected Issue Date: FY 1998

Physician Case Management Billings

This review will determine if, when a home health claim has been denied by the regional home health intermediary, the Part B carrier also denies any related payments submitted by the physician for oversight of the plan of care. Payment to physicians for plan care oversight is to be recovered when a claim did not meet Medicare criteria for home health services. The intermediaries and carriers should be interacting with regard to such claims. Based on our early survey work, physician billings for plan care oversight could be substantially reduced based on the potential denial rate that should have taken place.

OAS; W-00-98-30009; A-06-98-00000
Expected Issue Date: FY 1998

Home Health Agency Cost Reports

Our limited-scope reviews will determine if, in their Medicare cost reports, home health agencies in selected States properly documented the reasonableness of costs such as salary, and miscellaneous and accrued costs for which reimbursement was claimed. In coordination with the appropriate regional home health intermediary and HCFA, we will select home health agencies based on total reimbursement, the average number of visits per patient and location. Our audit methodology will focus on a limited number of cost categories that can be reviewed in a relatively short period.

OAS; W-00-98-30009
Expected Issue Date: FY 1998

Home Health Agency Eligibility Reviews

At HCFA's request, we will continue to determine whether home health care visits claimed by various home health care providers meet Medicare reimbursement guidelines. We will determine if the home health visits are needed, properly authorized, and furnished to eligible beneficiaries. These reviews are being conducted

in partnership with HCFA and appropriate State agencies as a continuation of the review methodology developed under Operation Restore Trust.

*OAS; W-04-97-30016; A-04-97-01165; A-0-4-97-01166; A-04-97-01169;
A-04-97-01170; A-04-97-01171*

Expected Issue Date: FY 1998

Home Health Aides

We will examine claims for home health aide services ostensibly provided to Medicare beneficiaries in residential care facilities in California. The State requires such facilities to provide assisted living services, such as meal preparation, room cleaning, and bathing in order to be licensed. The residents pay the facilities for these services. Nonetheless, past work has disclosed instances where home health aides (via home health agencies) claimed Medicare reimbursement as though they--not the resident care facilities--provided the services to beneficiaries. Our study will offer recommendations on how Medicare can prevent payments for these inappropriate claims.

OAS; W-00-98-30009; A-09-98-00000

Expected Issue Date: FY 1998

Overhead Costs of Home Health Agencies

This financial analysis will determine how much of Medicare payments to home health agencies are actually benefiting Medicare beneficiaries. Medicare reimburses home health agencies on the basis of their reasonable and allowable costs. We are finding, however, that few incentives exist for agencies to control costs and operate in a fiscally prudent manner. Indeed, an analysis of a major agency in California disclosed that only 46 cents of every Medicare dollar paid the agency was used to provide direct medical and aide services to beneficiaries. The majority of the Medicare payments--54 cents of every dollar--went for the agency's overhead and its subcontractors' overheads and profits. There are proposals to change how Medicare pays home health agencies--from a cost reimbursement system to a prospective payment system. Whether the current system is retained or changed, the findings

produced by this study will be of value in establishing fair and reasonable Medicare payments for home health services.

OAS; W-00-98-30009; A-09-98-00000

Expected Issue Date: FY 1998

NURSING HOME CARE

Therapy in Nursing Facilities

A series of OIG reviews will evaluate the reasonableness of and costs associated with therapy services provided in skilled nursing facilities. The Medicare skilled nursing facility benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services. These rehabilitative services may include physical and occupational therapy which may be paid by either Medicare Part A or Part B: Part A if the services are provided by nursing home staff or by outside staff paid by the nursing facility; Part B if the outside provider bills Medicare Part B directly. Past OIG work has found that services purchased under arrangement with outside providers were significantly higher than salaried therapy costs.

We will examine a number of issues connected with these services and payment arrangements, including medical necessity and excessive costs.

OAS; W-00-98-30014; A-04-98-00000

OEI; 09-97-00120

Expected Issue Date: FY 1998

Revenue Codes Billed By Nursing Facilities

The OIG, using the methodology and protocol developed in its joint work with HCFA and Florida's Agency for Health Care Administration, will target abusive and unallowable or fraudulent use of certain revenue codes (for types of services billed) by skilled nursing facilities in Florida and other States.

OAS; W-00-96-30015; A-04-96-01145

Expected Issue Date: FY 1998

Physicians with Excessive Nursing Home Visits

We will identify and audit physicians with excessive visits to Medicare patients in skilled nursing facilities (SNF). The OIG nursing home project identified trends in Medicare and Medicaid payments and populations and identified aberrant providers of nursing home services by type of service. Using this data as well as other computer screening techniques, we identified physicians with aberrant billing patterns for visits to SNF patients, such as an excessive number of visits in a given day and excessive visits to the same beneficiaries. Individual reviews will be conducted for those physicians with the most egregious billing patterns. We also plan to determine how the carriers could better identify and prevent such billings.

OAS; W-00-96-30015; A-09-97-00062; A-06-97-00050

Expected Issue Date: FY 1998

Financial Conflicts of Interest

We will examine nursing homes that have been purchased, either partially or wholly, by durable medical equipment supplier chains and/or physician groups. This review will look at claims submitted for Medicare beneficiaries in these homes and identify any aberrant billing patterns for services and supplies provided by owners with a substantial financial interest.

OAS; W-00-98-30014; A-03-98-00000

Expected Issue Date: FY 1998

Nursing Home Care After Less Than 3-Days of Hospitalization

This review will determine if payments for skilled nursing facility stays meet Medicare's coverage conditions. In order to be paid by Medicare, a patient's nursing home stay must be preceded by a 3-day or more hospital stay. Our survey work in Illinois indicated some nursing home stays were reimbursed by Medicare although they were not preceded by the required hospital stay. We plan to use HCFA's automated data to identify nursing homes in Illinois where the existence of this condition is indicative of potential abuse.

OAS; W-00-98-30014; A-05-98-00000

Expected Issue Date: FY 1998

Mental Health Services in Nursing Facilities: A Follow Up

We will determine the continued existence of vulnerabilities to Medicare resulting from the expanded provision of mental health services to nursing facility residents. In a 1996 OIG study, we found medically unnecessary or questionable Medicare mental health services in nursing facilities in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent inappropriate payments for these services, such as developing guidelines for carriers, developing screens to implement these guidelines, and conducting focused medical review and providing physician educational activities. This study will determine whether mental health services in nursing facilities continue to be inappropriately billed. Our work will be coordinated with that on outpatient mental health care.

OEI; 00-00-00000

Expected Issue Date: FY 1999

HOSPICE

Hospice and Hospital/Skilled Nursing Facility Overpayments

This follow-up review will update and expand a recent nationwide review which disclosed a significant number of improper payments to hospitals and skilled nursing facilities for hospice patients. The review will include an evaluation of whether controls implemented by HCFA in response to the prior review are effective in preventing overpayments.

OAS; W-00-96-30015; A-02-96-01047

Expected Issue Date: FY 1998

Part B Payments

We will determine the appropriateness of payments made to physicians, durable medical equipment suppliers and other providers of Part B services on behalf of hospice patients. Separate Part B payments for hospice beneficiaries are appropriate only for conditions unrelated to the patient's terminal illness. A recent nationwide review disclosed significant problems in Part A payments to hospitals and skilled

nursing facilities for hospice patients; a similar situation appears to be occurring on the Part B side.

OAS; W-00-96-30015

Expected Issue Date: FY 1998

Hospice Reimbursement Rates

This review will examine the basis for periodic adjustments to hospice rates. Hospices are reimbursed by Medicare using a capitated daily reimbursement rate, with geographical variations. The rates were set by HCFA in the 1980s and they are adjusted upward periodically. We will determine the basis for the rates and their reasonableness.

