

Centers for Medicare and Medicaid Services

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Medicare Hospitals

Oversight of Nonaccredited Hospitals

We will determine the time between onsite surveys at nonaccredited hospitals and compare it with earlier performance as reported in our July 1999 report, “The External Review of Hospital Quality: The Role of Medicare Certification.” This followup will also examine resource allocation and variations in State performance.

(OEI; 00-00-00000; expected issue date: FY 2005)

Oversight of the Joint Commission on Accreditation of Healthcare Organizations

We will examine the extent to which the Centers for Medicare and Medicaid Services (CMS) oversees the Joint Commission on Accreditation of Healthcare Organizations by examining what information CMS collects about the commission’s performance, what feedback it provides, and what information it discloses publicly. Because the joint commission accredits approximately 80 percent of the 6,200 hospitals that participate in Medicare, its performance is critical to effective quality oversight.

(OEI; 01-02-00490; expected issue date: FY 2004)

Medical Education Payments for Dental and Podiatry Residents

We will continue to determine the appropriateness of graduate medical education (GME) payments to hospitals for dental and podiatry residents. Under the Balanced Budget Act, dental and podiatry residents are excluded from caps on the number of residents that hospitals are allowed to claim for direct and indirect GME. The act also allows hospitals to count residents at nonhospital sites as long as the hospitals incurred all or substantially all of the costs of training at the nonhospital sites.

(OAS; W-00-03-35025; A-04-03-00000; expected issue date: FY 2004)

Nursing and Allied Health Education Payments

We will determine the appropriateness of payments for provider-operated nursing and allied health education programs. The Medicare program makes such payments to hospitals on a reasonable cost basis. Our work will be done at various fiscal intermediaries and providers to determine the validity of claims for these payments. The Office of Management and Budget (OMB) has expressed interest in this area.

(OAS; W-00-04-35123; A-00-04-00000; expected issue date: FY 2005)

Inpatient Capital Payments

This series of reviews will examine Medicare inpatient hospital capital payments, including the accuracy and appropriateness of the CMS process for updating the capital rates. We will also determine whether hospitals have used capital payments for their intended purposes. Medicare pays hospitals over \$6 billion each year, and prior OIG reviews showed that the rates were inflated.

(OAS; W-00-04-35106; A-00-04-00000; expected issue date: FY 2005)

Inpatient Prospective Payment System Update Factors

We will examine the elements that make up the inpatient prospective payment system rates and analyze whether the factors included in the market basket updates adequately cover the elements of the prospective payment system and represent fair and equitable increases in Medicare rates. We will analyze the impact of using estimated rather than actual data in calculating the update factors. Although we will begin our work with inpatient prospective payment system updates, we intend to expand our analysis to include other Part A providers' prospective payment rates and update factors. We will also examine wage indices that affect Medicare payment rates.

(OAS; W-00-04-35100; various reviews; expected issue date: FY 2004)

Inpatient Outlier and Other Charge-Related Issues

We will continue to determine whether claims for inpatient outlier payments were submitted in accordance with Medicare laws and regulations. We will also continue to assess program vulnerabilities in the current reimbursement policies for outlier payments, including the mechanisms used to establish the outlier threshold. Since many of the vulnerabilities identified to date are related to charge issues, we will examine other areas in hospital inpatient reimbursement that are affected by hospital charges, including diagnosis-related group (DRG) assignments and payments for new technologies.

(OAS; W-00-03-35056; various reviews; expected issue date: FY 2004)

Long-Term-Care Hospital Payments

This study will determine the extent to which long-term-care hospitals operate as "hospitals-within-hospitals." To retain prospective payment system-exempt status, long-term-care hospitals 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 two stays should be paid as a single discharge. We will determine whether those conditions have been met.

(OEI; 01-02-00630; expected issued 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 2004)

Organ Acquisition Costs

We will determine whether organ acquisition costs claimed on Medicare hospital cost reports were accurate and appropriate and excluded costs that should have been allocated to posttransplant activities or other benefiting cost centers. Medicare uses a reasonable cost basis to retrospectively reimburse hospitals for the costs of acquiring organs for transplant. Overpayments can occur if hospitals claim expenses not related to organ acquisition by shifting costs from posttransplant activities to pretransplant activities and from other hospital cost centers to the organ acquisition cost center.

(OAS; W-00-03-35083; various reviews; expected issue date: FY 2004)

Medical Necessity of Inpatient Psychiatric Stays

This review 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 outpatient psychiatric services provided by prospective payment hospitals and specialty psychiatric hospitals 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 2005)

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 2005)

Inpatient Rehabilitation Payments

We will determine the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered late. Under the inpatient rehabilitation facility prospective payment system, admission and discharge assessments must be entered and transmitted within defined time limits or payment is reduced. We will determine how fiscal intermediaries make these adjustments and confirm that payments are accurate.

(OEI; 00-00-00000; expected issue date: FY 2005)

Home Office Costs–Critical Access Hospitals

We will review critical access hospital cost reports to determine whether home office costs and related-party transactions were properly allocated and treated in accordance with Medicare requirements. Medicare payments to critical access hospitals are based on a cost reimbursement system.

(OAS; W-00-04-35101; A-06-04-00000; expected issue date: FY 2004)

Diagnosis-Related Group Payment Limits

We will assess the ability of Medicare contractors to limit payments to hospitals for patients who are discharged from a prospective payment system inpatient hospital and admitted to one of several post-acute-care settings. This limitation applies to certain DRGs. Our prior reviews indicated that a lack of controls had resulted in significant overpayments.

(OAS; W-00-04-35102; various reviews; expected issue date: FY 2004)

Update on Diagnosis-Related Group Coding

This update will examine DRGs that have a history of aberrant coding to determine whether some acute hospitals exhibit aberrant coding patterns. The prospective payment system, or DRGs, for inpatient acute care depends on accurate coding of diagnoses and procedures. Inaccurate coding by hospitals can lead to Medicare 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 2004)

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)

Charges and Payments Under New Prospective Payment Systems

We will analyze the new prospective payment systems to determine the impact, if any, of providers' charges on Medicare reimbursement. Where charges have an impact, we will assess the appropriateness of Medicare payments and determine whether reimbursement policies need to be revised. We will specifically look at long-term-care hospitals, rehabilitation hospitals, and psychiatric hospitals. We will also examine the appropriateness of the prospective payments to these hospitals, compliance with the criteria for classification as a rehabilitation hospital, and the appropriateness and accuracy of payments to long-term-care hospitals.

(OAS; W-00-04-35103; various reviews; expected issue date: FY 2004)

Coronary Artery Stents

We will review inpatient and outpatient claims involving arterial stent implantation to determine whether Medicare payments for these services were appropriate. Through medical reviews, we will determine if the services were medically necessary and supported by adequate documentation. We will also review claims for beneficiaries who had stent implantations during multiple surgical procedures to determine if the implantations should have been performed simultaneously.

(OAS; W-00-04-35124; A-00-04-00000; expected issue date: FY 2005)

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 (x-rays) and an additional \$70 million for advanced imaging (such as MRIs and CAT scans). We will determine whether the services were medically necessary and whether the tests were interpreted contemporaneously with the beneficiary's treatment.

