



Department of Health and Human Services

**Office of
Inspector General**

Work Plan

Health Care Financing Administration Projects

Fiscal Year 1999

**June Gibbs Brown
Inspector General**






Office of Inspector General

MISSION:

Under the authority of the IG Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.






VISION

WE ARE GUARDIANS OF THE PUBLIC TRUST

-  Working with management, we will ensure effective and efficient HHS programs and operations.
-  Working with decision-makers, we will minimize fraud, waste and abuse in HHS programs.
-  Working with our talented and motivated staff, we will manifest the highest standards as a Federal OIG.

VALUES

WE VALUE:

-  Quality products and services that are timely and relevant.
-  A service attitude that is responsive to the needs of decision-makers.
-  Fairness, integrity, independence, objectivity, proficiency, and due care in performing our work.
-  Teamwork and open communication among OIG components.
-  A positive environment that supports our personal and professional needs and encourages us to be innovative and reach our full potential.

Department of Health and Human Services

Office of Inspector General



Work Plan for Fiscal Year 1999

INTRODUCTION

The Office of Inspector General (OIG) Work Plan is set forth in five chapters encompassing the various projects to be addressed during Fiscal Year (FY) 1999 by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The first four chapters present the full range of projects planned in each of the Department of Health and Human Services' (HHS) major entities: the Health Care Financing Administration, the Public Health Service agencies, the Administration for Children and Families, and the Administration on Aging. The fifth chapter embraces those projects related to issues that cut across Department programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary.

In preparing this edition of the OIG Work Plan, we have provided a brief description of the various project areas that we perceive as critical to the mission of the OIG and the Department. Unless otherwise noted, reports on all projects are expected to be issued in FY 1999. However, as the work planning process tends to be ongoing and dynamic, the focus and timing of many of these projects can evolve in response to new information, new issues, and shifting priorities of the Congress, the President, and the Secretary and may be altered over time.

Given these variables, the OIG objective still remains the targeting of available resources on those projects that best identify vulnerabilities in the Department's programs and

activities that have been designed to serve and protect the safety, health, and welfare of the American people and promote the economy, efficiency, and effectiveness of the Department's programs. The Health Insurance Portability and Accountability Act of 1996, strengthened by the Balanced Budget Act of 1997, brought much needed authorities and resources to achieving this objective.

Program Audits

The Office of Audit Services (OAS) conducts comprehensive financial and performance audits of departmental programs and operations to determine whether program objectives are being achieved and which program features need to be performed in a more efficient manner. The OAS also provides overall leadership and direction in carrying out the responsibilities mandated under the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

The audit portion of the OIG Work Plan represents the most significant audit work that will be conducted in FY 1999.

Program Inspections

The Office of Evaluation and Inspections (OEI) seeks to improve the effectiveness and efficiency of departmental programs by conducting program inspections to provide timely, useful, and reliable information and advice to decision makers. These inspections are program and management evaluations that focus on specific issues of concern to the Department, the Congress, and the public. The inspections identified in this Work Plan focus on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The results of these inspections should generate accurate and up-to-date information on how well those programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

Investigative Focus Areas

The OIG's 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 the programs and operations of HHS. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in areas of program vulnerability 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.

Legal Counsel Focus Areas

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of health care fraud and abuse cases, including the litigation and imposition of administrative sanctions, such as program exclusions, and civil monetary penalties and assessments; the global settlement of cases arising under the Civil False Claims Act; and the development of corporate agreements for providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry awareness of models for corporate integrity and compliance programs and monitors ongoing integrity agreements. The OCIG also provides all administrative litigation services required by OIG, such as patient dumping cases and all administrative 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 new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG counsels OIG components on personnel and operations issues, subpoenas, audit and investigative issues, and other legal authorities.

Internet Address

The FY 1999 OIG Work Plan and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

<http://www.hhs.gov/progorg/oig>

Department of Health and Human Services

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Health Care Financing Administration Projects

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HOSPITALS

Hospital Quality Oversight

We will assess HCFA's oversight of private accreditation and State certification activities, as well as the role of private accreditation and State licensure. In order for hospitals to receive Medicare payments, they must be certified by Medicare (through federally reimbursed State surveys) as meeting Medicare requirements or they must be accredited by a recognized accrediting association. Of the 6,200 hospitals currently participating in the Medicare program, over 70 percent are accredited: about 4,700 through the Joint Commission on the Accreditation of Health Care Organizations and 144 through the American Osteopathic Association.

OEI; 01-97-00050

Relationship Between Hospital Costs and Revenues

We will examine the relationship between hospitals' costs and revenues to assess the reasonableness of Medicare payment levels for inpatient services. Under Medicare's prospective payment system, hospitals are paid a predetermined payment rate per discharge for each patient treated. Since hospitals receive millions of dollars annually comprising the largest portion of Medicare Part A reimbursements, it is critical that the predetermined payment rates be set at appropriate levels.

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

Hospital Services Billed Under Arrangement

We will determine the extent to which hospitals purchase services under arrangement and identify the services that hospitals purchase most frequently. We will also assess the fiscal effects of these arrangements. Previous work conducted by the OIG found that Medicare pays substantially more when nursing homes purchase services "under arrangement" from ancillary service providers, such as therapy/rehabilitation agencies and portable x-ray suppliers. "Under arrangement" means that a facility purchases ancillary services from a service provider who bills the facility rather than a Medicare contractor. We found that the facility then included those services as costs on the claims

it submitted to the fiscal intermediary, marking them up as much as 250 percent for overhead and administrative expenses. We will determine if similar problems occur at hospitals.

OEI; 04-98-00230

Hospital-Owned Physician Practices: Provider-Based Status

We will identify the potential vulnerabilities to Medicare arising from the proliferation of provider-based physician practices. Hospitals that meet certain criteria may receive higher reimbursement by having a “provider-based” designation for facilities housing practices they own, such as physician practices. We will review HCFA’s oversight of the process for approving “provider-based” status and for monitoring hospitals that receive the additional benefit. We will also explore any benefits of provider-based facilities to Medicare and its beneficiaries.