OAS; W-00-98-30014; A-05-98-00000

Expected Issue Date: FY 1998

PHYSICIANS

Physicians at Teaching Hospitals (PATH)

This initiative is designed to verify compliance with the Medicare rules governing payment for physician services provided in the teaching setting, and to ensure that claims accurately reflect the level of service provided to the patient. The PATH initiative has been undertaken as a result of the OIG's audit work in this area which suggested that many providers were not in compliance with the applicable Medicare reimbursement policies.

OAS; W-00-96-30021; A-03-96-00006

Expected Issue Date: FY 1998 and FY 1999

Physician Perspectives on Medicare HMOs

This study will determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs). The OIG has issued numerous reports on Medicare HMOs over the past several years. Some of these reports have raised concerns with the impact of HMOs on the access and quality of

health care provided to Medicare beneficiaries. These previous studies have surveyed only Medicare HMO enrollees and administrators. This study will obtain the perspectives of another important player in the Medicare HMO industry, the physician.

OEI; 02-97-00070

Expected Issue Date: FY 1998

Physician Certification of Durable Medical Equipment

This study will assess how effectively physicians are meeting Medicare expectations that they act as controls against unnecessary use of non-physician services and supplies. This study will build on our work assessing the physician's role in home health (OEI-02-94-00170) and in completing certificates of medical necessity (OEI-03-96-00010). We will identify common obstacles and successes in ensuring that physicians perform this important service.

OEI; 00-00-00000; 00-00-00000

Expected Issue Date: FY 1998

Hospital Ownership of Physician Practices

We will assess Medicare billing practices and utilization when hospitals own physician practices. In recent years, integration in the health care marketplace has included hospital purchases of physician practices. Vulnerabilities may include inappropriate referrals (in either direction) between hospitals and physicians, excessive costs and billings, and overutilization of services when hospitals bill the Medicare program through physician practices they own.

OEI; 04-97-00090

Expected Issue Date: FY 1998

Accuracy of and Carrier Monitoring of Physician Visit Coding

We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for

evaluation and management services. Generally, the codes represent type and complexity of services provided, and patient status, such as new or established. Previous work by the OIG has found that physicians are not accurately or uniformly using visit codes. This analysis will build upon this previous work and add more definitive data regarding the accuracy of physician visit coding.

OEI; 00-00-00000; OAS; W-00-98-30021; A-04-98-00000;
Expected Issue Date: FY 1998

Use of Surgical Modifier

We will determine whether physicians are improperly using modifier 25 on their Medicare Part B claims to increase reimbursements. Modifier 25 is for physicians to claim “Significant, Separately Identifiable Evaluation and Management Service on the Day of Surgery”--the key words being “Separately Identifiable.”

OAS; W-00-98-30021; A-04-98-00000
Expected Issue Date: FY 1998

Physician and Other Service Provider Use of Diagnosis Codes

This review will examine a sample of services paid by Medicare. By comparing Medicare claims to beneficiary medical records, a medical reviewer will determine the extent to which diagnosis codes on claims match the reason for ordering and providing various services. In a previous report entitled “Imaging Services for Nursing Facility Patients: Medical Necessity and Quality of Care” (OEI-09-95-00092), we found that physicians and other providers of imaging services do not follow HCFA’s guidance on use of diagnosis codes.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Physician Credit Balances

This review will determine whether physicians are reviewing their records for Medicare credit balances and refunding to their carriers those indicating an overpayment. A credit balance occurs when a provider receives and records higher reimbursement than the amount actually charged to a specific Medicare beneficiary.

Some credit balances result from duplicate payments and in these cases a Medicare overpayment exists. Past OIG work which identified credit balances at hospitals resulted in significant recoveries for the Medicare program.

OAS; W-00-98-30021

Expected Issue Date: FY 1998

Multiple Discharges

We will determine whether duplicate payments have been made for day of discharge patient management services. Discharge day management can only be billed by the admitting physician. In one State, we have noted examples where two or more physicians are billing for discharge day management for the same beneficiary admission. We will develop a computer application to identify those beneficiaries whose discharge day management was billed by more than one physician during a single inpatient stay.

OAS; W-00-98-30021; A-03-98-00000

Expected Issue Date: FY 1997

Anesthesia Services

This review will identify anesthesiologists who bill for personally performed services and determine if these services were in compliance with Medicare regulations. We found several instances where anesthesiologists were improperly billing for supervising residents in three or more operating rooms at the same time.

OAS; W-00-98-30021; A-03-98-00000

Expected Issue Date: FY 1999

Critical Care Services

This review will focus on those providers who incorrectly bill Medicare for critical care based on the location of the patient and not the actual services provided by the physician. Critical care is that requiring the constant attention of the physician. It is usually, but not always, provided in a critical care area, such as a coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Physician

services for patients who are not critically ill but happen to be in a critical care unit are to be claimed using “subsequent care” hospital codes.

OAS; W-00-98-30021; A-03-98-00-00000

Expected Issue Date: FY 1999

Billing for Services Rendered By Physician Assistants

We will determine whether physicians are improperly billing for services rendered by physician assistants. Medicare allows physician assistants to render certain services as “incident to” services, which are billed by the employing physician as if the service was personally rendered by the physician. However, if the services do not fall under the “incident to” criteria, the employing physician must bill using a modifier which reduces the Medicare payment. Medicare is overpaying physicians who improperly bill physician assistant services as “incident to” rather than using the proper modifiers.

OAS; W-00-97-30021; A-06-97-00047

Expected Issue Date: FY 1998

Billing Service Companies

This review will determine whether: (1) Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided to beneficiaries; and (2) the agreements between providers and billing service companies meet Medicare criteria. Medicare allows providers to contract with billing service companies that provide billing and payment collection services. The contractual agreements between the provider and the billing service company must meet certain Medicare criteria and a copy of the agreement must be provided to the applicable Medicare Carrier. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians. The HCFA officials have expressed concern that the agreements may not meet the required criteria.

OAS; W-00-97-30021; A-06-97-00044

Expected Issue Date: FY 1998

Improper Billing of Psychiatric Services

We will determine whether providers are properly billing Medicare for psychiatric services in the following three areas: (1) providers' billing Medicare for individual psychotherapy rather than inpatient hospital care, resulting in Medicare overpayments, (2) providers' billing Medicare for a psychological testing code on a per test basis rather than a per hour basis, as required, or (3) providers' billing Medicare for group psychotherapy in cases which do not qualify for Medicare payment because either the group sessions do not involve actual psychotherapy services or the patients cannot benefit by group psychotherapy. Improper billing of these psychiatric services results in Medicare overpayments.

OAS; W-00-97-30021; A-06-97-00045

Expected Issue Date: FY 1998

MEDICAL EQUIPMENT AND SUPPLIES

Allowances for Wound Care

This review will follow up our earlier work (Questionable Medicare Payments for Wound Care Supplies (OEI-03-94-00790) which identified \$65 million in questionable allowances for wound care between June 1994 and February 1995. As a follow up, we will determine the impact of new Medicare guidelines on questionable allowances for wound care supplies in 1996. We will identify and analyze 1996 claims that exceed the established parameters. Suppliers who submit questionable claims will also be identified.

OEI; 03-94-00793

Expected Issue Date: FY 1998

Reimbursement for Diabetic Shoes

This review will determine the appropriateness of supplier billings for diabetic shoes. Medicare beneficiaries with diabetes have an increased risk of developing foot problems which could lead to amputation. Effective May 1, 1993, Medicare covers therapeutic shoes and related footwear designed to prevent the occurrence of serious foot problems. Medicare payments for such footwear have been increasing rapidly.

Preliminary allowances for 1996 climbed to more than \$12 million, an increase of over 20 percent from 1995 figures. Because of this rapid increase, we will review program expenditures in this area to determine if abusive billings are occurring.

OEI; 03-97-00300

Expected Issue Date: FY 1998

Medical Necessity of Oxygen

This review will assess Medicare beneficiaries' self-reported use of home oxygen therapy compared with documentation supporting the medical need for such therapy. We will assess the prescribing practices of physicians who order the systems and how Medicare monitors utilization and medical necessity for the systems. Allowances for oxygen equipment increased from about \$835 million in 1992 to over \$1.6 billion in 1995.