(OEI; 00-00-00000; expected issue date: FY 2005)

Outpatient Prospective Payment System

We will determine whether payments under the hospital outpatient prospective payment system were in accordance with Medicare laws and regulations. We intend to review several aspects of the payment system, including multiple procedures performed during a single encounter and transitional pass-through payments. We will also assess the appropriateness of payments to community mental health centers for psychotherapy services.

(OAS; W-00-04-35104; various reviews; expected issue date: FY 2004)

Outpatient Outlier and Other Charge-Related Issues

We will determine whether outlier payments to hospital outpatient departments and community mental health centers were in accordance with Medicare laws and regulations and

whether current Medicare reimbursement mechanisms appropriately reimburse providers as intended. Since our prior work has shown vulnerabilities related to hospitals' charges, we will expand our work to include other prospective payment system mechanisms that are affected by providers' charges.

(OAS; W-00-04-35105; various reviews; expected issue date: FY 2004)

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.

(OAS; W-00-03-35059; various reviews; expected issue date: FY 2004)

Medicare Home Health

Beneficiary Access to Home Health Agencies

We will assess the effect of the prospective payment system on access to home health services by Medicare beneficiaries who have been discharged from the hospital. Since October 2000, when the home health prospective payment system was implemented, the average number of visits per episode of care has fallen dramatically. Home health agencies may be reluctant to accept beneficiaries who need extensive services. We will update our previous work in this area.

(OEI; 00-00-00000; expected issue date: FY 2005)

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. In 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 2005)

Home Health Payment System Controls

Through a series of reviews, we will examine the appropriateness of prospective payments to home health agencies and 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. In addition, we will determine whether payments were inappropriately made for overlapping home health episodes and whether payments for dually eligible beneficiaries were appropriate.

(OAS; W-00-03-35070; various reviews; expected issue date: FY 2004)

Home Health Outlier Payments

We will determine whether outlier payments to home health agencies were in compliance with Medicare regulations. Intended to be a loss-sharing mechanism for costly cases, an outlier payment is made for an episode whose estimated cost exceeds a threshold amount for each case-mix group. We will evaluate the frequency of outliers and whether they cluster in certain

Home Health Resource Groups or geographical areas. We also plan to determine whether the current outlier methodology is equitable to all home health agencies.

(OAS; W-00-04-35107; various reviews; expected issue date: FY 2004)

Enhanced Payments for Home Health Therapy

We will determine whether home health agencies' therapy services met the therapy threshold for higher payments in compliance with Medicare regulations. We will analyze the number of therapy visits provided per episode period and the duration of therapy visits.

(OAS; W-00-04-35108; A-01-04-00000; expected issue date: FY 2004)

Home Health Agencies' Arrangements With Other Facilities

This review will determine the propriety of claims by selected home health agencies that are part of a comprehensive health care system. These comprehensive systems provide other types of services, such as those furnished by nursing and adult homes, rehabilitation facilities, and hospitals. We will examine exclusive arrangements between home health agencies and members of the comprehensive system to determine whether beneficiaries were offered a choice of home health agencies. In a second series of reviews, we will analyze payments to home health beneficiaries who reside in assisted living facilities to determine the appropriateness of episode payments to the home health agencies.

(OAS; W-00-04-35109; various reviews; expected issue date: FY 2004)

Medicare Nursing Homes

Access to Skilled Nursing Facilities Under the Prospective Payment System

In this followup study, we will determine whether the prospective payment system for skilled nursing facilities has affected Medicare beneficiaries' access to care. Studies in 1999, 2000, and 2001 found that under the system, 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 2005)

Nurse Aide Registries

We will evaluate nursing home and State compliance with Federal nurse aide registry requirements. Federal regulations require that each State establish and maintain a registry of nurse aides and that nursing homes verify the registry status of a nurse aide before employing the individual. This study will evaluate how registries are established and maintained, how consistently nursing homes check registries, and how State nursing home surveyors assess compliance with registry requirements.

(OEI; 07-03-00830; expected issue date: FY 2004)

Nursing Home Reporting of Minimum Data Set

We will examine nursing home compliance with Minimum Data Set reporting requirements and the accuracy of Minimum Data Set assessments. The Minimum Data Set is one of the primary mechanisms for addressing residents' quality of care. This assessment tool partially determines payment for Part A stays, and Medicare conditions of participation require that it be reported on all residents for quality oversight purposes as well. We will review data submissions and nursing home records to assess the accuracy of reporting for beneficiaries in Part A covered stays and the timeliness of reporting for all nursing home residents.

(OEI; 02-02-00830, 06-02-00180; expected issue date: FY 2004)

Resource Utilization Group Assignments: Followup

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

(OEI; 01-03-00180; expected issue date: FY 2004)

Nursing Home Payment System Controls

We will conduct a series of reviews to determine the appropriateness of prospective payments to skilled nursing facilities. We intend to examine aspects of the prospective payment system, including nursing homes' use of Medicare funds, quality initiatives underway, payments made on the day of discharge, payments made while the beneficiary is a hospital inpatient, and payments made under the default category. We will also determine whether claims involving infusion therapy and rehabilitation services were reimbursed in accordance with Medicare rules. In addition, we will analyze payment mechanisms to determine if the charge structures of skilled nursing facilities affect reimbursement.

(OAS; W-00-04-35110; various reviews; expected issue date: FY 2004)

Skilled Nursing Facilities' Involvement in Consecutive Inpatient Stays

This study will determine whether skilled nursing facility care provided to Medicare beneficiaries with consecutive inpatient stays was medically reasonable and necessary. All skilled nursing facility stays must be preceded by an inpatient hospital stay. This study will focus on beneficiaries who experience three or more consecutive stays, including at least one skilled nursing facility stay. We will also examine the extent and nature of consecutive Medicare hospital inpatient stays.

(OEI; 00-00-00000; expected issue date: FY 2005)

Part B Payments for Beneficiaries in Nursing Homes

We will analyze Medicare Part B payments for nursing facility residents to determine whether unbundling, payment for inappropriate services, or aberrant billing patterns occurred. Skilled nursing facilities are reimbursed through prospective, case-mix adjusted, per diem payments that cover routine, ancillary, and capital-related costs, including most items and services for which payment was previously made under Medicare Part B. We will identify any duplicate Part B payments and services that are most problematic.

(OEI; 05-03-00100; expected issue date: FY 2004)

Imaging and Laboratory Services in Nursing Homes

We will determine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. Medicare pays more than \$200 million a year for such imaging and laboratory services. We will review a sample of services and examine utilization patterns in nursing facilities.

(OEI; 00-00-00000; expected issue date: FY 2005)

Nursing Home Compliance With Dietary Services Requirements

We will assess nursing home compliance with Federal dietary services requirements and the adequacy of these services. Nursing facilities must meet residents' nutrition and hydration

needs and conduct assessments when a resident eats less than 75 percent of most meals. Despite a 1997 CMS initiative to promote an interdisciplinary approach to identifying, preventing, and addressing risk factors associated with malnutrition and dehydration among nursing home residents, the number of dietary/nutritionally related deficiencies has steadily increased.

