

Department of Health and Human Services

**Office of Inspector General
Projects**



**HEALTH CARE FINANCING ADMINISTRATION
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HOSPITALS

One-Day Hospital Stays

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

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

Hospital Discharges and Subsequent Readmissions

This series of reviews will continue to examine Medicare claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same acute care prospective payment system hospital. We will review procedures in place for these related admissions at selected hospitals, fiscal intermediaries, and peer review organizations. With the assistance of the Health Care Financing Administration (HCFA), we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine the effectiveness of existing system edits used to identify and review related admissions.

OAS; W-00-00-30010; A-14-00-00043

Payments for Related Hospital and Skilled Nursing Stays

We will determine the extent of Medicare payments for short- and long-stay hospital and skilled nursing facility care that was provided sequentially to the same beneficiary. Inpatient services may be denied, based on peer review organization reviews, for patients admitted unnecessarily for one stay or multiple stays. As part of our review, we will assess HCFA's instructions on identifying and evaluating consecutive beneficiary stays at different providers, including skilled nursing facilities and prospective payment system-exempt units.

OEI; 09-00-00210

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 HCFA's 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

We will continue to support the Department of Justice's assistance to the Department in seeking recovery of overpayments and penalties from Medicare prospective payment system hospitals that incorrectly reported transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between prospective payment system hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. We are working with HCFA to initiate a nationwide recovery of overpayments from hospitals that are not covered by the Justice Department's project.

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

Prospective Payment System Transfers Between Chain Members

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

OAS; W-00-98-30010; A-06-99-00050

Prospective Payment System Transfers: Administrative Recovery

We will work with HCFA and the Medicare fiscal intermediaries to administratively recover overpayments resulting from incorrectly reported prospective payment system transfers. Our work will focus on the incorrectly reported transfers declined for investigation. We are currently working with HCFA to draft instructions to the fiscal intermediaries. The

intermediaries' performance will determine whether it is necessary to issue individual regional reports recommending resolution action on the part of the HCFA regions.

OAS; W-00-98-30010; A-06-00-00041

Prospective Payment System Transfers During Hospital Mergers

We will determine the extent that 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. Our preliminary work identified a number of hospitals for referral for investigation or recovery.

OAS; W-00-98-30010; A-06-99-00051, -00-00044

Postacute Services for Diagnosis-Related Groups Considered Transfers

We will assess early changes in utilization patterns for the 10 diagnosis-related groups for which postacute services are considered transfers rather than discharges for payment purposes. The Balanced Budget Act required the Secretary to select the 10 diagnosis-related groups. This review will examine whether providers exhibit different utilization patterns for these diagnosis-related groups, such as sending beneficiaries home for several days before admission to inpatient rehabilitation, using a second postacute provider to render care, issuing notices of noncoverage to beneficiaries, or coding inpatient stays to fall into other diagnosis-related groups.

OEI; 00-00-00000

Uncollected Beneficiary Deductibles and Coinsurance

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

OAS; W-00-00-30010; A-04-00-06005

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, imposed by the Balanced Budget Act of 1997, applies to certain diagnosis-related groups.

OAS; W-00-00-30010; A-04-00-01210

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; A-01-00-00503

Diagnosis-Related Group Payment Window - Hospitals

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

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

OAS; W-00-00-30010; A-01-00-00506

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. This is a companion review to our work at hospital providers. 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 diagnosis-related group payment window are not allowed whether the claims are submitted by hospital providers or by Part B providers, such as laboratories and ambulance companies.

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

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 HCFA'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

Outpatient Prospective Payment System

We will review 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-00-00-30010; A-03-00-00019

Outpatient Pharmacy Services at Acute Care Hospitals

Our review will determine whether pharmacy services rendered on an outpatient basis were billed and reimbursed in accordance with Medicare requirements. With certain exceptions, Medicare Part B does not cover self-administered drugs. Survey work indicates that hospitals may 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; A-01-01-00000

Outpatient Medical Supplies at Acute Care Hospitals

This review will determine whether medical supply services rendered on an outpatient basis were billed and reimbursed in accordance with Medicare requirements. Our survey work indicates that hospitals may 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-01-01-00000

Followup on Peer Review Organizations' Complaint Process

We will evaluate the effectiveness of the Medicare peer review organizations' beneficiary complaint process. This followup to our 1995 report (OEI-01-93-00250) will examine the progress that HCFA has made in implementing our recommendations. It will also assess the current complaint process for accessibility, objectivity, responsiveness, timeliness, investigative capacity, enforcement follow-through, improvement orientation, and accountability.

OEI; 01-00-00060

HOME HEALTH

Home Health Compliance Programs

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

OEI; 00-00-00000

Physician Involvement in Approving Home Health Care

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

involvement in monitoring their patients. This will be particularly important as the new prospective payment system is implemented in FY 2001.