OEI; 03-96-00090

Expected Issue Date: FY 1998

Orthotic Body Jackets

In 1993, the OIG issued a report on Medicare payments for orthotic body jackets and found that 95 percent of the claims submitted should not have been paid because the "body jackets" did not meet construction and medical necessity criteria. Many of the devices were primarily used to keep patients upright in wheel chairs. A follow-up study will be done to determine if suppliers are still billing for "non-legitimate" orthotic body jackets.

OEI; 04-97-00390

Expected Issue Date: FY 1998

Comparison of Payers for Hospital Beds

This study will compare Medicare payment methodologies and reimbursement levels for hospital beds with rates paid for the same items by other payers, e.g., other Federal programs, State Medicaid agencies, private insurance plans, managed care organizations. Information about rates and payment methodologies will be obtained from other payers and analyzed in relation to Medicare payments to determine

whether Medicare is paying excessively. The data will also be used to calculate potential savings of alternative reimbursement approaches. This study follows up work in progress analyzing Medicare payments for hospital beds under the capped rental methodology.

OEI; 07-96-00021

Expected Issue Date: FY 1998

Operations of Durable Medical Equipment Carriers

We will assess whether the establishment of the durable medical equipment regional carriers has met its intended objectives. Starting on October 1, 1993, HCFA began consolidating claims processing activities for durable medical equipment, prosthetics, orthotics, and supplies into four regional carriers. The four durable medical equipment regional carriers, replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of these regional carriers with respect to medical guidelines, oversight of claims processing, and detection and referral of fraudulent activity.

OEI; 04-97-00330

Expected Issue Date: FY 1998

Durable Medical Equipment Credit Balances

This review will determine whether durable medical equipment providers are reviewing their records for Medicare credit balances and refunding to their carriers those indicating an overpayment. A credit balance occurs when a provider receives and records higher reimbursement than the amount actually charged to a specific Medicare beneficiary. Some credit balances result from duplicate payments and in these cases a Medicare overpayment exists. Past OIG work which identified credit balances at hospitals resulted in significant recoveries for the Medicare program.

OAS; W-00-98-30007; A-04-98-00000

Expected Issue Date: FY 1998

LABORATORY SERVICES

Clinical Laboratory Improvement Amendments

This study will determine how HCFA is enforcing the numerous provisions of the Clinical Laboratory Improvement Amendments of 1988; determine the relative strengths and weaknesses of its enforcement strategy; and recommend improvements if needed. The 1988 amendments strengthened quality standards under the Public Health Service Act and extended these requirements to all entities performing laboratory testing, including those in physicians' offices.

OEI; 05-92-01020

Expected Issue Date: FY 1998

Utilization of Laboratory Services

This study will review trends in utilization of Medicare laboratory services. We will review these changes in light of the Clinical Laboratory Improvement Amendments of 1988, new laboratory test procedures, changes in physician fee schedules and growth in managed care. We will also look at possible mechanisms that can be effectively used to control utilization, including bundling of services into physician office visit reimbursement. Such a proposal was advocated in a 1991 OIG report and was estimated to save \$12 billion over 5 years.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Fraud and Abuse in Cytology Laboratories

This review will assess the extent that cytotech workload records may be falsified and the reliability of laboratory procedures in workload record keeping. The Clinical Laboratory Improvement Amendments of 1988 imposed strict limits on the number of cytology slides that could be read in a day. No more than 100 slides can be read by one person in a 24-hour period. This review is being undertaken at the request of

HCFA officials because they have found through their inspection activity that the limit is being circumvented.

OEI; 02-95-00290

Expected Issue Date: FY 1998

Claims for Outpatient Hospital Laboratory Services

This follow-up review will determine the adequacy of procedures and controls used by fiscal intermediaries to process Medicare payments for clinical laboratory services performed by hospital laboratories on an outpatient basis. Clinical laboratory services include chemistry, hematology and urinalysis tests. The review will focus on whether providers properly bill for tests provided to the same beneficiary on the same day. The need for more effective controls was addressed in our prior review, "Nationwide Review of Laboratory Services Performed by Hospitals as an Outpatient Service" (A-01-93-00520).

OAS; W-00-98-30011; A-01-97-00000

Expected Issue Date: FY 1998

Independent Physiological Laboratories

This review will identify program vulnerabilities associated with independent physiological laboratories and explore ways to safeguard the Medicare program from fraudulent and abusive providers. Concerns about improper billing by independent physiological laboratories include upcoding, performance of medically unnecessary services, billing for services not rendered and billings by questionable providers. We will analyze claims and related data associated with a sample of providers to determine whether the providers are legitimate and whether the claims meet other criteria for reimbursement.

OEI; 05-97-00240

Expected Issue Date: FY 1998

END STAGE RENAL DISEASE

Epogen Reimbursement Relating to Hematocrit Levels

This review will determine whether HCFA's new policy on hematocrit levels will be effective in controlling the escalating cost to Medicare of the drug Epogen (EPO). EPO is a Medicare-covered drug used in the treatment of anemia associated with chronic renal failure. The HCFA recently issued a program memorandum (AB-97-2) which restricts payments for EPO when a patient's hemocrit reading exceeds a certain level.

OAS; W-00-98-30025; A-01-98-00000

Expected Issue Date: FY 1998

Dialysis Supply Kits

This study will determine whether Medicare payments for dialysis supply kits are appropriate. Medicare has created a separate benefit category known as "dialysis supplies and equipment" for beneficiaries who qualify for Medicare because they suffer from end stage renal disease. Such supplies and equipment are covered for patients who receive dialysis at home under the supervision of a Medicare-approved dialysis facility. In 1996, Medicare allowances for the two major procedure codes representing dialysis supply kits are projected to exceed \$150 million for the year.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Bad Debts - Nationwide Chain

This review will determine whether home office costs and bad debts reported by a nationwide chain organization are in accordance with Medicare reasonable cost principles, and provisions of the Provider Reimbursement Manual. Under Medicare's composite rate reimbursement system, ESRD facilities are reimbursed 100 percent of their allowable bad debts, up to their unreimbursed Medicare reasonable costs. However, prior reviews have identified unallowable costs in cost reports for facilities claiming bad debts, thus overstating the reimbursable amount. Further, these facilities did not identify unallowable costs on prior cost reports. We will assess the

internal controls for Medicare cost reporting, cost allocation, and general ledger maintenance. We will also perform substantive testing to determine whether reported costs are allowable.

OAS; W-00-98-30025; A-01-98-00000

Expected Issue Date: FY 1998

Dialysis Procedure/Evaluation and Management Code Double Billing

We will determine if renal/nephrology physicians are billing for a dialysis evaluation on the same day that they bill for evaluation and management services. The Medicare Carriers Manual states that a dialysis procedure cannot be paid on the same day as evaluation and management services, unless the services are unrelated to the dialysis, as dialysis and any related physician services are included in the monthly capitation payment. We will study this area to determine the significance of this issue.

OAS; W-00-98-30025; A-03-98-00000

Expected Issue Date: FY 1999

DRUG REIMBURSEMENT

Medicare Licensing Requirements for Drug Suppliers

This review will determine if entities that bill for providing drugs and similar medications to Medicare beneficiaries meet the required licensing requirements. Effective December 1, 1996, HCFA issued a new policy requiring entities which bill for providing drugs to Medicare patients to have pharmacy licenses. Previously, suppliers could bill the Medicare program for providing drugs even though they did not have pharmacy licenses in accordance with applicable State laws. Many suppliers had agreements with pharmacies to dispense the drugs, but the suppliers did the actual billing. The new policy was developed, in part, because of questionable practices encountered in South Florida.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Medicare Nebulizer Drugs

We will determine the extent to which durable medical equipment suppliers have either paid or received referral fees to or from other equipment suppliers for filling Medicare nebulizer drug prescriptions. We have identified some of these suppliers and referred them to our investigative staff. We will determine whether other suppliers have entered into similar arrangements.

