

# Department of Health and Human Services

## Office of Inspector General Projects



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## MEDICARE HOSPITALS

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### **Medicare Payment Error Prevention Program**

We will assess the progress of the Medicare peer review organizations' Payment Error Prevention Program in reducing hospital payment errors. This \$148 million program began in August 1999 with a State-by-State surveillance system, including an aggregate sample of about 60,000 medical review cases. We will use these data, along with interviews with various beneficiary and provider organizations, to identify the nature of payment errors, the actions taken by peer review organizations, and the extent of recoupment by fiscal intermediaries.

*OEI; 00-00-00000*

### **Medical Education Payments**

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

*OAS; W-00-01-30010; A-04-01-01002*

### **Hospital Privileging Activities**

We will review the nature and extent of hospital privileging activities within the context of Medicare conditions of participation. One of the most fundamental internal safeguards in hospitals is the routine practice of granting initial or renewed privileges to physicians. Hospital privileging is the process by which a hospital determines the scope of allowable practice for each physician within that hospital. It occurs at the onset of a physician's relationship with a hospital and on some recurring basis thereafter.

*OEI; 00-00-00000*

### **One-Day Hospital Stays**

We will evaluate controls designed to ensure the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only 1 day in a hospital. Recent data indicate that approximately 10 percent of all Medicare patients admitted are released the following day. Our review will concentrate on the adequacy of controls to detect and deny

inappropriate payments for 1-day stays and the Centers for Medicare and Medicaid Services (CMS) program integrity studies in this area.

*OAS; W-00-00-30010; A-03-00-00007*

### **Hospital Discharges and Subsequent Readmissions**

This series of reviews will examine Medicare claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same or another acute care prospective payment system hospital. We will review procedures at selected hospitals, fiscal intermediaries, and peer review organizations for these time-related admissions. With the assistance of CMS medical review resources, we plan to determine if these claims were appropriately paid. We will also review claim processing procedures to determine the effectiveness of existing system edits used to identify and review diagnosis- and/or time-related admissions.

*OAS; W-00-00-30010; A-14-00-00430, -03-01-00011*

### **Consecutive Inpatient Stays**

We will examine the extent to which Medicare beneficiaries receive acute and postacute care through sequential stays in different providers. Medicare allows care in different facilities according to each beneficiary's needs; however, inpatient services may be denied, based on peer review organization review, for patients admitted unnecessarily for one stay or multiple stays. As part of our review, we will assess CMS instructions for identifying and evaluating consecutive beneficiary stays, including those in skilled nursing facilities, long-term-care hospitals, and prospective payment system-exempt units.

*OEI; 03-01-00430*

### **Payments to Acute Care Prospective Payment System Hospitals**

This update will examine diagnosis-related groups that have a history of abusive coding to determine whether some prospective payment system hospitals continue to exhibit aberrant coding patterns. Our study will incorporate the results of a recent review by the Payment Error Prevention Program on diagnosis-related groups with significant patterns of coding errors.

*OEI; 00-00-00000*



## **Implementation of Critical Access Hospital Program**

We will examine the implementation of the critical access hospital program. This program allows certain small, limited-service hospitals to receive Medicare reimbursement for acute care on a cost basis rather than a prospective payment basis. We will assess the approved State plans for compliance with statutory provisions and CMS regulations. We will also characterize utilization in these new Medicare providers, including the length of stays and geographic locations of beneficiaries who use them.

*OEI; 00-00-00000*

## **Satellite Hospitals**

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

*OEI; 00-00-00000*

## **Prospective Payment System Transfers During Hospital Mergers**

We will determine the extent to which prospective payment system hospitals improperly billed for Medicare inpatient transfers when merging or consolidating multiple hospitals. Our preliminary review identified a number of cases in which two or more hospitals merged or were consolidated under a single provider number and improperly reported Medicare patients transferred to the new provider number. In the case of a change of ownership (including consolidation of providers), Medicare regulations permit only the discharging hospital to bill and receive payment.

*OAS; W-00-98-30010; A-06-00-00044*

## **Diagnosis-Related Group Payment Limits**

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

groups. Our prior reviews indicated that a lack of controls had resulted in significant overpayments.

*OAS; W-00-00-30010; A-04-00-01220, -02162*

### **Outlier Payments for Expanded Services**

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

*OAS; W-00-00-30010, W-00-01-30010; Various CINs*

### **Periodic Interim Payments**

This review will evaluate the need for some hospitals to continue to receive periodic interim payments. These payments are based on historical data, rather than the number and diagnoses of current Medicare patients. At the close of a hospital’s cost reporting period, the payments are reconciled with the actual claim volume processed by the hospital. According to CMS records, approximately 1,000 hospitals receive periodic interim payments.

*OAS; W-00-01-30010; A-07-01-02616*

### **Uncollected Beneficiary Deductibles and Coinsurance**

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

*OAS; W-00-00-30010; A-04-00-06005, -06010, -14-00-00445*

### **Diagnosis-Related Group Payment Window–Part B Providers**

This review will determine the extent of duplicate claims submitted by Part B providers for services, such as ambulance, laboratory, or x-ray services, provided to hospital inpatients. Under the prospective payment system, hospitals are reimbursed a predetermined amount, depending on the illness and its classification under a diagnosis-related group, for inpatient services furnished to Medicare beneficiaries. Separate payments for nonphysician services

rendered within the current 72-hour diagnosis-related group payment window are not allowed whether the claims are submitted by hospital providers or by Part B providers.

*OAS; W-00-01-30010; A-01-01-00502*

### **Expansion of Diagnosis-Related Group Payment Window**

We will determine the extent of preadmission services rendered outside the current 72-hour diagnosis-related group payment window and the amount of savings that can be achieved by expanding the payment window. In a 1994 report, we identified \$91.8 million of nonphysician outpatient services rendered 4 to 7 days before the day of admission. Our analysis indicated that \$77.2 million, or 84 percent, of these services either were scheduled before the admission or resulted in inpatient admissions. The CMS's longstanding policy is to treat nonphysician outpatient services related to an admission as inpatient services. Our previous review found that the industry practice is to provide preadmission services beyond the current 72-hour payment window.

*OAS; W-00-02-30010; A-01-02-00000*

### **Hospital Reporting of Restraint-Related Deaths**

We will assess hospital compliance with Medicare requirements, issued July 1, 1999, to report all patient deaths that may have been caused by use of 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 are being reported.

*OEI; 00-00-00000*

### **Reporting of Restraint and Seclusion Use in Psychiatric Hospitals**

This followup study will evaluate the extent of mandatory State reporting of restraint and seclusion use, document how States use the reported information, and identify how reporting affects restraint and seclusion usage. The extent to which restraints and seclusion are used in psychiatric hospitals is unknown nationally, since reporting and monitoring are inconsistent and are often hospital- or case-specific or limited to only State public psychiatric hospitals. Recently enacted Medicare conditions of participation for psychiatric hospitals require only reporting on restraints and seclusion that led to a death.