(OEI; 00-00-00000; expected issue date: FY 2005)

State Compliance With Complaint Investigation Guidelines

We will determine the extent to which States follow CMS guidelines, as well as their own procedures, in investigating abuse complaints. States must investigate all allegations of immediate jeopardy within 2 days and all allegations of actual harm within 10 days. We will examine the procedures that States use to receive, investigate, and resolve complaints.

(OEI; 00-00-00000; expected issue date: FY 2005)

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. We 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 2004)

Nursing Home Enforcement

We will examine the effectiveness of CMS and State enforcement actions taken against noncompliant nursing homes. Under contracts with CMS, States conduct surveys at least every 15 months to certify that nursing facilities meet the required standards for the Medicare and Medicaid programs. For noncompliant Medicare facilities, CMS is responsible for enforcement actions, including denial of payments, collection of civil monetary penalties, loss of Nurse Aide Training and Competency Evaluation Programs, and other mandatory enforcement actions. We will also assess compliance with and the effectiveness of nursing home plans of correction and determine if States appropriately refer nursing home enforcement cases to CMS.

(OEI; various reviews; expected issue date: FY 2005)

Medicare Physicians and Other Health Professionals

Consultations

This study will determine the appropriateness of billings for physician consultation services and the financial impact of any 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 2004)

Coding of Evaluation and Management Services

We will examine physician coding of evaluation and management services, for which Medicare allowed over \$23 billion in 2001. We will 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. We will also assess the accuracy and carrier monitoring of evaluation and management coding.

(OEI; 00-00-00000; expected issue date: FY 2005)

Use of Modifier –25

We will determine whether providers used modifier –25 appropriately. In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is unrelated to such procedure or service. A provider reports such a circumstance by using modifier –25. In 2001, Medicare allowed over \$23 billion for evaluation and management services. Of that amount, approximately \$1.7 billion was for evaluation and management services billed with modifier –25. We will determine whether these claims were billed and reimbursed appropriately.

(OEI; 07-03-00470; expected issue date: FY 2004)

Use of Modifiers With National Correct Coding Initiative Edits

We will determine whether claims were paid appropriately when modifiers were used to bypass National Correct Coding Initiative edits. 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. A provider may include a modifier to allow payment for both services within the code pair under certain circumstances. In 2001, Medicare paid \$565 million to providers who included the modifier with code pairs within the National Correct Coding Initiative. We will determine whether modifiers were used appropriately.

(OEI; 00-00-00000; expected issue date: FY 2004)

ESRD Monthly Capitation Payment Relative-Value Units

Our review will determine whether the physician work component of the fee schedule for monthly capitation payments accurately reflects the number of physician services provided to end stage renal disease (ESRD) beneficiaries. The monthly capitation payment covers all physician services associated with the continuing medical management of a beneficiary receiving maintenance dialysis. The payment is the same for each beneficiary, regardless of whether dialysis is provided at home or at an outpatient ESRD facility. It includes evaluation and management services for examinations, treatments, and similar services.

(OAS; W-00-04-35112; various reviews; expected issue date: FY 2005)

Place-of-Service Errors

This review will determine whether physicians properly coded the place of service on claims for services provided in ambulatory surgical centers and hospital outpatient departments. Medicare regulations provide for different levels of payments to physicians depending on where the service is performed. Higher payments are made for physician office services.

(OAS; W-00-04-35113; various reviews; 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 2005)

Care Plan Oversight

We will evaluate the efficiency of controls over Medicare payments for care plan oversight claims submitted by physicians. Under the Medicare home health and hospice benefits, care plan oversight is physician supervision of beneficiaries who need complex or multidisciplinary care requiring ongoing physician involvement. Reimbursement for care plan oversight increased from \$15 million in 2000 to \$41 million in 2001. We will assess whether these services were provided in accordance with Medicare regulations.

(OAS; W-00-04-35114; A-02-04-00000; expected issue date: FY 2004)

Billing for Diagnostic Tests

We will assess the medical necessity of diagnostic tests, such as nerve conduction studies, performed by physicians. Medicare covers a range of diagnostic tests, including nerve conduction studies, which are electrodiagnostic tests of the integrity of peripheral nerves. Medicare-allowed amounts for nerve conduction studies increased from \$136 million in 2000 to \$186 million in 2001--approximately 37 percent. We will determine the cost of any medically unnecessary and incorrectly paid nerve conduction studies.
(OEI; 00-00-00000; expected issue date: FY 2005)

Radiation Therapy Services

Our review will determine whether physicians nationwide were correctly reimbursed for radiation therapy management services. Medicare regulations require that the professional component of radiation therapy management services be reimbursed to physicians as one billable unit of service for every five sessions of treatment. In a prior review limited to payments made by one Medicare carrier, we identified a high percentage of overpayments to physicians for radiation therapy management services.
(OAS; W-00-04-35115; various reviews; expected issue date: FY 2004)

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 2004)

Ordering Physicians Excluded From Medicare

This review will quantify the extent, if any, of services ordered by physicians excluded from Federal health care programs and the amount paid by Medicare Part B. Under Federal regulations, physicians who are excluded from Federal health care programs are precluded from ordering, as well as performing, services for Medicare beneficiaries. During a current review, we identified a significant number of services that had been ordered by excluded physicians.
(OAS; W-00-04-35116; various reviews; expected issue date: FY 2004)

Medicare Medical Equipment and Supplies

Certificates of Medical Necessity

We will determine whether suppliers appropriately used and maintained certificates of medical necessity for durable medical equipment and whether ordered items were reasonable and necessary. Medicare pays for medical equipment and supplies that are ordered or prescribed by a treating physician and are appropriate for the patient's diagnosis and symptoms as determined by the durable medical equipment regional carrier. Medicare requires that certain medical equipment and supplies billed to these carriers have a certificate of medical necessity.

(OEI; 09-03-00260; expected issue date: FY 2004)

Medical Necessity of Durable Medical Equipment

This review will determine the appropriateness of Medicare payments for certain items of durable medical equipment, including power wheelchairs and therapeutic footwear. 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, 00-00-00000; expected issue date: FY 2004)

Medicare Pricing of Equipment and Supplies

We will compare Medicare payment rates for certain medical equipment and supplies with the rates of other Federal and State health programs, as well as with wholesale and retail prices. Our review will cover such items as wheelchairs, enteral nutrition, and oxygen equipment and supplies.

(OEI; 03-02-00700, 03-02-00460, 09-03-00160; expected issue date: FY 2004)

Medicare Drug Reimbursement

Drug Prices Paid by Medicare Versus Other Sources

This study will compare Medicare reimbursement for prescription drugs with costs incurred by the Department of Veterans Affairs, the physician/supplier community, and Medicaid. Although Medicare does not pay for most outpatient prescription drugs, Medicare Part B covers certain prescription drugs under specific circumstances. A 2001 OIG report showed that Medicare reimbursed for prescription drugs at significantly higher prices than those available to the Department of Veterans Affairs, Medicaid, and the physician/supplier community.

