

**Department of Health and Human Services
Office of Inspector General
Projects**



**CENTERS FOR MEDICARE AND MEDICAID SERVICES
Table of Contents**

MEDICARE HOSPITALS

| | |
|--|---|
| Hospital Quality Oversight | 1 |
| Medical Education Payments | 1 |
| Hospital Privileging Activities | 1 |
| Inpatient Capital Payments | 1 |
| Long-Term-Care Hospital Payments | 2 |
| Consecutive Inpatient Stays | 2 |
| Certification of Heart Transplant Centers | 2 |
| Organ Donation at Transplant Hospitals | 2 |
| Medical Necessity of Inpatient Psychiatric Stays | 3 |
| Medical Necessity of Inpatient Rehabilitation Facility Stays | 3 |
| Prospective Payment System for Inpatient Rehabilitation Facilities | 3 |
| Critical Access Hospitals | 4 |
| Diagnosis-Related Group Payment Limits | 4 |
| Update on Diagnosis-Related Group Coding | 4 |
| Medicare Hospital Outlier Payments | 4 |
| Uncollected Beneficiary Deductibles and Coinsurance | 5 |
| Expansion of Diagnosis-Related Group Payment Window | 5 |
| Hospital Reporting of Restraint-Related Deaths | 5 |
| Potentially Excessive Payments for Inpatient and Outpatient Services | 5 |
| Diagnostic Testing in Emergency Rooms | 6 |
| External Oversight of Hospital Outpatient Departments | 6 |
| Outpatient Prospective Payment System | 6 |
| Outlier Payments Under Outpatient Prospective Payment System | 6 |
| Outpatient Cardiac Rehabilitation Services | 7 |
| Procedure Coding of Outpatient and Physician Services | 7 |

MEDICARE HOME HEALTH

| | |
|---|---|
| Effect of Prospective Payment System on Quality of Home Health Care | 7 |
| Home Health Payment System Controls | 8 |

MEDICARE NURSING HOMES

| | |
|---|----|
| Medicare Beneficiary Access to Skilled Nursing Facilities Under the Prospective Payment System | 8 |
| Nursing Home Quality Assessment and Assurance Committees | 8 |
| Nursing Home Medical Directors | 9 |
| Accuracy of Nursing Home Quality and Deficiency Data | 9 |
| Nursing Home Survey and Certification: Consistency and Accuracy | 9 |
| Nursing Home Survey and Certification: Identifying Repeat Offenders | 9 |
| Nursing Home Reporting of Minimum Data Set | 10 |
| Resource Utilization Group Assignments: Follow-up | 10 |
| Program Integrity Safeguards | 10 |
| Three-Day Stay Requirement | 11 |
| Consolidated Billing Requirements | 11 |
| Part B Payments for Beneficiaries in Nursing Homes | 11 |
| Social Work Services in Skilled Nursing Facilities | 11 |
| Nursing Home Deficiencies and Complaints | 12 |
| Nursing Home Complaints to State Ombudsmen | 12 |
| Nursing Home Informal Dispute Resolution Trends | 12 |
| Nursing Home Enforcement | 12 |

MEDICARE PHYSICIANS AND OTHER HEALTH PROFESSIONALS

| | |
|---|----|
| Consultations | 13 |
| Coding of Medicare Physician Services | 13 |
| Coding of Evaluation and Management Services | 13 |
| Coding of Physician Evaluation of Dialysis | 13 |
| “Long Distance” Physician Claims | 14 |
| Bone Density Screening | 14 |
| Billing for Chiropractic Care | 14 |
| Cataract Surgery Comanagement | 15 |
| Financial Arrangements Between Physicians and Ambulatory Surgical Centers | 15 |
| Services and Supplies Incident to Physicians’ Services | 15 |
| Reassignment of Benefits | 15 |
| Medicare Payments to Nonphysician Practitioners | 16 |

MEDICARE MEDICAL EQUIPMENT AND SUPPLIES

| | |
|--|----|
| Medical Necessity of Wheelchairs | 16 |
|--|----|

| | |
|--|----|
| Payments for Enteral Nutrition | 16 |
| Payments for Parenteral Nutrition | 17 |
| Payments for Oxygen Equipment and Supplies | 17 |
| Payments for Therapeutic Shoes | 17 |

MEDICARE LABORATORY SERVICES

| | |
|---|----|
| Laboratory Proficiency Testing | 18 |
| Clinical Laboratory Testing Outside Certified Specialties | 18 |
| Part B Claims for Glucose Testing | 18 |

END STAGE RENAL DISEASE

| | |
|---|----|
| Prevalence of Method II Dialysis in Nursing Homes | 19 |
| Ambulance Transport for End Stage Renal Disease Beneficiaries | 19 |

MEDICARE DRUG REIMBURSEMENT

| | |
|---|----|
| Payments for Non-End Stage Renal Disease Epoetin Alfa | 19 |
| Allergy Treatments | 19 |

OTHER MEDICARE SERVICES

| | |
|---|----|
| Beneficiaries' Experiences With Medigap Insurance | 20 |
| Medicare Payments in Outpatient Settings | 20 |
| Hospice Payments and Plans of Care | 20 |
| Medicare Payments for Clinical Trials | 21 |
| Independent Diagnostic Testing Facilities | 21 |
| New Payment Provisions for Ambulance Services | 21 |
| Nonemergency Ambulance Payments | 22 |
| Intraocular Lens Reimbursement in Ambulatory Surgical Centers | 22 |
| Nail Debridement Services | 22 |

MEDICARE MANAGED CARE

| | |
|---|----|
| Adjusted Community Rate Proposals | 22 |
| Follow-up on Adjusted Community Rate Proposals | 23 |
| Intraorganization Transfers | 23 |
| Marketing Practices by Managed Care Organizations | 23 |
| Managed Care Encounter Data | 24 |
| Cost-Based Managed Care Plans | 24 |
| Enhanced Managed Care Payments | 24 |
| Managed Care Additional Benefits | 25 |

MEDICARE CONTRACTOR OPERATIONS

| | |
|--|----|
| Preaward Reviews of Contract Proposals | 25 |
| CMS Oversight of Contractor Evaluations | 25 |
| Handling of Beneficiary Inquiries | 25 |
| Provider Education and Training by Carriers | 26 |
| Payments for Ineligible Aliens and Deported Individuals | 26 |
| Suspension of Payments to Providers | 26 |
| Contractors' Administrative Costs | 26 |
| Medicare Data Center Claim Processing Costs | 27 |
| Postretirement Benefits and Supplemental Employee Retirement Plans | 27 |
| Segment Closing/Costs Claimed | 27 |
| Pension Termination | 27 |

MEDICAID HOSPITALS

| | |
|---|----|
| Medicaid Graduate Medical Education Payments | 28 |
| Hospital-Specific Disproportionate Share Payment Limits | 28 |
| Medicaid Diagnosis-Related Group Payment Window | 28 |
| Medicaid Hospital Patient Transfers | 29 |
| Medicaid Outpatient Hospital Payments | 29 |
| Credit Balances in Inpatient Accounts | 29 |

MEDICAID NURSING HOMES

| | |
|---|----|
| Medicaid Payments to Skilled Nursing Facilities for Medicare-Covered Services ... | 29 |
| Payments to Public Nursing Facilities | 30 |
| Payments for Ancillary Services in Nursing Homes | 30 |
| Nursing Facility Administrative Costs | 30 |
| Nursing Facility Staffing Requirements and Waivers | 31 |
| Nursing Home Quality-of-Care Sanctions | 31 |

MEDICAID MANAGED CARE

| | |
|---|----|
| Marketing and Enrollment Practices by Medicaid Managed Care Entities | 31 |
| Public-Sponsored Managed Care Health Plans | 31 |
| Managed Care Payments as Part of the Fee-for-Service Upper-Payment-Limit Calculation | 32 |

MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM

| | |
|--|----|
| Adolescent Enrollment in Medicaid/State Children's Health Insurance Program | 32 |
| Preventing Medicaid Eligibles From Enrolling in the State Children's Health Insurance Program | 32 |
| State Children's Health Insurance Renewal Process | 33 |

| | |
|---|----|
| Duplicate Claims for Medicaid and State Children's Health Insurance Program | 33 |
| State Children's Health Insurance Program Disenrollment Data System | 33 |
| State Children's Health Insurance Program: State Evaluation Reports | 34 |

MEDICAID DRUG REIMBURSEMENT

| | |
|---|----|
| State Strategies to Control Prescription Drug Costs | 34 |
| Medicaid Drug Utilization | 34 |
| Medicaid Drug Rebate Program | 35 |
| Medicaid Drug Rebates–Computation of Average Manufacturer Price and Best Price | 35 |
| Medicaid Rebates for Physician-Administered Drugs | 35 |
| Medicaid Drug Rebate Collections | 36 |
| Pricing Drugs in the Federal Upper Limit Program | 36 |
| “Dead Net” Acquisition Cost Paid by Chain Pharmacies | 36 |
| Mental Health Drugs | 36 |
| Schedule II Controlled Substance Prescriptions | 37 |

OTHER MEDICAID SERVICES

| | |
|--|----|
| Medicaid Waiver Programs | 37 |
| Payments for Services to Dually Eligible Beneficiaries | 37 |
| Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees | 38 |
| Contingency Fee Payment Arrangements | 38 |
| Upper-Payment-Limit Calculations | 38 |
| Intergovernmental Transfers | 39 |
| Distribution of Medicaid Funds by Nongovernmental Organizations | 39 |
| Claims for Residents of Institutions for Mental Diseases | 39 |
| Home Health Payments | 39 |
| Coding of Medicaid Physician Services | 40 |
| Payments for Inmates of Public Institutions | 40 |
| Durable Medical Equipment Reimbursement Rates | 40 |
| School-Based Health Services | 41 |
| Personal Care Services | 41 |
| Chiropractic Benefits for Children Under the Early and Periodic Screening, Diagnosis, and Treatment Program | 41 |
| Payments for Services to Deceased Beneficiaries | 41 |
| Medicaid Accounts Receivable | 42 |

GENERAL ADMINISTRATION

| | |
|---|----|
| State Medical Boards as a Source of Patient Safety Data | 42 |
| Administrative Simplification: Readiness for Electronic Standards | 42 |

| | |
|---|----|
| Improper Medicare Fee-for-Service Payments | 43 |
| Analysis of Medicare Errors | 43 |
| Medicare Beneficiaries With High Utilization Rates | 43 |
| Medicare Secondary Payer | 43 |
| Medicaid Recovery of Payments From Liable Third Parties | 44 |
| Payments to Psychiatric Facilities Improperly Certified as Nursing Facilities | 44 |
| Group Purchasing Organizations | 44 |
| Corporate Integrity Agreements | 44 |
| Joint Work With Other Federal and State Agencies | 45 |

INVESTIGATIONS

| | |
|--------------------------------|----|
| Health Care Fraud | 45 |
| Provider Self-Disclosure | 46 |

LEGAL COUNSEL

| | |
|---|----|
| Compliance Program Guidance to the Health Care Industry | 47 |
| Resolution of False Claims Act Cases and Negotiation of Corporate Integrity Agreements | 47 |
| Providers' Compliance With Corporate Integrity Agreements | 48 |
| Advisory Opinions and Fraud Alerts | 48 |
| Anti-Kickback Safe Harbors | 48 |
| Patient Anti-Dumping Statute Enforcement | 49 |
| Program Exclusions | 49 |
| Civil Monetary Penalties | 49 |

MEDICARE HOSPITALS

Hospital Quality Oversight

We will examine accreditation and state agency certification of Medicare-participating hospitals. In response to our previous review of quality oversight processes, the Centers for Medicare and Medicaid Services (CMS) drafted a detailed plan for improving hospital oversight. We will examine the current status of accreditation, Medicare certification, and CMS activities relative to the agency's plan.