OEI; 04-97-00090

Hospital-Owned Physician Practices: Financial Impact

We will review the financial impact of trends in physician-hospital integration. In recent years, hospitals have acquired or become affiliated with physician practices. Medicare reimbursement may be affected, e.g., when a newly acquired physician group becomes a “provider-based” entity for the purposes of enhancing reimbursement through hospital claims for overheard expenses. There may also be an impact on beneficiary copayment responsibilities. We will determine whether and to what extent Medicare expenditures are increased as a result of physician-hospital integration and identify other potential vulnerabilities, such as questionable patient referral practices.

OEI; 05-98-00110

Prospective Payment System Transfers

We will continue to support the Department of Justice’s assistance to the Department in seeking recovery of Medicare overpayments to prospective payment system (PPS) hospitals that incorrectly reported PPS transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between PPS hospitals, the first (transferring)

hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. We also plan to issue a report recommending recovery of overpayments from hospitals that are not covered by the Justice Department's project.

OAS; W-00-98-30010; A-06-98-00010, A-06-98-00024

Prospective Payment System Transfers During Hospital Mergers

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

OAS; W-00-98-30010; A-06-98-00012

Hospital Reporting of Patients Who Left Against Medical Advice

We will identify prospective payment system (PPS) hospitals that routinely report that Medicare patients left the hospital against medical advice (self-discharged). Such reporting may indicate that facilities are trying to circumvent the PPS transfer payment policy, which exempts situations in which the patient left the first PPS hospital against medical advice. A significant increase in the reporting of "left against medical advice" transfers has occurred since the OIG's first PPS transfer recovery project (January 1986 through November 1991).

OAS; W-00-98-30010; A-02-98-01016, A-06-98-00013

Same-Day Discharge and Readmission to Same Hospital

This review will examine Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same prospective payment system hospital. We will review procedures in place for these readmissions at selected hospitals, fiscal intermediaries, and peer review organizations. With the assistance of medical review staff, we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine what system edits are used to identify and review readmissions.

OAS; W-00-98-30010; A-01-98-00504

Updating Diagnosis-Related Group Codes

We will evaluate the process by which HCFA updates diagnosis-related group codes. The basis for payments to hospitals is the diagnosis-related group code for each discharge under the prospective payment system. Each diagnosis-related group represents the average resources required to care for cases in that particular diagnosis-related group relative to the average resources used to treat cases in all diagnosis-related groups. Resources required to care for hospitalized Medicare beneficiaries can increase over time due to changes in the distribution of cases among diagnosis-related groups and increases in the average resource requirements of cases assigned to specific groups. We will assess the adequacy of the data used in recalibrations and reclassifications and examine how new technologies and treatments are incorporated into diagnosis-related groups.

OEI; 00-00-00000

Expected Issue Date: FY 2000

Monitoring Diagnosis-Related Group Coding

We will assess the extent and quality of HCFA's monitoring of diagnosis-related group coding by hospitals. In a medical record abstraction of 1996 hospital discharges done by the data abstraction contractors, the contractors found a variation of 8 to 10 percent between initial hospital coding and the data abstraction contractor coding. The OIG also found significant coding error rates in a recent sample of hospital medical records. This

current study will explore reasons why these errors are occurring and what HCFA does to monitor and correct the errors.

OEI; 00-00-00000

Expected Issue Date: FY 2000

Outpatient Base Year Costs

In partnership with HCFA, we will conduct a series of audits of the base year costs used to develop the prospective payment system rates for hospital outpatient department services. The Balanced Budget Act of 1997 required HCFA to implement a prospective payment system for hospital outpatient department services. Our audits will help determine if the prospective outpatient rates are reasonable.

OAS; W-00-99-30026; A-14-99-00000, A-01-98-00519

Outpatient Psychiatric Services

This review will determine whether psychiatric services rendered on an outpatient basis are billed and reimbursed in accordance with Medicare regulations. The regulations require that payments be limited to covered services that are supported by medical records. We have indications from one fiscal intermediary that some services rendered in outpatient hospital settings were not documented, not ordered by a physician, or not covered services. We will determine if this is also a problem at other fiscal intermediaries.

OAS; W-00-98-30010; A-01-98-00503

Experimental Drug Trials

We will conduct reviews to determine whether hospitals and other providers are inappropriately billing Medicare for items or services provided to beneficiaries as part of research grants and experimental drug trials. Many research projects are funded by the Public Health Service agencies and private foundations, whereas experimental drug trials

are usually paid by pharmaceutical companies. We will determine if claims for these projects are also being paid by Medicare.

OAS; W-00-98-30010; A-03-98-00000

Hospital Closure: 1997

This will be the 11th in a series of reports on hospital closure, examining the extent, characteristics, reasons for, and impact of closures in 1997. In the mid to late 1980s, closure of general, acute care hospitals generated considerable public and congressional interest. Our first report on closures in 1987 showed that the problem was not as severe as generally believed. Few hospitals had closed, most were small and had low occupancy, and few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there is continuing interest in this issue, and our annual reports have become a standard reference on it.

OEI; 04-98-00200

HOME HEALTH

Home Health Base Year Costs

Working with HCFA, we will perform a series of audits of the base year costs used in developing prospective payment system rates for home health agencies. The implementation of this prospective payment system was required by the Balanced Budget Act of 1997. Our audits will help evaluate the reasonableness of the prospective rates.