(OEI; 00-00-00000; expected issue date: FY 2004)

Payments for Non-ESRD Epoetin Alfa

We will determine the appropriateness of Medicare payments for epoetin alfa used by beneficiaries who have not been diagnosed with ESRD. 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 whether beneficiaries received medically necessary allergy treatments 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

Inpatient Rehabilitation Payments to Skilled Nursing Facilities, Long-Term-Care Hospitals, and Inpatient Rehabilitation Facilities

This study will examine differences in Medicare reimbursement among skilled nursing facilities, long-term-care hospitals, and inpatient rehabilitation facilities for similar services. Although all three provider categories may provide rehabilitation on an inpatient basis, each categorizes patients differently and each is paid under a different prospective payment system. We will identify services commonly needed by Medicare beneficiaries and determine any differences in payment and length of stay based on the setting of care.

(OEI; 00-00-00000; expected issue date: FY 2005)

Ambulatory Surgical Center Payment Rates

We will review the costs and charges reported by ambulatory surgical centers and provide CMS with information for determining whether rates for these centers are reasonable or need revision. Since 1982, Medicare has covered the facility costs of certain surgical procedures in freestanding or hospital-owned ambulatory surgical centers. CMS surveyed the centers' costs and charges in 1986 and 1994. However, according to the Medicare Payment Advisory

Commission, the current rates are based on the 1986 survey data.
(OAS; W-00-04-35118; various reviews; expected issue date: FY 2004)

Independent Diagnostic Testing Facilities

We will review the medical necessity of Medicare services provided to beneficiaries by 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. We will determine whether (1) individual facilities provided services for which they had prior approval, (2) the designated level of physician supervision was provided, and (3) the nonphysician personnel who performed the diagnostic tests were properly licensed.
(OAS; W-00-03-35066; various reviews; expected issue date: FY 2004)

Therapy Services Provided by Comprehensive Outpatient Rehabilitation Facilities

We will determine whether comprehensive outpatient rehabilitation facilities (CORF) provided and billed physical therapy, speech language pathology, and occupational therapy services in accordance with Medicare eligibility and reimbursement requirements. The Balanced Budget Act of 1997 required a prospective payment system for all CORF services. The Medicare physician fee schedule is used as the prospective payment system for CORF services dated on or after July 1, 2000. Prior OIG reviews found that Medicare paid significant amounts for unallowable or highly questionable therapy services in outpatient rehabilitation facilities and nursing homes. The majority of these services were not reasonable and necessary for the beneficiary's health condition or lacked sufficient documentation.
(OAS; W-00-04-35119; various reviews; expected issue date: FY 2004)

Rural Health Clinics

This study will examine changes in Medicare certification and reimbursement of rural health clinics since our 1996 report. Rural health clinics receive enhanced reimbursement in order to maintain and expand rural access to care. We will examine responses by CMS and the Health Resources and Services Administration to our prior report and recent trends in rural health clinic locations and billings.
(OEI; 05-03-00170; expected issue date: FY 2004)

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

Our study 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)

Hospital Laboratory Services

We will evaluate whether hospitals separately billed Medicare for laboratory services that were already included in their ESRD composite rate. Under Medicare's composite rate reimbursement system, ESRD facilities are reimbursed 100 percent of their costs. Because laboratory services are paid for under the composite rate, hospitals should not separately bill for these services.

(OAS; W-00-04-35117; A-02-04-00000; expected issue date: FY 2004)

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 2004)

New Payment Provisions for Ambulance Services

This review will determine whether payments for ambulance services complied with new Medicare reimbursement regulations. In accordance with the Balanced Budget Act of 1997, CMS implemented a national fee schedule covering five 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-00-04-35076; A-01-04-00000; expected issue date: FY 2004)

Ambulance Payments

We will determine whether Medicare claims for 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 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; 05-02-00590; expected issue date: FY 2004)

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, managed care organizations (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 whether changes in adjusted community rate values to reflect updated per-member-per-month cost, utilization, and membership assumptions were appropriately documented.

(OAS; W-00-03-35041; various reviews; expected issue date: FY 2004)

Followup 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 have been completed. Errors in the proposals, identified during the audits, may affect Medicare beneficiaries' additional

benefits or reduced cost-sharing amounts.

(OAS; W-00-04-35077; various reviews; expected issue date: FY 2004)

Marketing Practices by Managed Care Organizations

We will examine the marketing methods used by MCOs to attract and enroll beneficiaries. CMS prohibits discriminatory marketing activities, which 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 to 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)

Monitoring Compliance With Marketing Provisions

We will assess how CMS monitors compliance with Medicare+Choice marketing requirements. In 1998, we reported on CMS's managed care monitoring process and staffing. Effective January 2003, CMS restructured its monitoring protocol. This study will assess whether CMS's oversight activities are consistent with the monitoring protocol.

(OEI; 00-00-00000; expected issue date: FY 2005)

Managed Care "Deeming" Organizations

This study will determine whether CMS effectively oversees the Medicare+Choice "deeming" organizations. The Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 authorized CMS to establish and oversee a program that allows private, national accreditation organizations to deem compliance with certain Medicare+Choice requirements.

(OEI; 00-00-00000; expected issue date: FY 2005)

Managed Care Encounter Data

This review will determine the accuracy of Part A encounter data on Medicare beneficiaries. All MCOs are required to submit these data for CMS's use in developing 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 reviews; expected issue date: FY 2004)

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 ESRD 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-00-03-35054; various reviews; expected issue date: FY 2004)

Enhanced Payments Under the Risk Adjustment Model

We will review CMS's actuarial assumptions and calculations applicable to current payment rates for special status beneficiaries, as well as any projection of future rates. Medicare has traditionally paid an enhanced monthly rate for beneficiaries who are institutionalized or dually eligible for Medicaid. To help ensure that payments more closely reflect the costs of providing care, CMS is currently phasing risk adjustment factors into the payment system; some portion of the current payment enhancement may be left in place. Prior OIG work has shown significant overpayments and underpayments attributable to the enhanced rate system. Given the phase-in of risk adjustment, we will examine the need for continuing enhanced payments.

(OAS; W-00-04-35120; various reviews; expected issue date: FY 2004)

Managed Care Excessive Medical Costs

This review will analyze the cost of health care services furnished to beneficiaries enrolled in Medicare+Choice MCOs. Federal rules do not limit the amount that MCOs pay for health care services. They only require the organizations to report actual expenses derived from an accrual accounting system that uses generally accepted accounting principles. Also, Medicare regulations require that MCOs have effective procedures to monitor utilization and control the costs of basic and supplemental health services. We noted that some MCOs reported certain medical costs that were two to three times higher than the national average of all MCOs or significantly higher than similar costs at other plans in the same geographic area or under Medicare fee-for-service. Although CMS has no control over the costs paid by MCOs for services, we believe that understanding the reasons for wide cost variations could help in evaluating the adequacy of Medicare payments.

(OAS; W-00-04-35121; various reviews; expected issue date: FY 2004)

Duplicate Medicare Payments to Cost-Based Plans

This review will quantify the extent, if any, of duplicate Medicare capitation and fee-for-service payments to selected cost-based MCOs. Generally, under capitation agreements, health care providers are paid for services furnished to an MCO's Medicare enrollees through monthly per capita payments from the MCO. The MCO receives Medicare reimbursement for these payments by claiming them on Medicare cost reports. Accordingly, any Medicare fee-for-service billings that the capitated providers submit for services provided to the MCO's Medicare enrollees will result in duplicate payments. Under CMS regulations, the MCO is responsible for establishing internal controls to detect and prevent such duplicate

reimbursement.