OEI; 01-02-00490

Expected Issue Date: FY 2003

Medical Education Payments

We will continue reviews to evaluate the efficiency of controls over Medicare payments for medical education and controls over resident counts. We will visit fiscal intermediaries and providers to determine the validity of claims for these payments. Our pilot review at one large hospital disclosed problems in computing full-time equivalents for interns and residents.

OAS; W-00-02-35023/35025; Various CINs

Expected Issue Date: FY 2003

Hospital Privileging Activities

We will review hospital privileging activities within the context of Medicare conditions of participation. Hospital privileging is the process by which a hospital determines the scope of allowable practice for each physician within that hospital. One of the most fundamental internal safeguards in hospitals is the routine practice of granting initial or renewed privileges to physicians.

OEI; 01-02-00500

Expected Issue Date: FY 2003

Inpatient Capital Payments

This series of reviews will examine Medicare inpatient hospital capital payments. We will examine the accuracy and appropriateness of the CMS process for updating the capital rates and analyze the effects of excess capacity on those rates. In addition, we will examine capital payments in relation to hospitals' financial status. Medicare pays hospitals over \$6 billion each year, and prior OIG reviews showed that the rates were inflated.

OAS; W-00-02-35056; A-07-02-04003

Expected Issue Date: FY 2003

Long-Term-Care Hospital Payments

We will determine the extent to which long-term-care hospitals operate as satellite units and “hospitals-within-hospitals.” To retain prospective payment system-exempt status, long-term-care satellite units are required to have average stays of over 25 days. Further, if more than 5 percent of discharges from a hospital-within-a-hospital to its host hospital result in subsequent readmission to the hospital-within-a-hospital, the first stay may be denied. We will determine whether those conditions have been met.

OEI; 01-02-00630

Expected Issue Date: FY 2004

Consecutive Inpatient Stays

We will examine the extent to which Medicare beneficiaries received acute and postacute care through sequential stays at different hospitals. Although Medicare allows care in different facilities according to the beneficiary’s needs, payments may be denied when one or multiple stays constitute an attempt to circumvent the prospective payment system. We will analyze claims to identify questionable patterns of inpatient and long term care.

OEI; 03-01-00430

Expected Issue Date: FY 2003

Certification of Heart Transplant Centers

We will determine compliance with Medicare certification criteria and estimate the impact of enforcement of those criteria on Medicare payments and beneficiary access to care. Medicare heart transplant programs are required to perform at least 12 transplants each year and achieve a 1-year survival rate of at least 73 percent. Failure to meet these criteria should result in loss of Medicare certification for the following year.

OEI; 01-02-00520

Expected Issue Date: FY 2003

Organ Donation at Transplant Hospitals

We will assess the organ donation performance of hospital organ transplant programs. About 260 medical institutions operate hospital organ transplant programs in the United States. To help alleviate the organ shortage, Medicare conditions of participation require that hospitals, as of August 1998, notify organ procurement organizations about individuals whose deaths are imminent or who die in the hospital. Because of the need for organ donation, hospitals that operate transplant programs would logically be leaders in organ donation. Despite this

expectation, indications are that donation rates at hospitals with transplant programs are considerably lower than rates at other hospitals.

OEI; 01-02-00210

Expected Issue Date: FY 2003

Medical Necessity of Inpatient Psychiatric Stays

We will determine the extent that any improper Medicare payments for inpatient psychiatric stays were due to medical necessity or coverage issues. Prospective payment system-exempt psychiatric units and specialty hospitals received over \$2.8 billion for Medicare inpatient stays in 2000. Medical reviews of prospective payment hospital and specialty psychiatric hospital outpatient psychiatric services found very high rates of unsupported or unallowable services (58 percent and 42 percent, respectively). We will also assess the ability of controls to detect improper payments for inpatient psychiatric services.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medical Necessity of Inpatient Rehabilitation Facility Stays

We will determine the extent that any improper Medicare payments for inpatient rehabilitation stays in specialty hospitals and units were due to medical necessity or coverage issues. Inpatient rehabilitation facilities received over \$4 billion from Medicare in 2000. Quality improvement organizations, formerly known as peer review organizations, ceased routine medical reviews of prospective payment system-exempt services in 1995. We will assess the adequacy of controls to detect improper payments for inpatient rehabilitation facility services.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Prospective Payment System for Inpatient Rehabilitation Facilities

We will monitor implementation of the new Medicare prospective payment system for inpatient rehabilitation facilities, which became effective January 1, 2002. Before that time, interim payments to inpatient rehabilitation facilities were based on the lesser of reasonable costs or charges and were subject to cost settlements at the end of each cost reporting period. Reimbursement under the new system is based on individual assessments designed to classify beneficiaries by medical and demographic characteristics. We will conduct surveys and pilot audits at fiscal intermediaries, providers, and other participants to identify potential vulnerabilities. We will then review controls and payments under the new system to test any vulnerabilities, assess their impact, and consider solutions to the problems.

*OAS; W-00-03-35073; A-02-03-00000
A-04-03-00000*

Expected Issue Date: FY 2003

Critical Access Hospitals

We will determine whether costs reported on critical access hospitals' cost reports for both inpatient and outpatient services were reasonable, allowable, and necessary for patient care. Critical access hospitals are small, rural facilities with a limited number of inpatient and swing beds. They may also provide outpatient services. Medicare payments are based on reasonable costs for both inpatient and outpatient services. Since the number of such hospitals has steadily grown over the past several years, we plan to assess whether services were provided in accordance with Medicare guidelines and analyze utilization patterns to identify potential vulnerabilities to the Medicare program.

OAS; W-00-03-35074; A-00-03-00000

Expected Issue Date: FY 2003

Diagnosis-Related Group Payment Limits

We will continue to 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 applies to certain diagnosis-related groups. Our prior reviews indicated that a lack of controls had resulted in significant overpayments.

OAS; W-00-02-35027; A-04-02-07005

Expected Issue Date: FY 2003

Update on Diagnosis-Related Group Coding

This update will examine diagnosis-related groups that have a history of aberrant coding to determine whether some acute hospitals exhibit aberrant coding patterns. The prospective payment system, or diagnosis-related groups, for inpatient acute care depends on accurate coding of diagnoses and procedures. Inaccurate coding by hospitals can lead to overpayments. We will determine coding payment error rates and incorporate the results of a recent review by quality improvement organizations.

OEI; 03-02-00780

Expected Issue Date: FY 2003

Medicare Hospital Outlier Payments

We will review Medicare inpatient claims for cost outliers. Although prospective payment system hospitals are paid a fixed amount for various types of inpatient stays, additional payment may be claimed for stays with charges exceeding a preset limit. We will examine

whether these payments were appropriate and review the adequacy of controls over outlier claims.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Uncollected Beneficiary Deductibles and Coinsurance

We will continue reviews addressing the reasonableness of Medicare payments to inpatient and outpatient 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 the effectiveness of existing controls to ensure their validity.

OAS; W-00-02-35006/35007; Various CINs

Expected Issue Date: FY 2003

Expansion of Diagnosis-Related Group Payment Window

This review will determine whether it would be reasonable and appropriate to treat as inpatient services all admission-related services rendered up to 14 days before a hospital admission. The Omnibus Budget Reconciliation Act of 1990 requires that all services rendered within 3 days before the date of admission be treated as inpatient services. Prior OIG work and additional analytical work detected growth in nonphysician outpatient services rendered 4 to 14 days before an inpatient admission. This review will focus on those diagnosis-related groups that contribute to the highest percentage of Medicare payments outside the 3-day window.

OAS; W-00-02-35038; A-01-02-00503

Expected Issue Date: FY 2003

Hospital Reporting of Restraint-Related Deaths

We will assess hospital compliance with Medicare conditions of participation, issued in July 1999. These conditions require hospitals to report all patient deaths that may have been caused by restraints or seclusion. We will examine CMS's early experiences with hospital reporting and review Medicare claims and enrollment data to determine whether patient deaths have been adequately reported.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Potentially Excessive Payments for Inpatient and Outpatient Services

This review will evaluate controls to detect potentially excessive Medicare payments to institutional providers for inpatient and outpatient services. Prior OIG work identified simple clerical billing errors which generated significant excessive payments. We plan to assess the

adequacy and extent of actions taken on the recommendations in our prior report as well as potentially excessive inpatient and outpatient payments during subsequent years.

OAS; W-00-02-35065; A-01-02-00516

Expected Issue Date: FY 2003

Diagnostic Testing in Emergency Rooms

This study will assess the appropriateness of Medicare billings for diagnostic tests performed in hospital emergency rooms. Medicare pays approximately \$85 million a year for standard imaging (i.e., x-rays) and an additional \$70 million for advanced imaging (e.g., MRIs and CAT scans). We will determine if the services were medically necessary and if the tests were interpreted contemporaneously with the patient's treatment.

OEI; 00-00-00000

Expected Issue Date: FY 2004

External Oversight of Hospital Outpatient Departments

We will assess the performance of accrediting organizations and state survey and certification agencies in providing quality oversight of hospital outpatient departments. These departments provide a significant portion of ambulatory care, including 20 percent of all outpatient surgeries reimbursed by Medicare. Hospitals must either be accredited or receive Medicare certification through the state agency; however, current Medicare conditions of participation for hospitals and the survey processes may be largely focused on inpatient care.

OEI; 01-02-00480

Expected Issue Date: FY 2003

Outpatient Prospective Payment System

We will continue to review the implementation of the new prospective payment system for care provided to Medicare beneficiaries by hospital outpatient departments. Previously, Medicare paid outpatient departments their reasonable costs. We will evaluate the effectiveness of internal controls intended to ensure that services are adequately documented, properly coded, and medically necessary. Controls over "pass-through" costs will also be reviewed.

OAS; W-00-02-35014-35017; Various CINs

Expected Issue Date: FY 2004

Outlier Payments Under Outpatient Prospective Payment System

We will determine whether outlier payments under the outpatient prospective payment system were made in accordance with Medicare reimbursement regulations. Vulnerability assessments found that these types of outlier payments posed a high risk of being incorrect, and subsequent

pilot reviews at several hospitals identified overpayments for outliers. We plan to expand this review nationwide based on data analysis identifying high-risk providers.

OAS; W-00-02-35048; Various CINs

Expected Issue Date: FY 2003

Outpatient Cardiac Rehabilitation Services

At the request of CMS, we will determine whether cardiac rehabilitation services provided by hospital outpatient departments met Medicare coverage requirements. Medicare covers such rehabilitation under the “incident-to” a physician’s professional services benefit, which requires that the services of nonphysician personnel be furnished under the physician’s direct supervision. Direct supervision means that a physician must be in the exercise program area and immediately available and accessible for a medical emergency at all times during the exercise program. Our review will focus on whether direct physician supervision has been provided.

OAS; W-00-02-35059; Various CINs

Expected Issue Date: FY 2003

Procedure Coding of Outpatient and Physician Services

We will review the procedure coding of outpatient services billed by both a physician and a hospital/ambulatory service center for the same service. Our previous review identified a 23-percent nationwide rate of inconsistency between hospital outpatient department procedure coding and physician procedure coding for the same outpatient service. We will follow up to determine whether these coding differences are still significant under the new outpatient hospital prospective payment system as well as in ambulatory service centers and, if so, how they affect the Medicare program.

