

Department of Health and Human Services

**Office of Inspector General
Projects**



**HEALTH CARE FINANCING ADMINISTRATION
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HOSPITALS

One-Day Hospital Stays

We will evaluate the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only 1 day in a hospital. Recent data indicate that approximately 10 percent of all Medicare patients admitted are released the following day.

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

Same-Day Discharge and Readmission to Same Hospital

This series of reviews will continue to examine Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same acute care prospective payment system hospital. We will review procedures in place for these readmissions at selected hospitals, fiscal intermediaries, and peer review organizations (PRO). With the assistance of Health Care Financing Administration (HCFA) and PRO staff, we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine the effectiveness of existing system edits used to identify and review readmissions. We may expand our reviews to include readmissions within several days and readmissions to another prospective payment system and hospital.

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

Payments for Related Hospital and Skilled Nursing Stays

We will determine the extent of Medicare payments for short- and long-stay hospital and skilled nursing facility care when provided sequentially to the same beneficiary. Hospitals are prohibited by law from admitting patients unnecessarily, admitting them multiple times, or engaging in other inappropriate medical practices. As part of our review, we will assess HCFA's instructions for identifying and evaluating consecutive beneficiary stays at different providers, including skilled nursing facilities and prospective payment system-exempt units.

OEI; 00-00-00000

Skilled Nursing Facility Coverage After Unnecessary Hospital Stays

This review will determine whether Medicare pays for skilled nursing care when the qualifying hospital stay was determined to be not medically necessary. Medicare requires that all covered skilled nursing facility stays be preceded by a 3-day, medically necessary hospital stay. Current indications are that fiscal intermediaries do not have procedures to deny skilled nursing

claims when peer review organizations determine that the qualifying hospital stay was not medically necessary. We will estimate the cost to Medicare for such claims.

OEI; 00-00-00000

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 hospitals that incorrectly reported transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between prospective payment system hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is 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. We also plan to issue a report recommending recovery of overpayments from hospitals that are not covered by the Justice Department's project.

OAS; W-00-98-30010; A-06-98-00010

Prospective Payment System Transfers Between Chain Members

We will review Medicare Part A controls to prevent improper payment of claims for transfers between chain members. During a recent review, we found that the receiving hospitals in many of the incorrectly reported prospective payment system transfers were members of the same chain. We are expanding our work to include all transfers and all hospitals of selected chains. Additionally, selected chains may be separately reviewed at the request of the Justice Department or our Office of Investigations. We will prepare an advisory report to the HCFA Administrator detailing questionable patient transfer patterns.

OAS; W-00-98-30010; A-06-98-00024

Prospective Payment System Transfers: Administrative Recovery

We will work with HCFA and the Medicare fiscal intermediaries to administratively recover overpayments resulting from incorrectly reported prospective payment system transfers. Our work will focus on the incorrectly reported transfers declined for investigation. We are currently working with HCFA to draft instructions to the fiscal intermediaries. The intermediaries' performance will determine whether it is necessary to issue individual regional

reports recommending resolution action on the part of the HCFA regions. We plan to issue an advisory report to the HCFA Administrator during the first half of Fiscal Year (FY) 2000.

OAS; W-00-99-30010; A-04-99-00000

Prospective Payment System Transfers During Hospital Mergers

We will review cases in which patients were transferred from acquired prospective payment system hospitals to acquiring prospective payment system hospitals without leaving their hospital beds. We will determine whether Medicare paid the acquired hospital under the prospective payment system transfer policy (per diem based payments) and the acquiring hospital the full diagnosis-related group payment. The prospective payment system was designed to pay a hospital for all care a Medicare beneficiary needed for discharge. However, when a hospital is acquired, the new owner receives a new provider number, and the patient does not leave the hospital bed, only one Medicare payment should be made. 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-06-98-00012

Uncollected Beneficiary Deductibles and Coinsurance

We will evaluate the reasonableness of Medicare payments to inpatient hospital providers that fail to collect deductible and coinsurance amounts from beneficiaries. Under current law, these uncollected patient liabilities may be reimbursed, in part, by the Medicare program. We will assess the impact of such payments and evaluate controls to ensure their validity.

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

Updating Diagnosis-Related Group Codes

This study will evaluate the process by which HCFA updates diagnosis-related group codes. Under the prospective payment system, the basis for payments to hospitals is the diagnosis-related group code for each discharge. Each code represents the average resources required to care for cases in that particular group relative to the average resources used to treat cases in all diagnosis-related groups. Resources required to care for hospitalized Medicare beneficiaries can increase over time due to changes in the distribution of cases among codes and increases in the average resource requirements of cases assigned to specific diagnosis-related groups.

We will assess the adequacy of the data used in recalibrations and reclassifications and examine how new technologies and treatments are incorporated into diagnosis-related groups.

OEI; 00-00-00000

Medicare Payment for Diagnosis-Related Group 14

This study will analyze reasons for miscodings of diagnosis-related group 14, Specific Cerebrovascular Disorders Except Trans Ischemic Attack. We examined upcoding in this group in three previous studies. Our recent examination of 1996 data raises concerns that upcoding is again a problem. We will further analyze the results from our recent upcoding analysis and identify hospitals with typically high billing patterns for diagnosis-related group 14.

OEI; 03-99-00240

Diagnosis-Related Group Payment Limits

We will assess the ability of Medicare contractors to limit payments to hospitals for patients who are discharged from a prospective payment system hospital and admitted to one of several post-acute-care settings. This limitation, imposed by the Balanced Budget Act of 1997, applies to certain diagnosis-related groups.

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

Outlier Payments for Expanded Services

We will examine the financial impact of outlier Medicare payments made in unusual cases for inpatient care. The “extra” payments (i.e., in addition to diagnosis-related group payments) are made on behalf of Medicare beneficiaries who receive services far in excess of services rendered to the average Medicare patient.

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

Changes in the Inpatient Case Mix Index for Medicare

We will examine trends in the case mix index of individual hospitals to determine whether historic increases and the recent decline in case mix occurred uniformly across the industry. We will also identify any diagnosis-related group that significantly influenced national trends

or individual hospital variations. The case mix index may be a tool to identify hospitals that systematically upcode patient diagnoses to inflate reimbursement.

OEI; 00-00-00000

Diagnosis-Related Group Payment Window

This review will (1) determine whether hospitals have complied with settlement agreements with the Office of Inspector General (OIG) to preclude duplicate billing for nonphysician outpatient services under the prospective payment system and (2) determine the extent of duplicate claims submitted by Part B providers for services, e.g., ambulance, laboratory, or x-ray services, provided to hospital inpatients. Under the prospective payment system, hospitals are reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group. Separate payments for nonphysician services rendered within the diagnosis-related group payment window are not allowed.

After several OIG reviews, the Department of Justice conducted a nationwide project to recover overpayments plus penalties and interest through the Civil False Claims Act. As a result of this project, affected prospective payment system hospitals entered into settlement agreements to comply with Medicare billing rules for nonphysician services rendered in connection with inpatient stays and to eliminate the submission of duplicate claims.

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

Hospitals Exempt From the Prospective Payment System

We will conduct a series of reviews of hospitals exempt from the prospective payment system. In 1996, almost 3,500 hospitals, which received almost \$10.3 billion in Medicare payments, were exempt. We will evaluate controls at Medicare fiscal intermediaries to review costs at these facilities, as well as the imposition of cost control measures mandated by the Balanced Budget Act of 1997.