(OAS; W-00-04-35122; various reviews; expected issue date: FY 2004)

Prompt Payment

We will determine whether MCOs have adhered to Medicare+Choice prompt payment requirements for noncontracting providers. Regulations require that written agreements between MCOs and providers contain a prompt payment provision, the terms of which are developed and agreed to by both the MCO and the relevant provider. Claims must be approved or denied within 30 calendar days from the date of the request. We will examine CMS's oversight of MCOs' compliance with the regulation.

(OAS; W-00-03-35072; various reviews; expected issue date: FY 2004)

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-00-04-35002; various reviews; expected issue date: FY 2004)

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)

Fiscal Intermediary Review of Hospitals Exempt From Prospective Payment System

We will assess the effectiveness of fiscal intermediary reviews of hospitals exempt from the prospective payment system. While quality improvement organizations currently review acute care inpatient stays, in April 2002, CMS instructed fiscal intermediaries to include these types of hospitals in their routine medical review activities. We will examine the frequency and extent of these reviews.

(OEI; 00-00-00000; expected issue date: FY 2004)

Program Safeguard Contractor Performance

We will examine the effectiveness of CMS program safeguard contractors in identifying fraud and abuse. In 2002, CMS began transferring benefit integrity functions from carriers and fiscal intermediaries to specialized entities called program safeguard contractors. We will also evaluate whether program safeguard contractors effectively coordinate information with CMS and its other contractors, determine whether inefficiencies result from any duplication of effort, and determine the adequacy of CMS oversight of these entities.

(OEI; 00-00-00000; expected issue date: FY 2005)

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 2005)

Provider Education and Training by Carriers

This study will examine Medicare carriers' efforts to educate and train providers. 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; expected issue date: FY 2004)

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 2004)

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-00-03-35005; various reviews; expected issue date: FY 2004/05)

Pension Segmentation

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 segments of their pension plans. We will also assess Medicare's share of future pension costs on a segmented basis.

(OAS; W-00-03-35067; various reviews; expected issue date: FY 2004/05)

Pension Costs Claimed

At CMS's request, we will determine whether Medicare contractors calculated pension costs claimed for reimbursement in accordance with their Medicare contracts and Cost Accounting Standards. We will also determine whether the costs claimed were allocable and allowable under the Medicare contracts.

(OAS; W-00-03-35067; various reviews; expected issue date: FY 2004/05)

Unfunded Pension Costs

Requested by CMS, this review will determine whether Medicare contractors identified and eliminated unallowable costs when computing pension costs charged to the Medicare program. Additionally, we will determine whether pension costs that would have been tax deductible had they been funded were reassigned to future periods.

(OAS; W-00-03-35067; various reviews; expected issue date: FY 2004/05)

Pension Segment Closing

As requested by CMS, 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 each 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-00-03-35094; various reviews; expected issue date: FY 2004/05)

Postretirement Benefits and Supplemental Employee Retirement Plan Costs

At CMS's request, we will review the postretirement health benefit costs and the supplemental employee retirement plans of fiscal intermediaries and carriers. Our reviews will determine the allowability, allocability, and reasonableness of the benefits and plans, as

well as the costs charged to Medicare contracts.
(OAS; W-00-04-35095; various reviews; expected issue date: FY 2004)

Medicaid Hospitals

Medicaid Graduate Medical Education Payments

This review will examine Medicaid GME payment programs and the coordination of these payments with Medicare GME payments. Although GME is generally considered a part of the Medicare program, States may elect to provide funds under Medicaid through CMS-approved waivers or State plan amendments. Preliminary work in two States showed that a lack of coordination between Medicaid and Medicare payments caused hospitals to receive substantially more than the total costs of their teaching programs. We will expand our efforts to include as many as 15 States.

(OAS; W-00-03-31018; various reviews; expected issue date: FY 2004)

Hospital Outlier Payments

We will determine whether day and cost outlier payments under State Medicaid programs were in accordance with Federal requirements and approved Medicaid State plans. Prior OIG work involving Medicare claims for hospital outliers identified vulnerabilities in the Medicare payment methodology. We plan to expand this review to several States based on data analysis identifying high-risk providers.

(OAS; W-00-04-31067; various reviews; expected issued date: FY 2004)

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 DRG discharge rate.

As a result of our prior reviews in the Medicare program, fiscal intermediaries recovered over \$100 million in overpayments for the period 1983 to 1991, and as a result of an OIG-Department of Justice (DOJ) project, over \$100 million was collected for the period 1992 to 1996. We will determine if these types of overpayments exist in State Medicaid programs that have regulations similar to those of the Medicare program.

(OAS; W-00-03-31029; various reviews; expected issue date: FY 2004)

Hospital Patient Transfers

This review will examine the propriety of Medicaid claims for hospital patient transfers in States that use prospective payment principles to reimburse 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 DRG 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 which identified significant overpayments as a result of incorrectly reported transfers.

(OAS; W-00-02-31023; various CINs; expected issue date: FY 2004)

Medicaid Nursing Homes

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 whether 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 public nursing facilities had returned to State governments through intergovernmental transfers.

(OAS; W-00-03-31030; various reviews; expected issue date: FY 2004)

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-00-03-31031; various reviews; expected issue date: FY 2004)

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-00-03-31020; various reviews; expected issue date: FY 2004)

Nursing Home Quality-of-Care Sanctions

We will determine whether 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 whether 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; various reviews; expected issue date: FY 2004)

Medicaid/State Children’s Health Insurance Program

Coverage of Parents Through State Children’s Health Insurance Program

This study will examine the extent to which States have provided health insurance to parents of children eligible for Medicaid and the State Children’s Health Insurance Program (SCHIP) and whether parent coverage increases the participation rate for children. CMS provides States the option to use unspent SCHIP funds to expand coverage to parents through SCHIP waivers. While coverage of low-income children has improved in recent years, census data show that the percentage of low-income parents insured by Medicaid fell by almost one-quarter from 1995 to 2000. Recent research indicates that extending coverage to parents can increase the extent to which eligible children secure coverage and make better use of medical services. We will focus on how many States have used this option and how well they have applied it.