OAS; W-00-02-35049; A-01-02-00524

Expected Issue Date: FY 2003

MEDICARE HOME HEALTH

Effect of Prospective Payment System on Quality of Home Health Care

This study will assess the quality of home health care since the implementation of the home health prospective payment system. Under the new system, effective October 2000, reimbursement for home health services changed from a cost-based system to a prospective payment system of fixed, predetermined rates. We will determine whether any changes have

occurred in the level and mix of services, the number of hospital readmissions or emergency room admissions, and the number of deficiencies found by the survey and certification process.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Home Health Payment System Controls

Through a series of reviews, we will monitor implementation of the new prospective payment system used to pay home health agencies for providing care to Medicare beneficiaries. The prior payment system was based on cost reimbursement principles. We will evaluate the adequacy of controls intended to ensure that services are needed and properly paid. We will also determine whether services were properly coded and whether any services were inappropriately unbundled and paid separately by Medicare.

OAS; W-00-01-35021/35022; Various CINs

Expected Issue Date: FY 2003

OEI; 02-02-00650

Expected Issue Date: FY 2004

MEDICARE NURSING HOMES

Medicare Beneficiary Access to Skilled Nursing Facilities Under the Prospective Payment System

In this follow-up study, we will determine if the prospective payment system for skilled nursing facilities has affected Medicare beneficiaries' access to care. Prior studies found that under the system, Medicare beneficiaries generally had access to needed skilled nursing facilities. However, some patients with certain medical conditions or service needs experienced delays, and some discharge planners attributed these delays to the prospective payment system.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Nursing Home 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 home to maintain a committee comprising the director of nursing, a physician, and at least three other members of a facility's staff. The committee should meet at least quarterly to identify quality assessment and assurance activities and to develop and implement appropriate action plans to correct identified quality deficiencies. In July 1995, CMS required surveyors to determine whether facilities have quality assessment and assurance

committees and whether the committees have a method to "identify, respond to, and evaluate" quality-of-care issues.

OEI; 01-01-00090

Expected Issue Date: FY 2003

Nursing Home Medical Directors

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

OEI; 06-99-00300

Expected Issue Date: FY 2003

Accuracy of Nursing Home Quality and Deficiency Data

We will analyze the accuracy and validity of the Online Survey Certification and Reporting system. The system includes quality and deficiency data on Medicare-certified nursing homes. It is important that these data be accurate to effectively monitor quality of care in nursing homes. The database is populated either by state surveyors or nursing home self-reporting. This study will examine how state survey staff and CMS update, monitor, and ensure the integrity of the data.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Nursing Home Survey and Certification: Consistency and Accuracy

This study will determine the consistency and accuracy of state nursing home survey and certification processes and reports. We will examine state survey procedures, including those for determining and documenting deficiencies. In addition, we will examine how states and CMS ensure accuracy and consistency in the survey process.

OEI; 02-01-00600

Expected Issue Date: FY 2003

Nursing Home Survey and Certification: Identifying Repeat Offenders

This study will review how states identify nursing homes that receive repeated patient care deficiency ratings from state surveyors and how enforcement tools are used to encourage compliance with federal regulations. We will also examine how federal and state agencies track facilities repeatedly cited for deficiencies related to quality and how consistently penalties

are applied. The study will also assess how CMS and state enforcement efforts affect repeated deficiencies.

OEI; 06-02-00320

Expected Issue Date: FY 2003

Nursing Home Reporting of Minimum Data Set

We will assess nursing home compliance with Minimum Data Set (MDS) reporting requirements. The MDS is one of the primary mechanisms for addressing residents' quality of care. Although the MDS partially determines payment for Part A stays, Medicare conditions of participation require that the MDS be reported on all residents for quality oversight purposes. This study will focus on nursing home MDS reporting for residents who are not in a Part A covered stay. We will review data submissions and nursing home records to assess the accuracy and timeliness of reporting.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Resource Utilization Group Assignments: Follow-up

This study will examine changes in the proportion of Medicare beneficiaries assigned to each Resource Utilization Group in light of recent legislative changes to the prospective payment system for skilled nursing facilities. The Benefit Improvement and Protection Act directs OIG to review the Medicare payment structure for services classified within the rehabilitation Resource Utilization Groups. We will examine the trends in the proportion of Medicare beneficiaries categorized in each group, as well as any changes in these trends since the recent legislative changes to the payment rate.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Program Integrity Safeguards

We will assess controls over the skilled nursing facility prospective payment system's program integrity safeguards and determine how the results of safeguard activities can be used to identify and prevent provider noncompliance. The Balanced Budget Act of 1997 required CMS to implement a prospective payment system for skilled nursing facilities. Prior OIG risk analyses of the system identified several potential areas of vulnerability, including compliance with the MDS assessment process. Accordingly, one of our focus areas will be provider compliance with this assessment process to ensure the appropriate level of Medicare payment and the quality of skilled nursing care. We will also follow up on our prior review of infusion therapy services provided to skilled nursing facility residents.

OAS; W-00-02-35061/35063; A-01-02-00511,
A-06-03-00000

Expected Issue Date: FY 2003

Three-Day Stay Requirement

We will continue reviews of patient eligibility for care in skilled nursing facilities. We found that some Medicare beneficiaries were not eligible for such care because they had not received sufficient hospital/nursing home care before the skilled nursing care. In general, the nursing care must be preceded by 3 days in a hospital.

OAS; W-00-02-35043; Various CINs

Expected Issue Date: FY 2003

Consolidated Billing Requirements

This review will determine whether controls are in place to preclude duplicate billing under the skilled nursing facility prospective payment system. Under this system, the nursing facility has the Medicare billing responsibility for virtually all of the Medicare-covered services that its residents receive. As a result, the outside supplier must look to the nursing facility, rather than the Part B carrier, for payment. Prior OIG work identified millions of dollars in potentially improper payments associated with outpatient hospital, ambulance, laboratory, radiology, and durable medical equipment services during calendar year 1999. This review will identify any additional potentially improper payments for such services during calendar years 1999 and 2000.

OAS; W-00-02-35013; A-01-02-00513

Expected Issue Date: FY 2003

Part B Payments for Beneficiaries in Nursing Homes

We will analyze Medicare Part B payments for nursing facility residents to determine if unbundling, inappropriate services, or aberrant billing patterns occurred. The Balanced Budget Act of 1997 requires consolidated billing of Part B payments to suppliers and providers of services in skilled nursing facilities. We will identify any duplicate Part B payments and services that are most problematic.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Social Work Services in Skilled Nursing Facilities

We will determine if Medicare skilled nursing facilities have provided the psychosocial services required by the 1987 Nursing Home Reform Act. This study will identify social work

services received by residents of skilled nursing facilities and examine the qualifications of persons providing the services.

OEI; 02-01-00610

Expected Issue Date: FY 2003

Nursing Home Deficiencies and Complaints

This study will describe trends in nursing home deficiencies and complaints to assess quality of care. We will examine deficiencies that are cited most frequently, as well as those with the most serious scope and severity levels. This study will also examine the number of complaints received by state survey and certification agencies.

OEI; 02-02-00290

Expected Issue Date: FY 2003

Nursing Home Complaints to State Ombudsmen

This study will determine the extent and nature of nursing home quality-of-care problems by examining trends in ombudsmen complaint data and information. We will assess the number of complaints, the most common type of complaints over the past 5 years, changes in the types of complaints, and the specific nature of complaints.

OEI; 09-02-00160

Expected Issue Date: FY 2003

Nursing Home Informal Dispute Resolution Trends

This study will review trends and outcomes of the nursing home Informal Dispute Resolution process. By law, CMS is required to provide nursing homes an informal opportunity to dispute cited deficiencies. This study will examine the types of deficiencies more likely to be disputed, the types of nursing homes more likely to use the resolution process, and the implications for nursing home survey processes.

OEI; 06-02-00750

Expected Issue Date: FY 2003

Nursing Home Enforcement

This study will determine whether enforcement actions taken against nursing homes have been effectively implemented. Specifically, we will determine the amount of penalties assessed against nursing homes in recent years and whether these monies were actually collected. We will review other enforcement actions as well.

OEI; 06-02-00720

Expected Issue Date: FY 2003

MEDICARE PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Consultations

This study will determine the appropriateness of billings for physician consultation services and the financial impact of inaccurate billings on the Medicare program. In addition, we will determine the primary reasons for any inappropriate billings. In 2000, allowed Medicare charges for consultations totaled \$2 billion.

OEI; 09-02-00030

Expected Issue Date: FY 2003

Coding of Medicare Physician Services

We will test whether carriers are appropriately applying edits required by Medicare's National Correct Coding Initiative. The initiative, one of CMS's tools for detecting and correcting improper billing, is designed to provide Medicare Part B carriers with code pair edits for use in reviewing claims. Specifically, code pair edits include comprehensive and component codes, as well as mutually exclusive codes, that generally should not be billed together. We will determine whether physicians were improperly paid for claims that should have been rejected based on the coding initiative.

OEI; 03-02-00770

Expected Issue Date: FY 2004

Coding of Evaluation and Management Services

We will examine whether physicians accurately coded evaluation and management services, for which Medicare paid over \$17 billion in 2001. We will also assess the adequacy of controls to identify physicians with aberrant coding patterns, specifically coding disproportionately high volumes of high-level evaluation and management codes that result in greater Medicare reimbursement.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Coding of Physician Evaluation of Dialysis

We will review claims for physician evaluation during dialysis to determine the extent of any improper Medicare reimbursement due to upcoding. Procedures requiring multiple evaluations are reimbursed at a higher rate than those requiring a single evaluation. Physicians received \$115 million for single and multiple evaluations during dialysis in the first 9 months of 2001.

We will also assess the ability of controls to identify providers who bill for the higher paying codes significantly more often than their peers.

OEI; 00-00-00000

Expected Issue Date: FY 2004

“Long Distance” Physician Claims

We will review Medicare claims for face-to-face physician encounters where the practice setting and the beneficiary’s location were separated by a significant distance. While all beneficiaries may seek professional services for specialized consultation during leisure travel, those with ongoing illnesses requiring skilled care would be unlikely to travel long distances from home. We will examine these claims to confirm that services were provided and accurately reported. If warranted, we will recommend enhancements to existing program integrity controls.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Bone Density Screening

We will evaluate the impact of the recent standardization and expansion of Medicare coverage of bone density screening. Bone mineral density studies assess an individual’s risk for fracture. Before the Balanced Budget Act of 1997, coverage for bone mass measurements varied by carrier. Effective July 1998, the act standardized coverage of these tests. As the number of claims for bone density screening increases, we will determine the extent of any inappropriate payments.

OEI; 04-02-00040

Expected Issue Date: FY 2003

Billing for Chiropractic Care

We will determine the appropriateness of Medicare billings for chiropractic services. Currently, the only Medicare-reimbursable chiropractic treatment is manual manipulation of the spine to correct a subluxation. Medicare does not cover chiropractic maintenance treatments. Previous work showed that, in 1996, 759,400 Medicare beneficiaries received almost 2.9 million probable chiropractic maintenance treatments at a cost to Medicare of \$68 million. We will update the estimate of such treatments inappropriately billed to Medicare.