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

Outpatient Hospital Psychiatric Claims

We will review outpatient psychiatric services rendered by both acute care and psychiatric hospitals to Medicare beneficiaries. Our reviews will determine whether the claims were for

services actually provided and whether all Medicare billing and reimbursement requirements were met.

OAS; W-00-00-30026; Various CINs

Outpatient Hospital Revenue Centers Without Common Procedure Codes

We will examine outpatient hospital claims that contain revenue centers (e.g., the hospital emergency room) with no HCFA common procedure code to describe the service. Since July 1987, HCFA has required hospitals to use these codes when reporting outpatient services to Medicare beneficiaries. However, a review of a sample of 1997 claims indicated that nearly 35 percent of the revenue centers had no associated codes. The lack of a descriptive code creates the potential for duplicate payments for supplies and services, as well as inclusion of nonallowable costs. Because outpatient claims data are being used to establish prospective payment system rates, such errors could have impact beyond improper payment for the individual claim or cost report.

OEI; 00-00-00000

Billing Routine Services on a “Stat” Basis

This review will analyze billing practices where there are two levels of billing for the same medical procedure depending on whether the services are ordered on a “routine” basis or on an immediate, or “stat,” basis. Billing on a stat basis generally results in a higher charge to Medicare and more income for the hospital.

OAS; W-00-00-30010; A-09-00-00000

Payments for Capital Items

We will study the financial impact of the prospective payment system on Medicare reimbursement to hospitals for capital items, such as buildings and equipment. Since 1991, Medicare has been gradually shifting from a cost reimbursement system to a prospective payment system for capital items.

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

Graduate Medical Education Payments

We will evaluate the financial impact of the prospective payment system on Medicare payments for graduate medical educational activities. Starting in 1990, Medicare shifted from a cost reimbursement system to a facility-specific prospective payment system.

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

Hospital Closures: 1998

We will examine the extent, characteristics, reasons for, and impact of hospital closures in 1998, the 12th in a series of annual reports. In the mid to late 1980's, closure of general, acute-care hospitals 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, and few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there is continuing interest in this issue, and our annual reports have become a standard reference.

OEI; 04-99-00330

HOME HEALTH

Home Health Compliance Programs

We will determine how many home health agencies have compliance programs in place. The OIG issued its "Compliance Program Guidance for Home Health Agencies" in August 1998 to address areas of concern both to the Government and the industry. We will also look at which elements of the OIG compliance program were implemented and examine the benefits and difficulties associated with their implementation.

OEI; 00-00-00000

Physician Involvement in Approving Home Health Care

This follow-up review will determine the current extent of physician involvement in approving and monitoring home care for Medicare beneficiaries. Earlier OIG work found that physicians often did not have a relationship with their home health patients and relied extensively on home health agencies to determine the care needed. As part of our review, we will look at how

frequently physicians examine home care patients and identify obstacles to physician involvement in monitoring their patients.

OEI; 00-00-00000

Screening of Home Health Beneficiaries

This review will evaluate whether home health agencies are discouraging admission of very ill beneficiaries. The home health interim payment system created by the Balanced Budget Act of 1997 imposed a new per-beneficiary limit based on historical visit rates, and the prospective payment system, to be implemented in FY 2000, provides a simple payment per episode of care under either it or the interim payment system. As a result, home health agencies now have an incentive to keep visits and associated expenditures down. We will determine whether the agencies are “dumping” their sicker beneficiaries or are cutting off care before it is medically warranted.

OEI; 00-00-00000

Payments Based on Location of Service

We will evaluate the implementation of a relatively recent change in paying for home health care. Effective October 1997, home health services are to be paid based on the location where the service is provided (in the patient’s home), rather than where the service is billed (typically the urban location of the parent home health agency).

OAS; W-00-99-30009; A-06-99-00063, A-04-00-00000

Reasonableness of Current Payments

At the request of the HCFA Administrator, we will review 1998 data and compute error rates for Medicare payments to home health agencies in several States. Prior OIG reviews computed error rates for earlier periods. This current review should assist in measuring the effectiveness of corrective actions on the part of providers.

OAS; W-00-00-30009; A-04-00-00000

NURSING HOME CARE

Nursing Home Resident Assessments

We will determine how implementation of nursing home resident assessments affects quality of care and nursing home reimbursement. Federal law requires nursing homes to conduct initial and periodic assessments of each resident's functional capacity that are comprehensive, accurate, and standardized and then to develop a comprehensive plan of care based on the assessment. The assessment information is also used to determine the level of Medicare and Medicaid payments to nursing homes. We plan to examine the process used to perform the resident assessments, the extent to which the assessments are used to develop plans of care, and payment accuracy. This review is one of a series on the quality of care in nursing homes.

OEI; 02-99-00040

Role of the Nursing Home Medical Director

We will examine how the role of the nursing home medical director has been interpreted and implemented and how the medical director affects quality of care. The Omnibus Budget Reconciliation Act of 1987 broadly requires nursing homes to designate a medical director to be responsible for implementation of resident care policies and coordination of medical care in the facilities. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Quality Assessment and Assurance Committees

We will examine the role and effectiveness of quality assessment and assurance committees in ensuring quality of care in nursing homes. The Omnibus Budget Reconciliation Act of 1987 requires each nursing facility to maintain a committee comprised of the director of nursing, a physician, and at least three other staff members. The committee is to meet at least quarterly to identify quality assessment and assurance activities and to develop and implement appropriate plans of action to correct identified quality deficiencies. The HCFA requires surveyors to determine whether a facility has such a committee and whether it has a method to "identify, respond to, and evaluate" issues in quality of care. However, surveyors are not required to evaluate the committee's adequacy or effectiveness. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Nurse Aide Training

We will examine whether the Omnibus Budget Reconciliation Act of 1987 nurse aide training requirements are followed. The act requires that nurse aides complete a training and competency evaluation program within 4 months of employment, unless the individual has been deemed competent. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Family Experience With Nursing Home Care

We will assess the quality of care that Medicare and Medicaid beneficiaries receive in nursing homes, as perceived by their family members. Family members who visit their loved ones in a nursing home are in a position to provide an “insider’s perspective” on the quality of care they see being delivered on a regular basis. We will conduct a mail survey of family members. This review is one of a series on the quality of care in nursing homes.

OEI; 04-98-00550

Nursing Home Vaccination Rates: State Initiatives

We will describe initiatives taken by State governments to increase influenza and pneumococcal vaccination rates in nursing homes. The Healthy People 2010 objective is to increase the immunization rates for influenza and pneumococcal disease to 90 percent for institutionalized chronically ill or older people. However, some evidence suggests that immunization rates may be much lower than the target rate. We will identify ways to accelerate fulfillment of the Healthy People 2010 objective. This review is one of a series on the quality of care in nursing homes.

OEI; 01-99-00010

Implementing the Skilled Nursing Facility Prospective Payment System

We will review the implementation of the new payment system for care rendered by Medicare’s skilled nursing facilities. Effective July 1, 1998, a prospective payment system replaced the traditional cost reimbursement system for these facilities. On a pilot basis at selected payment contractors and providers, we will determine, among other things, whether current claims are properly calculated and documented. We will also review the use of claim edits and their adjudications.