OEI; 00-00-00000

Impact of Prospective Payment System on Access to and Quality of Care

This study will assess how the prospective payment system for home health agencies is affecting Medicare beneficiaries' access to home health care and the adequacy of that care. Changing Medicare reimbursement from a cost-based system to a prospective system will alter the incentives in how home health agencies admit and treat Medicare beneficiaries. We will update prior work in which we evaluated access to home health services and measured indicators of quality of care under the interim payment system.

OEI; 02-00-00320

Home Health Prospective 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. We will also evaluate controls over advance payments to providers.

OAS; W-00-00-30009; A-06-00-00065

Payments Based on Location of Service

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

OAS; W-00-99-30009; A-06-99-00063

Assessments Used for Case-Mix Adjustment

We will determine how implementation of the Outcomes and Assessment Information Set affects quality of care and home health reimbursement. Home health agencies are required to

conduct initial and periodic assessments of each patient's functional capacity. This assessment information helps to establish the case-mix adjustment used in determining the level of Medicare payment to a home health agency for a particular patient. We plan to examine the assessment process, the extent to which assessments are used to develop plans of care, and the case-mix accuracy.

OEI; 00-00-00000

Debt Management Process

A series of reviews will identify major obstacles inhibiting Medicare's ability to collect debts owed by home health agencies. Available data show that some debts are not liquidated and that HCFA collects only pennies on the dollar for debts owed by home health agencies that leave the Medicare program.

OAS; W-00-00-30009; A-14-00-00470

NURSING HOME CARE

Role of the Nursing Home Medical Director

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

OEI; 06-99-00300

Quality Assessment and Assurance Committees

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

evaluate the committee's adequacy or effectiveness. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Nurse Aide Training

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

OEI; 00-00-00000

Family Experience With Nursing Home Care

We will assess the quality of care that Medicare and Medicaid beneficiaries receive in nursing homes, as perceived by their family members. The HCFA 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

Consolidated Billing Requirements

We will determine the extent of overpayments during Calendar Year 1999 for 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 for over one-third of the claims reviewed, Medicare contractors made separate Part B payments 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.

OAS; W-00-00-30014; A-01-00-00538

Ineligible Stays in Skilled Nursing Facilities

This review will quantify improper payments, nationwide, for skilled nursing facility stays that did not meet Medicare's coverage conditions. In order to be paid by Medicare, a beneficiary's nursing home stay must be preceded by at least a 3-day inpatient hospital stay. Our survey work in one State disclosed that skilled nursing facilities received over \$900,000 in Medicare reimbursement for stays that did not meet the coverage conditions. Based on the State error rate, we estimate that Medicare could be paying over \$20 million a year for ineligible nursing stays nationwide. In addition to recommending corrective action, we will identify nursing homes where a pattern of this condition could indicate potential program fraud or abuse.

OAS; W-00-01-30014; A-05-01-00000

Followup on Mental Health Services in Nursing Facilities

This review will ascertain whether the Medicare program is still vulnerable from the expanded provision of mental health services to nursing facility residents. In a 1996 study, we found that Medicare had paid for medically unnecessary or questionable mental health services in nursing facilities in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent these inappropriate payments, such as developing guidelines for carriers, developing screens to implement the guidelines, conducting focused medical reviews, and providing physician education activities. This study will determine whether mental health services in nursing facilities continue to be inappropriately billed.

OEI; 02-99-00140

Therapy Services for Medicare Part B Nursing Home Patients

At HCFA's request, we will review the utilization and quality of care of physical, occupational, and speech therapy provided to nursing home patients in Calendar Year 1999 and billed to Medicare Part B by nursing homes, rehabilitation agencies, and hospital outpatient departments. The Balanced Budget Refinement Act of 1999 required HCFA to (1) recommend a mechanism to ensure the appropriate utilization of Medicare outpatient therapy and (2) establish a payment policy based on diagnostic categories, functional status, and prior use of therapy. This study will provide information to assist the agency in meeting these requirements.

OEI; 09-99-00560

Ancillary Medical Supplies

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

OAS; W-00-00-30014; A-09-00-00059

Followup on 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, HCFA has taken a number of steps to strengthen survey and enforcement efforts. We will evaluate these nursing home initiatives.

OEI; 00-00-00000

Complaint Process

We will examine the timeliness and effectiveness of State nursing home complaint processes since HCFA's Complaint Improvement Project began. The Omnibus Budget Reconciliation Act of 1987 required each State to establish a complaint investigation process. As part of that process, HCFA requires that States investigate, within 2 working days, the most serious complaints alleging immediate jeopardy of the health or safety of residents. The timing, scope, duration, and conduct of other complaint investigations were left largely to the State survey agency. In March 1999, HCFA directed State survey and certification directors to investigate, within 10 working days, any complaint that alleges actual harm to nursing home residents. At the same time, HCFA initiated the Complaint Improvement Project to strengthen key elements of the complaint investigation and resolution process.