OEI; 09-02-00530

Expected Issue Date: FY 2003

Cataract Surgery Comanagement

We will determine if relationships between ophthalmologists and optometrists violate anti-kickback laws. The CMS established modifiers 54 and 55 to avoid duplicate payments to practitioners when the patient was unable to receive preoperative and postoperative care from the surgeon. The optometry and ophthalmology specialties account for the majority usage of these modifiers. We will assess whether optometrists referred surgical cases contingent upon the surgeon's referral of the patient back to the optometrist for postsurgical care so that the optometrist could share in the global surgical fee.

OEI; 06-02-00550

Expected Issue Date: FY 2003

Financial Arrangements Between Physicians and Ambulatory Surgical Centers

This study will determine if physician ownership in ambulatory surgical centers affects utilization and the cost of outpatient surgeries. We will evaluate whether a relationship exists between physician investments and the number of certain surgical procedures performed in comparison to national norms.

OEI; 04-00-00480

Expected Issue Date: FY 2003

Services and Supplies Incident to Physicians' Services

We will evaluate the conditions under which physicians bill "incident-to" services and supplies. Physicians may bill for the services provided by allied health professionals, such as nurses, technicians, and therapists, as incident to their professional services. Incident-to services, which are paid at 100 percent of the Medicare physician fee schedule, must be provided by an employee of the physician under the physician's direct supervision. Because little information is available on the types of services being billed, questions persist about the quality and appropriateness of these billings.

OEI; 09-02-00200

Expected Issue Date: FY 2003

Reassignment of Benefits

We will examine the use of staffing companies and the effect of this practice on emergency room physicians. We will also identify any vulnerabilities in relation to Medicare reassignment rules. Hospitals commonly contract with billing and staffing companies to handle administrative functions. Over 50 percent of the hospitals in the United States use practice management or staffing companies to administer the daily operation and coverage of emergency room departments. Under these arrangements, emergency room physicians work for the staffing companies as either employees or independent contractors. These physicians

may reassign their Medicare benefits to the staffing company only if they are employees of the staffing company.

OEI; 04-01-00080

Expected Issue Date: FY 2003

Medicare Payments to Nonphysician Practitioners

We will analyze trends in nonphysician practitioners' billings, identify the proportion of complex procedures that they perform, and assess whether they have billed for procedures not covered by their scopes of practice. Nonphysician practitioners, including nurse practitioners, clinical nurse specialists, and physician assistants, are health care providers who practice either in collaboration with or under the supervision of physicians. Nonphysician practitioners may provide Medicare Part B billable services. This study is a follow-up to our previous work in which we noted a fourfold increase in nonphysician practitioner services and identified several potential vulnerabilities.

OEI; 00-00-00000

Expected Issue Date: FY 2004

MEDICARE MEDICAL EQUIPMENT AND SUPPLIES

Medical Necessity of Wheelchairs

We will determine the appropriateness of Medicare payments for wheelchairs. We will assess whether the suppliers' documentation supports the claim, whether the item was medically necessary, and whether the beneficiary actually received the item.

OEI; 03-02-00600

Expected Issue Date: FY 2003

Payments for Enteral Nutrition

We will compare Medicare payments for enteral nutrition formulas with manufacturers' charges, wholesale prices, and prices available to members of group purchasing organizations. Medicare payments for enteral formulas totaled over \$310 million in 2001. In addition, preliminary research shows that Medicare reimbursement significantly exceeds group purchasing organization and wholesale prices for most types of enteral formulas. Bringing Medicare reimbursement rates in line with prices available to enteral formula suppliers may result in significant savings.

OEI; 02-02-00700

Expected Issue Date: FY 2003

Payments for Parenteral Nutrition

We will compare Medicare payments for parenteral nutrition formulas with manufacturers' charges, wholesale prices, and prices available to members of group purchasing organizations. Medicare payments for parenteral formulas totaled over \$119 million in 2000. In a prior study, we found that Medicare allowances for the four major parenteral nutrition codes averaged 45 percent higher than Medicaid prices, 78 percent higher than prices available to Medicare managed care organizations (MCO), and 11 times higher than some manufacturers' contract prices. Bringing Medicare reimbursement rates in line with prices available to parenteral formula suppliers may result in significant savings.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Payments for Oxygen Equipment and Supplies

We will determine whether Medicare payments for home oxygen equipment and supplies were reasonably priced and compare these payments with charges by various sources. Medicare paid over \$1.6 billion for oxygen equipment and supplies in 2001. The CMS has implemented several competitive bidding demonstration projects that include oxygen equipment and supplies, resulting in significant reductions in allowances for these products compared with local fee schedule amounts. Additionally, the Balanced Budget Act of 1997 reduced oxygen payments by 30 percent.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Payments for Therapeutic Shoes

We will determine the appropriateness of Medicare payments for diabetic footwear. In 2001, Medicare paid over \$87 million for the footwear, a sixfold increase since 1996. Our 1998 report found that suppliers were unable to provide adequate supporting documentation for 57 percent of the claims sampled and that certain suppliers increased billings by maximizing the number of custom inserts provided with the shoes. As part of our review, we will determine whether beneficiaries have used the footwear provided.

OEI; 00-00-00000

Expected Issue Date: FY 2004

MEDICARE LABORATORY SERVICES

Laboratory Proficiency Testing

We will assess laboratory compliance with Clinical Laboratory Improvement Amendments (CLIA) of 1988 requirements to participate in proficiency testing. Proficiency testing is a statutorily mandated condition of participation in which laboratories are graded for their accuracy in analyzing clinical specimens. It is one of the primary mechanisms for ensuring quality testing. Medicare pays over \$4 billion annually for clinical laboratory services, all of which must meet CLIA requirements.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Clinical Laboratory Testing Outside Certified Specialties

We will determine the extent to which Medicare paid for any testing outside the scope of a laboratory's CLIA certification. Laboratories must be certified for each specialty in which testing is conducted; however, certifying additional specialties can raise the cost of certification. Medicare currently does not compare billed testing with CLIA specialty certification before paying claims. We will compare claims with certification records to quantify any improper payments and lost CLIA certification fees, as well as evaluate existing programmatic controls.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Part B Claims for Glucose Testing

We will examine the extent to which claims for finger-stick glucose testing may have been billed as more complex testing procedures. Medicare reimbursement for glucose testing varies, depending on the test method. The cost of obtaining a CLIA certification also varies; simpler methods are substantially less expensive to certify. We will examine both Medicare and laboratory data to assess vulnerabilities.

OEI; 00-00-00000

Expected Issue Date: FY 2003

END STAGE RENAL DISEASE

Prevalence of Method II Dialysis in Nursing Homes

We will determine the extent to which nursing home and skilled nursing facility residents received home dialysis supplies from durable medical equipment suppliers rather than dialysis facilities. This benefit option, called Method II, requires a physician to certify that the beneficiary is capable of home dialysis. In nursing facilities, this raises questions about who is performing the dialysis and whether the beneficiaries are receiving adequate clinical support.

OEI; 00-00-00000

Expected Issue Date: FY 2003

Ambulance Transport for End Stage Renal Disease Beneficiaries

This study will determine whether dialysis-related ambulance claims for beneficiaries with end stage renal disease met Medicare's medical necessity guidelines. Under Medicare Part B, ambulance transport to a dialysis facility is covered only if other forms of transport would endanger the beneficiary's health. Persons receiving outpatient dialysis treatments are not ordinarily ill enough to require an ambulance.

OEI; 05-02-00590

Expected Issue Date: FY 2003

MEDICARE DRUG REIMBURSEMENT

Payments for Non-End Stage Renal Disease Epoetin Alfa

We will determine the appropriateness of Medicare payments for epoetin alfa used by beneficiaries who have not been diagnosed with end stage renal disease. In 2001, Medicare paid over \$800 million for epoetin alfa, nearly four times more than the \$212 million paid in 1998. We will conduct a medical review based on supporting documentation to determine whether the drug was medically necessary, administered in the proper manner, and provided for an indicated usage.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Allergy Treatments

We will determine if beneficiaries received medically necessary allergy treatment in accordance with Medicare requirements. Medicare allowed approximately \$148 million for

allergen immunotherapy codes and related services in 2000. In a recent probe medical review, the reviewers found that allergen immunotherapy treatment was medically inappropriate in 12 of 18 cases. Inappropriateness was often based on the length of treatment or the presence of strong contraindications, which greatly increased the risk of adverse reaction to the treatment. In addition, the majority of the claims were either inadequately documented or medically unnecessary.

OEI; 09-00-00531

Expected Issue Date: FY 2004

OTHER MEDICARE SERVICES

Beneficiaries' Experiences With Medigap Insurance

This study will examine beneficiary access to and experiences with Medigap insurance. Many beneficiaries purchase supplemental insurance policies, referred to as Medigap policies, to cover items and charges not covered by the Medicare program. The Federal Government regulates and sets policies on this insurance. As part of our study, we will assess the factors that influence a beneficiary's decision to purchase a Medigap policy, such as affordability and available pricing and premium information.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medicare Payments in Outpatient Settings

We will determine the extent to which payments for the same procedure codes vary between hospital outpatient departments and ambulatory surgical centers and assess the effect of this variance on the Medicare program. Our reports in the early 1990s documented that Medicare was paying higher rates in outpatient departments than in ambulatory surgical centers for the same procedure codes. The Congress subsequently made a number of payment reductions for services in outpatient departments.

OEI; 05-00-00340

Expected Issue Date: FY 2003

Hospice Payments and Plans of Care

This follow-up study will examine the financial implications of Medicare hospice payments made on behalf of beneficiaries residing in nursing facilities. Our previous work found that such payments may be excessive. When a patient is entitled to both Medicare and Medicaid, the nursing home no longer bills the state Medicaid program for the patient's long term care. Instead, the nursing home bills and receives payment from the hospice, and the hospice bills both Medicare and Medicaid. Medicaid payments are for room and board and are in addition to

Medicare's daily fixed rate paid to the hospice. For private pay patients, Medicare pays the hospice and the resident continues to pay the nursing facility directly. This study will focus on private pay patients and assess whether patients are receiving care in accordance with their plans of care.

OEI; 05-02-00570

Expected Issue Date: FY 2004

Medicare Payments for Clinical Trials

This review will determine whether Medicare payments associated with clinical trials were made in accordance with program requirements. After the President issued an executive memorandum in June 2000, Medicare began to cover the routine health care costs of beneficiaries in clinical trials. Our review will examine whether Medicare is making payments associated with noncovered aspects of clinical trials and whether Medicare billing systems have adequate controls to identify and monitor the appropriateness of these payments.

OEI; 09-02-00360

Expected Issue Date: FY 2003

Independent Diagnostic Testing Facilities

We will review the appropriateness of Medicare payments to independent diagnostic testing facilities. These facilities (formerly known as independent physiological laboratories) may be fixed-location or mobile entities that are independent of a hospital or a physician's office. Medicare covers diagnostic tests performed by such facilities when the services are medically necessary and satisfy certain criteria regarding, among other things, physician supervision and the qualifications of nonphysician personnel.

OAS; W-00-02-35066; A-03-02-00017

Expected Issue Date: FY 2003

New Payment Provisions for Ambulance Services

We will determine whether payments for ambulance services complied with new Medicare reimbursement regulations. The Balanced Budget Act of 1997 required CMS to implement a national fee schedule covering seven levels of service intensity for ground transport and two levels for air transport. The fee schedule is being phased in over the 5 years that began in April 2002. By reviewing billing and medical record documentation, we will determine whether ambulance companies billed Medicare for the appropriate level of service intensity.