OAS; W-00-00-30014; A-01-00-00000, A-02-00-00000

Beneficiary Access to Skilled Nursing Facility Care

We will examine the impact of the skilled nursing facility prospective payment system on beneficiary access to Part A services. Concern exists that some beneficiaries may be unable to find a skilled nursing facility placement after a hospital stay because the anticipated cost of their care may be “too expensive.” We will examine whether beneficiaries are experiencing difficulties in finding placements and the reasons for those difficulties.

OEI; 02-99-00400

Financial Screening and Distinct Part Rules

At HCFA’s request, we will examine the extent to which financial screening and distinct part rules in nursing homes create access problems for low-income and minority beneficiaries. Distinct part certification rules provide a mechanism by which nursing homes can limit the number of Medicaid-eligible residents they admit. Additionally, nursing homes can financially screen private-pay applicants and use such information to refuse admission to individuals they believe will soon be eligible for Medicaid.

OEI; 02-99-00340

Physician Routine Nursing Home Visits

This review will assess whether HCFA needs to establish controls over Medicare payments for routine nursing home visits. Currently, physicians bill one of three possible procedure codes, depending on the level of care, when providing services to nursing home residents. The HCFA allows payments for physicians’ routine monthly examinations, in addition to other medically necessary services. Our analysis in five States revealed that physicians sometimes billed for more services than they could perform in a normal workday. In these States, Medicare paid over \$120 million for nursing home visits in FY 1998. Based on the level of care required for the codes billed, we have concerns about the quality of care provided to beneficiaries and the payments allowed for these services.

OAS; W-00-00-30014; A-06-00-00000

Therapy Services in Skilled Nursing Facilities

We will determine the medical necessity of physical and occupational therapy services provided to patients of 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, including physical and occupational therapy. A probe sample in one State revealed significant evidence of medically unnecessary therapy services and other issues

related to the provision of therapy services. Because of these findings, we plan to conduct a national review.

OEI; 09-97-00121

Ancillary Medical Supplies

These ongoing reviews will determine whether certain skilled nursing facilities have claimed unallowable costs for ancillary medical supplies. Medicare reimbursement rules describe those items and services that are allowable as ancillary costs as opposed to routine costs. If costs are misclassified, we will quantify the financial impact of errors and, if warranted, recommend procedural changes to eliminate or reduce future errors.

OAS; W-00-00-30014; A-04-00-00000, A-09-00-00000

PHYSICIANS

Physicians at Teaching Hospitals

This initiative is designed to verify compliance with Medicare rules governing payment for physician services provided in the teaching hospital setting and to ensure that claims accurately reflect the level of service provided to patients. Previous OIG work in this area suggested that many providers were not in compliance with applicable Medicare reimbursement policies.

OAS; W-00-99-30021; Various CINs

Automated Encoding Systems for Billing

We will determine whether errors found in Medicare billings for physician services are associated with providers' use of automated encoding software. We will also examine billing processes to identify vulnerabilities that occur when physician offices bill independently or through use of a third party system.

OEI; 05-99-00100

Reassignment of Physician Benefits

We will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the

physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

OEI; 00-00-00000

Podiatrists' Medicare Billings

This national review will determine the extent to which podiatrists improperly bill Medicare. Our work at a podiatrist in one State disclosed a very high error rate (99 percent), and anecdotal evidence suggests that other podiatrists' claims may be a significant problem.

OAS; W-00-00-30021; A-09-00-00000

Podiatry Services

This study will review podiatry claims to determine if the services met HCFA coverage policy. From 1992 through 1995, Medicare expenditures for nail debridement increased 46 percent, while Medicare expenditures for all other Part B services increased only 18 percent. We will examine a national sample of podiatry claims to gain a better understanding of the possible factor(s) affecting the extreme variation in allowed charges per thousand beneficiaries.

OEI; 00-00-00000

Myocardial Perfusion Imaging

We will assess the medical appropriateness of myocardial perfusion imaging and explain the high increase in utilization since 1997. Myocardial perfusion imaging is a cardiac imaging procedure that is used to detect coronary artery disease and determine prognoses. This type of imaging procedure accounted for a large portion of the 23 percent increase in billing for all nuclear imaging services between 1997 and 1998.

OEI; 00-00-00000

Private Physician Contracting

This study will review the impact of private contracting between Medicare beneficiaries and physicians. Under the 1997 Balanced Budget Act, physicians and beneficiaries may enter into agreements specifying that the beneficiary will pay out-of-pocket for Medicare-covered services provided by that physician. Physicians who choose to provide covered services under these contracts must “opt out” of the Medicare program for 2 years. They may not receive payment from Medicare for any service regardless of whether it is provided on a fee-for-service or capitated basis. Though relatively few physicians have chosen this option, its impact on beneficiaries’ access to care, as well as other beneficiary protections, is unclear.

OEI; 00-00-00000

Advance Beneficiary Notices

We will examine the use of advance notices to Medicare beneficiaries and their financial impact on beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment. Indications are that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to noncovered laboratory services.

OEI; 00-00-00000

MEDICAL EQUIPMENT AND SUPPLIES

Operations of Durable Medical Equipment Carriers

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

OEI; 04-97-00330

Duplicate Billings for Medical Equipment and Supplies

We will determine whether duplicate billings for 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 that provide equipment and supplies to beneficiaries bill the durable medical equipment carrier for these products using the HCFA common procedure coding system. As part of the services provided to qualified beneficiaries, home health agencies may 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 claim processing, it is conceivable that Medicare could pay both providers for the same supplies.

OEI; 04-97-00460

Balance Billing for Medical Equipment and Supplies

This review will determine the extent to which Medicare beneficiaries are subject to financial liability when receiving medical equipment and supplies. Currently there is no restriction on amounts that suppliers can “balance-bill” a beneficiary for services if the supplier does not accept Medicare assignment. This is not the case in other areas of the program. For example, Medicare does not allow beneficiaries to be charged more than 20 percent of the allowed amounts for inpatient hospital stays, and Medicare limits amounts beneficiaries can be billed for the balance of physician service charges. We will assess the extent to which those suppliers that do not accept assignment bill beneficiaries in excess of 20 percent of the Medicare-allowed amount.

OEI; 00-00-00000

Appropriateness of Home Medical Equipment and Supplies

We will conduct a series of studies on the appropriateness of Medicare payments for certain medical equipment used in the home. Such studies may include reviews of osteogenesis stimulators, airway pressure devices, ventilators, lower limb prosthetics, and seat lift mechanisms. With the assistance of medical staff, we will review randomly selected claims to assess the appropriateness of Medicare payments.

OEI; 00-00-00000

Medicare Payments for Orthotics

This study will determine the extent to which Medicare may be continuing to inappropriately pay for orthotics. An October 1997 OIG report noted that at least 19 percent of orthotics were medically unnecessary. The report also found that the most problematic claims were those submitted by durable medical equipment companies and those submitted for beneficiaries residing in nursing homes. The OIG made recommendations to improve the coding system for orthotics and to institute stricter standards for who is allowed to bill for orthotics. While HCFA concurred with our recommendations, corrective action has yet to be implemented.

OEI; 02-99-00120

Blood Glucose Test Strips

We will review the appropriateness of Medicare claims and payments for blood glucose test strips. These disposable accessories for blood glucose monitors are used by insulin-dependent diabetics to manage their illness. Billings and payments for the strips have increased sharply in recent years. We will contact suppliers and beneficiaries to identify factors contributing to these increases. We will also examine the appropriateness of utilization rates.