*OEI; 00-00-00000*

## **Outpatient Prospective Payment System**

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

*OAS; W-00-00-30026; A-03-01-00013, -06-00-00045*

## **Outlier Payments Under Outpatient Prospective Payment System**

We will determine the appropriateness of outlier payments under the outpatient prospective payment system and identify any outlier payments paid in error. Significant overpayments can result if providers submit claims with clerical errors that result in overstated charges for services.

*OAS; W-00-02-30026; A-01-02-00000*

## **Outpatient Services on Same Day as Discharge and Readmission**

We plan to review outpatient services provided on the same day that a beneficiary was discharged and readmitted to the same prospective payment system hospital. Our previous review identified Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same acute care prospective payment system hospital. This review will determine (1) whether beneficiaries were discharged from a prospective payment system hospital, transported to another prospective payment system hospital for outpatient services, and readmitted to the first hospital on the same day and (2) the appropriateness of Medicare reimbursement for the outpatient services.

*OAS; W-00-02-30026; A-01-02-00000*

## **Outpatient Pharmacy Services at Acute Care Hospitals**

Our review will determine the effectiveness of controls over pharmacy services rendered on an outpatient basis. With certain exceptions, Medicare Part B does not cover self-administered drugs. Our work indicates that some hospitals have charged Medicare for self-administered drugs on an outpatient basis. This review will focus on periods before implementation of the outpatient prospective payment system.

*OAS; W-00-01-30026; Various CINs*

## **Outpatient Medical Supplies at Acute Care Hospitals**

This review will assess the effectiveness of controls intended to ensure that medical supply services rendered on an outpatient basis are billed and reimbursed in accordance with Medicare requirements. Our work indicates that some hospitals have charged Medicare for undocumented, unnecessary, and noncovered services. This review will focus on periods before implementation of the outpatient prospective payment system.

*OAS; W-00-01-30026; A-01-01-00501, -00503, -00509*

## **Procedure Coding of Outpatient and Physician Services**

We plan to review the procedure coding of outpatient services billed by a hospital and a physician for the same service. In a previous review, we identified a 23-percent nationwide rate of inconsistency between hospital outpatient department procedure coding and physician procedure coding for the same outpatient service. This review will determine whether these coding differences continue and, if so, how they affect the Medicare program.

*OAS; W-00-02-30026; A-01-02-00000*

## **Peer Review Organization Sanction Authority**

This study will determine the types of providers and types of violations for which peer review organizations bear responsibility for sanction referral. We will also examine program performance and any reasons for changes over time, and we will look at other Medicare contractors that hold similar responsibilities.

*OEI; 00-00-00000*

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## **HOME HEALTH**

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### **Oversight of Home Health Care Quality**

This study will assess the overall capacity of systems designed to monitor the quality of Medicare home health care, particularly the State survey and certification program. All home health agencies participating in Medicare must be surveyed by the State in order to be certified as meeting Federal requirements. We will follow up on a recent OIG report which raised concerns about the infrequency of home health surveys and noted inconsistencies among State survey protocols.

*OEI; 00-00-00000*

## **Home Health Compliance Programs**

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

*OEI; 00-00-00000*

## **Home Health Payment System Controls**

We will monitor implementation of the new prospective payment system used to pay home health agencies for providing care to Medicare beneficiaries. The prior payment system was based on cost reimbursement principles. We will evaluate the adequacy of controls intended to ensure that services are provided only to homebound individuals and are adequately documented, properly coded, and medically necessary, as well as controls over advance payments to providers. We will also determine whether payments are appropriately based on the location where the service is provided (in the patient's home), rather than where the service is billed (typically the urban location of the parent home health agency).

*OAS; W-00-01-30009; Various CINs*

## **Coding of Home Health Resource Groups**

This review will determine whether home health agencies classified their patients in the appropriate case-mix category. Under the prospective payment system, home health agency payments are based on a 60-day episode and are case-mix- and wage-adjusted. The case mix is based on data elements from the patient's medical assessment that incorporates the Outcomes and Assessment Information Set and the projected number of therapy hours. We will assess whether home health agencies received higher payments than warranted due to miscoding.

*OEI; 00-00-00000*

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## NURSING HOME CARE

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### **Quality Assessment and Assurance Committees**

We will examine the role and effectiveness of quality assessment and assurance committees in ensuring quality of care in nursing homes. The Omnibus Budget Reconciliation Act of 1987 requires each nursing facility to maintain a committee composed of the director of nursing, a physician, and at least three other staff members. The committee is to meet at least quarterly to identify quality assessment and assurance activities and to develop and implement appropriate plans of action to correct identified quality deficiencies. The CMS requires surveyors to determine whether a facility has such a committee and whether it has a method to “identify, respond to, and evaluate” issues in quality of care. This review is one of a series on the quality of care in nursing homes.

*OEI; 01-01-00090*

### **Nurse Aide Training**

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

*OEI; 05-01-00030*

### **Family Experience With Nursing Home Care**

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

*OEI; 04-98-00550*

### **Three-Day Stay Requirement**

We will follow up on the CMS response to the findings and recommendations of our prior review of patient eligibility for care in skilled nursing facilities. We found that some Medicare patients were not eligible for such care because they had not received sufficient hospital/nursing home care before the skilled nursing care.

*OAS; W-00-02-30014; A-05-02-00000*

*Expected Issue Date: FY 2003*

### **Consolidated Billing Requirements**

We will monitor CMS's efforts to determine the extent of overpayments during Calendar Year 2000 for certain Part B services subject to the consolidated billing provisions of the prospective payment system for skilled nursing facilities. As set forth in the Balanced Budget Act of 1997, consolidated billing requires that skilled nursing facilities bill Medicare for virtually all services rendered to their residents during Part A stays. Prior OIG work found that Medicare contractors made millions of dollars of separate Part B overpayments to outside suppliers for services that were subject to consolidated billing. As a result, Medicare paid twice for the same service—once to the nursing facility under the Part A prospective system and again to an outside supplier under Part B. We will also monitor the success of CMS's collection of previously identified overpayments.

*OAS; W-00-00-30014; A-01-00-00538, -01-01-00528*

### **Survey and Certification Process**

This study will follow up on two reports, dated March 1999, on the State survey and certification process and trends in deficiency data from the Online Survey, Certification, and Reporting System. Since we issued those reports, CMS has taken a number of steps to strengthen survey and enforcement efforts. We will evaluate these nursing home initiatives.

*OEI; 00-00-00000*

### **Use of Penalties**

We will examine availability and use of State and Federal penalties imposed on deficient nursing home providers. The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 set the standards that nursing facilities must meet to participate in Medicare and established the State survey and certification process to determine compliance with Federal standards. In December 1999, as part of its initiative on nursing homes, CMS



issued new guidance to States on enforcing nursing home quality standards. We will examine trends in the use of penalties before and after the nursing home initiative.