OAS; W-00-03-35076; A-01-03-00000

Expected Issue Date: FY 2004

Nonemergency Ambulance Payments

We will determine whether Medicare claims for nonemergency ambulance transportation met medical necessity guidelines and identify the procedures used to prevent or detect payment of claims that do not meet these guidelines. Medicare covers both scheduled and unscheduled nonemergency ambulance services if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. With certain exceptions, a signed certification by the beneficiary's attending physician is required.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Intraocular Lens Reimbursement in Ambulatory Surgical Centers

We will determine whether Medicare reimbursement for intraocular lenses is reasonable and relates to the cost of acquiring the lenses in ambulatory surgical centers. The Congress reduced reimbursement for intraocular lenses in 1994. Although that legislation expired in 1999, CMS has not surveyed ambulatory surgical centers to determine the reasonableness of costs. Medicare paid \$120 million for intraocular lenses in 2001.

OEI; 06-02-00710

Expected Issue Date: FY 2003

Nail Debridement Services

This study will determine the underlying reasons why Medicare carriers made inappropriate payments for nail debridement services. We recently estimated that 23 percent of nail debridement claims, or \$51 million, did not have adequate medical justification to support Medicare payment. In 2000, Medicare paid \$233 million for nail debridement services. This study will also assess the adequacy of CMS policy on these services and carriers' consistency in applying the policy.

OEI; 04-99-00461

Expected Issue Date: FY 2003

MEDICARE MANAGED CARE

Adjusted Community Rate Proposals

This review will determine whether modifications of the 2001 adjusted community rate proposals were properly supported. Under the Benefits Improvement and Protection Act of 2000, MCOs may make one or more of the following changes to the proposals: reduce

beneficiary premiums; reduce beneficiary cost sharing; enhance benefits; put additional payment amounts received after March 1, 2001 in a benefit stabilization fund; or use additional payment amounts to retain providers (stabilize access) or expand the provider network (enhance access), as long as this stabilization or enhancement does not result in increased premiums, increased cost sharing, or reduced benefits.

We will verify documentation that MCOs used the additional payments in accordance with the act. We will also determine if changes in adjusted community rate values to reflect updated per-member-per-month cost, utilization, and membership assumptions were appropriately documented.

OAS; W-00-02-35041/35042; Various CINs

Expected Issue Date: FY 2003

Follow-up on Adjusted Community Rate Proposals

This review will examine CMS's actions to resolve the problems identified in prior audits of adjusted community rate proposals and remedies to ensure that future proposals are accurate and that repayments or enhanced benefits are provided to account for audit findings. Under the Balanced Budget Act of 1997, CMS is required to audit at least one-third of the adjusted community rate proposals of the MCOs participating in the Medicare+Choice program each year. With the start of FY 2003, audits covering 3 years should be completed. Errors in the proposals, identified during the audits, may affect Medicare beneficiaries' additional benefits or reduced cost-sharing amounts.

OAS; W-00-03-35077; Various CINs

Expected Issue Date: FY 2003

Intraorganization Transfers

This review will examine the indirect costs included in the administrative cost component of adjusted community rate proposals to determine whether the costs and the allocation method were reasonable and supportable. The review will focus on the indirect cost allocation methodology and related-party costs assessed by MCOs' corporate offices. Specifically, we will determine whether related-party costs within the proposals represented actual costs to the related party and were distributed on the basis of a reasonable allocation.

OAS; W-00-02-35052; A-06-01-00033

Expected Issue Date: FY 2003

Marketing Practices by Managed Care Organizations

We will examine the marketing methods used by MCOs to attract and enroll beneficiaries. The CMS prohibits discriminatory marketing activities that include selectively enrolling beneficiaries through monetary inducements, soliciting enrollment door-to-door, and using

providers to distribute or accept plan materials. Our prior study found that 43 percent of beneficiaries were asked about health problems when applying with an MCO. This study will identify any suspected violations of marketing standards that may support selective enrollment of healthier enrollees.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Managed Care Encounter Data

This review will determine the accuracy of Part A encounter data on Medicare beneficiaries, which MCOs are required to submit. The CMS uses the data to develop a portion of each organization's monthly capitation rate. The portion of the monthly rate that relates to the encounter data is the risk-adjusted portion, which comprises 10 percent of the rate. The risk-adjusted portion will eventually comprise 100 percent of the monthly rate. Thus, incorrect or incomplete encounter data could have a significant impact on future Medicare reimbursement.

OAS; W-00-03-35078; Various CINs

Expected Issue Date: FY 2003

Cost-Based Managed Care Plans

At CMS'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 CMS currently contracts with more than 30 of these plans, which provide services to more than 300,000 members. The plans file cost reports with CMS 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. Our review, which we will coordinate with CMS and its contractors, will also determine whether cost-based plans received any duplicate payments through the fee-for-service program.

OAS; W-00-00-35012; Various CINs

Expected Issue Date: FY 2003

Enhanced Managed Care Payments

We will complete several reviews to determine whether CMS made proper enhanced capitation payments to MCOs. Medicare provides enhanced capitation payments for beneficiaries who are institutionalized, in end stage renal disease status, or dually eligible for Medicare and Medicaid. Our reviews are focused on the accuracy of controls at both CMS and the MCOs regarding special status categories warranting these enhanced payments.

OAS; W-00-02-35054/35071; Various CINs

Expected Issue Date: FY 2003

Managed Care Additional Benefits

This review will analyze the cost to Medicare MCOs for providing additional benefits to beneficiaries and determine the extent to which beneficiaries receive such benefits. Additional benefits, which are provided to beneficiaries as part of their basic Medicare benefit package, vary among MCOs. Our review will also determine whether the value of additional benefits, as presented in adjusted community rate proposals, is consistent with the benefits actually provided.

OAS; W-00-02-35040; A-06-00-00073

Expected Issue Date: FY 2003

MEDICARE CONTRACTOR OPERATIONS

Preaward Reviews of Contract Proposals

At the request of the CMS contracting officer, we will review the cost proposals of various bidders for Medicare contracts. The reports produced by these reviews should assist CMS in negotiating favorable and cost-beneficial contract awards.

OAS; W-00-03-35002; A-00-03-00000

Expected Issue Date: FY 2003

CMS Oversight of Contractor Evaluations

This study will evaluate CMS oversight of the Contractor Performance Evaluation process, which is intended to monitor contractor performance. We will review contractor evaluation findings and recommendations, as well as carrier corrective actions. We will also determine whether the evaluation process is an effective mechanism for monitoring contractor performance and assess the effectiveness of contractor performance improvement plans.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Handling of Beneficiary Inquiries

We will assess Medicare carriers' handling of beneficiary inquiries and complaints. Carriers receive nearly 15 million calls from beneficiaries annually. Our previous work identified some beneficiary problems with access to and accuracy of information. We will evaluate the accuracy of information provided by carriers and assess beneficiary satisfaction with carrier services.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Provider Education and Training by Carriers

We will examine Medicare carriers' efforts to educate and train providers. The CMS funds provider education, a significant part of carrier budgets, to reduce payment errors and Medicare program losses. We will assess provider education from the standpoint of carriers, CMS, and providers.

OEI; 02-02-00760, 02-02-00820

Expected Issue Date: FY 2003

Payments for Ineligible Aliens and Deported Individuals

We will expand our prior work on deported beneficiaries to assess the adequacy of controls over Medicare payments made on behalf of (1) individuals who, although not formally deported, have been expelled through other processes and (2) ineligible aliens who are not lawfully present in the United States. We will quantify the extent of such payments and, if warranted, recommend actions to preclude future unallowable payments.

OAS; W-00-03-35003; A-04-03-00000

Expected Issue Date: FY 2003

Suspension of Payments to Providers

We will assess the extent to which suspension of payments to Medicare providers has been used as a tool to recoup Medicare monies and compliance with program rules. Medicare allows contractors to suspend payment under several procedures, depending on the reason for the action. We will examine any variation in procedures among contractors, the impact of suspension on providers, and the efficacy of suspension in protecting the Trust Fund.

OEI; 07-02-00620

Expected Issue Date: FY 2003

Contractors' Administrative Costs

As requested by CMS, we will review 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 CMS staff.

OAS; W-00-02-35005; Various CINs

Expected Issue Date: FY 2003

Medicare Data Center Claim Processing Costs

We will determine whether the processing costs charged by a claim processing data center were reasonable, allowable, and allocable and met contractual conditions. Several Medicare contractors act as Medicare claim processing data centers for other Medicare contractors (users) through subcontractual arrangements known as interplan operating agreements. Under the agreements, processing fees charged by the data centers are to be based on costs and billed on a per-claim basis. User contractors include the amounts paid to the data centers as part of their administrative cost submissions to CMS. Thus, CMS pays 100 percent of the claim processing costs.

OAS; W-00-03-35005; A-09-03-00000

Expected Issue Date: FY 2003

Postretirement Benefits and Supplemental Employee Retirement Plans

At CMS's request, we will review the postretirement benefits and/or supplemental employee retirement plans of Medicare fiscal intermediaries and carriers. Our review will determine the allowability, allocability, and reasonableness of the benefits and plans as well as the costs charged to Medicare contracts.

OAS; W-00-03-35067; Various CINs

Expected Issue Date: FY 2003

Segment Closing/Costs Claimed

At CMS's request, we will determine whether Medicare contractors 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 used a reasonable method for claiming reimbursement for pension costs under their Medicare contracts.

OAS; W-00-02-35067; Various CINs

Expected Issue Date: FY 2003

Pension Termination

At CMS's request, we will review Medicare carriers and fiscal 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 Medicare contracts provide that pension gains that occur when a Medicare segment closes should be credited to the Medicare program.

OAS; W-00-02-35067; Various CINs

Expected Issue Date: FY 2003

MEDICAID HOSPITALS

Medicaid Graduate Medical Education Payments

This review will examine Medicaid graduate medical education payment programs, the coordination of these payments with Medicare graduate medical education payments, and the existence and effectiveness of CMS safeguards and controls over the payment process. Although these Medicaid payments are not specifically authorized by Medicaid statute, CMS has approved a wide range of payment arrangements through the state plan amendment process and 1115 waivers. Annual payments by state Medicaid programs for graduate education are estimated to total over \$3 billion.

OAS; W-00-02-31018; Various CINs

Expected Issue Date: FY 2003

Hospital-Specific Disproportionate Share Payment Limits

At CMS's request, we are reviewing 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 FYs beginning in 1994 and 1995 for public and private hospitals, respectively. The CMS 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 payment limits.

OAS; W-00-02-31001; Various CINs

Expected Issue Date: FY 2003

Medicaid Diagnosis-Related Group Payment Window

This review will determine whether prospective payment system hospitals submitted Medicaid claims for inpatient-stay-related laboratory and other services within 3 days of hospital admission and the potential cost savings that would result from state prohibition of this practice. Several previous reviews found that hospitals had improperly submitted separate Medicare billings for inpatient-stay-related laboratory and other services performed within 3 days of admission. Such billings are prohibited by Medicare regulations because the costs of these services are already included in each hospital's diagnosis-related group discharge rate. We will determine if this condition exists in state Medicaid programs that have regulations similar to those of the Medicare program.

OAS; W-00-03-31038; A-00-03-00000

Expected Issue Date: FY 2003

Medicaid Hospital Patient Transfers

This review will examine the propriety of Medicaid claims for hospital patient transfers in states that use prospective payment principles in reimbursing hospitals for inpatient admissions. In these states, the payment policy stipulates that when a 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. This review is an extension of a previous Medicare review that identified significant overpayments as a result of incorrectly reported transfers.