*OAS; W-00-98-30024; A-06-96-00048; A-06-96-00067; A-06-96-00068;
A-06-97-00036; A-06-97-00042
Expected Issue Date: FY 1998*

OTHER MEDICARE SERVICES

Medicare Beneficiary Satisfaction: 1997

This review will assess Medicare beneficiary satisfaction with the administration of the program, including timely processing of claims, response to inquiries, understanding of coverage and payment policies, and use of publications. This is the sixth such survey which can be used as a measurement of the program's performance in serving its clients. Previous surveys have shown generally high levels of satisfaction with the Medicare program.

*OEI; 04-97-00030
Expected Issue Date: FY 1998*

Comparison of Ambulance Reimbursement Policies

We will contact different payers (e.g., fee for service, contracts, health maintenance organizations, preferred provider organizations) to identify how much these groups are reimbursing ambulance suppliers for services. We will compare this data with Medicare reimbursement for the same services in similar geographic areas and use all

data to project savings for the geographic areas. Our recent studies of Medicare ambulance services have raised concerns that Medicare allowances may be excessive.

OEI; 09-95-00411

Expected Issue Date: FY 1998

Medical Necessity, Quality of Care, and Reimbursement of Ambulance Services

We will assess potential policy issues and the appropriateness of payments for ambulance services provided to Medicare beneficiaries through a sample of claims paid in 1996. In 1995, Medicare Part B paid approximately \$2.0 billion for ambulance services. We will target high-volume providers who have billed at least 50 percent of their services associated with emergency room care (without subsequent inpatient admission), transportation to or from physicians' offices, or unexplained destinations.

OEI; 09-95-00412

Expected Issue Date: FY 1998

Scheduled Ambulance Transports of Beneficiaries With End Stage Renal Disease

This study will determine whether Medicare Part B's payment system takes advantage of the predictable nature of some ambulance transport for beneficiaries, e.g., those with end-stage renal disease. Persons with end stage renal disease must have dialysis treatments at least three times per week in order to survive. Under Medicare Part B, ambulance transport to dialysis facilities is covered if other forms of transport would endanger the beneficiary's health. The 1995 allowed charges for ambulance transports for beneficiaries with end stage renal disease were \$183.5 million. This study will follow-up previous OIG work which found that payments for dialysis-related ambulance claims were based on an outmoded payment system.

OEI; 00-00-00000

Expected Issue Date: FY 1998

OIG-Excluded Providers

This review will examine how OIG exclusion data is used outside the OIG and identify improvements needed in the government's ability to protect federally-funded programs and their beneficiaries from fraudulent or poor-performing health care providers. Every year the OIG excludes 1,200-1,500 fraudulent or unqualified practitioners from Medicare and Medicaid participation for varying durations. Interested parties are able to identify these excluded providers by virtue of broad dissemination of OIG exclusion data and other means. However, anecdotal indications are that interested parties other than HCFA are not using this information, even though these providers are potentially harmful to Federal programs and their beneficiaries.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Administrative Law Judges' Decisions

We will review the Medicare claims process, including the mechanism by which beneficiary claim denials are aggregated for appeal before Administrative Law Judges. An Administrative Law Judge is empowered to reverse a carrier denial of a claim or group of similar claims, resulting sometimes in substantial post-denial payments to providers and suppliers. Such reversals occur in 70 percent of the appeals submitted to these judges. Under existing laws, the Medicare program has limited recourse to appeal the decision of an Administrative Law Judge.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Inappropriate Anesthesiology Claims

This review will assist the Office of Investigations to determine whether the Medicare program has been inappropriately charged for anesthesiology services. The intermediary is concerned that a provider's billing practices for services furnished by

Certified Registered Nurse Anesthesia (CRNA) and the related costs included in its cost reports has resulted in double billing to the Medicare program.

OAS; W-04-97-30018; A-04-97-01167

Expected Issue Date: FY 1998

MEDICARE MANAGED CARE

Cost Data for HMOs

This review will focus on the verification and analysis of data used in the development of the adjusted community rates proposed by risk-based health maintenance organizations (HMO). This rate represents the HMO's premium if it provided the Medicare covered services package to its general membership. An HMO must provide its Medicare enrollees with additional benefits if its rate is less than the Medicare payment. This review will help HCFA to ensure that the information submitted by the HMOs is accurate and supportable.

OAS; W-04-97-30012; A-04-97-01164

Expected Issue Date: FY 1998

General and Administrative Costs

This review will determine if the administrative costs allocated for Medicare beneficiaries enrolled in risk-based health maintenance organizations (HMO) are proper. General and administrative costs include costs associated with enrollment, marketing, membership costs, directors salaries and fees, executive and staff administrative salaries, organizational costs and other plan administrative costs. Inflated general and administrative costs could increase plan profits and the plans would be required to return the excess to HCFA, lower Medicare enrollees' premiums, offer extra benefits to Medicare enrollees, or take a reduction in Medicare payments. A cap on these costs would require legislative action.

OAS; W-00-98-30012

Expected Issue Date: FY 1998

Payments Based on Institutional Status

This review will determine if HCFA is making proper capitation payments to risk-based health maintenance organizations (HMO) for beneficiaries classified as institutionalized. Risk-based HMOs are paid based on a prospectively determined capitation rate. However, a higher capitation rate is paid for beneficiaries classified as institutionalized. Preliminary findings indicate that HCFA's data bases are not being updated for changes in beneficiary status. We will focus on both HCFA and HMO controls of beneficiary status with recommendations for corrective action.

OAS; W-00-98-30012; A-10-98-00000
Expected Issue Date: FY 1998

Beneficiaries in Institutions in Ohio

We will review two large risk-based HMOs in Ohio to determine if Medicare beneficiaries reported as institutionalized actually were in institutions during periods when the HMOs received enhanced rate payments from Medicare. Medicare pays a higher capitation rate to risk-based HMOs for beneficiaries who are institutionalized. In a nationwide study of such HMOs, we have identified numerous Medicare beneficiaries who were incorrectly classified as institutionalized resulting in Medicare overpayments.

OAS; W-00-98-30012; A-05-98-00000
Expected Issue Date: FY 1998

Hospital Billings for Beneficiaries in HMOs

This review will examine bills submitted to Medicare by hospitals on behalf of beneficiaries who are enrolled in a risk-based health maintenance organization (HMO). Under a Medicare risk contract, an HMO must provide all Medicare-covered services that are medically necessary. We will determine if any bills were inappropriately reimbursed under the fee-for-service program. We will also determine if any additional payment amounts, such as on a passthrough basis, were inappropriately charged to the Medicare program.

OAS; W-00-98-30012; A-07-98-00000
Expected Issue Date: FY 1998

Enrollee Access To Emergency Services

This study will determine if existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. Two OIG enforcement authorities are relevant: the so-called “anti-dumping” law and the Medicare/Medicaid health maintenance organization sanction authorities. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or reject a person who comes to the emergency room. The health maintenance organization sanctions protect Medicare and Medicaid beneficiaries from health maintenance organizations’ unreasonable refusal to provide needed care. Violation of either protection may result in sanctions, including penalties and program exclusion. This study will examine whether the reach of these Federal enforcement authorities adequately protects patients who need and seek emergency care but are prevented from receiving such care by operations of managed care rules and hospital policies.