OAS; W-00-98-30009; A-14-98-00410, A-04-99-00000

Payment Based on Location of Service

We will evaluate the implementation of a 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-00-99-00000

Physician Case Management Billings

We will review the reasonableness of physician claims for home health care. Among other things, this review will determine if, after a regional home health intermediary denies a home health claim, the Part B carrier also denies any related payments submitted by the physician for oversight of the plan of care. Payment to physicians for plan care oversight is to be recovered when a claim does not meet Medicare criteria for home health services. The intermediaries and carriers should be interacting with regard to such claims.

OAS; W-00-99-30009; A-06-99-00000

Access to Home Health Services

We will assess the effect of the Medicare home health interim payment system on beneficiary access to home health services. In response to rapidly rising Medicare home health costs, the Balanced Budget Act of 1997 made significant changes in the way home health agencies will be paid. Effective October 1, 1999, cost-based reimbursement will be replaced with a prospective payment system under which Medicare pays agencies a predetermined amount per unit of service. In the meantime, for cost report periods beginning on or after October 1997, the Balanced Budget Act reduces the per visit limit to 105 percent of median national costs for each type of visit (instead of the 112 percent of the mean as under the previous method) and establishes a per beneficiary limit based on 1994 costs. We will examine how home health agencies have responded to the new interim payment system and what effect this has had on beneficiary access to home health services.

OEI; 00-00-00000

Utilization Patterns of Home Health Services

This study will determine if recent reimbursement changes to certain hospital discharges has altered the use of home health services. We will specifically determine whether home health services have increased 3 days after certain inpatient discharges. Under the provisions of the Balanced Budget Act, certain hospital discharges to home health agencies and to skilled nursing facilities will be reimbursed under a formula that treats these discharges as transfers, effective January 1, 1999. Regulations implementing this provision have specified that for the selected discharges, a beneficiary's use of home health services will cause the discharge to be reimbursed under the transfer methodology. Use of home health services after the 3-day period will result in reimbursement based on the current discharge methodology.

OEI; 00-00-00000

Home Health Aides

We will examine claims for home health aide services provided to Medicare beneficiaries in residential care facilities in one State. The State requires such facilities to provide assisted living services, such as meal preparation, room cleaning, and bathing in order to be licensed. The residents pay the facilities for these services. It has been alleged that in some situations home health aides (via home health agencies) claimed Medicare reimbursement as though they--not the resident care facilities--provided the services to beneficiaries.

OAS; W-00-98-30009; A-09-98-00056

NURSING HOME CARE

State Survey and Certification Process

We will examine the variation in State nursing home survey and certification processes. The Omnibus Reconciliation Act of 1987 established requirements for surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation in the Medicare and Medicaid programs and for certifying compliance or noncompliance. We will examine process issues, such as how often States conduct

surveys, number of surveyors, surveyor training, time spent at each facility, and sampling techniques. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 02-98-00330

Analysis of State Survey and Certification Data

We will examine trends in State survey and certification data and the extent to which the data indicates quality of care problems in nursing facilities. The Online Survey Certification and Reporting System is a national HCFA database comprised of information entered by State survey agencies during periodic inspection and/or certification of Medicare and Medicaid facilities. The database includes basic demographic and deficiency information on facilities. We will analyze the data for a sample of States. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 02-98-00331

State Resident Abuse Data

We will examine trends in nursing facility patient abuse reports to State agencies. The law requires that all alleged patient abuse incidents be reported immediately to the facility administrator and to State officials in accordance with State law. Further, following a thorough investigation of each incident, the results of all investigations must be reported to the administrator and to State officials in accordance with State law within 5 working days of the incident. We will examine types of reports received, investigations, and confirmations of abuse. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 06-98-00340

Nursing Home Survey Results

We will examine the manner in which States and HCFA make survey results public. Federal law requires States and HCFA to make public (upon request) all information concerning survey and certifications of skilled nursing facilities and nursing facilities, a

service for which the States and HCFA may charge. States require that survey results be posted in the nursing home. We will determine how easily the public can obtain survey results, comprehend the information, and compare quality among facilities.

OEI; 06-98-00280

Resident Assessments and Plans of Care

We will determine whether quality of care concerns exist with resident assessments and plans of care and whether Medicare and Medicaid payment levels are correct. Federal law requires nursing facilities to conduct initial and periodic assessments of each resident's functional capacity that are comprehensive, accurate, and standardized and then to develop a comprehensive plan of care based on the assessment. The assessment information is also used to determine the level of Medicare and Medicaid payments to nursing facilities.

OEI; 00-00-00000

Resident Immunizations

We will examine the obstacles to immunizing Medicare-eligible nursing home residents against influenza and pneumococcal disease. The Centers for Disease Control's Advisory Committee on Immunization Practices recommends that all persons aged 65 and older and residents of nursing homes be vaccinated for these diseases. The Healthy People 2000 objective is to increase the immunization level for influenza and pneumococcal disease to 80 percent for institutionalized, chronically ill, or older people. Recent evidence suggests that many nursing home residents do not receive both vaccinations, and some data indicates a dual vaccination rate as low as 21 percent. Medicare Part B pays for both vaccinations.

OEI; 00-00-00000

Skilled Nursing Facility Base Year Costs

In conjunction with HCFA, we will perform a series of audits of the base year costs used in developing the prospective payment system rates for skilled nursing facilities.

Implementation of this prospective payment system was required by the Balanced Budget Act of 1997. Our work will help evaluate the reasonableness of the prospective rates.

OAS; W-00-98-30014; A-01-98-00519

Ancillary Medical Supplies

These ongoing reviews will determine if skilled nursing facilities have claimed unallowable costs for ancillary medical supplies. Pre-PPS Medicare reimbursement rules describe those items and services that are allowable as ancillary costs. Reviews conducted in two States have identified items and services that are unallowable as ancillary costs.