OAS; W-00-02-31023; Various CINs

Expected Issue Date: FY 2003

Medicaid Outpatient Hospital Payments

This study will identify any Medicaid expenditures for outpatient hospital services that were either unnecessary or unsupported. States are given flexibility to define medical necessity and determine when services do not meet their definition. However, it is CMS's role to ensure that federal outlays are directed toward medically appropriate services in the Medicaid program. We will examine the extent of any inappropriate Medicaid payments and the potential impact on federal Medicaid outlays.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Credit Balances in Inpatient Accounts

This national review will determine whether credit balances in Medicaid beneficiary inpatient accounts at hospitals have been identified and returned to the appropriate state agencies. We will build upon recent work in one state and reviews performed in the early 1990s.

OAS; W-00-02-31022; Various CINs

Expected Issue Date: FY 2003

MEDICAID NURSING HOMES

Medicaid Payments to Skilled Nursing Facilities for Medicare-Covered Services

We will determine if any Medicaid payments were made for skilled nursing facility care covered and paid for by Medicare. Preliminary information indicates that several state Medicaid agencies may lack controls to prevent duplicate Medicare and Medicaid payments for

services provided to dually eligible beneficiaries. We will determine if this control weakness exists in other states and the financial impact on the Medicaid program.

OAS; W-00-03-31039; A-06-03-00000

Expected Issue Date: FY 2003

Payments to Public Nursing Facilities

We will determine the adequacy of Medicaid payments to public nursing facilities in states that have enhanced payment programs for such facilities. Focusing on those facilities that have been identified as providing low quality of care, we will determine if such care resulted from inappropriately spent Medicaid payments or from Medicaid payment rates that were not adequate to support higher quality of care. If we find that the rates were inadequate, we will determine if enhanced Medicaid payments remained at the nursing facilities or were returned to the states through intergovernmental transfers. During prior reviews of upper payment limits, we identified millions of dollars in Medicaid payments that had been returned by public nursing facilities to state governments through intergovernmental transfers.

OAS; W-00-02-31030; A-02-02-01020

Expected Issue Date: FY 2003

Payments for Ancillary Services in Nursing Homes

We will determine the appropriateness of Medicaid payments to providers of ancillary services in nursing homes. According to Medicaid payment policy, nursing homes are paid a per diem rate to provide 24-hour nursing care to each Medicaid-eligible resident. In some states, the Medicaid nursing home reimbursement rate also covers numerous ancillary services, such as pharmacy, dental, and restorative therapy services. Nursing homes either deliver these services directly or contract with ancillary service providers. If Medicaid pays separately for a resident's ancillary services, it may be paying twice for the same service.

OAS; W-00-02-31031; A-02-02-01025

Expected Issue Date: FY 2003

Nursing Facility Administrative Costs

This national review will determine whether nursing facilities that participate in the Medicaid program claimed unallowable or highly questionable administrative expenses. Prior OIG work identified a nursing facility chain that falsely inflated the administrative expenses claimed for reimbursement on cost reports. Improper expenses included salaries and benefits for "ghost" employees, personal automobile expenses, and other expenditures that were unrelated to nursing facility operations.

OAS; W-00-02-31020; Various CINs

Expected Issue Date: FY 2003

Nursing Facility Staffing Requirements and Waivers

This review will determine if CMS should prevent states from waiving the current federal staffing requirements for nursing facilities. The focus will be on determining if nursing homes' staffing levels and quality of care are linked, i.e., if there is a difference between the quality of care offered at facilities with staffing levels that are higher than, equal to, and lower than the federal requirements.

OAS; W-00-02-31037; A-03-02-00205

Expected Issue Date: FY 2003

Nursing Home Quality-of-Care Sanctions

This review will determine if nursing homes cited for substandard care have complied with the CMS prohibition on admitting new patients and whether state controls are adequate to prevent improper Medicaid payments for such new patients. As a penalty for failing to meet quality-of-care standards, CMS sanctions nursing homes, forbidding them to admit new Medicaid patients either for a designated period or until the provider meets the standards. We will determine if selected sanctioned nursing homes admitted new Medicaid patients during the sanction period and were paid for the days related to those new patients. We will also explore alternative measures for enforcing nursing home compliance with quality-of-care standards.

OAS; W-00-03-31040; A-04-03-00000

Expected Issue Date: FY 2003

MEDICAID MANAGED CARE

Marketing and Enrollment Practices by Medicaid Managed Care Entities

We will determine whether managed care entities used appropriate marketing and enrollment practices for Medicaid beneficiaries. Under the Balanced Budget Act of 1997, managed care entities may not distribute marketing materials without prior state approval; may not distribute false or misleading information; must distribute marketing materials within the entire service area specified in their contract; and may not conduct door-to-door, telephone, or other cold-call marketing practices.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Public-Sponsored Managed Care Health Plans

This review of the funding arrangements between states and public-sponsored health plans will determine to what extent intergovernmental transfers or other financing mechanisms have been used to maximize federal Medicaid reimbursement. States are developing managed care

programs for special populations (e.g., mentally ill and developmentally disabled people) by contracting exclusively with public-sponsored health plans.

OAS; W-00-02-31019; Various CINs

Expected Issue Date: FY 2003

Managed Care Payments as Part of the Fee-for-Service Upper-Payment-Limit Calculation

We will determine whether states have expanded their Medicaid upper-payment-limit financing arrangements by applying fee-for-service upper payment limits to managed care payments. Traditional Medicaid fee-for-service payments and Medicaid managed care payments are subject to separate upper payment limits. If a state pays an MCO to assume the risk of caring for Medicaid patients, the payments and beneficiary days should not be included in determining aggregate payment limits under the fee-for-service upper-payment-limit regulations.

OAS; W-00-03-31015; A-05-03-00000

Expected Issue Date: FY 2003

MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Adolescent Enrollment in Medicaid/State Children's Health Insurance Program

We will determine the extent to which states have enrolled eligible adolescents in the state Medicaid program and the State Children's Health Insurance Program (SCHIP). Medicaid has extended eligibility to 19 years of age for children born after September 30, 1983, who are living at or below 100 percent of poverty. Under SCHIP, states have the option to provide coverage to all eligible children or a focused segment of children under age 19 who are at or below 200 percent of the federal poverty level. Despite these opportunities, a 1999 American Academy of Pediatrics study projected that in 2000 nearly 2.4 million, or one in six, adolescents aged 13 through 18 would be eligible for but not enrolled in Medicaid or SCHIP. This population has a higher rate of uninsurance than most age groups in the United States. We will assess the challenges and vulnerabilities in reaching this population.

OEI; 05-02-00370

Expected Issue Date: FY 2003

Preventing Medicaid Eligibles From Enrolling in the State Children's Health Insurance Program

We will determine whether states have enrolled Medicaid-eligible children in SCHIP. The Balanced Budget Refinement Act of 1999 requires that OIG examine this issue every 3 years. We issued the first of these studies in February 2001. As mandated by the act, we took our

sample from those states that operate separate SCHIP programs and concluded that Medicaid-eligible children were not being enrolled in SCHIP. We will expand the scope of our follow-up study to include an examination of enrollment experiences in a sample of states that use the other two SCHIP models.

OEI; 00-00-00000

Expected Issue Date: FY 2004

State Children's Health Insurance Renewal Process

We will examine the states' SCHIP renewal process and identify opportunities for improvement. The CMS reports that more than 4.6 million children who would otherwise be without health insurance coverage are enrolled in SCHIP. Despite this progress, many eligible children still lack health care coverage. A July 2001 report by the Urban Institute indicated that 18 percent of low-income children who were uninsured at the time of the survey had been enrolled in Medicaid or SCHIP in the past year but had dropped out. Numerous states documented in their annual reports that many parents never responded to the SCHIP renewal notices, and thus many children were disenrolled at renewal time. We will examine the barriers that parents encounter as they negotiate this process.

OEI; 06-01-00370

Expected Issue Date: FY 2003

Duplicate Claims for Medicaid and State Children's Health Insurance Program

We will determine if states have obtained federal funds under both the Medicaid program and SCHIP for services provided to the same beneficiary. Preliminary information obtained in one state indicates that the state Medicaid agency may have claimed federal funding through both programs for services provided to the same beneficiary. We will determine if this situation exists in other states and the financial impact of the problem.

OAS; W-00-03-31041; A-00-03-00000

Expected Issue Date: FY 2003

State Children's Health Insurance Program Disenrollment Data System

We will determine if states have complied with regulations requiring the collection of valid data on SCHIP disenrollment and how effectively they have incorporated this information into their disenrollment data system. States are required to report disenrollment data to CMS on a quarterly basis. The data are important to the Secretary, policy makers, and the Congress in evaluating the effectiveness and efficiency of SCHIP. Invalid information results in an inaccurate measure of disenrollment and potentially an inaccurate measure of the number of uninsured children in the United States. We will examine how CMS and states use these data

to improve the effectiveness and efficiency of their efforts to insure uninsured children and highlight any vulnerabilities in the process.

OEI; 06-01-00371

Expected Issue Date: FY 2003

State Children's Health Insurance Program: State Evaluation Reports

This follow-up study will assess states' evaluations of their SCHIP performance goals, particularly those focused on reducing the number of uninsured children. The Balanced Budget Refinement Act of 1999 requires that OIG make this assessment every 3 years. Our first study, issued in February 2001, found that questionable evaluations undermined the reliability of state reports of success and that the evaluations demonstrated technical and conceptual weaknesses. We recommended that CMS develop a more specific framework for the content and structure of the state reports and that CMS and the Health Resources and Services Administration provide guidance and assistance to states in conducting useful evaluations.

OEI; 00-00-00000

Expected Issue Date: FY 2004

MEDICAID DRUG REIMBURSEMENT

State Strategies to Control Prescription Drug Costs

We will review state-initiated efforts to control the cost of Medicaid prescription drugs. Spending for these drugs has increased 14.8 percent annually. Facing escalating drug costs that are straining their Medicaid budgets and the budgets of their residents, states have taken measures to control costs. Thirty-one states have enacted or authorized legislation to reduce prescription drug costs through discount programs, bulk purchasing programs, expanded manufacturer rebates, price controls, and the use of pharmaceutical benefit managers. A review of these programs and activities will provide invaluable insights into the most effective, innovative cost containment measures available to the Medicaid program at the state level.

OEI; 05-02-00680

Expected Issue Date: FY 2004

Medicaid Drug Utilization

We will determine how effectively states have implemented Drug Utilization Review programs. The Omnibus Budget Reconciliation Act of 1990 requires states to establish these programs to monitor and control the cost of prescription drugs. States are required to provide for prospective review of drug therapy before prescriptions are filled and retrospective review through drug claim processing and information retrieval systems. We will evaluate those

prepayment and postpayment controls and outcomes. Medicaid expenditures for prescribed drugs rapidly increased from \$12.4 billion in 1995 to \$21 billion in 2000.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medicaid Drug Rebate Program

We will analyze the effect of new versions of existing drugs on the Medicaid drug rebate program. Part of the rebate calculation for brand name drugs is based on an inflation adjustment. The rebate is the amount by which the current average manufacturers' price for a drug exceeds the base average manufacturers' price, indexed to the consumer price index for urban consumers from the time a drug enters the market. Under current rules, a manufacturer could change a drug slightly (e.g., change the color) to obtain a new national drug code, resulting in a new start for indexing purposes. We will calculate the increase in rebates that would result from decreasing the base price for new versions of drugs by an amount equal to the percentage increase above the consumer price index for the earliest version of the drugs.