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, HCFA

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

HOSPICE CARE

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 current 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; 00-00-00000

Use of Continuous Home Care by Hospice Agencies

This study will examine how fiscal intermediaries ensure that hospices provided the services for which they submitted claims. The Medicare hospice benefit provides for palliative care for patients who have a terminal diagnosis. The benefit covers four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. For routine, inpatient respite, and general inpatient care, only one rate applies per day. For continuous

home care, the payment is based on the number of hours of continuous care provided to the patient; a minimum of 8 hours must be provided for reimbursement at this level. We will focus on continuous home care because of its complexity, expense, and vulnerability.

OEI; 00-00-00000

PHYSICIANS

Physicians at Teaching Hospitals

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

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

Reassignment of Physician Benefits

We will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

OEI; 04-99-00660

Podiatrists' Medicare Billings

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

OAS; W-00-00-30021; A-09-99-00058

Podiatry Services

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

OEI; 04-99-00460

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

Critical Care Codes

We will examine the use of two critical care codes that may be billed to Medicare only if the patient is critically ill and requires constant attention by the physician. Payment for critical care is based on the time spent with the patient. We will examine claim data to determine whether some physicians may be billing inappropriately for critical care as well as identify any other potential vulnerabilities.

OEI; 05-00-00420

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 can diagnose osteoporosis and 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

Role of Nonphysician Practitioners

We will describe the scope of services that nonphysician practitioners provide to Medicare beneficiaries and identify any potential vulnerabilities that may have emerged since the Balanced Budget Act of 1997. Nurse practitioners, clinical nurse specialists, and physician assistants practice either in collaboration with or under the supervision of a physician and provide services according to their State's scope-of-practice requirements. Recent changes in the way Medicare pays for nonphysician practitioner services and concerns about the complexity of services they provide have increased interest in these providers.

OEI; 02-00-00290

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

MEDICAL EQUIPMENT AND SUPPLIES

Medicare Payments for Equipment and Supplies

We will examine Medicare payment rates for a sample of medical equipment and supplies and compare the Medicare rates with the rates of other Federal and State health programs as well as with wholesale and retail prices. We will also compare supplier costs for these items with the Medicare-allowed charges.

OEI; 00-00-00000

National Supplier Clearinghouse

We will review implementation of the National Supplier Clearinghouse, which was established to certify that durable medical equipment suppliers meet certain standards before receiving a Medicare billing number. The HCFA has consolidated processing of all durable medical equipment claims at four carriers, one of which maintains the clearinghouse. We will assess the extent to which the clearinghouse has met its goals and test the collected data for accuracy, completeness, accessibility, and usefulness.

OEI; 04-99-00670

Payments for Nebulizer Drugs

This joint OIG/HCFA review will determine whether durable medical equipment (DME) suppliers submitted proper claims for nebulizer drugs and supplies to the Medicare region C carrier and were reimbursed in accordance with Medicare requirements. In 1998, Medicare payments for nebulizer drugs totaled \$486 million — an increase of \$57 million, or 13.3 percent, over the 1997 total of \$429 million. The region C carrier accounted for \$274 million, or 56 percent, of the 1998 national total.

OAS; W-00-00-30022; A-06-00-00053

LABORATORY SERVICES

Clinical Laboratory Improvement Amendments Certifications

We will determine whether laboratories are conducting tests and billing 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

END STAGE RENAL DISEASE

Medicare Composite Rate Reimbursement

We will review and suggest changes to the end stage renal disease composite rate, which is an "all inclusive" rate used for reimbursing facilities for dialysis patients. The current rate (about \$126 for free-standing facilities and \$130 for hospital-based facilities) is based on medical science practices and data as of 1973. We will determine whether including other drugs and services in the composite rate would be appropriate and assess the potential financial implications to the Medicare program.

OEI; 00-00-00000

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. The HCFA has since reduced the rate 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-00-01-30025; A-01-01-00000

Hepatitis Tests

This study will identify Medicare payments to hospital laboratories for hepatitis tests provided to dialysis patients that were not reasonable and necessary for the diagnosis or treatment of illness at the frequency provided. The HCFA and the Centers for Disease Control and Prevention issue testing guidelines associated with the Hepatitis B Virus and other strains of hepatitis. These guidelines require that dialysis facilities consider a patient's immune status and susceptibility to the various strains of hepatitis in determining testing frequency.