OAS; W-00-98-30015; A-09-98-00076

Nursing Home Implementation of Consolidated Billing

We will examine the early implementation of consolidated billing in nursing homes. The Balanced Budget Act legislated a new billing method for all Part B services provided to Medicare beneficiaries residing in nursing homes, effective July 1, 1998. For nursing home stays not paid by Medicare Part A, nursing facilities will be responsible for submitting bills to Medicare contractors for most Part B services. Outside entities will no longer be able to directly bill the program. This is known as consolidated billing. We will examine nursing homes' response to the consolidated billing requirements and the guidance HCFA provided to nursing homes on implementing consolidated billing.

OEI; 00-00-00000

Therapy in Nursing Facilities

A series of OIG reviews will evaluate the reasonableness of and costs associated with therapy services provided in skilled nursing facilities. The Medicare skilled nursing facility benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services. These rehabilitative services may include physical and occupational therapy which may be paid by either Medicare Part A or

Part B. We will examine a number of issues connected with these services and payment arrangements, including medical necessity.

OAS; W-00-98-30014; A-04-98-00000
OEI; 09-97-00121

Mental Health Services in Nursing Facilities: A Follow-Up

We will determine whether mental health services in nursing facilities continue to be inappropriately billed. A 1996 OIG study found that medically unnecessary or questionable mental health services in nursing facilities were charged to Medicare, in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent inappropriate payments, such as developing guidelines for carriers, developing screens to implement those guidelines, conducting focused medical review, and providing physician educational activities.

OEI; 00-00-00000

PHYSICIANS

Accuracy and Carrier Monitoring of Physician Visit Coding

We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for evaluation and management services. Generally, the codes represent the type and complexity of services provided and patient status, such as new or established. Previous work by the OIG has found that physicians do not accurately or uniformly use visit codes. Our analysis will build upon this previous work and add more definitive data on the accuracy of physician visit coding.

OAS; W-00-98-30021; A-04-98-00000

Physicians at Teaching Hospitals (PATH)

This initiative is designed to verify compliance with the Medicare rules governing payment for physician services provided in the teaching setting and to ensure that claims accurately reflect the level of service provided to the patient. The PATH initiative has been undertaken as a result of the OIG's audit work in this area, which suggested that many providers were not in compliance with the applicable Medicare reimbursement policies.

OAS; W-00-99-30021; A-04-99-00000

Physicians with Excessive Nursing Home Visits

We will identify and audit billings of physicians with excessive visits to Medicare patients in skilled nursing facilities. A past OIG nursing home project identified trends in Medicare and Medicaid payments and populations and identified aberrant providers of nursing home services by type of service. Using this data, as well as other computer screening techniques, we identified physicians with aberrant billing patterns for visits to nursing home patients, such as an excessive number of visits in a given day and excessive visits to the same beneficiaries. We also plan to determine how Medicare carriers could better identify and prevent such billings.

OAS; W-00-99-30021; A-03-99-00000

Podiatry

We will assess whether podiatry services paid by Medicare were medically necessary and 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. Total Medicare allowances for foot care totaled almost \$300 million in 1995. We will select a random sample of paid claims for podiatry services and, with the assistance of medical staff, conduct a medical review of these services.

OEI; 00-00-00000

Automated Encoding Systems for Billing

We will determine if errors found in Medicare billings for physician services are associated with providers' use of automated encoding software. Using billing errors identified in recent audits of HCFA's financial statements, we will contact providers to determine if automated software was used to prepare the billing. By comparing providers known to have submitted erroneous records with those that did not, we can take a first step in identifying any adverse effect of this software. Results of this work may lead to further reviews.

OEI; 00-00-00000

Billing Service Companies

This review will determine whether (1) Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided to beneficiaries and (2) the agreements between providers and billing service companies meet Medicare criteria. Medicare allows providers to contract with billing service companies that provide billing and payment collection services. The contractual agreements between the provider and the billing service company must meet certain Medicare criteria, and a copy of the agreement must be provided to the applicable Medicare carrier. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians. The HCFA officials have expressed concern that the agreements may not meet the required criteria.

OAS; W-00-97-30021; A-06-98-00029

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, allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number.

This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

OEI; 00-00-00000

Improper Billing of Psychiatric Services

We will determine whether providers are properly billing Medicare for psychiatric services in the following three areas: (1) providers' billing Medicare for individual psychotherapy rather than inpatient hospital care, resulting in Medicare overpayments, (2) providers' billing Medicare for a psychological testing code on a per test basis rather than a per hour basis, as required, or (3) providers' billing Medicare for group psychotherapy in cases that do not qualify for Medicare payment because either the group sessions do not involve actual psychotherapy services or the patients cannot benefit by group psychotherapy. Improper billing of these psychiatric services results in Medicare overpayments.

OAS; W-00-97-30021; A-06-98-00009

Patient Billing Records

In one State, we will review a sample of physicians' patient billing records to identify and obtain refunds for Medicare and Medicaid overpayments. Should we detect significant problems in this State, we will expand the review to include other geographical areas and other types of providers.

OAS; W-00-98-30030; A-03-98-00017, A-09-99-00000

MEDICAL EQUIPMENT AND SUPPLIES

Operations of Durable Medical Equipment Carriers

We will assess whether the establishment of durable medical equipment regional carriers has met its intended objectives. Starting October 1, 1993, HCFA began consolidating claim processing activities for durable medical equipment, prosthetics, orthotics, and

supplies into four regional carriers. The four carriers, replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of these regional carriers with respect to medical guidelines, oversight of claim processing, and detection and referral of fraudulent activity.

OEI; 04-97-00330

Duplicate Billings for Medical Equipment and Supplies

We will determine if duplicate billings for medical equipment and supplies are being made to both durable medical equipment regional carriers and regional home health intermediaries. Medicare Part B provides coverage for a wide range of durable medical equipment and supplies that can be used by beneficiaries receiving Medicare-reimbursed home health services. Suppliers that provide equipment and supplies to beneficiaries bill the durable medical equipment carrier for these products using the HCFA common procedure coding system. As part of the services it provides to qualified beneficiaries, a home health agency may also furnish supplies. These supplies are billed to the regional home health intermediaries. Because of the nature of the billing codes used and the difference in contractor claim processing, it is conceivable that Medicare could pay both providers for the same supplies.