OEI; 03-98-00230

END STAGE RENAL DISEASE

External Oversight of Dialysis Facilities

We will assess the extent and nature of HCFA's monitoring and oversight of quality of care for Medicare beneficiaries on dialysis. We will examine end stage renal disease network activity, State surveys and certification, complaint processes, and data collection and analysis regarding dialysis quality.

OEI; 01-99-00050

Separately Billable Services

This review will determine the type and extent of separately billable maintenance dialysis services, the Medicare reimbursement for these services, and whether these services were included in the composite reimbursement rate. Under the prospective method of paying for maintenance dialysis, HCFA uses a composite rate per treatment to reimburse renal dialysis facilities for maintenance dialysis. This is a comprehensive payment for all services related to

the dialysis treatment. Only those services whose costs were specifically excluded from the composite rate calculation are separately billable.

OAS; W-00-99-30025; A-01-99-00506

Method II Billing for End Stage Renal Disease

We will assess method II billing for end stage renal disease services for program vulnerabilities, the adequacy of HCFA oversight, the impact on nursing home residents, and beneficiary satisfaction. End stage renal disease beneficiaries have the option to elect method II, in which a durable medical equipment supplier provides dialysis supplies, rather than method I, in which an end stage renal disease facility provides supplies and services. The use of method II appears to be growing in some States. A series of reports will look at both financial and quality perspectives of method II.

OEI; 00-00-00000

Medical Appropriateness of Tests and Other Services

We will assess the medical appropriateness of laboratory tests and other services ordered for end stage renal disease patients. A recent General Accounting Office (GAO) report found that clinically similar patients received laboratory tests at widely disparate rates. It concluded that the wide variation was probably the result of financial incentives, as well as a lack of knowledge and differences in medical practices. We will select a random sample of end stage renal disease beneficiaries and, with the assistance of medical staff where appropriate, conduct medical reviews to determine if laboratory and other services provided to these individuals were medically necessary and provided in accordance with Medicare requirements.

OEI; 04-98-00470

Questionable Dialysis Claims

We will examine claims for dialysis services to assess the variability in provider billing patterns and to identify any aberrant providers. Dialysis treatments may be provided and billed either as single visits (common procedure codes 90935 and 90945) or, for patients with more complications, as multiple visits (codes 90937 and 90947) which are reimbursed by Medicare at a higher rate. On average, the ratio of services for the high to low codes is approximately 1 to 7. A fraud alert was issued to carriers to periodically make comparisons in their areas to

determine if any nephrologist is extremely deviant from the norm. Aberrant providers would be easy to identify by examining data showing the physicians' billing patterns.

OEI; 00-00-00000

Duplicate Payments for Office Visits to Nephrologists

This review will identify situations in which Medicare made separate payments to nephrologists for dialysis patients' office visits but the services were already included in the monthly capitation payment for physician services during the same period.

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

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount on Medicare Prescription Drugs

We will determine whether average wholesale prices used to calculate Medicare reimbursement for prescription drugs have increased since January 1, 1998. Prior to that date, Medicare Part B payments for covered prescription drugs were based on the lower of the estimated acquisition cost or the national average wholesale price. The average wholesale price is reported by the industry and is generally inflated over actual acquisition costs. In an effort to reduce Medicare payments for prescription drugs, the Balanced Budget Act of 1997 required HCFA to apply a 5-percent discount to the published average wholesale price, beginning January 1, 1998. We will determine if average wholesale prices for Medicare-covered drugs have increased since that time disproportionately to other drugs and the effect of any such increases on Medicare savings.

OEI; 03-97-00291

Medicare Outpatient Prescription Drugs

We will review Medicare-covered outpatient prescription drugs to quantify potential revenues that would result from a drug rebate similar to that used in the Medicaid drug rebate program. More specifically, we will calculate a rebate based on the difference between current reimbursement--average wholesale price minus 5 percent--and the "best price" which has already been identified for the Medicaid program. We will also project the rebate estimates to the proposed expanded Medicare drug program, if applicable.

OAS; W-00-00-30022; A-06-00-00000

Medicare Payments for “Not Otherwise Classified”

This study will determine whether carriers have been properly paying for common procedure code J9999, defined as “not otherwise classified antineoplastic drug.” Medicare does not pay for most over-the-counter outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs for certain purposes, including chemotherapy. The HCFA and its carriers use codes in HCFA’s Common Procedure Coding System to define the type of drug and, in most cases, a dosage amount. However, HCFA has not classified every drug into a code; therefore, code J9999 is used to bill for chemotherapy (anti-neoplastic) drugs that meet coverage guidelines but do not have their own code. Total allowances for J9999 were over 12 times higher in 1997 than in 1995, increasing from \$11 million to \$147 million. Ten carriers accounted for 56 percent of the 1997 allowance for J9999.

OEI; 03-98-00500

OTHER MEDICARE SERVICES

Outpatient Rehabilitation Facilities

We will conduct a six-State review of outpatient rehabilitation facility (ORF) providers to determine whether their services met Medicare eligibility and reimbursement requirements. In addition, we will review selected ORF providers’ cost reports to determine the types of expenditures included and the allowability of those items. Under Medicare Part B, ORF providers may be reimbursed only for outpatient therapy services, specifically, physical therapy, occupational therapy, and speech pathology services. These services are often provided at offsite locations, such as nursing homes and assisted living facilities.

OAS; W-00-00-30026; A-04-00-00000

Comprehensive Outpatient Rehabilitation Facilities

We will conduct a nationwide review of comprehensive outpatient rehabilitation facility (CORF) providers to determine whether the services provided met Medicare eligibility and reimbursement requirements. The review will determine whether the beneficiaries were eligible for the services and whether the services provided were medically necessary and rendered in accordance with Medicare requirements. In addition, we will review selected providers’ cost reports to determine the types and allowability of expenditures. To participate as a CORF, a provider must furnish at least physicians’ services, physical therapy, and social or psychological services. Unlike an outpatient rehabilitation facility, services are often furnished on the premises of the CORF, and the Medicare provider number applies to the

certified location only. A CORF must provide the services of a physician who specializes in rehabilitation medicine, and these services must be part of a CORF treatment plan.

OAS; W-00-00-30026; A-04-00-00000

Vulnerable Medicare Beneficiaries

We will examine the postaudit utilization patterns of beneficiaries who received unnecessary or noncovered services in community mental health centers. Prior reviews identified an extremely high rate of unnecessary services in several centers. Little is known about how beneficiaries became entangled with illegitimate providers or, more importantly, what happened to them after their mental health centers withdrew from the Medicare program or were terminated. This review will test the theory that following claims activity for beneficiaries who were victims of dishonest providers might lead to the discovery of other, undiscovered questionable providers or services.

OEI; 00-00-00000

Clinical Laboratory Proficiency Testing

We will determine whether clinical laboratories that serve the Medicare population participate in proficiency testing programs and take appropriate action in response to failures. The Clinical Laboratory Improvement Amendments of 1988 established quality standards for all laboratory testing. A key condition of participation is proficiency testing in which a lab is sent samples for analysis and is graded on its performance in each testing specialty. This review will assess how well laboratories perform on these tests and what actions are taken in the case of unsatisfactory test results.

OEI; 00-00-00000

Excess Payments for Ambulance Services

This review will determine whether excess Medicare payments are being made for certain types of ambulance services. We recently completed a review of medical claims for one company's ambulance services and found that the carrier's system did not prevent excess payments for some ambulance transports. We plan to determine if similar situations are occurring at other ambulance providers throughout the United States.