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

Method II Billing

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

OEI; 00-00-00000

Duplicate Payments for Office Visits to Nephrologists

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

OAS; W-00-00-30025; A-01-00-00519

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount on Medicare Prescription Drugs

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

OEI; 00-00-00000

Medicare Outpatient Prescription Drugs

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

OAS; W-00-01-30022; A-06-01-00000

Expected Issue Date: FY 2002

OTHER MEDICARE SERVICES

Beneficiaries' Experiences With Medigap Insurance

This study will assess 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.

OEI; 07-00-00580

Outpatient Diabetes Self-Management Training Services

This national study will assess the reasonableness of Medicare payment rates for outpatient diabetes self-management training services. The Balanced Budget Act of 1997 expanded coverage for such services furnished by non-hospital-based programs and required that payments for the services be established after consultation with appropriate organizations, such as the American Diabetes Association. Our prior work indicated that payment rates appeared to be substantially higher than the actual cost of providing the services. We will compare payment rates with the costs of providing the services at a selected number of providers throughout the country.

OAS; W-00-00-30026; A-14-00-02802

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 HCFA could take to improve the functioning and oversight of this program.

OEI; 00-00-00000

Payments to Community Mental Health Centers That Withdrew From Medicare

We will review overpayments to community mental health centers (CMHC) that voluntarily withdrew from the Medicare program. A prior OIG/HCFA review in five States, which accounted for about 77 percent of CMHC partial hospitalization program (PHP) payments nationally during Calendar Year 1996, found that 93 percent of the services reviewed were ineligible for Medicare reimbursement. Accordingly, HCFA implemented corrective actions to ensure that only qualified providers participated in the Medicare PHP. Our current review will identify those CMHCs that voluntarily withdrew from participation in the Medicare program and will determine the Medicare payments they received from October 1995 to April 1999, the providers that received overpayments, and the amount of the overpayments.

OAS; W-00-99-30026; A-03-99-00005

MEDICARE MANAGED CARE

New Adjusted Community Rate Proposal Process

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

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

General and Administrative Costs

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

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

Cost-Based Managed Care Plans

At HCFA's request, we will evaluate the integrity of the cost reporting process used by cost-based managed care plans (Section 1876 Cost Plans and Health Care Prepayment Plans). The HCFA currently contracts with over 30 of these plans which provide services to more than 300,000 members. The plans file cost reports with HCFA outlining the costs they incur in providing health care. Although the reports are audited to ensure that costs are properly allocated, they do not undergo medical reviews to ensure that only Medicare-covered services are included.

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

Enhanced Managed Care Payments

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

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

HMO Profits

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

OAS; W-00-01-30012; A-14-01-00000

Physician Incentive Plans

We will review physician incentive plans included in contracts between physicians and managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on utilization levels. It also requires plans to disclose these arrangements to beneficiaries. As part

of this review, we will also look at other clauses in these contracts that may affect the quality of care provided.

OEI; 05-00-00010

Managed Care Additional Benefits

This review will analyze the cost to Medicare managed care organizations for providing additional benefits to Medicare beneficiaries and determine the extent that beneficiaries receive such benefits. Additional benefits, which are provided to beneficiaries as part of their basic Medicare benefit package, vary among managed care organizations.

OAS; W-00-01-30012; A-14-01-00000

Prescription Drug Benefit

This review will provide information on the coverage and payment of prescription drugs in Medicare managed care plans. Fee-for-service Medicare generally does not pay for outpatient prescription drugs, although some drugs, such as injectables for chemotherapy and medications used with durable medical equipment, are covered. Medicare managed care plans may offer a capped prescription drug benefit, paying up to \$1,500 per year for drugs. We will examine the extent that beneficiaries use this benefit, how the limit is calculated for each beneficiary, which drugs are included, and how drug costs are determined by the managed care plan.

OEI; 03-00-00430

Final Verification of Marketing Materials

We will evaluate HCFA's final reviews of Medicare managed care marketing materials. A previous OIG study detailed how few 1998 marketing materials were in full compliance with HCFA's marketing guidelines, and a General Accounting Office report found that HCFA reviewers did not ensure that final copies of marketing materials incorporated required corrections. In response, HCFA instituted a new policy requiring that regional offices conduct final verifications of beneficiary notification materials before final HCFA approval. This study will examine the regional offices' policies and procedures for final verification of marketing materials.

OEI; 00-00-00000

Role of State Health Insurance Counselors

We will examine the role of Health Insurance Counseling and Assistance Program counselors in informing Medicare beneficiaries of their health insurance options. The Omnibus Budget Reconciliation Act of 1990 authorized State grants to develop programs which would provide health insurance information and counseling to Medicare beneficiaries. The volunteer counselors are required to participate in State training programs, which can vary by State. They provide their services in various settings, including the beneficiary's home, community centers, hospitals, retirement communities, and over the phone. We will look at how counselors are trained and whether they provide accurate information to Medicare beneficiaries.