OEI; 00-00-00000

Expected Issue Date: FY 1998

End Stage Renal Disease Beneficiaries

This study will describe and assess the experiences of end stage renal disease beneficiaries in risk-based health maintenance organizations and whether their experience differs significantly from that of fee-for-service patients. Based on a 1993 OIG study of beneficiaries enrolled in or recently disenrolled from risk-based health maintenance organizations, disabled/end stage renal disease Medicare beneficiaries indicated that they experienced more enrollment and service access problems than their aged counterparts. Specifically, 39 percent said their health maintenance organization doctors failed to provide Medicare services when needed. These findings raise serious concerns about the responsiveness of health maintenance organizations when confronted with patients with this condition.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Disabled Medicare Beneficiaries

This study will describe and assess the experiences of disabled Medicare beneficiaries with risk-based health maintenance organizations. In 1993, about 3000 Medicare beneficiaries who were enrolled in, or recently disenrolled from, risk-based health maintenance organizations, responded to our survey on their health maintenance organization experiences. We had focused primarily on their enrollment and access to services. The responses of disabled Medicare beneficiaries, who comprised a sub-group of those surveyed, indicate that they may experience more enrollment and service access problems than their aged counterparts. Specifically, we reported that such disenrollees most often reported service access problems in several crucial areas of their health maintenance organization care.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Quality-of-Care Safeguards

This study will assess the fraud and abuse and quality-of-care safeguards that health maintenance organizations with Medicare contracts use in managing their provider networks. As of March 1, 1997, 5.1 million Medicare beneficiaries were enrolled in 368 managed care plans. About 70 percent of these plans are independent practice network arrangements in which an health maintenance organization contracts with physician groups, individual physicians, physician-hospital organizations, or other emerging entities for the provision of health care services. Many providers contract with multiple health maintenance organizations. To further complicate matters, mergers and buy outs of health maintenance organizations are occurring with increasing frequency, leading to further changes in network arrangements. As Medicare changes from a simple reimbursement program to one based on prudent purchasing of care in a health care marketplace, it must understand the contractual relationships between managed care organizations and their providers.

OEI; 00-00-00000

Expected Issue Date: FY 1998

National Marketing Guidelines for Medicare Managed Care Plans

This study will assess the usefulness to HCFA and to managed care organizations of HCFA's new national marketing guidelines for managed care plans. HCFA regional offices are responsible for approval of all marketing and sales materials that managed care plans provide to beneficiaries. Different review practices among regions have led to discrepancies among the types of materials presented to beneficiaries. In addition, the managed care industry has raised concerns that large national plans are treated differently from region to region and have had to develop different marketing material for each region in which they operate. In an effort to remedy these problems, HCFA has developed national marketing guidelines, which are scheduled to be implemented shortly.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Physician Incentive Plans in Managed Care Contracts

We will review physician incentive plans that are included in contracts that physicians enter into with managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangement that financially reward or penalize physicians based on the utilization levels. It also requires plans to disclose these arrangements to beneficiaries. As part of this review, we will also look at other clauses in these contracts that may impact the quality of care provided.

OEI; 00-00-00000

Expected Issue Date: FY 1998

HMO Disenrollment

This review will examine HMO disenrollments to determine if HMOs are using prohibited practices to encourage unhealthy individuals to disenroll from their plans. Having unhealthy beneficiaries disenroll from their plans increases HMOs'

profitability. This review will identify both systemic problems and individual HMOs for an indepth audit of their enrollment/disenrollment practices.

OAS; W-00-97-30012; A-07-97-01200

Expected Issue Date: FY 1998

Medicare Beneficiary Experiences in HMOs

This study will update prior OIG work which obtained information directly from current Medicare enrollees and recent disenrollees from risk-based health maintenance organizations. We will ask beneficiaries about their experiences in obtaining appointments, access to specialist care, and other such experiences.

OEI; 06-95-00430

Expected Issue Date: FY 1998

Medicare HMO Beneficiaries Who Enroll in Hospice Care

We will determine whether Medicare HMOs hospice beneficiary eligibility determinations are proper and HMO payments are suspended timely. Health maintenance organizations participating in risk based Medicare contracts receive capitated rates for each enrollee. Only terminally ill patients are eligible to be enrolled in hospice care. Payments to the HMO on behalf of a Medicare enrollee who has elected hospice care are to be suspended, except for the portion of the payment applicable to additional benefits provided by the HMO contractor. By shifting non-terminally ill patients to hospice care or failing to suspend hospice enrollees timely, the HMO could overbill the Medicare program.

OAS; W-00-98-30012

Expected Issue Date: FY 1998

Medicare Payments to HMOs for Medicaid-Eligible Beneficiaries

This review will determine if any HMOs have submitted data to HCFA to increase their captation payments by claiming that Medicare beneficiaries were also eligible for Medicaid when they knew the information was not correct. The amount that Medicare pays HMOs for Medicare beneficiaries who are also eligible for Medicaid is higher than the amount it pays for beneficiaries in general. In November 1996, we

reported to HCFA that as much as \$15 million may have been paid to HMOs in enhanced capitations payments for beneficiaries that were not eligible for Medicaid as reported by HMOs. Various investigative units are interested in this ongoing review.

OAS; W-04-97-30012; A-04-97-01154

Expected Issue Date: FY 1998

Medicare Payments to HMOs for Medicaid-Eligible Beneficiaries Living in Medicaid Nursing Facilities

We will examine Medicare payments to risk-based HMOs for Medicaid eligible-beneficiaries living in Medicaid nursing facilities. The Medicare HMO receives an enhanced payment rate for these beneficiaries although the Medicaid reimbursed nursing facility is required to provide most of the patients needs. We will determine the reasonableness of the enhanced payment rate.

OAS; W-00-98-30012; A-06-98-00000

Expected Issued Date: FY 1998

HMO Costs, Revenue, and Profit

We will examine the overall profitability of a large HMO that has contracts with both Medicare and Medicaid. The study will include an analysis of costs and revenue by line of business and the overall profit or loss realized by the contractor for a defined period. The review will focus on an organization's profitability rather than issues covered in other reviews of risk contractors (i.e., reimbursement rate determinations concentrating on HCFA's rate setting procedures).

OAS; W-00-98-30012

Expected Issue Date: FY 1998

MEDICAID MANAGED CARE

Waivers for Persons with HIV/AIDS

This review will determine the impact of Medicaid managed care waivers granted to States for special services for persons with HIV/AIDS. Medicaid provides care for roughly 50 percent of adults with AIDS and 90 percent of children with HIV at a cost of about \$4 billion annually. States with large numbers of HIV/AIDS patients have begun to experiment through waivers with the provision of care to this population in managed care settings. This study would determine the initial impact that these waivers have had on access to care, cost savings, and linkage with other programs, especially the Ryan White program.

OEI; 05-97-00210

Expected Issue Date: FY 1998

Impact on Mental Health Services

We will provide a preliminary description of the impact of managed care on the delivery of mental health services to the Medicaid population. State Medicaid programs are increasingly adopting managed care approaches. This study will gather information on how the managed care approach has affected: the number and types of services available to adults with serious mental illnesses and children with serious emotional disturbances; the mental health delivery systems (prior approval, limits on services, etc); and standards and performance measures.

OEI; 04-97-00340

Expected Issue Date: FY 1998

Helping Medicaid Recipients Make Informed Choices

We will assess HCFA's efforts to inform Medicaid recipients about managed care plans. There is widespread agreement that, like all consumers, Medicaid recipients need better information about the choices available to them between fee-for-service medicine and managed care, and among managed care health plans. We will review the types of information that HCFA provides to recipients and the methods used to

disseminate this material. In addition, we will assess its usefulness to recipients as they choose their health care coverage.

OEI; 00-00-00000

Expected Issue Date: FY 1998

MEDICAID REIMBURSEMENT

Medicaid Outreach & Eligibility Determinations Under Welfare Reform

We will evaluate States' use of administrative funds to enroll eligible children in the Medicaid program. While expressing the intent to preserve Medicaid eligibility for low-income eligible families, the automatic eligibility linkage to Medicaid through Aid to Families with Dependent Children was eliminated under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. However, enhanced matching funds are available to States for administrative costs for Medicaid eligibility determinations, up to a fixed national cap of \$500 million. We will determine how States are using their administrative funds to support their Medicaid outreach and eligibility determination processes following implementation of the Act.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Outpatient Detoxification Services

This study will examine the linkage between detoxification services and further treatment in both inpatient and outpatient settings. Detoxification services are usually delivered to Medicaid recipients in hospitals or other residential facilities. Because of the high cost, some States (and many national private sector health insurance providers) have begun to cover some of these detoxification services in outpatient settings. Though some question the appropriateness of this, others believe this approach may be beneficial in motivating some clients into further treatment, breaking the "revolving door" sometimes associated with detoxification for some clients. In addition, the study will examine the appropriateness and cost-saving

nature of this policy. We will study how this policy has been implemented in the four States where this is being done and assess the implications for other States.