*OEI; 00-00-00000*

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## **HOSPICE CARE**

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### **Plans of Care**

This study will examine the variance among hospice plans of care and the extent to which services are provided to hospice patients in accordance with the plans of care. Although hospice patients are required to have plans of care, there are no requirements or minimum standards that the plans must meet. In previous OIG work on the nursing home population, we found that plans of care varied and that services were generally provided in accordance with the plans of care. We will examine the plans of care for both nursing home and non-nursing-home populations.

*OEI; 00-00-00000*

### **Hospice Payments to Nursing Homes**

We will examine the financial implications of Medicare hospice payments made on behalf of patients residing in nursing facilities. Our previous work found that payment levels for patients in nursing facilities may be excessive. When a patient is entitled to both Medicare and Medicaid, the nursing home no longer bills the State Medicaid program for the patient's long-term care. Instead, the nursing home bills and receives payment from the hospice and the hospice is reimbursed by Medicaid. Medicaid payments for room and board are in addition to Medicare's daily fixed rate paid to the hospice. For private pay patients, Medicare pays the hospice and the resident continues to pay the nursing facility directly. This study will follow up on our early work with a special emphasis on private pay patients.

*OEI; 05-01-00170*

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## **PHYSICIANS**

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### **Beneficiary Access to Preventive Services**

This study will evaluate beneficiaries' access to the expanded preventive services offered by Medicare since the passage of the Balanced Budget Act of 1997. The act created four classes of covered preventive services: annual screening mammography for all women aged 40 and

over; screening pap smear and pelvic exams every 3 years; colorectal screening; and bone mass measurements to identify bone mass, detect bone loss, or determine bone quality.

*OEI; 00-00-00000*

### **Advance Beneficiary Notices**

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

*OEI; 00-00-00000*

### **Physicians at Teaching Hospitals**

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

*OAS; W-00-02-30021; A-03-02-00000*

*Expected Issue Date: No Report*

### **Billing for Residents' Services**

We will determine whether hospitals have properly used residents' physician identification numbers to bill Medicare. Medicare regulations allow residents, who are licensed physicians, to be issued physician identification numbers for purposes of billing Medicare for their services. However, residents may bill Medicare only when they are "moonlighting," which is defined as providing medical treatment, other than in their field of study, in an outpatient clinic or an emergency room.

*OAS; W-00-02-30021; A-00-02-00000*

*Expected Issue Date: FY 2003*

## **Physician Evaluation and Management Codes**

We will determine whether physicians correctly coded evaluation and management services in physician offices and effectively used documentation guidelines. We will also assess whether carriers identified any instances of incorrect coding and what corrective actions they took. Medicare payments for evaluation and management codes total approximately \$18 billion per year and account for almost half of Medicare spending for physician services. Since 1992, Medicare has used visit codes developed by the American Medical Association to reimburse physicians for evaluation and management services. Generally, the codes represent the type and complexity of services provided and the patient status, such as new or established. Revised guidelines were issued in the 1995 and again in 1997. Following the issuance of the 1997 guidelines, providers were told that they could use either the 1995 guidelines or the 1997 guidelines. Revised guidelines are again under development.

*OEI; 00-00-00000*

## **Consultations**

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

*OEI; 00-00-00000*

## **Inpatient Dialysis Services**

This review will determine whether Medicare payments for inpatient dialysis services met the billing requirements of Medicare Part B. The Medicare Carrier Manual requires that the physician be physically present with the patient at some time during the dialysis and that the medical records document this in order for the physician to be paid on the basis of dialysis procedure codes. If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, physician services are billable under the appropriate hospital visit codes. Fee schedule amounts for inpatient dialysis codes are higher than those for hospital visit codes.

*OAS: W-00-01-30021; A-09-01-00068*

## **Bone Density Screening**

We will evaluate the impact of the recent standardization and expansion of Medicare coverage of bone density screening. Bone mineral density studies assess an individual's risk for fracture. Before the Balanced Budget Act of 1997, coverage for bone mass measurements

varied by carrier. Effective July 1, 1998, the act standardized coverage of these studies. As the number of claims for bone density screening increases, there are questions about the appropriateness and quality of some services.

*OEI; 00-00-00000*

### **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 and 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; 00-00-00000*

### **Reassignment of Benefits**

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

*OEI; 04-01-00080*

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## **MEDICAL EQUIPMENT AND SUPPLIES**

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### **Medical Necessity of Durable Medical Equipment**

We will determine the appropriateness of Medicare payments for certain items of durable medical equipment, including wheelchairs, support surfaces, 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; 00-00-00000*

## **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 manual wheelchairs, support surfaces, blood glucose test strips, diabetic supplies, and parenteral and enteral nutrition.

*OEI; 00-00-00000*

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## **LABORATORY SERVICES**

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### **Clinical Laboratory Improvement Amendments Certifications**

We will determine whether laboratories conduct tests and bill Medicare within the scope of their certifications under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Laboratories with certifications of waiver or physician-performed microscopy procedures may perform only a limited menu of test procedures. Moderate- and high-complexity laboratories are also restricted to testing certain preapproved specialty groups and must meet CLIA standards. We will use CLIA certification and Medicare billing records to assess compliance with these requirements.

*OEI; 05-00-00050*

### **Medicare Billings for Cholesterol Testing**

We will determine whether cholesterol tests billed to Medicare are medically necessary and accurately coded. Although total cholesterol testing can be used to monitor many patients, Medicare claims reflect a preponderance of claims for lipid panels, which include HDL cholesterol and triglycerides also. Systems capable of doing all three tests, plus glucose, are advertised on the Internet as CLIA-waived. We will examine Medicare claims for the frequency of testing and the medical necessity of lipid panels.

*OEI; 00-00-00000*

### **Clinical Laboratory Proficiency Testing**

We will assess the policies and procedures used for proficiency testing under CLIA and examine the quality of the testing results. The CLIA requires all moderate- and high-complexity laboratories to enroll with an approved proficiency testing agency for certain tests. These agencies are responsible for grading the accuracy of a laboratory's results; repeated failures can cause the laboratory to lose approval to perform those and similar tests. Because

of the critical importance of proficiency testing, we will examine the testing and grading process.

*OEI; 00-00-00000*

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## **END STAGE RENAL DISEASE**

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### **Utilization Service Patterns of Beneficiaries**

We will describe the utilization of health care services by end stage renal disease beneficiaries and assess the medical necessity and accuracy of coding of selected categories of services provided outside the composite rate. Recent settlements with major corporations and laboratories that serve end stage renal disease patients have raised questions about Medicare payments for a wide range of services.

*OEI; 00-00-00000*

### **Medicare Payments for EPOGEN®**

We will evaluate controls used to adjudicate potentially excessive Medicare claims submitted by dialysis facilities for the drug EPOGEN®. The Omnibus Budget Reconciliation Act of 1990 established the EPOGEN® reimbursement rate at \$11 per 1,000 units administered. Subsequently, the rate was reduced by statute to \$10 per 1,000 units administered. During an ongoing review of outpatient services, we identified claims for an excessive number of units; e.g., 7.5 million units were claimed when, in fact, only 75,000 units were administered, resulting in an overpayment of approximately \$74,000.