(OEI; 00-00-00000; expected issue date: FY 2005)

Enrollment of Medicaid Eligibles in State Children’s Health Insurance Program

We will determine whether States have enrolled Medicaid-eligible children in SCHIP. The Medicare, Medicaid, and SCHIP 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 followup study to include an examination of enrollment experiences in a sample of States that use the two other SCHIP models.
(OEI; 07-03-00220; expected issue date: FY 2004)

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

This review will determine whether States have obtained Federal funds under both the Medicaid program and SCHIP for services provided to the same beneficiary. Preliminary information indicates that one State 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; various reviews; expected issue date: FY 2004)

State Children's Health Insurance Program: State Evaluation Reports

We will assess States' evaluations of their SCHIP performance goals, particularly those focused on reducing the number of uninsured children. The Medicare, Medicaid, and SCHIP 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. This followup study will assess the extent to which the Department has enhanced its technical assistance to States on using program evaluations to reduce the number of uninsured children.
(OEI; 05-03-00280; expected issue date: FY 2004)

Quality of State Children's Health Insurance Program

We will evaluate States' efforts to measure the quality of SCHIP services. During the first few years of SCHIP funding, States focused on setting up their programs, outreach efforts, and enrollment. Given the newness of the program, States have had little experience in developing, implementing, and tracking quality measures. This study will examine States' progress in measuring the quality of care provided in 2003, about 5 years after the program began.
(OEI; 00-00-00000; expected issue date: FY 2005)

Medicaid Drug Reimbursement

Physician Acquisition Costs

We will determine physicians' acquisition costs for prescription drugs billed to the Medicaid program. Specifically, we will determine the discount below average wholesale price (AWP) at which physicians purchase drugs. Most States use AWP as a basis for drug reimbursement. Previous studies have examined the discount for pharmacies but not for physicians. The results of this review will provide States with information that will allow them to set reimbursement for physician-administered drugs at a reasonable level. The results may also be useful to the Medicare program.

(OAS; W-00-04-31071; A-00-04-00000; expected issue date: FY 2005)

Average Manufacturer Price and Average Wholesale Price

This review will examine the relationship between average manufacturer price (AMP) and AWP. AMP is used for Medicaid drug rebate purposes and is based on actual sales data for drug manufacturers. AWP is a published catalogue price that most States use as a basis for drug reimbursement. AWP has been the subject of numerous reviews, and its shortcomings as a basis for reimbursement have been widely documented. This review will provide additional information to help ensure that Medicaid does not overpay for prescription drugs. We will also examine other drug rebate trends, such as the significance of the additional rebate and best price in the rebate amount, to determine whether drug manufacturers are circumventing the intent of the drug rebate legislation.

(OAS; W-00-04-31072; A-06-04-00000; expected issue date: FY 2004)

New Versions of Existing Drugs

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 AMP for a drug exceeds the base AMP, indexed to the consumer price index for urban consumers (CPI-U) from the time a drug enters the market. Under current rules, a manufacturer could change a drug slightly (such as a change in 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 CPI-U for the earliest version of the drugs.

(OAS; W-00-02-31010; A-06-02-00067; expected issue date: FY 2004)

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

We will evaluate the adequacy of drug manufacturers' methodologies for computing 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 reports, issued in 1992, 1995, and 1997, noted that drug manufacturers did not consistently define the retail class of trade in their computations.

(OAS; W-00-03-31042; various reviews; expected issue date: FY 2004)

Indexing the Generic Drug Rebate

We will analyze generic drug expenditures over a period of time to determine whether pricing substantially increased compared with the CPI-U. For brand name drugs, the AMP is indexed to the CPI-U using a baseline AMP. No such comparisons and indexing are made for generic rebates, which are simply set at AMP times a fixed percentage. Our review will quantify any potential savings from indexing generic drugs.

(OAS; W-00-04-31073; various reviews; expected issue date: FY 2004)

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; various reviews; expected issue date: FY 2004)

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, CMS regulations created upper limit standards to limit the amount that Medicaid could reimburse for generic drugs. 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. This study will determine whether Federal Upper Limit prices are excessive and whether States are meeting their requirements for drugs covered under the Medicaid program.

(OEI; 00-00-00000; expected issue date: FY 2004)

Antipsychotic Drug Claims for Nursing Home Beneficiaries

We will analyze Medicaid claims for antipsychotic drugs prescribed for nursing home residents and determine whether mental illness was diagnosed. Based on a comprehensive assessment, nursing homes must ensure that (1) residents who have not used antipsychotic drugs are not given these drugs unless the therapy is necessary to treat a specific condition as diagnosed and documented in the clinical records and (2) residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(OAS; W-00-04-31074; various reviews; expected issue date: FY 2004)

Overprescribing of OxyContin

This review will analyze Medicaid paid claims data to identify beneficiaries who have received significant amounts of OxyContin, as well as the prescribing physicians. OxyContin is a pain medication with a very high street value. In 1999, various strengths of OxyContin represented three of the top four most reimbursed generic drugs (in terms of dollars) in the Medicaid program. Through analyses involving medical reviews, the nature of diagnoses, and physician specialties, we will evaluate the appropriateness of the prescriptions. As part of this review, we will examine prescribing patterns for other psychotropic drugs, including Hydrocodone, Xanax, Diazepam, and Soma.

(OAS; W-00-04-31075; A-06-04-00000; expected issue date: FY 2004)

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 have been expended in the absence of the waiver. We will also assess how consistently CMS calculates, approves, and monitors cost effectiveness.

(OAS; W-00-03-31065/31066; various reviews; OEI; 00-00-00000; expected issue date: FY 2004/05)

Medicaid Payments for Medicare-Covered Services

We will determine whether Medicaid paid for any services covered and paid for by Medicare. Preliminary information indicates that several States 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; various reviews; expected issue date: FY 2004)

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-00-04-31045; various reviews; expected issue date: FY 2004)

Upper Payment Limits

We will determine how CMS's March 2001 revised regulations have affected State enhanced payments. 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. Our work will focus on the amount of Medicaid funding claimed by selected States as part of upper-payment-limit programs, as well as the use of the funds. Our review will also determine whether States correctly calculated 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; various reviews; expected issue date: FY 2004)

Calculation of Upper Payment Limits for Transition States

At the request of CMS, we will determine whether State upper payment limits were reasonable and calculated in accordance with CMS's March 2001 revised regulations and the approved State plans. In addition, for States with upper-payment-limit methodologies for hospitals, we will determine if States properly included upper-payment-limit payments when calculating disproportionate share hospital-specific payment limits. Since the revised regulations include transition periods for State compliance, we will also determine whether selected States are properly transitioning into the new regulations.

(OAS; W-00-03-39001; various reviews; expected issue date: FY 2004)

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 private and county institutions for mental diseases. Our prior work found that some States did not comply with Federal regulations prohibiting Federal funding for services provided to such patients. We will also determine if improper claims were made

for residents of institutions for mental diseases who were under age 21.
(OAS; W-00-03-31005; various reviews; expected issue date: FY 2004)

Assisted Living Facilities

In several States, we will determine whether providers were improperly reimbursed for services provided to residents of assisted living facilities and the financial impact on the Medicaid program. In some States, assisted living facilities receive a daily Medicaid rate for their residents' home care services. Outside providers should not submit separate claims for home care services because these services are included in the Medicaid rates paid to the assisted living facilities.

(OAS; W-00-04-31076; various reviews; 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. 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)

State-Employed Physicians and Other Practitioners

We will review Medicaid payments to physicians and other health care practitioners who are State employees. Recently, several States submitted State plan amendments to CMS, requesting that enhanced payments be made to State-employed physicians. Often, these payments were supplemental values based on a relationship between regular physician payments and the physician's customary charges. Although CMS denied these proposed amendments, we are interested in further analyzing physician payments. OMB has expressed interest in this area.