OEI; 04-97-00460

Selected Providers

We will review selected providers to determine whether Medicare claims submitted by durable medical equipment providers are proper and in accordance with Medicare requirements. Prior OIG work, as well as additional analytical work, has detected a growth in expenditures and problems with services not rendered, upcoding, improper utilization, and medical necessity questions. Work will be performed in New York State and Puerto Rico.

OAS; W-00-98-30007; Various CINS

Hospice Part B Billings

We will determine the appropriateness of selected durable medical equipment Part B billings on behalf of hospice patients. Separate Part B payments for hospice beneficiaries are appropriate only for conditions unrelated to the patient's terminal illness. A recent nationwide review disclosed significant problems in Part A payments to hospitals and skilled nursing facilities for hospice patients; a similar situation appears to be occurring on the Part B side.

OAS; W-00-98-30015; A-02-98-00000

Medical Necessity of Oxygen

We will compare Medicare beneficiaries' self-reported use of home oxygen therapy with documentation supporting the medical need for such therapy. We will assess the prescribing practices of physicians who order the systems and how Medicare monitors utilization and medical necessity for the systems. Allowances for oxygen equipment increased from about \$835 million in 1992 to over \$1.6 billion in 1995.

OEI; 03-96-00090

Orthotic Body Jackets

In this follow-up study, we will examine whether suppliers are still billing for "non-legitimate" orthotic body jackets. In 1993, the OIG issued a report on Medicare payments for orthotic body jackets and found that 95 percent of the claims submitted should not have been paid because the "body jackets" did not meet construction and medical necessity criteria. Many of the devices were primarily used to keep patients upright in wheelchairs.

OEI; 04-97-00390

Licensing Requirements for Prescription Drug Suppliers

We will determine if entities that bill for providing drugs and similar medications to Medicare beneficiaries meet required licensing requirements. Effective December 1, 1996, HCFA issued a new policy requiring these entities to have pharmacy licenses.

Previously, suppliers could bill the Medicare program for providing drugs, even though they did not have pharmacy licenses in accordance with applicable State laws. Many suppliers had agreements with pharmacies to dispense the drugs, but the suppliers did the actual billing. The new policy was developed, in part, because of questionable practices encountered in South Florida.

OEI; 00-00-00000

END STAGE RENAL DISEASE

Clinical Laboratory Tests Provided to ESRD Beneficiaries

This review will identify inappropriate Medicare payments for clinical laboratory tests for end stage renal disease (ESRD) patients. Our survey disclosed that providers are either separately billing for laboratory tests that are included in the monthly composite rate or are providing laboratory tests that do not conform to professionally recognized standards.

OAS; W-00-98-30025; A-01-98-00000

Medical Appropriateness of Tests and Other Services

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

OEI; 00-00-00000

Bad Debts - Nationwide Chain

This review will determine whether home office costs and bad debts reported by a large nationwide chain of dialysis facilities during Calendar Years 1996 and 1997 are allowable and properly allocated in accordance with Medicare's reasonable cost principles and the *Provider Reimbursement Manual*. Under Medicare's composite rate reimbursement system, end stage renal disease (ESRD) facilities are reimbursed 100 percent of their allowable Medicare ESRD bad debts, up to their unreimbursed Medicare reasonable costs. However, if a facility's revenues exceed its costs, it would have no unrecovered cost and would not be eligible to receive payment for Medicare bad debts. Prior reviews have identified significant overpayments.

OAS; W-00-98-30025; A-01-98-00508

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount on Medicare Prescription Drugs

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

OEI; 03-97-00291

Infusion Therapy Services

We will assess the impact of infusion therapy suppliers' charges on nursing home cost reports submitted to Medicare. Medicare costs associated with infusion therapy in skilled

nursing facilities increased by 46 percent from 1995 to 1996. In the first 6 months of 1997, Medicare paid over \$80 million for the therapy. Nursing facilities are required to purchase supplies and equipment at a reasonable cost (prudent buyer theory). If the suppliers' costs are unreasonable or if amounts billed by suppliers are not supported by the services they provide, nursing home claims will adversely affect the Medicare program.

OAS; W-00-98-30022; A-06-97-00086, A-06-98-00031, A-06-97-00053, A-06-97-00061, A-06-97-00062, A-06-97-00063

Medicare Nebulizer Drugs

We will continue reviews to determine the extent to which durable medical equipment suppliers and/or mail order pharmacies have either paid or received referral fees to fill Medicare nebulizer drug prescriptions. These reviews will lead us to revisit pricing and reimbursement methodologies used by HCFA for nebulizer drugs and make appropriate recommendations. Excessive reimbursement rates have created an environment that encourages payment of referral fees.

OAS; W-00-98-30022; A-06-98-various

OTHER MEDICARE SERVICES

Excess Payments for Ambulance Services

This review will examine Medicare Part B carriers' payment systems to determine if excess payments are being made for certain types of ambulance services. We recently completed a review of medical claims for ambulance services by one company and found that the carrier's system did not prevent excess payments for some ambulance transports. We plan to determine if similar situations are occurring at other carriers.

OAS; W-00-99-00021; A-03-99-00000

Comparison of Ambulance Reimbursement Policies

We will identify how different payers (e.g., fee-for-service providers, health maintenance organizations, and preferred provider organizations) reimburse ambulance suppliers for services. We will compare this information with Medicare reimbursement for the same services in similar geographic areas and use all data to project savings for the geographic areas. Our recent studies of Medicare ambulance services have raised concerns that Medicare allowances may be excessive.