*OAS; W-00-02-30025; A-01-02-00000*

### **Method II Billing**

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

*OEI; 00-00-00000*

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## **DRUG REIMBURSEMENT**

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### **Medicare Coverage of Prescription Drugs**

We will assess whether prescription drugs paid for by Medicare met coverage requirements and determine the extent to which drug coverage decisions varied among Medicare carriers. Medicare does not pay for over-the-counter or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment. Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

*OEI; 00-00-00000*

### **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. Medicare and its beneficiaries paid \$3.9 billion for prescription drugs in 1999. Previous OIG reports 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*

### **Medicare Billings for Nebulizer Drugs**

This study will determine whether Medicare payments for inhalation drugs are appropriate and whether the drugs are priced appropriately. Medicare covers prescription inhalation drugs used with nebulizers if the nebulizer provides effective therapy for a beneficiary's respiratory illness. Allowances for inhalation drugs have increased steadily, from more than \$332 million in 1995 to over \$540 million in 1999. We will determine whether suppliers' documentation supports their claims and whether the claims are medically necessary. In addition, we will compare Medicare fee schedules for inhalation drugs with other sources, such as third-party coverage available to beneficiaries and prices paid by other Federal insurers.

*OEI; 00-00-00000*

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## OTHER MEDICARE SERVICES

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### **Beneficiaries' Experiences With Medigap Insurance**

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

*OEI; 00-00-00000*

### **Rural Health Clinics**

We will follow up on our previous study of rural health clinics to determine whether our recommendations have been implemented and what changes have occurred as a result of the Balanced Budget Act of 1997. Our study, as well as a review by the General Accounting Office, sparked legislative change that capped provider-based rural health clinic reimbursement and created a triennial certification process to prevent the proliferation of clinics in nonrural areas. Our report offered a number of measures that CMS could take to improve the functioning and oversight of this program.

*OEI; 00-00-00000*

### **Medicare Payments for Clinical Trials**

This study will determine whether Medicare payments associated with clinical trials were made in accordance with program requirements. We will also assess program safeguards related to clinical trial claim processing requirements. Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types and informing payers about what services to cover. Beginning in September 2000, Medicare began paying for items and services related to clinical trials. Payment now includes costs associated with items and services that Medicare would otherwise cover if they were not provided in the context of a clinical trial. Also covered are items and services required "solely for the provision of the investigational item or service," as well as monitoring and evaluation, device implantation, and other costs, such as room and board during a hospital stay required as part of a clinical trial. Medicare does not pay for the investigational intervention being tested in a trial.

*OEI; 00-00-00000*



## **Medicare Mental Health National Error Rate**

We will develop a national payment error rate for Medicare fee-for-service mental health claims. Medicare paid approximately \$4.85 billion in 1999 for services related to mental health. Hospital inpatient services amount to almost three-quarters of the total, while physicians, skilled nursing facilities, home health agencies, and community mental health centers account for lesser amounts. We will conduct medical reviews of a sample of claims to determine medical necessity, coding accuracy, coverage, and (for inpatient services) setting of care.

*OEI; 00-00-00000*

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## **MEDICARE MANAGED CARE**

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### **Adjusted Community Rate Proposals**

We will examine the trend factors used by managed care organizations (MCOs) to price their medical package of benefits over a several-year period. Through adjusted community rate proposals, MCOs present to CMS their estimate of funds needed to cover the costs of providing a Medicare package of covered services to an enrolled Medicare beneficiary. The proposals serve as a payment safeguard, requiring plans to demonstrate that the money received from Medicare is used to provide services to Medicare beneficiaries, and are used to verify compliance with the Medicare statute regarding required benefits and cost-sharing provisions. A plan's ability to accurately project its costs in an upcoming contract year affects its participation in the Medicare managed care program. We will also review the impact of changes to adjusted community rate proposals brought about by the Benefits Improvement and Protection Act of 2000.

*OAS; W-00-02-30012; Various CINs*

### **General and Administrative Costs**

This review, expected to be completed early in FY 2002, will examine the administrative cost component of adjusted community rate proposals and assess whether the costs were appropriate when compared with the Medicare program's general principle of paying only reasonable costs. Administrative costs include marketing costs, administrative salaries, interest expenses, and claim processing costs. Initiated at the request of the prior CMS administration, the review will include several MCOs located throughout the United States.

We will also review MCOs' increased use of management fees and their impact on additional benefits and the pricing of a plan's medical package.

*OAS; W-00-98-30012; Various CINs*

### **Cost-Based Managed Care Plans**

At CMS's request, we will evaluate the integrity of the cost reporting process used by cost-based managed care plans (Section 1876 Cost Plans and Health Care Prepayment Plans). The CMS currently contracts with more than 30 of these plans, which provide services to more than 300,000 members. The plans file cost reports with CMS outlining the costs they incur in providing health care. Although the reports are audited to ensure that costs are properly allocated, they do not undergo medical reviews to ensure that only Medicare-covered services are included. Our review will also determine whether cost-based plans received any duplicate payments through the fee-for-service program. We will coordinate our review with CMS and its contractors.

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

### **Enhanced Managed Care Payments**

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

*OAS; W-00-99-30012; Various CINs*

### **Managed Care Organization Profits**

This review will compare the profitability of the Medicare line of business with operating results from MCOs' other lines of business. Under the terms of a Medicare risk-based contract, an MCO is required to absorb any losses incurred, and is permitted to retain any savings earned, on its Medicare line of business. We will use this information to evaluate whether Medicare funding is adequate, how profits affect the benefit package, and whether CMS needs to establish criteria on the profitability of Medicare risk-based MCOs.

*OAS; W-00-02-30012; A-14-02-00000*

## **Managed Care Additional Benefits**

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

*OAS; W-00-02-30012; A-14-02-00000, -06-00-00073*

## **Educating Beneficiaries About Medicare+Choice**

We will evaluate the adequacy of CMS's most recent initiatives to educate beneficiaries about Medicare+Choice. As part of this review, we will assess the ease of obtaining program information, the various methods of education, and beneficiaries' understanding of the program.

*OEI; 00-00-00000*

## **Physician Perspectives on Managed Care Organizations**

This followup study will determine whether the experiences and perspectives of physicians who work with Medicare+Choice MCOs have changed since our May 1998 report. That study found that overall satisfaction with Medicare MCOs was low. Forty-three percent of physicians who contracted with Medicare MCOs said that they were very or somewhat dissatisfied, compared with 18 percent who said that they were somewhat or very satisfied. These physicians had numerous concerns relating to the MCO referral process, clinical independence, patient access to care, the complaint and appeal system, quality assurance efforts, and MCO marketing practices.