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

Hyperbaric Oxygen Treatment

We will examine the extent and appropriateness of hyperbaric oxygen treatment provided to Medicare beneficiaries. Medicare covers this treatment for 14 different conditions, though its effectiveness for many of these and other conditions is controversial. There are concerns that some physicians may be using the treatment for noncovered conditions or conditions for which the appropriate traditional treatments have not been tried. For example, though not covered, hyperbaric oxygen treatments for decubitus ulcers and diabetic foot wounds have been revealed through medical review. We will analyze payment and utilization trends, assess medical appropriateness, and examine the qualifications of hyperbaric oxygen treatment chambers and providers.

OEI; 06-99-00090

MEDICARE MANAGED CARE

New Adjusted Community Rate Proposal Process

At HCFA's request, we will audit the adjusted community rate proposals of managed care organizations as required by the Balanced Budget Act. The new adjusted community rate proposal process is designed for managed care organizations to present to HCFA their estimate of funds needed to cover the costs of providing a Medicare package of covered services to an enrolled Medicare beneficiary. The HCFA will initiate the new process effective January 2000. Our audits will focus on the propriety and accuracy of the proposals submitted.

OAS; W-00-00-30012; Various CINs

General and Administrative Costs

This review will examine the administrative cost component of adjusted community rate proposals and assess whether the costs were appropriate when compared with the Medicare program's general principle of paying only reasonable costs. Administrative costs include marketing costs, administrative salaries, interest expenses, and claim processing costs. The review will include several health maintenance organizations (HMO) located throughout the United States.

OAS; W-00-98-30012; A-03-98-00046, A-04-99-00000, A-07-00-00000

Cost-Based Managed Care Plans

At HCFA's request, we will evaluate the integrity of the cost reporting process used by cost-based managed care plans (Section 1876 Cost Plans and Health Care Prepayment Plans). The HCFA currently contracts with over 60 of these plans which provide services to more than 475,000 members. The plans, which receive about \$1 billion a year in Medicare payments, file cost reports with HCFA outlining the costs they incur in providing health care. Although the reports are audited to ensure that costs are properly allocated, they do not undergo medical reviews to ensure that only Medicare-covered services are included.

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

Enhanced Managed Care Payments

We will conduct several reviews to determine whether HCFA has made proper enhanced capitation payments to risk-based HMOs. Risk-based HMOs receive enhanced capitation payments for beneficiaries who are institutionalized, in end stage renal disease status, or dually eligible for Medicare and Medicaid. Our reviews will focus on the accuracy of controls at both HCFA and the HMOs regarding special status categories warranting these enhanced payments.

OAS; W-00-99-30012; A-03-99-00003; A-05-99-00027

HMO Profits

This review will compare the profitability of the Medicare line of business with operating results from HMOs' other lines of business. Under the terms of a Medicare risk-based contract, an HMO is required to absorb any losses incurred, and is permitted to retain any savings earned, on its Medicare line of business. We will use this information to determine whether HCFA needs to establish criteria on the profitability of Medicare risk-based HMOs.

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

Investment Income Earned by Risk-Based HMOs

This review will determine the potential financial impact on the Medicare program if risk-based HMOs were held accountable for investment income earned on Medicare funds. Since HCFA pays HMOs on a prospective basis for each Medicare beneficiary enrolled in their health plan, the HMOs have an opportunity to earn investment income on Medicare funds until they are used to pay for services rendered during the month. Any investment income earned on Medicare funds is not factored into the HMO's payment rates, nor is it required to

be used for the benefit of the Medicare beneficiary. We will estimate the amount of investment income earned on Medicare funds.

OAS; W-00-98-30012; A-02-98-01005

Physician Incentive Plans

We will review physician incentive plans included in contracts between physicians and managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on 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 affect the quality of care provided.

OEI; 00-00-00000

National Marketing Guidelines

We will assess the usefulness of HCFA's new national marketing guidelines for managed care plans to HCFA, beneficiaries, and managed care organizations. The HCFA regional offices are responsible for approving 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; 03-98-00270

Usefulness of Medicare+Choice Performance Measures

This review will examine the usefulness of Medicare+Choice performance measures from the perspective of Medicare beneficiaries. Medicare+Choice offers beneficiaries a broad array of insurance benefits from which to choose. One of the measures used for comparison is a Medicare version of the Health Plan Employers Data and Information Set, submitted by Medicare managed care organizations. Measuring quality is difficult because consumers, purchasers, and policymakers have different interests and priorities. We will examine how

beneficiaries interpret and use the various performance measures and determine the adequacy of these measures for beneficiary decision-making.

OEI; 00-00-00000

Educating Beneficiaries About Medicare+Choice

We will evaluate the adequacy of HCFA's efforts to educate beneficiaries about their options under Medicare+Choice. The Balanced Budget Act of 1997 expanded Medicare's health plan options with the creation of the Medicare+Choice program. These new options provide beneficiaries with more flexibility on health care decisions but also necessitate an extensive education campaign to ensure informed choices. As part of this review, we will assess how well beneficiaries understand the program, the variety of choices available, the implications associated with the various choices, and where to get information about the program.

OEI; 00-00-00000

Managed Care Health Plan Data

We will assess how HCFA uses and ensures the quality of Health Plan Employers Data and Information Set data submitted by Medicare managed care organizations. The HCFA required managed care organizations to submit these data, which provide encounter-level health care quality information, for the first time in 1997 and annually thereafter. In addition to reviewing the accuracy of the data, we will analyze how HCFA uses the data to assess the performance of managed care organizations and how plans are held accountable for poor performance.

OEI; 00-00-00000

Managed Care Additional Benefits

We will determine the extent to which (1) beneficiaries understand the additional benefits offered by Medicare managed care plans and (2) these benefits affect beneficiaries' decisions to join managed care plans. Medicare managed care plans that generate profits exceeding Medicare allowances have the option of refunding excess profits to HCFA or offering additional services to beneficiaries. These additional benefit packages differ from plan to plan and are approved by HCFA regional offices. We will also review the marketing materials associated with the additional benefits.

OEI; 02-99-00030

Enrollment Incentives/Disincentives

This review will assess the extent to which Medicare managed care organizations encourage the enrollment of healthy beneficiaries and discourage the enrollment of sick beneficiaries. Managed care organizations are currently paid a set amount to provide all Medicare-covered services to beneficiaries enrolled in their programs and, under the current payment method, have a financial incentive to enroll healthier beneficiaries. Although Medicare HMOs are required to enroll all eligible Medicare beneficiaries regardless of their age, health status, or the cost of the health services needed, there is some evidence that this does not always occur. Prior OIG work found that 18 percent of beneficiaries said that they were asked about health problems at the time of their application.

OEI; 00-00-00000

Enrollee Access to Emergency Services

We will determine whether existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or deny treatment to a person who comes to the emergency room. Violation of either of these protections may result in sanctions, including penalties and program exclusion. We will examine whether Federal enforcement authorities adequately protect patients who need and seek emergency care but are prevented from receiving such care by managed care rules or hospital policies.