OEI; 07-97-00270

Expected Issue Date: FY 1998

Targeted Case Management

We will assess States' implementation of Medicaid targeted case management. States may provide this as an optional service under Medicaid. States have provided these services to special populations, including pregnant women, the chronically mentally ill, individuals infected with HIV, and persons with developmental disabilities. It is unclear how States have incorporated this program with other authorities for providing case management services. There are also concerns about compliance with certain regulations under the targeted case management options.

OEI; 00-00-00000

Expected Issue Date: FY 1999

Routine and Postpartum Care for Undocumented Aliens

This review will determine if States are incorrectly paying for routine prenatal and postpartum care to undocumented aliens. This review follows up one completed in 1994 to determine if States were correctly interpreting the law concerning emergency services for undocumented aliens. If such misinterpretation does exist, then we will identify any overpayments and seek recovery.

OEI; 07-96-00310

Expected Issue Date: FY 1998

Adjustments to Medicaid Claims for Prior Quarters

We will determine whether a State's quarterly adjustments to Medicaid expenditures are allowable and adequately supported by financial records. A review of the State's

March 31, 1997 quarterly medical assistance claim disclosed substantial increases to Medicaid claims. We will determine the propriety of these adjustments.

OAS; W-00-98-30013; A-05-98-00000

Expected Issue Date: FY 1998

School-Based Medicaid Outreach Services

We will review the propriety of the costs claimed and the methodology used to accumulate and allocate the costs to the Medicaid program for school-based outreach services. Recently, there has been an increasing interest in securing reimbursement for Medicaid outreach activities provided by public education entities, such as, intermediate school districts. School based services are claimed for reimbursement at 90 percent Federal sharing for family planning, 75 percent for skilled professional medical services, and 50 percent for the remaining services. Costs are charged to the Medicaid program utilizing random time studies designed by CPA firms which reportedly receive a percentage of the reimbursements. During FY 1996, the one State's Medicaid Program claimed \$30 million for these school-based services.

OAS; W-00-98-30013; A-05-98-00000

Expected Issue Date: FY 1998

Patients of Institutions for Mental Diseases

We will determine whether hospitals are still operating as institutions for mental diseases and submitting unallowable claims for Medicaid reimbursement. Federal law does not allow Medicaid reimbursement for services to individuals between the ages of 22 and 65 in institutions that primarily treat mental diseases. A State agency identified three hospitals in FY 1989 that, in its opinion, were operating as such institutions and submitting unallowable claims for Medicaid reimbursement. The Congress, however, wanted more information regarding the exclusion. It placed a moratorium on treating these hospitals as institutions for mental diseases until the Secretary provided the Congress with a report on the issues involved. The moratorium expired on December 31, 1995.

OAS; W-00-98-30013; A-05-98-00000

Expected Issue Date: FY 1998

Medicaid Drug Rebates

The OIG will continue to review pricing and reimbursement issues, including determination of whether Medicaid is receiving its appropriate share of rebates due from drug manufacturers. The Omnibus Budget Reconciliation Act of 1990 required drug manufacturers to provide rebates to States based on Medicaid prescription drug utilization volume. The FY 1994 rebates reported by States totaled \$1.7 billion. The OIG has conducted a series of reviews dealing with prescription drug issues resulting from this legislation. At HCFA's request, we have conducted audits of acquisition costs of drugs at the retail level and made comparisons to average wholesale prices.

OAS; W-00-98-30023; A-06-97-00032
Expected Issue Date: FY 1998

Basing Drug Rebates on Average Wholesale Price

This review will examine the potential savings which could be realized by requiring drug manufacturers to pay Medicaid drug rebates based on average wholesale price. Currently, rebates are based on the average manufacturers price paid by wholesalers for drugs distributed to the retail pharmacy class of trade. Most states reimburse for drugs based on a percentage of the wholesale price. The results of this review will establish a much needed connection between the calculation of Medicaid drug rebates and the calculation of Medicaid's reimbursement for drugs at the pharmacy level.

OAS; W-06-97-30023; A-06-97-00052
Expected Issue Date: FY 1998

A State's Pursuit of Medicaid Drug Rebates

We will assess a State's effectiveness in pursuing drug rebates. The drug rebate program is mandated by the Omnibus Budget Reconciliation Act of 1990. Under the program, drug labelers are required to rebate part of the drug price to the Medicaid agencies for drugs purchased through Medicaid. A State audit showed that the State was not properly pursuing and accounting for rebates.

OAS; W-00-97-30023; A-06-97-00032
Expected Issue Date: FY 1998

Medicaid Coverage of Chiropractic Benefits

The chiropractic benefit available to Medicaid beneficiaries differs from State to State, ranging from some States that do not offer any coverage for chiropractic care to some that offer substantial benefits. An increasing number of States are offering chiropractic care as part of their package of Medicaid benefits. This study will determine the level of chiropractic benefits which are currently provided Medicaid beneficiaries by each of the various State Medicaid programs.

OEI; 00-00-00000

Expected Issue Date: FY 1998

MEDICARE CONTRACTOR OPERATIONS

Preaward Reviews of Medicare Contractors

At the request of HCFA's contracting officers, we will review costs proposed by various prospective Medicare contractors. Prior preaward reviews have enabled HCFA to negotiate contract amounts which were much less than proposed.

OAS; W-00-98-30006; Various CINs

Expected Issue Date: FY 1998

Peer Review Organization Closeout Audits

This series of reviews requested by HCFA will determine the allowability of costs claimed by peer review organizations under contracts for "fourth round" contract activities. Audits of claimed costs will be performed by independent public accounting firms. We will assist HCFA as co-project officer for these contracted audits and provide technical guidance and monitoring for these reviews. In addition, we will conduct special reviews of selected costs areas when requested to do so by HCFA.

OAS; W-00-98-30004; Various CINs

Expected Issue Date: FY 1998

Peer Review Organization Indirect Costs

These HCFA requested reviews will establish final indirect cost rates for peer review organizations (PRO) that bill using indirect cost rates. Final rates must be established in order to determine the allowable indirect costs properly charged to Medicare operations. These audits will be performed in conjunction with closeout audits of the peer review organizations.

*OAS; W-00-98-30004; Various CINs
Expected Issue Date: FY 1998*

Quality Improvement Projects for Medicare PROs

This study will assess the Medicare peer review organizations' (PROs) progress in conducting quality improvement projects under the Health Care Quality Improvement Program. In April 1993, the PROs began implementing their fourth contract with HCFA. These contracts marked major changes in the PROs' objectives and operations. The PROs now aim to improve the overall practice of medicine by working with the medical community in analyzing patterns of care and outcomes and by sharing their insights with that community. We will assess the nature and source of quality improvement projects undertaken by the PROs and the projects' results.

*OEI; 00-00-00000
Expected Issue Date: FY 1998*

Claims Processing Contractors' Administrative Costs

This series of reviews requested by HCFA will address costs claimed by various contractors for processing Medicare claims. Special attention will be given to costs claimed by terminated contractors. In the past, these reviews have been beneficial since HCFA has used the results to deny claims for millions of dollars of unallowable costs. We will coordinate the selection of the contractors with HCFA staff (per results of their completed risk assessment review guide) and determine whether the costs claimed were reasonable and allowable under the terms of the contracts.

*OAS; W-00-98-30004; Various CINs
Expected Issue Date: FY 1998*

Unfunded Pension Costs

This series of reviews requested by HCFA will determine if unallowable costs were identified and eliminated in computing allowable pension costs charged to the Medicare program. Regulations provide that pension costs not funded for an accounting period, plus interest on the unfunded amounts, are unallowable components of future year pension costs. These reviews will be performed in conjunction with our pension segmentation audits.