*OEI; 00-00-00000*

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# **MEDICAID HOSPITALS**

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## **Medicaid Graduate Medical Education Payments**

This review will examine Medicaid graduate medical education (GME) payment programs, the coordination of these payments with Medicare GME payments, and the existence and effectiveness of CMS safeguards and controls over the payment process. Although Medicaid GME payments are not specifically authorized by Medicaid statute, CMS has approved a wide

range of payment arrangements through the State plan amendment process and 1115 waivers. Annual payments by State Medicaid programs for GME are estimated to total over \$3 billion.

*OAS; W-00-02-30013; A-00-02-00000*

### **Hospital-Specific Disproportionate Share Payment Limits**

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

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

### **Medicaid Hospital Patient Transfers**

This review will examine the propriety of Medicaid claims for hospital patient transfers in States that use prospective payment principles in reimbursing hospitals for inpatient admissions. In these States, the payment policy stipulates that when a patient is transferred between prospective payment system hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. This review is an extension of a previous Medicare review that identified significant overpayments as a result of incorrectly reported transfers.

*OAS; W-00-02-30013; Various CINs*

### **Outpatient Clinical Diagnostic Laboratory Services Under Ambulatory Procedure Group Systems**

A nationwide review will determine the appropriateness of Medicaid payments to hospitals for outpatient clinical diagnostic laboratory services in States that use an ambulatory procedure group payment methodology. Specifically, we will determine whether Medicaid payments for certain laboratory and pathology tests exceeded rates allowed by Medicare. An analysis of

claim data found that one State paid hospitals substantially more than Medicare's allowable fee schedule for laboratory services.

*OAS; W-00-02-30027; A-01-02-00000*

### **Credit Balances in Inpatient Accounts**

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

*OAS; W-00-02-30013; A-05-02-00000*

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## **MEDICAID MANAGED CARE**

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### **Marketing and Enrollment Practices**

We will determine whether managed care entities use 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 evaluate how well States carry out these requirements.

*OEI; 00-00-00000*

### **Public-Sponsored Managed Care Health Plans**

This review of the funding arrangements between States and public-sponsored health plans will determine to what extent intergovernmental transfers or other financing mechanisms are used to maximize Federal Medicaid reimbursement. States are developing managed care programs for special populations (e.g., mentally ill and developmentally disabled people) by contracting exclusively with public-sponsored health plans.

*OAS; W-00-02-30013; A-00-02-00000*

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

We will determine whether States have expanded their Medicaid upper payment limit financing arrangements by applying fee-for-service upper payment limits to managed care

payments. Traditional Medicaid fee-for-service payments and Medicaid managed care payments are subject to separate upper payment limits. If a State pays an MCO to assume the risk of caring for Medicaid patients, the payments and beneficiary days should not be included in calculating enhanced payments available under the fee-for-service upper payment limit regulations.

*OAS; W-00-02-30013; A-00-02-00000*

### **Medicaid Fee-for-Service and Managed Care Duplicate Payments**

This review will determine whether Medicaid State agencies made fee-for-service payments to beneficiaries enrolled in Medicaid managed care programs. In selected States, we will examine the extent to which any duplicate payments were made and their financial impact (both Federal and State) and determine whether controls are in place to prevent duplicate payments.

*OEI; 00-00-00000*

### **Pharmacy Benefit Managers**

We will determine the number and experiences of States that contract with pharmacy benefit managers and the extent and effectiveness of CMS and State oversight. Pharmacy benefit managers have emerged as significant players who can help payers and health plans control rising drug costs and improve drug-related services. Our 1995 report indicated that the use of pharmacy benefit managers by Medicare and Medicaid MCOs yielded significant cost savings; however, the MCOs provided minimal oversight of the managers' performance. In 1998, Medicaid paid almost \$14 billion for prescription drugs.

*OEI; 00-00-00000*

### **HIV/AIDS Antiretroviral Drug Therapy**

We will evaluate the relationship between Medicaid MCOs and HIV/AIDS antiretroviral drug therapy coverage and payment. The Balanced Budget Act of 1997 authorized States to require that Medicaid beneficiaries enroll in MCOs. States may opt to exclude HIV/AIDS drug coverage from the MCO contract, in which case Medicaid pays for the drugs on the traditional fee-for-service basis. This study will evaluate the variations among the States' practices and policies on payment for antiretroviral therapy and the impact of MCO payment systems on access to appropriate services for AIDS patients.

*OEI; 00-00-00000*

## **Cost Containment of Medicaid Mental Health Drugs**

We will compare the amounts that Medicaid reimburses for mental health drugs with the prices paid by other Government purchasers. The rising cost of mental health pharmaceuticals presents a budgetary challenge to State Medicaid programs. Although many States have mandatory managed care plans in place for the mentally ill, States typically exclude coverage of prescription mental health drugs from their managed care contracts because of the difficulties in accurately setting capitation rates for those benefits. Therefore, most beneficiaries receive their prescription drugs through Medicaid's traditional fee-for-service system. We will survey States to identify the most-prescribed mental health drugs and to determine whether Medicaid is paying appropriate prices for these drugs.

*OEI; 00-00-00000*

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## **MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

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

We will examine how States manage Medicaid and State Children's Health Insurance Program (SCHIP) outreach and enrollment procedures to reach eligible adolescents. We will also highlight approaches that appear to enhance this population's access to these programs. Medicaid has extended eligibility to 19 years of age for children born after September 30, 1983, who are living at or below 100 percent of the poverty level. Under SCHIP, States also have the option to provide coverage to all children or a focused segment of children who are not eligible for Medicaid, under age 19, and at or below 200 percent of the Federal poverty level. Despite the opportunities offered by the Medicaid expansion and SCHIP, an American Academy of Pediatrics study issued in 1999 projected that in 2000 nearly 2.4 million, or one in six, adolescents aged 13 through 18 would be eligible for but not enrolled in Medicaid or SCHIP. This population has a higher rate of uninsurance than most age groups in the United States.

*OEI; 00-00-00000*

### **Educating Families of Children Newly Enrolled in Medicaid Managed Care**

We will determine whether materials provided by State MCOs adequately inform the families of newly enrolled children in Medicaid and Medicaid expansion programs of (1) the benefits available and (2) the system in place for accessing the services. In addition, we will determine how well States monitor beneficiaries' actual use of services. The CMS reported that as of December 1999, 54.5 percent of the Medicaid-eligible population was served through managed care systems, compared with 23.2 percent in 1994. Providing clear and

comprehensive information to new enrollees will facilitate their entry into the health system, while not offering such information may affect their access to services and possibly impinge on their patient rights.

*OEI; 00-00-00000*

### **Disenrollment From State Children's Health Insurance Program**

We will describe the current levels of SCHIP disenrollment and beneficiaries' reasons for disenrolling. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children's insurance program or expand the existing Medicaid program. Anecdotal evidence indicates that disenrollment levels are higher than CMS anticipated. Measuring the extent of disenrollment is problematic because States have different ways of capturing and reporting these data.