OEI; 00-00-00000

Usefulness of Medicare+Choice Performance Measures

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

OEI; 00-00-00000

Monitoring Medicare+Choice Managed Care Plans

We will assess how HCFA monitors the performance of Medicare managed care plans under the Medicare+Choice Program. In 1998, we reported on HCFA's managed care monitoring process and staffing. Since that time, HCFA has implemented the Medicare+Choice program, which contains numerous changes, including new types of managed care plans and additional responsibilities for the agency. This study will assess how HCFA has updated its monitoring procedures as a result of these changes.

OEI; 00-00-00000

Educating Beneficiaries About Medicare+Choice

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

OEI; 00-00-00000

Beneficiary Understanding of Medicare+Choice Benefits

We will assess how well Medicare beneficiaries enrolled in Medicare+Choice plans understand their extra benefits and financial responsibilities. In the last 2 years, numerous managed care organizations dropped out of Medicare or withdrew from certain market areas. Starting in 2000, many managed care organizations that remained in the program have reduced the extra benefits provided and have increased the beneficiary co-payments and premiums. This study will examine how well beneficiaries understand these changes and determine the impact of the changes.

OEI; 00-00-00000

Medicare+Choice Compliance Programs

We will determine how many Medicare+Choice organizations have compliance programs in place. To address areas of concern to both the Government and the industry, OIG issued "Compliance Program Guidance for Medicare+Choice Organizations" in November 1999. 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

Enrollment Incentives/Disincentives

This review will assess the extent to which Medicare managed care organizations encourage the enrollment of healthy beneficiaries and discourage the enrollment of sick beneficiaries. Managed care organizations are currently paid a set amount to provide all Medicare-covered services to beneficiaries enrolled in their programs and, under the current payment method, have a financial incentive to enroll healthier beneficiaries. Although the organizations are

required to enroll all eligible Medicare beneficiaries regardless of their age, health status, or the cost of the health services needed, there is some evidence that this does not always occur. Prior OIG work found that 18 percent of beneficiaries said that they were asked about health problems at the time of their application.

OEI; 00-00-00000

Fee-for-Service Costs Incurred by HMO Disenrollees

This review will examine the extent of and reasons for high fee-for-service costs incurred by beneficiaries who recently disenrolled from managed care organizations. In May 1999, we reported that beneficiaries who disenrolled from six managed care firms from 1991 to 1996 received inpatient services worth \$224 million within 3 months after disenrollment. In comparison, Medicare would have paid \$20 million in capitation payments to these six firms had the beneficiaries not disenrolled. This study will update that work and look at the reasons for a beneficiary's disenrollment before a high-cost fee-for-service procedure.

OEI; 00-00-00000

Disenrollee Feedback

We will obtain systematic disenrollee feedback on Medicare managed care organizations' performance and assess HCFA's implementation and use of disenrollee survey data. Our prior work demonstrated that structured surveys of disenrollees from managed care organizations could yield insightful information about service access and quality, plan performance, and reasons for disenrollment. We will update that information and examine the extent that HCFA uses disenrollment information.

OEI; 00-00-00000

Managed Care Organization Closings

This review will determine the impact on beneficiaries of recent closings of Medicare managed care organizations. In 1998, about 100 plans announced that they did not intend to renew their Medicare contracts or were reducing their service areas. In 1999, another 100 plans either withdrew from the Medicare program or reduced their service areas. We will look at the impact of the most recent withdrawals on beneficiaries' ability to access care and to obtain Medigap policies and their willingness to join or stay in Medicare managed care organizations.

OEI; 00-00-00000

MEDICAID MANAGED CARE

Marketing and Enrollment of Medicaid Managed Care Entities

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

Quality Improvement System for Managed Care

We will examine the extent that States use the Quality Improvement System for Managed Care standards and guidelines to measure the performance of Medicaid managed care organizations. These standards were developed by HCFA and other public and private agencies to serve as a model for State use. States that choose to adopt the standards and require managed care organizations to meet them will be in compliance with forthcoming regulations implementing the Balanced Budget Act of 1997 provisions pertaining to quality assessment and improvement. This review will look at the systems that States currently use to ensure quality assessment of managed care plans and how States monitor attainment of performance targets.