*OAS; W-00-98-30005; Various CINs
Expected Issue Date: FY 1998*

Pension Segmentation/Charges

At HCFA's request, we will determine whether Medicare contractors have fully implemented contract clauses requiring them to determine and separately account for the assets and liabilities for the Medicare segment of their pension plans and to assess Medicare's share of future pension costs on a segmented basis. We will also determine whether the contractors are using a reasonable method for charging pension contributions to Medicare contracts.

*OAS; W-00-98-30005; Various CINs
Expected Issue Date: FY 1998*

Fiscal Intermediary Fraud Units

This national study will evaluate the fraud control activities of Medicare's fiscal intermediaries, the contractors that process Part A claims and perform payment safeguard functions. The contractors fraud units are responsible for developing and referring cases to the OIG for recovery of maximum dollars possible through judicial and administrative processes. We will examine fiscal intermediaries' fraud control procedures and outcomes, including the amount of overpayments identified, number of referrals to the OIG for fraud investigations, and usefulness of referrals to the OIG. We will also review HCFA's oversight of fiscal intermediary fraud units.

*OEI; 03-97-00350
Expected Issue Date: FY 1998*

Medical Review

This study will assess how contractors are using medical review to deal with potential problem areas. Medicare carriers are using this approach to conduct much of their post payment reviews. Since physicians account for the majority of payments under Medicare Part B, much of the carriers' activity is expected to focus on this group. This study, following up on prior studies on Medicaid fraud control units and carrier fraud units, will assess how focused medical reviews are being performed by the carriers, what corrective actions are being pursued, and what educational interventions and/or referrals for fraud investigation are resulting from these activities.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Mutually Exclusive Medical Procedures

This review will determine the adequacy of procedures and controls used by Medicare carriers and fiscal intermediaries to prevent payments for mutually exclusive medical procedures. These procedures, based on their definition or the medical technique involved, are impossible or unlikely to be performed at the same session. Reimbursement to providers such as physicians, clinical laboratories, and ambulatory surgical centers are all based on the procedure code submitted to Medicare. The review will focus on whether providers were improperly paid for mutually exclusive procedures provided to the same beneficiary on the same date of service.

OAS; W-00-98-30003

Expected Issue Date: FY 1998

Duplicate Billings for Outpatient Services

We will determine the extent of duplicate billings resulting from outpatient claims being submitted to both intermediaries and carriers. Hospitals, nursing homes and other institutions (Part A providers) certified by the Medicare program submit their claims for reimbursement to intermediaries. Physicians, independent clinical laboratories and other (Part B) suppliers of services submit their claims for

reimbursement to carriers. We will assess vulnerabilities in the current systems that may lead to bills for some services being submitted to and paid by both.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Duplicate Billings for Home Health Equipment

This study will determine if duplicate billings for durable medical equipment and supplies are being made to both durable medical equipment regional carriers and regional home health intermediaries. Medicare Part B provides coverage for a wide range of durable medical equipment and supplies that can be used by beneficiaries receiving Medicare-reimbursed home health services. Suppliers who provide equipment and supplies to beneficiaries bill the durable medical equipment carrier for these products using the HCFA common procedure coding system. A home health agency as part of the services it provides to qualified beneficiaries can also furnish supplies. These supplies are billed to the regional home health intermediaries. Because of the nature of the billing codes used and the difference in contractor claims processing, it is conceivable that Medicare could be paying both providers for the same supplies.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Fair Hearing Review Thresholds

This study will update previous OIG work which identified management efficiencies and savings that could be attained if fair hearing review thresholds were amended to be indexed to inflation. Currently, a beneficiary enrolled under Part B is entitled to a fair hearing if the claimed amount (one or combination of claims) is \$100 or more, or if payment is not made promptly and a hearing request is filed within 6 months of the initial notice. These provisions were enacted in 1973. No changes to the thresholds have been made since that time.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Medicare's Correct Coding Initiative

We will evaluate Medicare's correct coding initiative, which is designed to improve the accuracy of Part B claims processed by Medicare carriers. Physicians use the HCFA common procedure coding system to bill Medicare for services provided to beneficiaries. We will evaluate the effectiveness of the initiative in detecting improper billings, and whether carriers are uniformly adopting practices being promoted by the initiative.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Provider Billing Numbers Issued to Resident Physicians

We will assess the extent of improper Medicare billings resulting from a control problem we noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities at another institution separate from the institution where the resident is pursuing his/her medical studies. We noted that a hospital in one State requested and received over 40 billing numbers for their residents over a 6 year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. We will determine the extent of this condition at the carrier in this State and other carriers.

OAS; W-00-98-30003; A-05-98-00000

Expected Issue Date: FY 1998

Control of Chiropractic Benefits

Chiropractic claims are one of the more frequently billed services to Medicare. While chiropractic benefits are not currently provided by all State Medicaid programs, an increasing number of States are preparing to offer these benefits. Due to the nature of the services, distinguishing between acute care (which is generally covered) and preventive care (which is not covered by Medicare and seldom covered by Medicaid) is difficult, creating control problems for Medicare carriers, State Medicaid agencies and private insurers. This study will identify the extent and nature of the control

problems and identify the mechanisms used by Medicare carriers, Medicaid agencies and private insurers to control the use of chiropractic benefits and to prevent fraud and abuse. In addition, this study will highlight the most effective control mechanisms currently in use.

OEI; 00-00-00000

Expected Issue Date: FY 1998

GENERAL ADMINISTRATION

Medicare as Secondary Payer

This study will assess the effectiveness of current procedures in preventing inappropriate Medicare payments when beneficiaries have other insurance that is required to pay primary. A 1991 OIG report found that inappropriate Medicare secondary payer payments totaled more than \$637 million in 1988 and identified several leading causes. In addition to repeating the 1991 study, we will review the consistency of secondary payer provisions and determine whether standardization would facilitate the implementation of the provisions.

OEI; 00-00-00000

Expected Issue Date: FY 1998

Medicare Secondary Payer Oversight

We will follow-up on HCFA's resolution of an OIG recommendation relating to the employer compliance with the Medicare secondary payer (MSP) Data Match Project. Our earlier report recommended that HCFA take action against employers that failed to provide the necessary employer group health plan information needed for the Data Match Project. In addition, a major insurance association agreed to a global settlement with the Department of Justice and HCFA to settle disputes over secondary payer claims. As part of the settlement, the association started a 3-year data exchange agreement with HCFA. Our review will examine what action HCFA is taking to

secure data exchange agreements with the association beyond the 3-year settlement and with other insurance companies not covered by the agreement.

OAS; W-00-98-30003

Expected Issue Date: FY 1998

Physician Referrals to Self-Owned Laboratory Services

This review will analyze HCFA's enforcement of the self-referral prohibition involving physicians and clinical laboratory services. Medicare law prohibits payment to physicians who have certain proscribed financial relationships with other providers, including entities that provide clinical laboratory services. Other penalties may also apply for violations of this law. We will analyze whether HCFA has adequate information (i.e., ownership and compensation data) to enforce the law with respect to clinical laboratory services, and document the actions taken to date.

OEI; 09-97-00250

Expected Issue Date: FY 1998

Medicare Part B Billings By State Owned Facilities

This review will use computer screens, developed by the OIG, to identify physicians with aberrant billing patterns for visits to patients in State-owned facilities. Prior focused medical reviews by Medicare contractors identified a variety of problems associated with these types of claims related to skilled nursing facilities. We will build on this prior work and determine if all types of State-owned facilities have similar problems.

OAS; W-00-98-30030

Expected Issue Date: FY 1998

Joint Work With Other Federal and State Agencies

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and Inspectors General, Medicaid agencies, and HCFA financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate

program, and durable medical equipment. Future joint initiatives will cover managed care issues, hospital transfers, prescription drugs, laboratory services, non-physician outpatient services, and nursing home services. In addition, we will continue to work with the National State Auditors Association on a joint audit of long-term care in six States. Potential audit areas include evaluating the licensing and inspection of nursing homes and the reimbursement system.