*OEI; 06-01-00370*

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## **OTHER MEDICAID SERVICES**

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### **Mutually Exclusive Procedure Codes**

We will determine the extent of potential overpayments or savings that could accrue to the Federal and State governments under the Medicaid program if edits were implemented to identify and deny payments for procedure codes that CMS has identified as mutually exclusive. These procedures represent medical services that cannot reasonably be rendered in the same session to the same patient by the same provider. The codes are mutually exclusive of one another based on either the Current Procedural Terminology definitions or the medical impossibility/improbability that the procedures could be performed at the same session. As part of the National Correct Coding Initiative, guidelines were established for billing a variety of services. Included within the guidelines, which are not mandated for use in the Medicaid program, are edits for mutually exclusive procedure codes.

*OAS; W-00-00-30027; Various CINs*

### **Payments for Services to Dually Eligible Beneficiaries**

This study will determine whether adequate coordination exists between Medicare and Medicaid in the identification and collection of improper payments. In some cases, Medicaid recipients are eligible for Medicare in addition to Medicaid. In these instances, Medicare is the primary payer for covered services. In accordance with a State's particular plan, Medicaid



assumes responsibility for the recipients' premiums, deductibles, and coinsurances. A November 1995 OIG report found that States did not review the appropriateness or necessity of their crossover payments. This study will assess the extent of any continuing lack of State notification of potentially improper payments.

*OEI; 00-00-00000*

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

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

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

### **Upper Payment Limit Calculations**

We will determine whether State Medicaid agencies correctly calculated Medicare upper payment limits. 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 aggregate limit applies separately to each type of facility in the State (private, State operated, and city/county operated). Federal funds are not available for expenditures that exceed the aggregate limits.

*OAS; W-00-02-30013; A-00-02-00000*

### **Intergovernmental Transfers**

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

payment limits and disproportionate share hospital payments were returned to States through intergovernmental transfers.

*OAS; W-00-02-30013; A-00-02-00000*

### **Nursing Facility Administrative Costs**

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

*OAS; W-00-02-30013; A-06-02-00000*

### **Medicaid Services for the Severely Mentally Ill**

We will review how CMS uses Medicaid home- and community-based services waivers to implement provisions of the U.S. Supreme Court’s Olmstead decision. The decision requires States to provide community-based, integrated services and treatment for people with mental and other disabilities when treatment professionals determine that such treatment is appropriate. According to recent CMS guidance, States may meet these requirements by using Medicaid waiver funds to pay for creative case management, accessibility evaluations, home modifications, and rehabilitation services. This study will focus on the role that the Medicaid program can play in providing integrated, community-based treatment for people with serious mental illness.

*OEI; 00-00-00000*

### **Medicaid Benefits for the Homeless Mentally Ill**

We will review States’ activities to reduce barriers to accessing Medicaid for the homeless mentally ill and follow up on our recommendations that CMS expand access to Medicaid for the homeless. Recent research shows that barriers to access still appear to present a problem for the homeless, especially the homeless mentally ill. This study will determine whether State and local Medicaid enrollment policies and procedures are responsive to the needs of the homeless mentally ill and whether CMS has made any progress in increasing access to Medicaid for eligible homeless people.

*OEI; 00-00-00000*

## **Claims for Residents of Institutions for Mental Diseases**

Our review will determine whether States have improperly claimed Federal financial participation under the Medicaid program for 21- to 64-year-old residents of institutions for mental diseases. Our prior work found that some State Medicaid agencies were not in compliance with Federal regulations that prohibit Federal funding for services provided to such patients.

*OAS; W-00-00-30013; A-02-00-01027*

## **Payments for Inmates of Public Institutions**

We will evaluate the extent to which States use Federal Medicaid funds to pay for health care services provided to inmates and the nature of those payments. Our work involving DSH payments has shown that several States include the cost of providing health services to inmates in the calculation of uncompensated care costs. We will examine current CMS policy regarding the appropriateness of both Federal financial participation and DSH payments for health care services provided to inmates.

*OAS; W-00-00-30013; A-14-00-04001*

## **Restraints and Seclusion in Residential Treatment Centers**

We will evaluate compliance with CMS standards for restraints and seclusion at residential treatment facilities (nonhospital settings) for children and youth. In January 2001, CMS issued a new condition of participation requiring psychiatric residential treatment facilities for individuals under age 21 to establish standards on using restraints or seclusion that protect the health and safety of residents. The new condition provides for the use of restraints or seclusion only in emergency situations to ensure the safety of the resident or others and only until the emergency situation ends. The new condition also prohibits the simultaneous use of restraints and seclusion and requires a facility to inform both the resident and, in the case of a minor, his or her parent(s) or guardian(s) of its policy regarding the use of restraints or seclusion. This study will look at States' policies and procedures for complying with the new condition of participation.

*OEI; 00-00-00000*

## **Discharge Planning: Intermediate Care Facilities/Institutions for the Mentally Retarded**

We will evaluate compliance by intermediate care facilities/institutions for the mentally retarded (ICF/MR) with CMS discharge planning requirements. Currently, about 110,000 developmentally disabled individuals reside in about 6,700 ICF/MRs. Individuals can be transferred or discharged from the facilities for a variety of reasons, such as when the facility can no longer meet the individual's needs, the individual no longer requires an active treatment program in an ICF/MR setting, the individual chooses to reside elsewhere, or another level of service or living situation would be more beneficial. The CMS regulatory guidance on discharge planning includes specific actions that a facility must take, including providing a postdischarge plan of care.

*OEI; 00-00-00000*

## **Durable Medical Equipment Reimbursement Rates**

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

*OAS; W-00-00-30013; A-05-00-00022*

## **Followup on Clinical Laboratory Services**

This review will follow up on our prior audits of clinical laboratory services in 22 States. We will determine the adequacy of State Medicaid agency procedures and controls over the payment of claims for clinical laboratory tests. Specifically, we will determine whether Medicaid payments for chemistry, hematology, and urinalysis tests were duplicated or exceeded amounts recognized by Medicare for the same tests. For clinical laboratory tests performed by a physician, an independent laboratory, or a hospital, Federal matching funds are not available to the extent that a State pays more than the amount Medicare recognizes.

*OAS; W-00-00-30027; A-01-00-00003*

## **Average Wholesale Drug Prices Reported to Medicaid**

We will compare the average wholesale prices reported to Medicaid by First Databank with actual acquisition costs for providers and the Department of Veterans Affairs. All 50 States and the District of Columbia offer prescription drug coverage for Medicaid recipients. Medicaid payments for prescription drugs totaled almost \$14 billion in 1998, accounting for nearly 10 percent of all Medicaid expenditures. Most State Medicaid agencies reimburse pharmacies based on the average wholesale price of a drug less a discount ranging from 4 to 15 percent. Previous OIG reports showed that reported average wholesale prices were significantly higher than the actual prices available to the physician/supplier community and the Department of Veterans Affairs. This study will examine State Medicaid agencies' use of revised average wholesale prices.