OEI; 00-00-00000

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 that 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

Emergency Services for Enrollees of Medicaid Managed Care

This review will assess how Medicaid managed care organizations are implementing the Balanced Budget Act's emergency service requirements. Under the statute, Medicaid managed care beneficiaries have the right to immediately obtain emergency care and services. A

managed care organization must pay for the cost of these services, and the services must be covered without regard to prior authorization or the emergency care provider's contractual relationship with the organization. Coverage of emergency services is to be determined under the "prudent layperson" standard; that is, services qualify as emergencies if a prudent layperson would interpret them that way. We will evaluate how managed care organizations are interpreting the prudent layperson standard and how frequently this interpretation is questioned.

OEI; 00-00-00000

MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Enrollment of Children in State Medical Insurance Programs

We will assess States' progress toward reducing the number of medically uninsured children and evaluate how States ensure that Medicaid and State Children's Health Insurance Program applicants are enrolled in the programs for which they are eligible. The Balanced Budget Revision Act of 1999 required that OIG evaluate these issues by sampling a number of States.

OEI; 05-00-00240

Role of Federal Health Centers

We will study the changing role of federally funded health centers in delivering health care to children covered by the State Children's Health Insurance Program and concurrent Medicaid expansions. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children's insurance program or expand the existing Medicaid program. We will study health centers' outreach to and enrollment of children in appropriate health insurance programs, their participation in managed care organizations, and their direct contracting with new and expanding programs.

OEI; 06-98-00321

Mental Health Screening and Services for Children

We will determine the extent of mental health services provided to children covered by Medicaid's Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. According to the December 1999 Surgeon General's report on mental health, about 70 percent of children in need of mental health services did not receive them. States must report to HCFA the amount of EPSDT screening conducted, but they are not required to report mental health

referrals. This study will focus on such issues as how much screening for mental health needs is conducted, whether certain practitioners or facilities are more likely to screen for mental health needs than others, how practitioners conduct the “assessment of mental health development” required by EPSDT, whether assessments are standardized, and to what type of mental health services children are referred.

OEI; 00-00-00000

Disenrollment From State Children’s Health Insurance Program

We will describe the current levels of State Children’s Health Insurance Program 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 HCFA anticipated. The HCFA recognizes the increased disenrollment rates but does not know why families are leaving the program. Furthermore, measuring the extent of disenrollment is problematic because States have different ways of capturing and reporting these data.

OEI; 00-00-00000

OTHER MEDICAID SERVICES

Reasonableness Edits

We will determine the adequacy of controls used by selected State agencies to adjudicate potentially excessive claims submitted by Medicaid providers. Prior OIG reviews found several instances of excessive payments made by State agencies. These payments occurred because claim processing system edits were not always extensive enough to evaluate the reasonableness of line item units and charges.

OAS; W-00-01-30013; A-01-01-00000

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

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

State Survey and Certification Costs

At HCFA's request, we are reviewing selected States' survey and certification costs to verify that costs have been allocated correctly among Medicare, Medicaid, and State licensing

agencies and that federally approved indirect cost rates have been applied. We will also study, to the extent possible, variations in survey and certification unit costs among the States to determine the extent that these variations reflect differences in salary and other costs versus efficiency (e.g., staff-hours allotted to a given type of survey) and other factors.

OAS; W-00-00-30013; A-05-00-00020

State Medicaid Agency Administrative Costs

We will review the use of administrative funds by State Medicaid agencies. In recent years, some States have focused on moving Medicaid beneficiaries out of the traditional fee-for-service environment and into managed care organizations. We have received information indicating that with this change, program administrative costs have increased significantly. Our review will determine the extent of this increase and the reason for it.

OAS; W-00-01-30013; A-05-01-00000

Impact of Intergovernmental Transfers

We will analyze the use of intergovernmental transfers by State and local governments as a means of increasing Federal Medicaid matching funds. To maximize Federal reimbursement, States are increasingly adopting aggressive payment methodologies for public providers. These methodologies use the upper payment limits and intergovernmental transfers to generate additional funds. In five States, we will (1) determine the accuracy of the funding pool that was calculated by the State Medicaid agency for distribution to public providers as enhanced payments, (2) track the dollars transferred between local and State governments, and (3) determine how selected county-owned nursing facilities that received enhanced payments used the excess funds.

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

Hospital-Specific Disproportionate Share Payment Limits

At HCFA'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 fiscal years beginning in 1994 and 1995 for public and private hospitals, respectively. The HCFA subsequently required that all inpatient hospital

State plan amendments contain an assurance that DSH payments to individual providers will not exceed the hospital-specific DSH payments limits.

OAS; W-00-00-30013; A-06-00-00026

Outpatient Psychiatric Services at Acute Care Hospitals

This review will determine whether psychiatric services rendered by acute care facilities on an outpatient basis are billed and reimbursed in accordance with Medicaid regulations. Our prior work found significant Medicare overpayments for such services. We will determine whether the problems we found with Medicare claims are also prevalent with claims submitted to State Medicaid agencies.