OAS; W-00-03-31010; A-06-03-00000

Expected Issue Date: FY 2003

Medicaid Drug Rebates—Computation of Average Manufacturer Price and Best Price

We will evaluate the adequacy of drug manufacturers' methodologies for computing average manufacturer price (AMP) and best price. Both the AMP and the best price reported to CMS by manufacturers are used in determining the drug rebates paid to states. Any inaccuracies in the amounts reported can significantly affect rebate amounts. Our prior reviews showed that drug manufacturers did not consistently define the retail class of trade in their AMP computations.

OAS; W-00-03-31042; A-06-03-00000

Expected Issue Date: FY 2003

Medicaid Rebates for Physician-Administered Drugs

This study will examine whether state Medicaid agencies have received the appropriate rebates for physician-administered drugs. Certain injectable and infusion drugs administered by physicians are often billed on a Medicare claim form and identified using the CMS Common Procedure Coding System rather than national drug codes. Because rebates are based on product-specific national drug codes, it is difficult for states to obtain rebates for drugs billed via the Common Procedure Coding System. We will determine the financial impact on the Medicaid program due to any uncollected rebates for physician-administered drugs.

OEI; 03-02-00660

Expected Issue Date: FY 2003

Medicaid Drug Rebate Collections

This review will determine the amount of uncollected drug rebates that states have billed to drug manufacturers. In order for a manufacturer's drugs to be eligible for reimbursement by state Medicaid programs, the manufacturer is required to enter into a rebate agreement with CMS and pay quarterly rebates to states. Our reviews in the early 1990s found large amounts of rebates in dispute; as a result, CMS established a dispute resolution team to aid the states and drug manufacturers in settling disputes. Recent information indicates that large amounts of drug rebates remain uncollected due to disputes by drug manufacturers.

OAS; W-00-03-31043; A-06-03-00000

Expected Issue Date: FY 2003

Pricing Drugs in the Federal Upper Limit Program

We will examine how CMS administers the Federal Upper Limit Program for drugs covered under Medicaid. In 1987, the Congress created the Federal Upper Limit Program to limit the amount that Medicaid could reimburse for generic drugs and ensure that the Federal Government acts as a prudent buyer. The Omnibus Budget Reconciliation Act of 1990 expanded the criteria and permitted the establishment of a Federal Upper Limit for a drug if at least three generic versions are rated therapeutically equivalent and at least three suppliers are listed in the current editions of published national compendia. Our previous studies indicated that the published Federal Upper Limit prices often did not reflect true market prices, costing the Medicaid program millions of dollars.

OEI; 03-02-00670

Expected Issue Date: FY 2003

“Dead Net” Acquisition Cost Paid by Chain Pharmacies

We will identify the average net purchase price paid by large chain pharmacies for both brand name and generic products in relation to average wholesale price. Chain pharmacies may receive substantial discounts, rebates, etc., that are not reflected on their purchase invoices, especially for generic drugs. The industry's terminology for the final price after all discounts is “dead net.” Our previous reviews of both independent and chain pharmacies generally addressed only the prices shown on the invoices.

OAS; W-00-03-31044; A-06-03-00000

Expected Issue Date: FY 2003

Mental Health Drugs

We will compare the amounts that Medicaid reimburses for mental health drugs with the prices paid by other government purchasers. The rising cost of mental health pharmaceuticals presents a budgetary challenge to state Medicaid programs. Although many states have

mandatory managed care plans in place for the mentally ill, states typically exclude coverage of prescription mental health drugs from their managed care contracts because of the difficulties in accurately setting capitation rates for those benefits. Therefore, most beneficiaries receive their prescription drugs through Medicaid's traditional fee-for-service system. We will identify the most frequently prescribed mental health drugs and determine whether Medicaid is paying appropriate prices for them.

OEI; 05-02-00080

Expected Issue Date: FY 2003

Schedule II Controlled Substance Prescriptions

This study will examine state Medicaid agencies' efforts to monitor, detect, prevent, and correct improper Medicaid expenditures for controlled substance prescriptions listed in Schedule II of the Controlled Substances Act. The act lists certain legal and illegal substances and drugs that are monitored by the Drug Enforcement Administration. Schedule II substances, such as OxyContin, have a high potential for abuse, which may lead to severe physical or psychological dependence.

OEI; 03-01-00650

Expected Issue Date: FY 2003

OTHER MEDICAID SERVICES

Medicaid Waiver Programs

We will review state documentation to assess the cost effectiveness of Medicaid waiver projects. State Medicaid agencies may seek CMS approval of such projects to expand coverage, access, and services for certain groups of indigent or disabled people or to change the ways in which services are provided. Although certain Medicaid rules are waived for an approved waiver project, the project must be cost effective in that expenditures must not exceed what would be expended in the absence of the waiver.

OAS; W-00-02-31036; A-09-02-00082

Expected Issue Date: FY 2003

Payments for Services to Dually Eligible Beneficiaries

This follow-up study will determine whether Medicaid and Medicare adequately coordinate the identification and collection of improper payments for beneficiaries who are dually eligible for both programs. 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 coinsurance. A 1995 OIG report found that states did not review the appropriateness or necessity of payments for dually eligible beneficiaries.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees

We will determine the appropriateness of Medicaid fee-for-service payments for services provided to dually eligible beneficiaries enrolled in Medicare risk-based MCOs. These organizations are required to provide all Medicare-covered services in exchange for the capitation payments they receive. Most MCOs elect to offer additional benefits, such as dental services, eyeglasses, prescription drugs, deductibles, and coinsurance amounts, that are not available under the Medicare fee-for-service program. 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 MCO.

OAS; W-00-02-31007; Various CINs

Expected Issue Date: FY 2003

Contingency Fee Payment Arrangements

We will determine the extent to which state Medicaid agencies have contracted with consultants through contingency fee payment arrangements and the impact of these arrangements on the submission of questionable or improper claims to the Federal Government. Some state Medicaid agencies use consulting firms to help identify ways to maximize federal Medicaid reimbursement. In some cases, the states pay the consulting firms a percentage of the increase in federal Medicaid funding.

OAS; W-00-03-31045; A-00-03-00000

Expected Issue Date: FY 2003

Upper-Payment-Limit Calculations

We will determine how state enhanced payments have been affected by CMS's March 2001 revised regulations. States have the flexibility to pay different rates to the same class of providers, such as hospitals or nursing facilities, as long as the payments, in aggregate, do not exceed the upper payment limits (what Medicare would have paid for the services). The revised CMS regulations include three separate aggregate limits—one each for private, state-operated, and city/county-operated facilities. Federal funds are not available for expenditures that exceed these limits. Our review will also determine whether state Medicaid agencies

correctly calculated Medicare upper payment limits and what the limits would have been if the states had used cost data in their calculations.

OAS; W-00-03-31002; A-00-03-00000

Expected Issue Date: FY 2003

Intergovernmental Transfers

We will analyze the extent to which states use intergovernmental transfers as a means of increasing federal Medicaid matching funds. Our prior work involving upper payment limits and DSH payments showed, in some cases, that public providers returned Medicaid funds to state agencies through the use of intergovernmental transfers. Once returned, the funds could be used for purposes unrelated to the Medicaid program. We will determine whether federal Medicaid payments other than those available under upper payment limits and DSH payments were returned to states through intergovernmental transfers.

OAS; W-00-02-31016; A-04-02-02010

Expected Issue Date: FY 2003

Distribution of Medicaid Funds by Nongovernmental Organizations

We will determine the extent to which nongovernmental organizations have distributed Medicaid funding and the financial impact on the Medicaid program. During prior work, we identified several states where nongovernmental organizations were involved in the distribution of Medicaid funds to providers. We will determine if all of the Medicaid funds were distributed to Medicaid providers or if funds remained with the nongovernmental organizations for other uses.

OAS; W-00-03-31046; A-00-03-00000

Expected Issue Date: FY 2003

Claims for Residents of Institutions for Mental Diseases

Our review will determine whether states improperly claimed federal Medicaid funds for 21- to 64-year-old residents of institutions for mental diseases. Our prior work found that some state Medicaid agencies did not comply with federal regulations prohibiting federal funding for services provided to such patients.

OAS; W-00-02-31003-31006; Various CINs

Expected Issue Date: FY 2003

Home Health Payments

This study will identify any Medicaid expenditures for home health services that were either unnecessary or unsupported. States are given flexibility to define “medical necessity” and determine when services do not meet their definitions. As part of the Medicaid federal/state

partnership, CMS's role is to ensure that federal outlays are directed toward medically appropriate services. We will also examine the ability of controls to detect inappropriate Medicaid payments.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Coding of Medicaid Physician Services

We will analyze claims to determine whether Medicaid can potentially save money by eliminating duplicate physician services. The CMS uses the National Correct Coding Initiative to detect and correct improper coding in Medicare. The initiative is designed to provide Medicare carriers with code pair edits for use in evaluating claims and to ensure that physicians are not improperly paid for services included in the designated edits. Using Medicaid Statistical Information System data, we will analyze Medicaid claims against the code pairs to identify potential Medicaid savings.

OEI; 03-02-00790

Expected Issue Date: FY 2004

Payments for Inmates of Public Institutions

We will evaluate the extent to which states used federal Medicaid funds to pay for health care services provided to inmates and the nature of those payments. Our work involving DSH payments showed that several states had included the cost of providing health services to inmates in the calculation of uncompensated care costs. We will examine current CMS policy regarding the appropriateness of both federal financial participation and DSH payments for health care services provided to inmates.

OAS; W-00-02-31014; Various CINs

Expected Issue Date: FY 2003

Durable Medical Equipment Reimbursement Rates

This review will determine the extent to which Medicaid payments for durable medical equipment exceeded allowable Medicare rates. Since the beginning of FY 1998, one state's federal share of payments to equipment providers has exceeded the allowable rates by \$8 million. Both the state statute and the state Medicaid plan prohibit Medicaid equipment payments that exceed allowable Medicare rates. These excess payments occurred because the state improperly based reimbursement rates on the 1993 Medicare fee schedule, rather than on the Balanced Budget Act of 1997, which significantly reduced some Medicare reimbursement rates. We will expand our audit work to other states that cite the Medicare fee schedule in their state plans or that have legislation requiring the use of the schedule.

OAS; W-00-02-31008; Various CINs

Expected Issue Date: FY 2003

School-Based Health Services

We will determine whether Medicaid payments for school-based health services were in accordance with applicable laws and regulations. States are permitted to use their Medicaid programs to help pay for certain health care services delivered to children in schools, such as physical and speech therapy. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach, application assistance, and coordination and monitoring of health services. Some of this work was requested by CMS.

OAS; W-00-02-31017; Various CINs

Expected Issue Date: FY 2003

Personal Care Services

We will identify any Medicaid expenditures for personal care services that were either unnecessary or unsupported and determine the potential impact on federal Medicaid outlays. While the personal care services benefit has been available since at least the early 1970s, the Medicaid statutory basis was clarified in 1993. Subsequent CMS regulations allowed states a great deal of flexibility in how they provide the services and monitor program quality. In 2001, payments for these services totaled \$5.3 billion.

OEI; 09-02-00740

Expected Issue Date: FY 2004

Chiropractic Benefits for Children Under the Early and Periodic Screening, Diagnosis, and Treatment Program

This study will determine the extent of any inappropriate chiropractic services provided to children under the Early and Periodic Screening, Diagnosis, and Treatment Program and examine the adequacy of controls to prevent any unnecessary care. Some states allow Medicaid beneficiaries to directly access chiropractic services without a physician referral or prior authorization.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Payments for Services to Deceased Beneficiaries

In selected states, we will determine whether providers billed and were reimbursed for Medicaid services that occurred after beneficiaries' dates of death. One state auditor's review determined that the state paid \$82 million for services to almost 27,000 apparently deceased beneficiaries during a period of almost 6 years.