*OEI; 03-00-00010*

## **Medicaid Outpatient Prescription Drug Pricing**

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

*OAS; W-00-00-30023; A-06-00-00023*

## **Medicaid Drug Rebate Program**

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

*OAS; W-00-00-30023; A-06-00-00012*

## **Medicaid Rebates for Physician-Administered Drugs**

We will determine whether State Medicaid agencies received rebates for physician-administered drugs. All 50 States and the District of Columbia offer prescription drug coverage for Medicaid recipients. For most drugs, Medicaid uses national drug codes to identify and reimburse for covered drugs. Each drug manufactured or distributed in the United States has a unique code. However, certain injectable and infusion drugs administered by medical professionals are often billed to the Medicaid program on a Medicare claim form and identified using the CMS Common Procedure Coding System rather than national drug codes. Because rebates are based on these product-specific codes, States may not receive rebates for drugs billed via the Common Procedure Coding System.

*OEI; 00-00-00000*

## **Collection of Medicaid Drug Rebates**

We will examine current rebates being collected for Medicaid drugs. To be eligible for Medicaid reimbursement, drug manufacturers are required by Federal law to enter into rebate agreements with Medicaid. Certain products, such as vaccines, are statutorily exempt from rebates. Previous OIG work identified a number of drugs for which there was no rebate amount listed in the CMS Medicaid Drug Rebate Initiative system, yet these drugs did not appear to meet the statutory exemptions. Without a rebate amount, States cannot collect rebates for these drugs. We will identify the dollars lost due to the missing information.

*OEI; 00-00-00000*

## **Medicaid Coverage for the Poor Working Disabled**

We will identify barriers to ensuring continuity of health coverage and increased employment levels among disabled Supplemental Security Income (SSI) recipients. People with disabilities indicate that fear of losing Medicaid coverage is a significant barrier to employment. Those receiving SSI benefits lose SSI eligibility if earned income exceeds \$700 a month (i.e., they are no longer considered disabled). Loss of SSI eligibility means loss of Medicaid eligibility. However, SSI recipients may work off their cash assistance while retaining Medicaid coverage. According to Social Security Administration data, rates of participation in this benefit vary considerably across and within States.

*OEI; 00-00-00000*

## **School-Based Health Services**

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

*OAS; W-00-02-30013; A-00-02-00000*

## **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, during a period of almost 6 years, the State paid \$82 million for services to 26,822 apparently deceased beneficiaries.

*OAS; W-00-01-30013; Various CINs*

## **Escheated Warrants**

This review will determine whether Medicaid payments were properly reported and promptly credited to the Federal program for uncashed or canceled checks, known as escheated warrants. Federal regulations require States to refund the Federal share of uncashed or canceled checks received. Also, at the end of each calendar quarter, States must identify those checks that remain uncashed beyond 180 days after issuance. Previous reviews found that States did not always report warrants timely or properly to ensure that monies were returned to the Federal Government.

*OAS; W-00-02-30013; Various CINs*

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# **MEDICARE CONTRACTOR OPERATIONS**

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## **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.

*OEI; 00-00-00000*

### **Program Safeguard Contractors**

This study will determine whether program safeguard contractors are meeting their intended objectives and are performing in accordance with their contracts. The Medicare Integrity Program was established, in part, to strengthen CMS's ability to deter fraud and abuse in the Medicare program. As part of this program, CMS has established program safeguard contractors dedicated to program integrity and enhanced data capabilities.

*OEI; 00-00-00000*

### **Contractor Fraud Control Units**

We will follow up on our previous studies of contractor fraud control units and identify factors that contribute to and work against successful program integrity operations. Our November 1996 report noted deficiencies in carriers' ability to properly identify potentially fraudulent activity and to consistently develop payment information, as well as deficiencies in case documentation and internal and external proactive safeguards. In our November 1998 report, we found that fraud units differed substantially in the number of complaints and cases handled and that some units produced few, if any, significant results. Additionally, half of the units did not open any cases proactively, and more than one-third did not identify program vulnerabilities.

*OEI; 00-00-00000*

### **Information System Controls**

As a secretarial initiative, we will conduct an ongoing assessment of information system controls at selected Medicare contractors. The reviews will focus on corrective action plans developed by contractors in response to previously identified audit findings, as well as any new areas of vulnerabilities identified during the reviews. We will cover all six major areas of general controls, as outlined in the General Accounting Office *Federal Information System Controls Audit Manual*.

*OAS; W-00-00-40002; A-17-00-02501*



## **Provider Education and Training**

We will examine Medicare carriers' provider education and training efforts and identify any promising practices. These efforts, required and funded by CMS, include training providers and their staff on the complexities of submitting claims (such as coverage, payment, and billing policy); answering providers' requests for guidance on coverage, reimbursement, and medical necessity policy; and identifying providers that habitually submit claims that create processing problems and targeting them for training.

*OEI; 00-00-00000*

## **Medicare Comprehensive and Component Procedure Codes**

This nationwide review will determine the adequacy of fiscal intermediary and carrier procedures and controls to prevent inappropriate Medicare payments for comprehensive and component procedure codes. The CMS has identified coding combinations and has developed related computer edits to preclude improper payments. The coding combinations involve "comprehensive and component" procedures for services provided to the same beneficiary by the same provider during the same session. In such situations, Medicare Part B should pay for the "comprehensive" procedure code and deny payment for the "component" code, which is included in the comprehensive code.

*OAS; W-00-02-30003; A-01-02-00000*

## **Payments for Incarcerated Persons**

We will continue to examine the extent to which Medicare has made unallowable payments for incarcerated individuals. Medicare is legally obligated to pay for such individuals only if certain conditions are met. We expect to perform fieldwork at selected providers, Medicare intermediaries/carriers, various prisons, and the Social Security Administration.

*OAS; W-00-00-30003; A-04-01-05005*

## **Payments for Deported Individuals**

We will continue to assess the adequacy of existing controls over payments made on behalf of individuals who have been deported from the country. The CMS data show that such payments do occur. We will quantify the extent of such payments and, if warranted, recommend actions to preclude future unallowable payments.

*OAS; W-00-00-30003; A-04-01-05004*

## **Bankrupt Providers**

This study will assess the frequency of bankruptcies among Medicare providers, the financial implication to the program, and the controls in place to prohibit bankrupt providers from reentering the Medicare program. Providers that participate in cost-based Medicare programs, such as home health agencies and community mental health centers, may encounter financial difficulties by receiving overpayments from Medicare that they are unable to repay or through fiscal mismanagement. Such providers often walk away from these debts, owing the Medicare trust fund millions of dollars. As part of this study, we will determine whether individuals who filed for bankruptcy later reentered the Medicare program under a different provider number.