OEI; 09-98-00220

Chiropractic Services

At HCFA's request, this review will provide baseline data on chiropractic utilization by Medicare enrollees in managed care organizations. Chiropractic claims have recently become one of the more frequently billed services in Medicare. However, no centralized managed care chiropractic reimbursement data are available. This review will assist HCFA in monitoring managed care organizations' compliance with HCFA policies on chiropractic care.

OEI; 04-97-00495

Medicare Managed Care Prescription Drug Benefit

This review will provide information on the coverage and payment of prescription drugs in Medicare managed care plans. Fee-for-service Medicare generally does not pay for outpatient prescription drugs, although some drugs, such as injectables for chemotherapy and medications

used with durable medical equipment, are covered. Medicare managed care plans may offer a capped prescription drug benefit, paying up to \$1,500 per year for drugs. We will examine how this limit is calculated for each beneficiary, which drugs are included, and how drug costs are determined by the managed care plan.

OEI; 00-00-00000

Managed Care Organization Closings

This review will determine the impact on beneficiaries of recent closings of Medicare managed care organizations. In the fall of 1998, 42 of 347 risk plans announced that they did not intend to renew their Medicare contracts. Another 52 risk contracts reduced their service areas. Additional managed care organization withdrawals are expected. We will look at the impact of recent withdrawals on beneficiaries' ability to access care and to obtain Medigap policies and their willingness to join or stay in Medicare managed care organizations.

OEI; 04-99-00170

MEDICAID MANAGED CARE

Medicaid Dually Eligible Fee-for-Service Payments

At HCFA's request, we will determine the appropriateness of Medicaid fee-for-service payments for services provided to dually eligible beneficiaries enrolled in Medicare risk-based managed care organizations. These organizations are required to provide all Medicare-covered services in exchange for the capitation payments they receive. Most HMOs elect to offer additional benefits that are not available under Medicare fee-for-service, such as dental services, eyeglasses, prescription drugs, deductibles, and coinsurance amounts. Because Medicaid is always the payer of last resort, the State is required to take reasonable measures to determine the legal liability of third parties to pay for services furnished under the Medicaid program. Therefore, Medicaid expenditures on behalf of dually eligible beneficiaries are unallowable if the services are covered by the Medicare HMO.

OAS; W-00-00-30013; Various CINs

Emergency Services to Enrollees of Medicaid Managed Care

This review will assess how Medicaid managed care organizations are implementing the Balanced Budget Act's emergency service requirements. Under the statute, Medicaid managed care beneficiaries have the right to immediately obtain emergency care and services. A managed care organization must pay for the cost of these services, and the services must be covered without regard to prior authorization or the emergency care provider's contractual

relationship with the organization. Coverage of emergency services is to be determined under the “prudent layperson” standard, that is, services qualify as emergencies if a prudent layperson would interpret them that way. This review will evaluate how managed care organizations are interpreting the prudent layperson standard and how frequently this interpretation is questioned.

OEI; 00-00-00000

MEDICAID - CHILDREN’S HEALTH INSURANCE PROGRAM

States' Outreach Efforts to Medicaid Eligibles

This study will determine the effectiveness of State outreach efforts to Medicaid eligibles as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. State Medicaid agencies are expected to incur additional administrative costs to determine Medicaid eligibility for individuals who no longer receive automatic Medicaid eligibility through cash assistance linkage. These additional expenditures include the costs of outreach to potentially eligible individuals who no longer receive cash assistance. Section 1931(h) of the Social Security Act established a \$500 million enhanced Federal matching fund to cover these expenses. As part of this review, we will examine how States re-engineered outreach efforts to promote Medicaid.

OEI; 00-00-00000

Performance Measures

This study will assess the current activities of the Department and the States to measure the effectiveness of the State Child Health Insurance Program and Medicaid expansions authorized by the Balanced Budget Act of 1997. We will address both legislative requirements and Institute of Medicine accountability recommendations. In addition, we will describe the activities currently underway to evaluate the programs regarding health service access, utilization, and health status outcomes of children covered by both programs.

OEI; 00-00-00000

Involvement of Federally Funded Health Centers in Children's Health

We will examine the changing role of federally funded health centers in health care delivery to the children covered by State Child Health Insurance Programs and Medicaid expansions. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children's health insurance program or expand the existing Medicaid program. We will study health centers' participation in managed care organizations, their direct contracting with the new and expanded programs, and their formation of networks with other "safety net" providers.

OEI; 06-98-00320

OTHER MEDICAID SERVICES

Hospital-Specific Disproportionate Share Payment Limits

At HCFA's request, we will review some States' disproportionate share hospital (DSH) payments to selected hospitals to verify that the States calculated the payments in accordance with their approved State plans and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act of 1993. Under the act, DSH payments to an individual hospital may not exceed that hospital's total unreimbursed costs. This provision took effect in State fiscal years beginning in 1994 and 1995 for public and private hospitals, respectively. The HCFA subsequently required that all inpatient hospital State plan amendments contain an assurance that DSH payments to individual providers will not exceed the hospital-specific DSH payments limits.

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

Payments for Services to Dually Eligible Beneficiaries

This study will determine whether adequate coordination exists between Medicare and Medicaid in the identification and collection of improper payments. In some cases, Medicaid recipients are eligible for Medicare in addition to Medicaid. In these instances, Medicare is the primary payer for covered services. In accordance with a State's particular plan, Medicaid assumes responsibility for the recipients' premiums, deductibles, and coinsurances. A November 1995 OIG report found that States did not review the appropriateness or necessity of their crossover payments. This study will assess the extent of any continuing lack of State notification of potentially improper payments.

OEI; 00-00-00000

State Survey and Certification Costs

At HCFA's request, we will review selected States' survey and certification costs to verify that costs have been allocated correctly among Medicare, Medicaid, and State licensing agencies and that federally approved indirect cost rates have been applied. We will also study, to the extent possible, variations in survey and certification unit costs from State to State to determine the extent that these variations reflect differences in salary and other costs versus efficiency (e.g., staff-hours allotted to a given type of survey) and other factors.

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

Credentialing Medicaid Providers

This study will identify effective practices used by States in credentialing Medicaid providers. Some States are very careful about who can participate in the Medicaid program. They employ a variety of credentialing practices, including bonding, certification, background checks, and other activities to ensure that providers are reputable, competent, and accountable. We will also assess steps taken by States to credential Medicaid providers and to address the supply and availability of each type of provider within a State.

OEI; 00-00-00000

HCFA Oversight of Institutions for the Mentally Retarded

We will review HCFA and State oversight of intermediate care facilities for the mentally retarded. About 7,200 institutions for the mentally retarded receive Medicaid reimbursement. These facilities, which house a total of about 130,000 residents, are surveyed annually by the appropriate State agency. A September 1996 GAO report raised questions about HCFA and State oversight. In response to the GAO report, HCFA regional offices are now to provide oversight of these surveys by accompanying State survey staff on a sample of visits. Recent news articles have raised questions about the quality of care in institutions for the mentally retarded.

OEI; 00-00-00000

Medicaid Payments to Institutions for the Mentally Retarded

This follow-up review will examine the extent and causes of variation among States in per resident Medicaid reimbursement rates for large intermediate care facilities for mentally retarded people. In 1996, estimated Medicaid expenditures for such facilities reached \$9.6 billion for approximately 110,000 residents. To be certified to receive Medicaid reimbursement, the intermediate care facilities must annually meet 489 Federal standards.