OAS; W-00-00-30013; A-02-00-01023

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-00-01-30013; A-06-01-00000

State Oversight of Home- and Community-Based Waivers for the Mentally Retarded

We will examine State oversight policies and procedures for services provided in accordance with Medicaid home- and community-based waivers for the mentally retarded. These waivers, which must be approved by HCFA, allow States to provide community-based care to persons who otherwise would be institutionalized. In 1998, almost 240,000 individuals received these services at a cost of nearly \$7.5 billion. Each State is responsible for implementing its own oversight practices and for providing health and welfare assurances to HCFA for services provided through home- and community-based waivers. Recent news articles have raised concerns about the level of oversight provided in this program.

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

Community Mental Health Services

We will determine whether providers of community mental health services met State Medicaid agency reimbursement requirements. Our prior work involving Medicare payments to community mental health centers identified a large number of unallowable or highly questionable services. Many of these services were not reasonable and necessary for the patients' condition or were not properly authorized by or furnished under the general supervision of a physician. We will determine if these problems exist in States that offer community mental health services through the Medicaid program.

OAS; W-00-01-30013; A-04-01-00000

Durable Medical Equipment Reimbursement Rates

This review will determine the extent that Medicaid payments for durable medical equipment 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 from exceeding 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

Durable Medical Equipment Payments on Behalf of Nursing Home Recipients

Our review will determine the adequacy of procedures and controls over Medicaid payments for durable medical equipment provided to residents of nursing facilities. Depending on how

each State's rate setting agency determines payments to nursing facilities, DME may be included in the facilities' per diem rate, in addition to the per diem rate, or billed directly to Medicaid by the DME provider. We will assess the appropriateness of payments to DME providers made on behalf of beneficiaries residing in nursing homes.

OAS; W-00-00-30007; A-01-00-00001

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

Medicaid Outpatient Prescription Drug Pricing

At HCFA'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., a change in 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

Unallowable Transportation Costs

We will determine whether payments for transportation claims met Medicaid reimbursement requirements. In one State, we found that nonemergency transportation claims were paid even though the trip dates did not coincide with medical provider claims for services on the same date. The State identified 57,000 transportation claims that did not match medical service provider claims. Our work will determine if this problem exists in other States.

OAS; W-00-00-30013; A-05-00-00017

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

MEDICARE CONTRACTOR OPERATIONS

Comparison of Payment Safeguard Activities

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

OEI; 00-00-00000

Followup on 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, "Carrier Fraud Units" (OEI-05-94-00470), noted deficiencies in carriers' ability to properly identify potentially fraudulent activity and to consistently develop payment information and in their case documentation, internal proactive safeguards, and external proactive safeguards. In our November 1998 report, "Fiscal Intermediary Fraud Units" (OEI-03-97-00350), 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

Carrier 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 HCFA, include training providers and their staff on the complexities of claims submission (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

Controls Over Financial Management

This demonstration project will evaluate two Medicare contractors' internal controls over financial management. Such controls are critical to ensuring the integrity of information generated by financial systems that process 935 million claims and provide \$180 billion in fee-for-service payments annually. Our primary goal is to identify and prioritize internal control weaknesses in the areas of cash management, reporting and collecting overpayments, claim processing, cost report settlements, Medicare secondary payer and credit balances, and postpayment and prepayment reviews.

OAS; W-00-00-40014; A-01-00-00535, -02-00-00000

Source Code Controls

We will evaluate one Medicare contractor's controls over standard Medicare claim processing systems' source code. This computer code, written in a human-readable form, is routinely provided to contractors using the Fiscal Intermediary Standard System and the Common Working File. The capability of individual users to modify source code represents a significant risk to the integrity of the standard system software. The widespread availability of source code has been reported as a material weakness in OIG's report on the audit of HCFA's financial statements. We will review application access and change control policies and procedures to determine whether controls are in place to prevent unauthorized change.

OAS; W-00-01-40002; A-09-01-00000

General and Application Controls

We will evaluate a Medicare contractor's general and application controls related to processing Medicare claims. The review will focus on those controls related to (1) entity-wide security program planning and management, (2) access controls, (3) application software controls, (4) system software, (5) segregation of duties, (6) service continuity, and (7) mainframe operating system security.

OAS; W-00-01-40002; A-06-01-00000

Controls Over Exorbitant Payments

We will review the effectiveness of controls designed to detect and investigate exorbitant payments for services provided to Medicare beneficiaries. Preliminary data show that such payments have been made in the past. If appropriate, we will recommend remedies for deficiencies in the existing control structure.