*OEI; 00-00-00000*

## **Contractors' Administrative Costs**

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

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

## **Medicare Data Center Claim Processing Costs**

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

*OAS; W-00-02-30004; A-00-02-00000*

## **Unfunded Pensions**

This series of reviews requested by CMS will determine if unallowable costs were identified and eliminated in computing allowable pension costs charged to the Medicare program. Regulations provide that pension costs not funded for an accounting period, plus interest on

the unfunded amounts, are unallowable components of future-year pension costs. These reviews will be performed in conjunction with our pension segmentation audits.

*OAS; W-00-00-30005; Various CINs*

### **Pension Segmentation/Costs Claimed**

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

*OAS; W-00-00-30005; Various CINs*

### **Pension Termination**

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

*OAS; W-00-00-30005; Various CINs*

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## **GENERAL ADMINISTRATION**

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### **Government Information Security Reform Act**

We will satisfy the requirements of the Government Information Security Reform Act of 2000 by evaluating CMS's security program and critical systems. The results of this effort will be included in the Department's annual report to the Office of Management and Budget (OMB) and the Congress, as required by law. The purpose of the Government Information Security Reform Act is to provide a comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating

division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; A-17-02-00000*

### **Improper Medicare Fee-for-Service Payments**

We will determine whether FY 2001 Medicare fee-for-service benefit payments were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) made in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented. Our determination will be made from a review of claims and patient medical records, with the assistance of medical staff. We will use statistical sampling techniques to project results nationwide and to compute a national error rate. Collectively known as "improper payments," these benefit payments could range from inadvertent mistakes to outright fraud and abuse. In FY 2000, estimated improper payments totaled \$11.9 billion, or 6.8 percent of the \$173.6 billion total spent on Medicare fee-for-service claims.

*OAS; W-00-01-40011; A-17-01-00000*

### **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 current CMS procedures for identifying and resolving credit balance situations; i.e., situations in which payments from Medicare and other insurers exceed the providers' charges. In addition, we will evaluate the effectiveness of data sharing between Medicare and private insurers. Lastly, we will determine the extent to which Medicare pays for defective devices and other nontherapeutic items.

*OAS; W-00-01-30030; Various CINs*

### **Group Purchasing Organizations**

We will review payments (fees) received by selected group purchasing organizations from vendors. These reviews will evaluate whether the group purchasing organizations' reporting

arrangements satisfy the statutory and regulatory requirements that exempt such payments from being considered kickbacks.

*OAS; W-00-02-30030; Various CINS*

### **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 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-00-01-30019; Various CINS*

*Expected Issue Date: No Report*

### **Joint Work With Other Federal and State Agencies**

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and inspectors general, Medicaid agencies, and CMS financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate program, and durable medical equipment. Future joint initiatives will cover hospice claims, managed care issues, hospital transfers, prescription drugs, laboratory services, outpatient therapy services, and transportation services.

*OAS; W-00-01-30001; Various CINS*

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## **INVESTIGATIONS**

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

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

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

identifies investigative focus areas in which we will concentrate our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

## **Health Care Fraud**

The costs of our Nation's health care dictate that OI spend a significant amount of resources investigating fraud committed against the Medicare and Medicaid programs. The OI also conducts investigations in conjunction with other law enforcement agencies, such as the Federal Bureau of Investigation, the United States Postal Inspection Service, the Internal Revenue Service, and the various State Medicaid fraud control units.

The OI will investigate individuals, facilities, or entities that bill the Medicare and/or Medicaid program 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. Special focus areas include pharmaceutical fraud and quality-of-care issues for beneficiaries residing in care facilities. The OI will also investigate business arrangements that violate anti-kickback statutes.

The OI will not allocate resources to conduct investigations of individuals, facilities, or entities that committed errors or mistakes on claims submitted to the Medicare or Medicaid program. The OI will work with CMS contractors, specifically the program safeguard contractors, to identify specific patterns of misconduct detected 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, the 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 the OIG.

In October 1998, the OIG announced a new, more flexible provider self-disclosure protocol for use by all health care providers doing business with Federal health care programs. Numerous providers have been accepted into the program under the new protocol. These providers range from hospitals to laboratories to physicians. The OIG believes that both the Government and the providers benefit from this program.

The self-disclosure protocol is designed only for providers that believe a potential violation of the law has occurred. Matters exclusively involving overpayments or errors that do not

indicate violations of the law should be brought directly to the attention of the entity responsible for claim processing and payment.

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## LEGAL COUNSEL

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In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of civil and administrative health care fraud cases, including the use of program exclusions and civil monetary penalties and assessments and the negotiation of corporate integrity agreements.

The OCIG represents OIG in administrative litigation, such as civil monetary penalty and program exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes and is responsible for developing OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2002 includes:

### **Compliance Program Guidance**

We will continue to issue compliance program guidance to assist the health care industry in establishing voluntary corporate compliance programs and in developing effective internal controls that promote adherence to applicable Federal statutes, regulations, and the program requirements of Federal health care plans. We plan to issue program guidance documents in FY 2002 pertaining to ambulance companies, pharmaceutical companies, and mental health service providers. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care programs while furthering the health care industry's fundamental mission to provide quality patient care.

*Expected Completion Date: Ongoing*

### **Corporate Integrity Agreements**

We will continue to monitor providers' and Medicare contractors' compliance with the terms of over 500 corporate integrity agreements (and settlements with integrity provisions) into which they entered in conjunction with the settlement of fraud and abuse allegations. We will increase the number of site visits to entities that are subject to the integrity agreements to verify compliance efforts and confirm information submitted by the entities to OIG. Included in this monitoring process will be systems reviews to determine whether a provider's or a contractor's compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action. Additionally, we will increase our coordination with CMS on appropriate measures regarding entities with ongoing problems. We will also modify the requirements of corporate integrity agreements, e.g., audit and training provisions, to

reduce the costs associated with implementing the agreements, while continuing to promote the integrity of Federal health care programs.

*Expected Completion Date: Ongoing*

### **Advisory Opinions and Fraud Alerts**

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

*Expected Completion Date: Ongoing*

### **Anti-Kickback Safe Harbors**

In FY 2002, we anticipate publishing regulations for several new safe harbor exemptions from the anti-kickback statute. Also, we will continue to evaluate comments that we solicited from the public concerning proposals for additional safe harbors.

*Expected Completion Date: Ongoing*

### **Patient Anti-Dumping Statute Enforcement**

We expect to continue the review, negotiation, settlement, and litigation of cases involving violations of the patient anti-dumping statute in FY 2002. In addition, we plan to continue our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel.

*Expected Completion Date: Ongoing*

### **Program Exclusions**

In coordination with OI, we anticipate increasing the number of program exclusions pursued by the OIG. We also expect to initiate program exclusions against individuals and entities that submitted false or fraudulent claims, failed to provide services that met professionally recognized standards of care, or otherwise engaged in conduct actionable under section 1128 of the Social Security Act.

*Expected Completion Date: Ongoing*



## **Civil Monetary Penalties**

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

*Expected Completion Date: Ongoing*