OEI; 09-95-00411

Partial Hospitalization Services

We will review partial hospitalization services, i.e., specialized outpatient mental health services, to identify services that do not meet Medicare reimbursement requirements. Medicare covers partial hospitalization services that are reasonable and necessary for the diagnosis and treatment of a beneficiary's mental condition. The OIG reviews will focus on noncovered services and those provided to beneficiaries who do not meet eligibility requirements. The reviews will be conducted in three modalities: a joint project with HCFA, individual providers, and a nationwide review.

OAS; W-00-98-30026; A-03-98-00000, A-04-98-02145; A-05-98-00000, A-07-98-01263

Medicare Reimbursement for Outpatient Psychotherapy

We will determine the medical necessity of a national sample of outpatient psychotherapy services paid by Medicare. Medicare reimbursement for the five most commonly reimbursed mental health codes for psychiatrists, clinical psychologists, and clinical social workers showed a 57 percent increase from \$353 million in 1991 to \$556 million in 1993. In 1996, Medicare-allowed charges for just code 90844 (45 to 50 minutes of psychotherapy) were almost \$500 million. This study is a follow-up to a recent OIG report on mental health services in nursing homes, which found a medically unnecessary service rate of 32 to 46 percent.

OEI; 00-00-00000

MEDICARE MANAGED CARE

General and Administrative Costs

This review will determine if the administrative costs allocated for Medicare beneficiaries enrolled in risk-based health maintenance organizations (HMO) are proper. General and administrative costs include costs associated with enrollment, marketing, membership costs, directors' salaries and fees, executive and staff administrative salaries, organizational costs, and other plan administrative costs. Inflated general and administrative costs could increase plan profits, in which case the plans would be required to return the excess to HCFA, lower Medicare enrollees' premiums, offer extra benefits to enrollees, or take a reduction in Medicare payments. A cap on these costs would require legislative action.

OAS; W-00-98-30012, A-01-98-00510, A-02-98-01004, A-03-98-00022, A-05-98-00049, A-06-98-00046, A-09-99-00000

Payments Based on Institutional Status

This series of reviews will determine if HCFA has made proper capitation payments to risk-based HMOs for beneficiaries classified as institutionalized. Risk-based HMOs are paid based on a prospectively determined capitation rate. However, a higher capitation rate is paid for beneficiaries classified as institutionalized. Preliminary findings indicate that HCFA's databases have not been updated for changes in beneficiary status. We will focus on both HCFA and HMO controls regarding beneficiary status.

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

Payments for End Stage Renal Disease Beneficiaries

This review will update past OIG work on the appropriateness of Medicare payments to risk-based HMOs for beneficiaries with end stage renal disease (ESRD). Risk-based HMOs are paid based on a prospectively determined capitation rate. That rate is enhanced for certain high-cost categories of beneficiaries, such as those with ESRD. Previous OIG work identified system problems that resulted in payments to HMOs for

beneficiaries no longer ESRD-eligible. Our current review will evaluate the effectiveness and timing of the system used to report beneficiaries' ESRD status.

OAS; W-00-98-30012; A-14-98-00211

Medicare Payments to HMOs for Medicaid-Eligible Beneficiaries Living in Medicaid Nursing Facilities

We will examine Medicare payments to risk-based HMOs for Medicaid-eligible beneficiaries living in Medicaid nursing facilities. The Medicare HMO receives an enhanced payment rate for these beneficiaries, although the Medicaid-reimbursed nursing facility is required to provide most of the patients' needs. We will determine the reasonableness of the enhanced payment rate.

OAS; W-00-98-30012; A-05-98-00000

Physician Incentive Plans in Managed Care Contracts

We will review physician incentive plans included in contracts that physicians enter into with managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on utilization levels. It also requires plans to disclose these arrangements to beneficiaries. As part of this review, we will also look at other clauses in these contracts that may affect the quality of care provided.

OEI; 00-00-00000

Duplicate Fee-for-Service Billings

This review will determine whether fiscal intermediaries and carriers improperly reimbursed Medicare providers for services provided to beneficiaries enrolled in risk-based managed care plans during calendar years 1995 through 1997. Medicare payments for beneficiaries enrolled in Medicare risk-based managed care plans are made directly to the managed care plans. The managed care plans are to arrange and pay for all necessary

medical services. The *Part A Fiscal Intermediary Manual* further instructs that Medicare contractors are not to duplicate payments for services the HMO has paid.

OAS; W-00-98-30012; A-07-97-01247

Investment Income Earned by Risk-Based HMOs

This review will determine if risk-based HMOs should be held accountable for investment income earned on Medicare funds. Since HCFA pays risk-based HMOs a predetermined rate for each Medicare beneficiary by the start of every month, the HMOs have an opportunity to earn investment income on Medicare funds until they are used to pay for services rendered during the month. Any investment income earned on Medicare funds is not factored into the HMOs' payment rates; this income also does not have to be used to increase services offered or reduce premiums charged to Medicare beneficiaries. We will estimate the investment income earned on Medicare funds and analyze the flow of this income to determine if HCFA needs to establish criteria on the application of investment income.

OAS; W-00-99-30012; A-02-99-00000

National Marketing Guidelines for Medicare Managed Care Plans

We will assess the usefulness of HCFA's new national marketing guidelines for managed care plans to HCFA, beneficiaries, and managed care organizations. The HCFA regional offices are responsible for approval of all marketing and sales materials that managed care plans provide to beneficiaries. Different review practices among regions have led to discrepancies among the types of materials presented to beneficiaries. In addition, the managed care industry has raised concerns that large national plans are treated differently from region to region and have had to develop different marketing material for each region in which they operate. In an effort to remedy these problems, HCFA has developed national marketing guidelines which are scheduled to be implemented shortly.