OAS; W-00-00-30026; A-01-00-00502

Payments for Incarcerated Persons

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

OAS; W-00-00-30003; A-14-00-00480, -04-00-05568

Payments for Deported Individuals

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

OAS; W-00-00-30003; A-14-00-00440, -04-00-00000

Medicare Part B Payments for Durable Medical Equipment

This followup review will determine the adequacy of durable medical equipment regional carrier procedures and controls intended to prevent inappropriate Medicare Part B payments for DME provided to inpatients of skilled nursing facilities. By law, DME suppliers are not entitled to payments under Medicare Part B when beneficiaries are skilled nursing facility inpatients. However, two previous OIG reports identified millions of dollars in these improper payments.

OAS; W-00-00-30007; A-01-00-00509

Contractor Hearings and Appeals

This study will assess contractors' procedures for processing hearings and appeals. Our September 1999 report on the Administrative Law Judge hearing process for Medicare Parts A and B fee-for-service appeals noted that HCFA incurred considerable administrative costs through its contractors for processing appeals. The cost totaled over \$4 million for Medicare Part A and about \$75 million for Medicare Part B in FY 1996. We will evaluate appeals at the contractor level, including reconsiderations, reviews, and carrier hearings.

OEI; 04-00-00230

Suspension of Payments to Providers

We will assess the extent to which Medicare contractors suspended payments to providers in an effort to recoup Medicare monies and whether they complied with applicable rules. The Medicare program specifies separate procedures for suspensions involving providers that owe overpayments and providers that owe overpayments where fraud is suspected. When claims are suspended, they remain in that category until a determination is made to release monies to the provider or to offset the amount against a Medicare or other governmental obligation. This

study will examine the procedures used and circumstances surrounding decisions to suspend payments and determine the effectiveness of payment suspension in recouping overpayments.

OEI; 00-00-00000

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 bankruptcies later reentered the Medicare program under a different provider number.

OEI; 00-00-00000

Private Sector Use of Recovery Firms

This study will assess the extent to which recovery specialists are used in the private sector and the types of activities they undertake. Medicare contractors take a variety of actions to recover misspent program funds, and the Senate Appropriations Committee has strongly encouraged HCFA and OIG to explore the use of private recovery firms in the Medicare program. We will identify any issues and impediments to the effective use of recovery specialists by Medicare.

OEI; 04-00-00220

Contractors' Administrative Costs

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

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

Unfunded Pensions

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

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

Pension Segmentation/Costs Claimed

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

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

Pension Termination

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

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

GENERAL ADMINISTRATION

Improper Medicare Fee-for-Service Payments

We will determine whether FY 2000 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 1999, estimated improper payments totaled \$13.5 billion, or 7.97 percent of the \$169.5 billion total spent on Medicare fee-for-service claims.

OAS; W-00-00-40011; A-17-00-02000

Collecting Nontax Delinquent Debt

As part of an initiative by the President’s Council on Integrity and Efficiency, we will assess HCFA’s process for collecting nontax delinquent Medicare debt, which is debt over 180 days delinquent. The Debt Collection Improvement Act of 1996 requires that Federal agencies maximize collections of delinquent debt owed to the Government and reduce losses arising from inadequate debt management activities. The objectives of our review are to determine whether (1) HCFA accurately reports Medicare delinquent debt and (2) HCFA’s debt management and collection activities follow the criteria set forth in the act.

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

Medicare Secondary Payer

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

OAS; W-00-99-30030; A-14-99-00420, -02-00-00000

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-00-00-30019; Various CINs

Joint Work With Other Federal and State Agencies

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

OAS; W-00-00-30001; Various CINs

INVESTIGATIONS

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

The OIG concentrates its resources on the conduct of criminal investigations relating to HHS programs and operations. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in vulnerable program areas that can be eliminated through corrective management actions, regulation, or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

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

Medicare Part A

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

Medicare Part B

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

Medicare Part C

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

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

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

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

Medicaid

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

Pneumonia Diagnosis-Related Group Upcoding Project

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

Prospective Payment System Transfer Project

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

LEGAL COUNSEL

In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of civil and administrative health care fraud cases, including the imposition 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 2001 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 2001 pertaining to ambulance companies. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans while furthering the health care industry's fundamental mission to provide quality patient care.

Expected Completion Date: Ongoing

Corporate Integrity Agreements

We will continue to monitor providers' compliance with the terms of over 400 corporate integrity agreements (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 the establishment of a tracking system to determine the overpayment amounts returned to the Medicare trust fund as a result of providers' having established certain mechanisms, including auditing and reporting, required by the OIG under corporate integrity agreements.

Expected Completion Date: Ongoing

Advisory Opinions and Fraud Alerts

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

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

In FY 2001, 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 2001. In addition, we plan to continue our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG.

Expected Completion Date: Ongoing

Civil Monetary Penalties

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

Expected Completion Date: Ongoing