However, Federal Medicaid rules for reimbursing States for the facilities are not clearly defined. A 1992 OIG report noted that Medicaid reimbursement per facility resident in some States was more than five times greater than that in other States. We also found that a lack of cost controls was correlated to excessive spending.

OEI; 00-00-00000

Medicaid Outpatient Prescription Drug Pricing

At HCFA's request, we will update our pricing studies on Medicaid outpatient prescription drugs. Our prior reviews, which were based on 1994 data, showed that the actual acquisition cost of brand name prescription drugs was 18.3 percent below average wholesale price and that the actual acquisition cost of generic drugs averaged 42.5 percent below average wholesale price. Recent studies conducted by the State of Utah showed that acquisition costs from June 1997 to May 1998 averaged 18.4 percent below average wholesale price for brand name drugs and 60.1 percent below for generic drugs.

OAS; W-00-00-30023; A-06-00-00000

MEDICARE CONTRACTOR OPERATIONS

Comparison of Payment Safeguard Activities

We will compare Medicare and Medicaid payment safeguard activities with those undertaken by other payers to determine promising approaches that could be adapted for HCFA programs. As national health care expenditures rise and public awareness of health care fraud increases, health care payers will continue to develop payment safeguards to control costs. These techniques may include prepayment screens, targeted medical review protocols, and establishment of special investigative units. This study will enhance the OIG's ability to reduce fraud and waste in addition to providing recommendations for Medicare and Medicaid fraud control.

OEI; 09-99-00080; 05-99-00070

Identifying and Collecting Overpayments

We will assess the effectiveness of contractor activities to identify and collect Medicare overpayments. Providers are often paid more than the appropriate amount for services they bill. Although contractors use a variety of methods to identify, quantify, and recover overpaid

trust fund amounts, some types of overpayments may never be identified. Further, once overpayments are identified, contractor efforts and success in recovering them vary widely.

OEI; 04-98-00530, -00531, -00532; 03-98-00520

Collecting Medicare Secondary Payer Overpayments

We will evaluate the Medicare contractors' diligence in collecting Medicare Secondary Payer (MSP) overpayments. By statute, Medicare is the secondary payer to certain types of other insurance plans when medical services are provided to Medicare beneficiaries with other insurance coverage. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary payments paid on behalf of these beneficiaries. Our review will follow through on the contractors' identification of and early action on potential MSP overpayments. Initially, we will develop and streamline our approach at one contractor before reviewing additional contractors across the Nation. As of March 31, 1999, the MSP accounts receivable (principal only) reported by the Medicare contractors in Region IV totaled over \$225 million.

OAS; W-00-00-40011; A-04-00-00000

Medicare Provider Numbers and Unique Physician Identification Numbers

We will determine whether information associated with Medicare provider numbers and unique physician identification numbers is accurate and up to date. A number of OIG reports have identified deficiencies in the issuance of provider numbers for specific areas of the program, such as durable medical equipment providers and independent physiological laboratories. Other studies have noted that unused provider numbers are not deactivated timely and thus constitute a potential fraud vulnerability. In recent years, HCFA has taken a number of actions to standardize Medicare enrollment and has required providers to submit more information to ensure compliance with Social Security Act reporting requirements. We will assess the current condition of this information.

OEI; 07-98-00410

Billing for Resident Services

We will assess the extent of improper Medicare billings resulting from the issuance of 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 unrelated to the resident's training program. Our work at one carrier found that a hospital had requested and received over 40 billing numbers for its 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 at other carriers.

OAS; W-00-98-30003; A-05-98-00053

Implementation of Therapy Caps

This review will examine whether HCFA contractors have developed the systems necessary to implement provisions of the Balanced Budget Act related to therapy caps. The act limits Part B physical therapy payments to \$1,500 per year, regardless of the setting in which the therapy is received. Currently, HCFA and the fiscal intermediaries do not have a system for comparing therapy provided in the home and in the nursing home. Such a system will be necessary to ensure that beneficiaries do not receive more than \$1,500 a year in therapy. We will review contractor operations to implement these provisions and determine whether the payment limits have been exceeded.

OEI; 00-00-00000

Contractors' Year 2000 Remediation Costs

At HCFA's request, we will determine the allowability, allocability, and reasonableness of the costs reported by approximately 50 fiscal intermediaries and carriers (contractors) for Year 2000 remediation of their Medicare computer systems. The HCFA has provided and is continuing to provide Year 2000 funding to each of its contractors based on budget requests. We will evaluate the contractors' reported expenditures in relation to the funding they have requested and received through HCFA's budget allocation process.

OAS; W-00-00-30031; Various CINs

Preaward Review of Medicare Integrity Program Contract Proposals

At the request of HCFA's contracting officer, we will review the cost proposals of various bidders under HCFA's Medicare Integrity Program. The results of these reviews will assist the HCFA contracting office in identifying the most cost-efficient bidders and in negotiating a cost-beneficial contract award.

OAS; W-00-00-30006; A-00-00-00000

Contract Close-Out Audits of Peer Review Organizations

At HCFA's request, we will audit the allowability, allocability, and reasonableness of costs incurred by various PROs whose contracts under HCFA's fifth Statement of Work will expire during the fiscal year. Our reports will provide HCFA's contracting officer with recommendations on the amount, if any, of the PROs' claimed costs that should be disallowed.

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

Contractors' Administrative Costs

This series of reviews requested by HCFA will audit administrative costs claimed by various contractors for their Medicare activities. Special attention will be given to costs claimed by terminated contractors. These reviews will determine whether the costs claimed were reasonable, allocable, and allowable under the terms of the contracts. We will coordinate the selection of the contractors with HCFA staff.

OAS; W-00-99-30004, W-00-00-30004; Various CINs

Unfunded Pensions

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-00-99-30005, W-00-00-30005; Various CINs

Pension Segmentation/Costs Claimed

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 of 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 contractors use a reasonable method for claiming reimbursement for pension costs under their Medicare contracts.

OAS; W-00-99-30005, W-00-00-30005; Various CINs

Pension Termination

At HCFA's request, these reviews will be performed at former Medicare carriers and intermediaries whose Medicare contracts have been terminated, resulting in the closing of their Medicare segments. We will determine the amount of any excess pension assets related to the Medicare segment as of the segment closing date. Regulations and the Medicare contracts provide that pension gains that occur when a Medicare segment closes should be credited to the Medicare program.

OAS; W-00-99-30005, W-00-00-30005; Various CINs

GENERAL ADMINISTRATION

Improper Medicare Fee-for-Service Payments

We will determine whether Medicare fee-for-service benefit payments are (1) furnished by certified Medicare providers to eligible beneficiaries, (2) made in accordance with Medicare laws and regulations, and (3) medically necessary, accurately coded, and sufficiently documented. Our determination will be made from a review of claims and patient medical records, with the assistance of medical staff. We will use statistical sampling techniques to project results nationwide and to compute a national error rate. Collectively known as "improper payments," these benefit payments could range from inadvertent mistakes to outright fraud and abuse. In FY 1998, estimated improper payments totaled \$12.6 billion, or 7.1 percent of the \$176.1 billion total spent on Medicare fee-for-service claims.

OAS; W-00-00-40011; A-17-00-00000

Year 2000 Computer Renovation Plans

We will continue to determine the adequacy of HCFA's planning, management, and assessment of the Year 2000 system compliance problem and assess the risk that HCFA's mission-critical, internal information systems may not operate effectively and efficiently at January 1, 2000. The scope of this review includes the 25 internal systems designated by HCFA as mission-critical, as well as other internal systems and data exchanges with external systems that are essential for the continuity of HCFA's programs and operations. This review is part of our Departmentwide Year 2000 compliance review.