OAS; W-00-02-31021; Various CINs

Expected Issue Date: FY 2003

Medicaid Accounts Receivable

This review will examine state Medicaid agencies' procedures for identifying, recording, and collecting overpayments from providers. According to recent information obtained in one state, the state may have written off overpayments without reporting these amounts to CMS and may not have pursued the most prudent methods for recovering identified overpayments. In such cases, the state may have avoided repayment of the federal share of overpayments.

OAS; W-00-03-31047; A-04-03-00000

Expected Issue Date: FY 2003

GENERAL ADMINISTRATION

State Medical Boards as a Source of Patient Safety Data

We will examine the extent and type of patient safety data available to state medical boards concerning possible systemic problems, as well as the extent that these data are shared or could be shared with CMS and health care facilities to reduce preventable medical errors. This inquiry is directly related to the central charge of the Secretary's Patient Care Task Force, which seeks to identify data sources that can improve patient safety. Our prior reviews of medical boards indicated that they were a potentially important, but largely untapped, source of patient safety data. Since the Institute of Medicine has indicated that preventable medical errors account for as many as 98,000 deaths a year, making full use of the boards' patient safety data is vital.

OEI; 01-02-00690

Expected Issue Date: FY 2004

Administrative Simplification: Readiness for Electronic Standards

We will examine health care entities' readiness for compliance with the Standards for Electronic Transactions under the Health Insurance Portability and Accountability Act of 1996. The regulations require covered entities to comply with standard transactions and code sets by October 16, 2002. However, covered entities may obtain a 1-year extension for compliance by October 16, 2003. The purpose of these administrative simplification requirements is to improve the transmission of certain health care information, such as claims, coordination of benefits, and health plan enrollment. The covered entities include health plans, providers, and clearinghouses.

OEI; 09-02-00420

Expected Issue Date: FY 2003

Improper Medicare Fee-for-Service Payments

We will determine whether FY 2002 Medicare fee-for-service benefit payments were (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 2001, estimated improper payments totaled \$12.1 billion, or 6.3 percent of the \$191.8 billion total spent on Medicare fee-for-service claims.

OAS; W-00-02-40011; A-17-02-02202

Expected Issue Date: FY 2003

Analysis of Medicare Errors

We will review Medicare fee-for-service claims that were found to be in error and determine how future inappropriate payments can be avoided. The CMS is employing contractors under the Medicare Integrity Program to review claims for medical necessity and proper payment. We will determine whether the resulting database accurately reflects the results of claims’ review and ascertain the status of efforts to use the database to prevent future errors.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medicare Beneficiaries With High Utilization Rates

This study will test the feasibility of using high utilization as a prediction of unallowable payments. We will determine the medical necessity of services received by beneficiaries with extremely high utilization rates--defined as those beneficiaries with at least 50 claim line items for services during any 30-day period. We will focus on beneficiaries who are not hospitalized. If the test is successful, we will recommend that CMS incorporate this method into its day-to-day program integrity activities.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Medicare Secondary Payer

We will continue 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 General Accounting Office 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 CMS procedures for identifying and resolving credit balance situations, i.e., situations in which payments from Medicare and other insurers exceed the providers' charges or the fee schedule payment amounts. We will also determine the extent to which Medicare pays for defective devices.

OAS; W-00-02-35032/35034; Various CINs

Expected Issue Date: FY 2003

Medicaid Recovery of Payments From Liable Third Parties

This study will examine the Medicaid dollars at risk of loss when Medicaid pays claims for beneficiaries who have other insurance. In seeking recovery from liable third parties, states are required to use cost avoidance but may use "pay and chase" methods if granted a waiver by CMS. We will quantify nonrecovered payments by liable third parties and determine if states using "pay and chase" methods have approved waivers.

OEI; 03-00-00031

Expected Issue Date: FY 2003

Payments to Psychiatric Facilities Improperly Certified as Nursing Facilities

We will determine whether psychiatric facilities have been improperly certified as nursing homes and quantify any resulting inappropriate Medicare and Medicaid expenditures. Medicare is prohibited by statute from certifying any nursing facility that is "primarily for the care and treatment of mental diseases." We will identify nursing facilities that operate primarily as psychiatric facilities, examine their state certification, and determine the amount of inappropriate Medicare and Medicaid reimbursement.

OEI; 00-00-00000

Expected Issue Date: FY 2004

Group Purchasing Organizations

We will review payments (fees) received by selected group purchasing organizations from vendors. These reviews will evaluate whether the group purchasing organizations' reporting arrangements satisfy the statutory and regulatory requirements that exempt such payments from being considered kickbacks. We will also analyze the impact of group purchasing arrangements on the Medicare program.

OAS; W-00-02-35050; Various CINs

Expected Issue Date: FY 2003

Corporate Integrity Agreements

We will continue to review compliance audit work plans and annual audit reports submitted by health care providers as required by the corporate integrity agreements that the providers signed

to settle false claims actions. The objective of our reviews is to ensure that the requirements of the settlement agreements have been met.

OAS; W-00-02-35028; Various CINs

Expected Issue Date: No Report

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 CMS 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, outpatient therapy services, and transportation services.

*OAS; W-00-02-31012/31013/31029/31033;
Various CINs*

Expected Issue Date: FY 2003

INVESTIGATIONS

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

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

Each year, literally thousands of complaints from various sources are brought to OIG's attention for development, investigation, and appropriate conclusion. Although managers will continue to make their investigative decisions on a case-by-case basis, this Work Plan identifies 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.

Health Care Fraud

The cost of our nation's health care dictates that OI spend significant resources in the investigation of fraud committed against the Medicare and Medicaid programs. The OI also

conducts investigations in conjunction with other law enforcement agencies, such as the Federal Bureau of Investigation, the United States Postal Inspection Service, the Internal Revenue Service, and the various state Medicaid fraud control units.

The OI will investigate individuals, facilities, or entities that bill Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, and other false claims submitted to obtain program funds. The OI will also investigate business arrangements that violate anti-kickback statutes.

Investigative focus areas include pharmaceutical fraud. Working jointly with such partners as the Drug Enforcement Administration and state and local authorities, OI will continue to identify and investigate illegal schemes to market, obtain, use, and distribute prescription drugs. By investigating these schemes, OI aims to deter the illegal use of prescription drugs, curb the danger associated with street distribution of highly addictive medications, stop the inflating of drug prices common in the pharmaceutical industry, and protect the Medicare and Medicaid programs from making improper payments.

The OI will also increase its attention on quality-of-care issues for beneficiaries residing in care facilities. With the continuous growth of the elderly population, nursing facilities and their residents have become common victims of fraudulent schemes. The Medicare and Medicaid programs have been improperly billed for medically unnecessary services and for services either not rendered or not rendered as prescribed. The OI must do everything that it can to ensure a safe environment for Medicare and Medicaid patients.

The OI will not allocate resources to investigations of individuals, facilities, or entities that committed errors or mistakes on claims submitted to the Medicare or Medicaid program. The OI will work with CMS contractors, specifically the program safeguard contractors, to identify specific patterns of misconduct by reviewing a compilation of integrated Medicare Part A and Part B claims.

Provider Self-Disclosure

To encourage health care providers to promptly self-disclose improper conduct that threatens federal health care programs, including Medicare and Medicaid, OIG has made a cognizant effort to educate providers on the protocol and advantages of the self-disclosure program. This program offers health care providers specific steps, including a detailed audit methodology, that may be undertaken if they wish to work openly and cooperatively with OIG.

In October 1998, OIG announced a new, more flexible provider self-disclosure protocol for use by all health care providers doing business with federal health care programs. Numerous providers have been accepted into the program under the new protocol. These providers range

from hospitals to laboratories to physicians. The OIG believes that both the government and the providers benefit from this program.

The self-disclosure protocol is designed only for providers that believe a potential violation of the law has occurred. Matters exclusively involving overpayments or errors that do not indicate violations of the law should be brought directly to the attention of the entity responsible for claim processing and payment.

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 civil and administrative health care fraud cases, including the use of program exclusions and civil monetary penalties and assessments, as well as the negotiation and monitoring of corporate integrity agreements. The OCIG represents OIG in administrative litigation, such as civil monetary penalty 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 developing OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2003 includes:

Compliance Program Guidance to the Health Care Industry

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 compliance program guidance documents in FY 2003 pertaining to ambulance companies and pharmaceutical companies, as well as revised guidance for the hospital industry. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in federal health care programs while furthering the health care industry's fundamental mission to provide quality patient care.

Expected Completion Date: Ongoing

Resolution of False Claims Act Cases and Negotiation of Corporate Integrity Agreements

We will continue to work closely with OIG investigators and auditors and with prosecutors from the Department of Justice (DOJ) to develop and pursue False Claims Act cases against individuals and entities that defraud the government, where adequate evidence of violations exists. We will provide further assistance to DOJ prosecutors in litigation and in settlement

negotiations arising from these cases. We also will continue to consider whether to implement the OIG's exclusion authority based on these defendants' conduct. When appropriate and necessary, we will continue to ask these defendants to implement compliance measures, in the form of corporate integrity agreements, aimed at ensuring future compliance with federal health care program requirements.

Expected Completion Date: Ongoing

Providers' Compliance With Corporate Integrity Agreements

We will continue to assess the compliance of providers and Medicare contractors with the terms of over 325 corporate integrity agreements (and settlements with integrity provisions) into which they entered while settling fraud and abuse allegations. We will increase the number of site visits to entities that are subject to the integrity agreements to verify compliance efforts, to confirm information submitted by the entities to OIG, and to assist with compliance generally. Included in this monitoring process will be systems reviews to determine whether a provider's or a contractor's compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action. Additionally, we will increase our coordination with CMS on appropriate measures regarding entities with ongoing problems.

Expected Completion Date: Ongoing

Advisory Opinions and Fraud Alerts

As part of OIG's ongoing efforts to foster compliance efforts by providers and industry groups, 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 practices that we determine are suspect.

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

In FY 2003, we anticipate publishing regulations for several new safe harbor exemptions from the anti-kickback statute. Also, we will continue to evaluate comments that we solicited from the public concerning proposals for additional safe harbors.

Expected Completion Date: Ongoing

Patient Anti-Dumping Statute Enforcement

We expect to continue to review and, when appropriate evidence exists, continue the negotiation, settlement, and litigation of cases involving violations of the patient anti-dumping statute in FY 2003.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with OI, we anticipate receiving an increased number of cases in which the evidence supports exclusion from federal health care programs. When warranted, we also expect to initiate program exclusions against individuals and entities that submitted false or fraudulent claims, failed to provide services that met professionally recognized standards of care, or otherwise engaged in conduct actionable under section 1128 of the Social Security Act or any statute authorizing exclusions by OIG.

Expected Completion Date: Ongoing

Civil Monetary Penalties

We expect to continue to pursue civil monetary penalty cases, when supported by appropriate evidence, based on the submission of false or fraudulent claims; the offer, payment, solicitation, or receipt of remuneration (kickbacks) in violation of section 1128B(b) of the Social Security Act; improper conduct by Medicare or Medicaid MCOs; and other offenses actionable under section 1128A of the act and other civil monetary penalty authorities delegated to OIG.

Expected Completion Date: Ongoing