(OAS; W-00-04-31081; A-00-04-00000; expected issue date: FY 2005)

Skilled Professional Medical Personnel

At the request of CMS, we will determine whether States have improperly claimed enhanced Federal funding for skilled professional medical personnel. For these professionals, States may claim Federal funds at the enhanced rate of 75 percent.

(OAS; W-00-04-31077; various reviews; expected issue date: FY 2004)

Family Planning Services

This review will determine whether several States improperly claimed enhanced Federal funding for family planning services and the financial impact on the Medicaid program. States may claim Medicaid reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. Prior work identified services that should not have been claimed at the enhanced rate.

(OAS; W-00-04-31078; various reviews; expected issue date: FY 2004)

Controls Over the Vaccine for Children Program

This study will determine whether controls are in place in State Medicaid billing systems to identify and prevent payments for vaccines that were provided under the Vaccines for Children Program. The program provides free vaccines to low-income children who are eligible for Medicaid, have no health insurance, are Native American, or are underinsured. The Centers for Disease Control and Prevention pays for the vaccines, either directly or through reimbursement to States. We will identify any physicians who have billed Medicaid for these free vaccines.

(OEI; 01-03-00240; expected issue date: FY 2004)

School-Based Health Services

We will determine whether Medicaid payments for school-based health services were in accordance with laws and regulations. States are permitted to use their Medicaid programs to help pay for certain health care services, such as physical and speech therapy, delivered to children in schools. 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-00-03-31048/31050/31051/39002/31017/31061/31062; various reviews; 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)

Adult Rehabilitative Services

At the request of CMS, we will determine whether adult rehabilitative services claimed by a selected State met Federal Medicaid reimbursement requirements. Preliminary work related to child rehabilitation services identified numerous claims for services not eligible for Medicaid. We will determine if similar problems exist in the adult services program.

(OAS; W-00-03-39005; various reviews; expected issue date: FY 2004)

Outpatient Alcoholism Services

We will determine whether providers were reimbursed for improper claims for outpatient alcoholism services. Medicaid reimbursement is available for outpatient alcoholism services provided in hospital-based or free-standing clinics. Prior work identified significant noncompliance with Federal and State regulations. In several States, we will conduct reviews at the providers that receive the largest amounts of Medicaid reimbursement.

(OAS; W-00-04-31079; various reviews; expected issue date: FY 2004)

Administrative Costs of Other Public Agencies

At the request of CMS, we will determine whether the administrative costs claimed by selected States were reasonable, allocable, and allowable for reimbursement under the Medicaid program. State Medicaid agencies have limited incentive or capacity to carefully scrutinize Medicaid administrative claims generated by other State agencies. Our work will include costs claimed at the regular 50-percent matching rate and at the enhanced 75-percent rate.

(OAS; W-00-03-39004; various reviews; expected issue date: FY 2004)

Home- and Community-Based Services Administrative Costs

At the request of CMS, we will determine whether a selected State claimed costs for home- and community-based services in accordance with Federal and State regulations. In this State, a mental retardation agency administers mental retardation services under a home- and community-based services waiver. The agency retains a portion of the amounts due to service providers to cover administrative costs. Our review will determine whether the State has properly followed Federal antifactoring and other rules governing provider rate setting and payment.

(OAS; W-00-03-39003; various reviews; expected issue date: FY 2004)

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. We will also review how States ensure compliance with these rules.

(OEI; 00-00-00000; expected issue date: FY 2004)

Administrative Costs of Medicaid Managed Care Organizations

In several States, we will determine whether administrative costs incurred by Medicaid MCOs were reasonable, necessary, and allocable. States generally do not regulate or analyze administrative costs incurred by Medicaid MCOs.

(OAS; W-00-04-31070; various reviews; 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-00-03-31021; various reviews; expected issue date: FY 2004)

Medicaid Accounts Receivable

This review will examine States' procedures for identifying, recording, and collecting Medicaid overpayments from providers. We will also determine whether States have refunded the Federal share of collected overpayments to the Federal Government, including Medicaid recoveries resulting from fraud and abuse collection efforts. According to recent information, one 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; various reviews; OEI; 00-00-00000; expected issue date: FY 2004/05)

Information Systems Controls

Security Planning for CMS Systems Under Development

We will determine whether CMS has adequately addressed information systems security requirements as major new systems are designed, developed/acquired, and implemented. Federal law and departmental policy require that information security be practiced throughout the life cycle of each system. CMS uses a Systems Development Life Cycle roadmap to manage the design, development, and implementation of new systems. At the CMS central

office, we will determine whether the roadmap was appropriately structured to meet all Federal information security requirements. Subsequently, we will review security plans and related internal control deliverables for major new systems, such as the Health Insurance General Ledger Accounting System, the Medicare Managed Care Systems Redesign, and the Common Working File System Redesign, to determine whether they conform to Federal guidelines and incorporate best practices from the public and private sectors.
(OAS; W-00-04-41001; various reviews; expected issue date: FY 2004/05)

Systems Controls in Medicare Quality-of-Care Systems

We will assess the effectiveness of general and application controls in Medicare quality-of-care systems, such as those used by quality improvement organizations, State certifying agencies, and ESRD networks. These systems receive, process, and store sensitive Federal information which, in a number of cases, is subject to the Privacy Act of 1974 and/or the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. They also exchange data with CMS using agency mission-critical network facilities and could pose a security risk to CMS. At the CMS central office, we will determine the nature and extent of CMS contractual requirements and oversight processes for internal controls covering the quality-of-care systems. Prior reviews disclosed that the systems were not fully included in CMS's systems security efforts.

(OAS; W-00-04-41002; A-17-04-00000; expected issue date: FY 2005)

Medicaid Statistical Information System

In two States, we will determine the integrity and completeness of eligibility and claim data in the Medicaid Statistical Information System. Federal legislation requires that all States submit their eligibility and claim data on a quarterly basis to CMS by using the system. The data are subject to quality edits to ensure that they fall within certain acceptable error tolerance guidelines. CMS then creates tape files, which serve as a historical source of nationwide Medicaid eligibility and paid claim data. These files are used for such purposes as health care research and evaluation, program utilization and expenditure forecasting, analyses of policy alternatives, and responses to congressional inquiries.

(OAS; W-00-04-41003; A-02-04-00000; expected issue date: FY 2004)

State Controls Over Medicaid Payments and Program Eligibility

We will evaluate State information systems controls over Medicaid claim processing and program eligibility. Medicaid uses several systems to process Medicaid claims and claims for beneficiaries who are dually eligible for Medicaid and Medicare. We have not reviewed these systems to determine the security of the data. Our review will cover (1) entity-wide security program planning and management, (2) access controls, (3) application software development and change controls, (4) system software, (5) segregation of duties, and (6) service continuity. In addition, we will follow up on the unresolved findings from self-assessments and any other

relevant audit reports on information systems controls.
(OAS; W-00-03-40019, -04-40019; various reviews; expected issue date: FY 2004)

Replacement State Medicaid System

We will assess the effectiveness of one State's monitoring of a replacement Medicaid system. The review will focus on the State's oversight of key dates for implementing system components and actions taken to ensure that effective controls are in place as the new system goes online. The State's \$340 million contract to develop the system calls for the establishment of an extensive data warehouse environment for analyzing hundreds of millions of annual Medicaid claims, the upgrade of the existing Medicaid Management Information System software, and the development of a new Electronic Medicaid Eligibility Verification System.