OAS; W-00-98-40007; A-14-00-00000

Analysis of HCFA Data

We will analyze existing HCFA data to identify vulnerable beneficiary populations and program benefits, test new methods of detecting high-risk claims and providers, and evaluate the efficiency and effectiveness of current programs and contractors. Through this series of reviews, we will also provide insight into the present health care environment and establish a baseline for observing change. Efficient administration of Medicare depends on making full use of available data for strategic decision-making.

OEI; 00-00-00000

OIG-Excluded Persons

We will examine how Federal programs use OIG exclusion data to protect federally funded programs and their beneficiaries from fraudulent or poorly performing health care providers. We will also identify the number of claims submitted by these excluded providers. Every year the OIG excludes 1,200 to 1,500 fraudulent or unqualified practitioners from Medicare and Medicaid participation for various 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 Federal programs other than Medicare and Medicaid do not use this information, even though these providers are potentially harmful to Federal programs and their beneficiaries.

OEI; 07-98-00380, -00381, -00382

Medicare Secondary Payer

We will conduct a series of reviews on Medicare payments for beneficiaries who have other insurance coverage. By statute, Medicare payments for such beneficiaries are required to be secondary to certain types of private insurance coverage. However, various OIG and GAO reports found that inappropriate Medicare secondary payer payments amounted to millions of dollars. We will assess the effectiveness of current procedures in preventing these inappropriate payments. For example, we will evaluate HCFA's current procedures for identifying and resolving "credit balance situations," i.e., where payments from Medicare and other insurers exceed the providers' charges.

OAS; W-00-99-30030; A-01-98-00531, A-09-99-00000

OEI; 07-98-00180

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, nonphysician 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-00-00-30001; Various CINs

INVESTIGATIONS

The 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 HHS programs and operations. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in vulnerable program areas 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 are brought to the OIG's attention for development, investigation, and appropriate conclusion, OI 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 concentrate our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

Medicare Part A

Medicare Part A helps pay for four kinds of medically necessary care: inpatient hospital care, inpatient care in a facility, home health care, and hospice care. Approximately 58 percent of the Medicare dollar is spent on Part A services. We will investigate facilities or entities that billed the Medicare program for services not rendered or that manipulated payment codes in an effort to inflate their reimbursement amount. We will also investigate business arrangements that violate anti-kickback statutes.

Medicare Part B

Medicare Part B helps pay for doctors' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies not covered by Medicare Part A. The most common Part B violation involves false provider claims to obtain payments. The OIG receives complaints from a variety of sources and conducts widespread investigations into fraudulent schemes in various areas of medical service. We will investigate a broad range of suspected fraud and present cases for both criminal and civil prosecution.

Medicare Part C

The Balanced Budget Act of 1997 established a new authority permitting HCFA to contract with a variety of different managed care and fee-for-service entities, including:

- coordinated care plans, HMOs, preferred provider organizations, and provider-sponsored organizations;
- religious fraternal benefit plans;
- private fee-for-service plans; and
- a 4-year demonstration project involving medical savings accounts.

Presently, 15 percent of Medicare beneficiaries are enrolled in managed care plans. The HCFA anticipates enrollment in Part C to increase to 33 percent by 2003.

The OIG is working directly with HCFA and the Department of Justice to ensure that the new Part C contracts meet the requirements for criminal, civil, and administrative actions. Additionally, we will continue to develop methods that identify schemes to defraud Medicare Part C.

Medicaid

The Medicaid program provides grants to States for medical assistance payments. The majority of States have taken advantage of available Federal funding to establish Medicaid fraud control units to investigate criminal violations. Medicaid fraud investigations by OIG will be conducted only in States without such units or where there is a shared interest. In addition to sustaining scrutiny of the principal health care programs administered by HCFA, the OIG will focus attention on HCFA grants and contracts with carriers and intermediaries.

Pneumonia Diagnosis-Related Group Upcoding Project

This cooperative effort with the Department of Justice focuses on information that hospitals have upcoded the diagnosis-related group for pneumonia claims from viral to bacterial pneumonia. By doing this, the hospitals obtained almost \$2,500 extra per claim in reimbursement. The OIG is looking at both civil and criminal implications.

Prospective Payment System Transfer Project

In another cooperative effort with the Department of Justice, the OIG is focusing on hospital misrepresentation of patient discharge status and the resulting unjustified reimbursements. By doing this, hospitals receive the full reimbursement due under the diagnosis-related group when, in fact, the transferring hospital should be paid a lesser amount.

LEGAL COUNSEL

In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of all major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. OCIG represents OIG in administrative litigation, such as patient dumping cases and program 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 OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2000 includes:

Compliance Program Guidance

We will continue to issue compliance program guidance to assist the health care industry in establishing voluntary corporate compliance programs and in developing effective internal controls that promote adherence to applicable Federal statutes, regulations, and the program requirements of Federal health care plans. We plan to issue program guidance documents during the first half of FY 2000 pertaining to Medicare+Choice organizations offering coordinated care plans and to nursing homes and ambulance companies. The adoption and

implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans while furthering the health care industry's fundamental mission to provide quality patient care.

Expected Completion Date: Ongoing

Corporate Integrity Agreements

We will continue to monitor providers' compliance with the terms of over 400 corporate integrity agreements into which they have entered in conjunction with the settlement of fraud and abuse allegations. We will increase the number of site visits to providers subject to the agreements to verify compliance efforts and confirm information submitted by the providers to OIG. Included in this monitoring process will be the establishment of a tracking system to determine the amounts returned to the Medicare trust fund as a result of providers' having established certain mechanisms, including auditing and reporting, required by the OIG under corporate integrity agreements.

Expected Completion Date: Ongoing

Advisory Opinions and Fraud Alerts

As part of the OIG's ongoing efforts to prevent fraud and abuse through industry guidance, we will respond to requests for formal advisory opinions on the application of the anti-kickback statute and other fraud and abuse statutes to particular circumstances. We will also issue special fraud alerts and advisory bulletins, as warranted, to inform the health care industry more generally of particular industry practices that OIG determines are highly suspect.

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

Near the beginning of FY 2000, we will publish final regulations establishing eight new safe harbor exemptions from the anti-kickback statute. Also, we will evaluate comments that the OIG solicited from the public concerning proposals for additional safe harbors. Where appropriate, we will develop proposed and final regulations for additional safe harbors.

Expected Completion Date: Ongoing

Patient Anti-Dumping Statute Enforcement

We expect to increase the number of patient anti-dumping cases reviewed, negotiated, and litigated and to resolve approximately 70 such cases in FY 2000. In addition, we plan to continue our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG. In addition, we intend to issue an advisory bulletin regarding the scope and effect of program exclusions.

Expected Completion Date: Ongoing

Civil Monetary Penalties

We will finalize regulations implementing new and revised civil monetary penalty authorities delegated to the OIG. We will also promulgate regulations for implementing the civil monetary penalty authorities applicable to Medicare+Choice organizations, codified at section 1857 of the Social Security Act, as well as Medicaid managed care, codified at section 1903(m) of the act. In addition, we will continue our enforcement activities in this area and specifically focus on cases involving improper conduct by managed care organizations.

Expected Completion Date: Ongoing