OEI; 03-98-00270

Assessing Managed Care Health Plan Data

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

OEI; 00-00-00000

Managed Care Additional Benefits

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

OEI; 00-00-00000

Enrollee Access to Emergency Services

We will determine if existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or deny treatment to a person who comes to the emergency room. In addition, the health maintenance organization sanctions protect Medicare and Medicaid beneficiaries from health maintenance organizations' unreasonable refusal to provide needed care. Violation of either of these protections may result in sanctions, including penalties and program exclusion. We will examine whether the reach of these Federal enforcement authorities

adequately protects patients who need and seek emergency care but are prevented from receiving such care by managed care rules or hospital policies.

OEI; 09-98-00220

Services Provided After Disenrolling

This series of reviews will examine the services paid by Medicare as fee-for-service after beneficiaries disenroll from a risk-based managed care organization as an indicator of whether all needed services were provided. We will focus on HCFA's monitoring of the risk plans' quality assurance programs to ensure compliance with Federal requirements. We will also review the plans' incentive arrangements to ensure that they do not include any specific payment to be made directly or indirectly to a physician or physician group as an inducement to withhold, limit, or reduce services to a specific enrollee. Under the Medicare risk-based program, managed care plans must assume responsibility for providing all Medicare-covered services in return for a predetermined capitated payment and must provide the same services as traditional Medicare fee-for-service. Beneficiaries may not be involuntarily disenrolled from the plan for medical reasons.

OAS; W-00-98-30012; A-07-98-01256

MEDICAID MANAGED CARE

States Use of External Quality Review Organizations

We will assess States' use of contractors to monitor the quality of care delivered by Medicaid managed care programs and identify lessons learned. The Balanced Budget Act of 1997 grants States increased authority to establish Medicaid managed care programs without waivers of Federal law. In addition, HCFA and the States must establish a method to identify entities that are qualified to perform external independent quality reviews and to contract with an independent quality review organization to develop the protocols to be used in conducting these reviews. The HCFA indicated that OIG's work would help identify qualified entities and effective review techniques.

OEI; 01-98-00210

Impact on Mental Health Services

We will provide a preliminary description of the impact of managed care on the delivery of mental health services to the Medicaid population. State Medicaid programs are increasingly adopting managed care approaches. We will gather information on how the managed care approach has affected the services available to adults with serious mental illnesses and children with serious emotional disturbances, the mental health delivery systems, and standards and performance measures.

OEI; 04-97-00340

Fraud and Abuse in Medicaid Managed Care

We will describe and assess the manner in which States detect, review, and refer for investigation Medicaid fraud and abuse cases in State-wide managed care programs. Many States are moving toward managed care to provide cost-effective medical care while enhancing access to quality care and preventing unnecessary medical treatment. Our review will provide information on mechanisms used by Federal and State Governments to detect, refer, and investigate fraud and abuse cases.

OEI; 07-96-00250

MEDICAID - CHILDREN S HEALTH INSURANCE PROGRAM

Best Practices in Medicaid and Children s Health Insurance Program Outreach

We will examine the strategies States use to inform eligible families about the Children's Health Insurance Program. We will also examine whether States with historically low take-up rates have enhanced their outreach and enrollment efforts for the new program. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. States are allowed to use up to 10 percent of their Federal Children's Health Insurance Program allotment for administrative costs, outreach, and services other than the standard benefit package for eligible children. Our

review will include a determination of the best practices used by a sample of States to promote cooperative outreach projects in both Medicaid and the Children's Health Insurance Program.

OEI; 00-00-00000

Special Needs Children

We will examine State strategies for providing insurance and access to appropriate health care for children with special health care needs. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. Approximately 10 million children have some type of chronic conditions, and about 4 million of these children are limited in school or play activities. We will document States' experiences and innovative approaches, including strategic planning activities, benefit packages, and service delivery systems.

OEI; 00-00-00000

Involvement of Federally Funded and Qualified Health Centers

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

OEI; 00-00-00000

States' Application Procedures

We will review selected States' application procedures under the Children's Health Insurance Program. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The law allows States to

expand Medicaid eligibility to new groups of children or to establish a new program to aid children who are ineligible for Medicaid or are uninsured. We will determine effective models for application and enrollment of children.

OEI; 00-00-00000

MEDICAID REIMBURSEMENT

Coordination of Care for Dual Eligibles

We will assess the coordination of care and identify issues related to beneficiaries entitled to both Medicare and Medicaid. Approximately 6 million Medicare beneficiaries have some level of supplemental care coverage under the Medicaid program and are known as “dual eligibles.” We will determine if these beneficiaries' care is monitored appropriately to ensure access to and use of services in both the managed care and fee-for-service settings. We will also look at innovative techniques used to coordinate care for dual eligibles.

OEI; 00-00-00000

Federal Reimbursement for Psychiatric Care

This series of reviews will determine whether one State is properly claiming Federal Medicaid reimbursement for services provided to psychiatric patients in different settings, including those released to acute care facilities or living in community residences, as well as the propriety of ancillary medical services for certain aged patients living in psychiatric hospitals. Previous work in this area disclosed the potential for improper charges. We will initially follow up on our earlier review related to patients temporarily released to acute care facilities.

OAS; W-00-98-30013; A-02-98-00000

Follow-Up on Medicaid Clinical Labs

This follow-up review at a State Medicaid agency will determine whether prior audit recommendations were implemented, i.e., whether (1) recommended edits are in place to

detect and prevent payments for unbundled tests and duplicate tests, (2) Medicaid laboratory fees do not exceed Medicare laboratory fees, and (3) overpayments have been recovered from those providers with the largest total potential overpayments.

OAS; W-00-98-30027; A-05-98-00000

MEDICARE CONTRACTOR OPERATIONS

HCFA Oversight of Medicare Contractors

We will evaluate HCFA's Contractor Performance Evaluation program which HCFA uses to monitor contractor performance. Beginning in 1993, HCFA revised this monitoring program by replacing numerical scoring with narrative reports. An August 1995 OIG report provided a preliminary assessment of the changes. This follow-up study will take a new look at the revised monitoring system now that it has been in place longer.