(OAS; W-00-04-41004; A-02-04-00000; expected issue date: FY 2004)

Smart Card Technology

At CMS's request, we will assess the use of "smart card" technology in Medicare demonstrations as a means of fostering portable, electronic patient medical records. Our review will focus on information security, data privacy, and program integrity concerns. The Secretary's Advisory Commission on Regulatory Reform recommended that HHS establish a multidisciplinary panel to evaluate the use of this technology in the Medicare program and that OIG provide technical assistance to prevent fraud and abuse. We plan to determine the current state of the technology; identify risk assessments performed by information security, data privacy, and insurance fraud experts; and provide recommendations on the suitability of using smart cards in Medicare health care demonstration projects, as well as measures to mitigate potential risks.

(OAS; W-00-04-41005; A-00-04-00000; expected issue date: FY 2005)

Compliance With the Health Insurance Portability and Accountability Act—University Hospital

Our review will determine whether a university hospital's information and security systems meet HIPAA standards. HIPAA mandated that all handlers of patient information meet standards on keeping the information private and confidential. We will determine whether Medicare and Medicaid beneficiary data are appropriately safeguarded. In addition, we will follow up on any unresolved findings from other audit reports on information systems controls.

(OAS; W-00-04-41006; A-05-04-00000; expected issue date: FY 2004)

Compliance With the Health Insurance Portability and Accountability Act-Managed Care Organization

We will evaluate an MCO's general and application controls over electronic transmission of patient data to determine compliance with HIPAA security requirements. HIPAA contained an electronic transactions rule that required health care providers to maintain adequate security to prevent accidental or intentional disclosure of patient health care data. (OAS; W-00-03-41007; A-04-03-00000; expected issue date: FY 2004)

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 2005)

FY 2003 Medicare Error Rate Estimate

We will determine whether CMS can produce a valid and reliable Medicare fee-for-service paid claims error rate estimate for FY 2003. From FY 1996 through FY 2002, OIG estimated and provided to CMS the Medicare nationwide error rate. From FY 2003 forward, CMS will produce the error rate. We will examine whether CMS has adequately implemented Comprehensive Error Rate Testing (CERT) to review all Medicare fee-for-service claims except prospective payment system inpatient claims and the Hospital Payment Monitoring Program (HPMP) to produce an error rate for prospective payment system hospitals. (OAS; W-00-03-40011; A-17-02-02202; expected issue date: FY 2004)

FY 2004 Medicare Error Rate Estimate

This followup review will determine whether CMS has produced a valid and reliable Medicare fee-for-service paid claims error rate estimate for FY 2004. FY 2004 will be the second year that CMS will have developed the error rate but the first year that the projection will include data on all provider types for a full year. We will examine whether CMS has adequately implemented CERT to review all Medicare fee-for-service claims except

prospective payment system inpatient claims and the HPMP to produce an error rate for prospective payment system hospitals.

(OAS; W-00-04-40011; A-17-04-00000; expected issue date: FY 2005)

Provider Overpayments

We will assess the controls in place at the CMS central office and the Medicare contractors and determine whether identified provider overpayments were properly established as accounts receivable, adequate recovery action was taken, identified overpayments were offset against other claims if warranted, and provider cost reports were properly adjusted. We will also determine whether CMS appropriately recovered overpayments from providers that receive periodic interim payments. We have indications that recovery actions are not being pursued on a significant amount of provider overpayments. This could cause serious financial management problems as well as losses to the Medicare trust fund.

(OAS; W-00-04-35111; various reviews; 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, which occur when 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-00-03-35032/35087; various reviews; expected issue date: FY 2004)

Payments for Services to Dually Eligible Beneficiaries

This study will determine whether State Medicaid agencies and Medicare contractors have complied with Medicare and Medicaid requirements when paying dually eligible claims. When individuals are dually eligible for both Medicare and Medicaid, Medicare is responsible for paying the Medicare benefits. When States identify a Medicare liability, they must submit claims to Medicare within certain time limits and request recovery. We will examine how effectively States and Medicare contractors coordinate to ensure timely and adequate payments.

(OEI; 00-00-00000; expected issue date: FY 2004)

Nursing Home Quality of Care: Best Practices

In a series of reviews, we will examine effective practices that lead to high quality of care in nursing homes. For example, we will examine functional status outcomes; staffing measures, including salary, training, recruitment, and retention levels; and organizational characteristics

and model practice systems associated with positive outcomes. We will also explore ways to assess the impact of reimbursement levels on quality of care.
(*OEI; 00-00-00000; expected issue date: FY 2005*)

Nursing Home Comparison Data

This study will assess the completeness and accuracy of “Nursing Home Compare” information. In 1998, HHS launched the Nursing Home Compare Web site, which provides information on the quality of individual nursing homes to help Medicare beneficiaries and their caregivers choose the home that best fits their needs. We will determine whether the Web site includes all Medicare- and Medicaid-certified nursing homes and whether posted nursing home inspection results accurately reflect actual State survey data.
(*OEI; 01-03-00130; expected issue date: FY 2005*)

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 any inappropriate Medicare and Medicaid reimbursement.
(*OEI; 00-00-00000; expected issue date: FY 2005*)

Group Purchasing Organizations

We will continue to determine how group purchasing organizations (GPOs) and their members used revenue obtained from vendor fees. We will also evaluate the economy and efficiencies of multiple layers of GPOs within GPOs. Because all GPOs operate with funds obtained from vendor fees, excessive costs translate into higher vendor prices for the goods and services ultimately paid for by Medicare, Medicaid, and private payers. We will analyze the impact of GPO arrangements on the Medicare program.
(*OAS; W-00-03-35093; various reviews; expected issue date: FY 2004*)

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-00-03-35028; various reviews; expected issue date: no report*)

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.

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. 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.

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. 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.

OI will also increase its attention to 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. OI must do everything that it can to ensure a safe environment for Medicare and Medicaid patients.

OIG 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. OIG 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. 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 OIG, the Office of Counsel to the Inspector General (OCIG) coordinates 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. OCIG represents OIG in administrative litigation, such as civil monetary penalty and program exclusion cases. In addition, OCIG issues special fraud alerts, special advisory bulletins, 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 2004 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. In FY 2004, we plan to issue revised compliance program guidance pertaining to 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.

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 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 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.

Providers' Compliance With Corporate Integrity Agreements

We will continue to assess the compliance of providers with the terms of over 350 corporate integrity agreements (and settlements with integrity provisions) into which they entered while settling fraud and abuse allegations. We will continue to conduct 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 compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action.

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.

Anti-Kickback Safe Harbors

In FY 2004, 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.

Patient Antidumping 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 antidumping statute in FY 2004.

Program Exclusions

Based on cases developed by OI, we anticipate reviewing and implementing the exclusion of several thousand providers from participation in Federal health care programs. When warranted, we also expect to affirmatively 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 other statute authorizing exclusions by OIG.

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; and other offenses actionable under section 1128A of the act and other civil monetary penalty authorities delegated to OIG.