OAS; W-00-98-30001; Various CINs
Expected Issue Date: FY 1998

Sharing of Medicaid and Medicare Audit Findings

This review will examine the information sharing process for audits of nursing homes that are conducted by State auditors for Medicaid purposes and by fiscal intermediaries' auditors for Medicare purposes. In a survey in one State, we found that the State's auditors and the intermediary auditors were not consistently sharing audit results. Consequently, overclaims by nursing homes went undetected. We will determine if similar problems are occurring in other States.

OAS; W-00-98-30030
Expected Issue Date: FY 1998

MEDICARE TRANSACTION SYSTEM

Our Information Resource Management reviews in FY 1998 will focus on the Medicare Transaction System. This system is intended to be a single, integrated claims/transaction processing system which HCFA anticipates will be implemented over the next 5-7 years. The overall initiative includes several separate projects. We anticipate the following work in FY 1998.

Medicare Transaction System Implementation - Phase II

Our continued monitoring of the Medicare Transaction System will cover system design and development as well as, HCFA's millennium planning for conversion, use of transition systems and implementation of new system components. Our review

will focus on the capabilities being built into MTS to help Medicare better detect and deter fraud and abuse.

OAS; W-00-98-30008

Expected Issue Date: FY 1998

National Provider Identifier/National Provider System

We will review the control requirements for the newly established National Provider Identifier/National Provider System, which will replace existing enumeration methodologies and processes in Medicare. Our review will include an examination of the system's integration with the Medicare Transaction System and other systems containing provider data to determine its potential effectiveness as a safeguard for the Medicare program. We will also determine the degree to which Medicare's use of the new system meets the requirements for a uniform provider numbering system as called for in the recently signed Health Insurance Portability and Accountability Act. Our review will include a determination of the extent previously identified weaknesses in Medicare provider enumeration are addressed.

OAS; W-00-98-30008

Expected Issue Date: FY 1998

Application Controls for Managed Care and New Medicare Activities

This series of reviews will address the effectiveness of the Medicare Transaction System controls to support group health plan operations and other managed care activities. These reviews will also examine the effectiveness of control requirements for the planned insurance file and other systems, such as those supporting beneficiary choice initiatives and other Medicare reforms as well as those providing the necessary tracking of beneficiary enrollment status. As Medicare beneficiaries become more knowledgeable about managed care, the potential exists for even greater enrollment in such plans. At the same time, HCFA is expecting major reforms in Medicare which will expand the types of plans available to beneficiaries. HCFA's major new application system--the Insurance File--will support these planned reforms.

OAS; W-00-98-30008

Expected Issue Date: FY 1999

Electronic Data Interchange in Medicare

This series of reviews will continue prior OIG electronic data interchange work including review of: (1) the adequacy of Medicare participation agreements to assure provider and plan accountability, particularly where third parties (e.g., billing services and claims clearinghouses) are involved; (2) the effectiveness of HCFA's promotional efforts (provider/plan training and outreach); (3) opportunities for increased/more effective use of electronic data interchange (particularly for electronic funds transfers and remittances); and (4) the degree to which standardization of electronic interchange is being used to facilitate collection of essential Medicare program management data.

OAS; W-00-98-30008

Expected Issue Date: FY 1999

INVESTIGATIONS

The OIG's Office of Investigations conducts investigations of fraud and misconduct to safeguard the Department's programs and protect the beneficiaries of those programs from individuals and activities that would deprive them of rights and benefits.

These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in areas of program vulnerability that can be eliminated through corrective management actions, regulation or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

While each year literally thousands of complaints from various sources will be brought to the OIG's attention for development, investigation and appropriate conclusion, the Office of Investigations has targeted certain high-risk areas for continued investigative concentration for as long as there appears to be a high probability that wrongdoing will be uncovered, prosecuted, and deterred in these areas. Although OIG managers will continue to make their investigative decisions on a case by case basis, this work plan identifies several investigative focus areas in which we will be concentrating our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

Incontinence Care Fraud - Project "04"

As part of OIG efforts to reduce questionable allowances for incontinence care product billings and prosecute suppliers involved in such billings, the Office of Investigations launched a national investigation known as the Incontinent Care Case Project. Under this initiative, OIG, along with other law enforcement agencies, has developed over 30 cases against incontinence suppliers. These cases involved over \$100 million in fraudulent Medicare claims. These investigations have resulted in recoveries of over \$50 million through seizures and restitutions. Thus far, 8 cases have resulted in 13 prosecutions. In most of the cases, suppliers were billing for female external urinary collection devices but providing beneficiaries residing in nursing homes with diapers, which are not covered under Medicare. This work continues.

Pneumonia DRG Upcoding Project

The Pneumonia DRG Upcoding Project was initiated to identify hospitals that falsify the diagnosis and diagnosis related group on claims from viral to bacterial pneumonia. The Office of Investigations is currently working with the Department of Justice to initiate a nationwide project in this area.

Project Bad Bundle

The Office of Investigations launched Project Bad Bundle to identify hospitals that unbundle blood chemistry tests when using automated equipment and then bill for each analysis separately, or bill for an automated test in addition to several of the analyses separately. "Unbundling" refers to the illegal practice of submitting individual bills for separate tests that should be bundled together into a single bill for a group of related tests. The amount allowed under Medicare for this "bundled" amount is considerable lower than the sum of the amount for tests billed separately. Under this initiative, the total civil settlement to date is \$8.8 million and involved 24 hospitals.

National Exclusions Project - Project Weed "QT"

Section 1128 of the Social Security Act requires that individuals and entities that engaged in specified misconduct be excluded from participation in all Federal health care programs. The Office of Investigations field offices are responsible for referral

and processing of proposed administrative exclusions of individuals and entities. The Project Weed commenced on July 1, 1996 and continued through March 31, 1997. Project WEED QT is a continuation of the initial project and will continue to focus on increasing the number and quality of these program exclusions.

Exclusion Data Transfer

We will collaborate with the Health Care Financing Administration to achieve full implementation of our goal to make available to Medicare contractors and Medicaid State Agencies current information about individuals and companies that have been excluded from the Medicare and Medicaid programs. We will do this via the internet. They need this information to ensure that health care providers who have been excluded from the programs cannot re-enter at another source.

Coordination with HCFA's Medicaid Bureau

We will coordinate with HCFA's Medicaid Bureau to assist the State Medicaid programs in strengthening and enforcing exclusion actions.

LEGAL COUNSEL

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. The OCIG also provides all administrative litigation services required by OIG, such as patient dumping cases and all exclusion administrative cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes, and is responsible for the development of new, and the modification of existing safe harbor regulations under the anti-kickback statute. Work planned in FY 1998 includes:

Fraud Alerts

We will issue several special fraud alerts to inform the health care industry of particular industry practices which OIG determines are highly suspect.

Expected Completed Date: FY 1998

Anti-Kickback Safe Harbors

We will evaluate comments from the public in response to OIG's solicitation of comments on the existing and additional proposals for safe harbor exemptions from the anti-kickback statute and, where appropriate, develop proposed regulations for additional safe harbors. We will also issue an interim final regulation implementing the new shared-risk exception to the anti-kickback statute.

Expected Completion Date: FY 1998

Implementing the Health Insurance Portability and Accountability Act of 1996 and Balanced Budget Act of 1997

We will prepare regulations to implement new exclusion and civil monetary penalty authorities contained in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the Balanced Budget Act of 1997 (Public Law 105-33) that have been delegated to the Inspector General for implementation.

Expected Completion Date: Ongoing

Implementation of Corporate Integrity Plans

We will continue to work with the OIG's Office of Evaluations and Inspections in reviewing the practices of providers who have had corporate integrity plans imposed in the settlement process. The OIG plans to use the results of this work to improve both the requirements of future corporate integrity plans and the monitoring process.

OCIG; 97-00004; OEI; 07-97-00280

Expected Completion Date: FY 1998