OEI; 00-00-00000

Comparison of Payment Safeguard Activities

We will compare Medicare and Medicaid payment safeguard activities with those undertaken by other payers to determine best practices and 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. A survey and comparison of payment safeguard activities will further the OIG's responsibility under the Health Insurance Portability and Accountability Act to coordinate national health care fraud control activities, in addition to providing recommendations for Medicare and Medicaid fraud control.

OEI; 00-00-00000

Factors in Identifying Potentially Fraudulent Providers

We will evaluate the various methods and approaches contractors use to identify potentially fraudulent providers and assess HCFA oversight in this area. Building on our previous work in evaluating contractor payment safeguard activities, we will focus on proactive techniques, such as payment edits and data analysis, and determine the factors present at the contractor level that contribute to the effectiveness of these techniques. We will make recommendations for HCFA to incorporate successful methods into its new anti-fraud contracting initiatives.

OEI; 00-00-00000

Excessive Numbers of Billings

We will determine the extent of inappropriate or unnecessary services for beneficiaries who receive a large number of medical services in a short time period. Using a computer edit, a Medicare carrier in one State identified numerous beneficiaries whose sheer number of Part B claims over a set period of time was considered "medically impossible." Through a medical review, we will determine whether this type of edit is effective and whether it should be used on a national basis. In addition, we will survey beneficiaries regarding the services they have received.

OEI; 07-97-00080

Mutually Exclusive Medical Procedures

This review will determine the adequacy of procedures and controls used by Medicare carriers and fiscal intermediaries to prevent payments for mutually exclusive medical procedures. These procedures, based on their definition or the medical technique involved, are impossible or unlikely to be performed at the same session. Reimbursement to providers, such as physicians, clinical laboratories, and ambulatory surgical centers, is based on the procedure code submitted to Medicare. The review will focus on whether providers were improperly paid for mutually exclusive procedures provided to the same beneficiary on the same date of service.

OAS; W-00-98-30003; A-01-98-00507

Suspension of Payments to Medicare Providers

We will evaluate contractor suspensions of payments to providers. The Medicare program may suspend payments under certain circumstances, such as to recover overpayments or to prevent program losses from fraud and abuse. We will review suspension actions under recent regulatory changes and determine if suspension of payment is an effective tool for averting overpayments. We will also assess whether contractors consistently adhere to program requirements regarding suspension of payments.

OEI; 00-00-00000

Identifying and Collecting Overpayments

We will assess the effectiveness of contractor activities to identify and collect Medicare overpayments. Providers are often paid more than the appropriate amount for services they bill. Although contractors use a variety of methods to identify, quantify, and recover overpaid trust fund amounts, some types of overpayments may never be identified. Further, once overpayments are identified, contractor efforts and success in recovering them vary widely. We will examine the methods of identifying overpayments with attention to overpayments that may not be captured through these methods. We will also describe the approaches and results of contractor efforts in overpayment collections.

OEI; 00-00-00000

Management Service Organizations

We will determine whether the advent of management service organizations in health care delivery systems has created vulnerabilities for Medicare. These organizations provide various services under contract to hospitals and physician groups, including management of contracts, information systems, credentialing, and financial transactions. The increasing use of these organizations may call for particular payment safeguards, such as enhanced protection of health insurance claim numbers and monitoring of billing patterns and practices for problems related to fraud and abuse. We will examine the

extent of vulnerabilities and assess the effectiveness of Medicare contractors' existing payment safeguard activities.

OEI; 00-00-00000

Contractor Medical Review

We will assess how contractors use medical review to identify potential problem areas. Medicare carriers use this approach to conduct many of their postpayment reviews. Since physicians account for the majority of payments under Medicare Part B, much of the carriers' activity is expected to focus on this group. This study, following up on prior studies on Medicaid fraud control units and carrier fraud units, will assess how carriers perform focused medical reviews, what corrective actions carriers pursue, and what educational interventions and/or referrals for fraud investigation result from these activities.

OEI; 06-98-00160

Medicare Provider Numbers and Unique Physician Identification Numbers

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

OEI; 00-00-00000

Provider Billing Numbers Issued to Resident Physicians

We will assess the extent of improper Medicare billings resulting from a control problem we noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to “moonlighting” activities unrelated to the resident’s training program. We noted that one hospital requested and received over 40 billing numbers for its residents over a 6-year period. The residents were not involved in “moonlighting” activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. We will determine the extent of this condition at the carrier in this State and at other carriers.

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

Medicare Administrative Appeals

We will identify potential improvements in the appeals process for Medicare providers, particularly those related to Part B claims and claims under the Part A home health benefit. The increasing rate of provider appeals is raising Medicare administrative costs and is contributing to other problems in Medicare claim payments. We will examine the appeals process, particularly from the perspective of the Medicare contractors and the administrative law judges.

OEI; 04-97-00160

Preaward Review of Medicare Integrity Program Contract Proposals

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

OAS; W-00-99-30006; Various CINs

Preaward Review of Medicare Peer Review Organizations

Throughout the fiscal year, we will review approximately 50 cost proposals submitted by the Medicare peer review organizations (PROs) under HCFA's sixth Statement of Work. Our reports to the HCFA contracting officer will contain recommendations on the propriety of the proposed costs. In the past, our reports have assisted the contracting officer in negotiating contract award amounts that were substantially lower than proposed.

*OAS; W-00-98-30006; Various CINs
Expected Issue Date: FYs 1999 and 2000*

Audit of Peer Review Organization Incurred Costs

We will audit the allowability, allocability, and reasonableness of costs incurred by approximately 17 PROs whose contracts under HCFA's fifth Statement of Work will expire at the end of the second fiscal quarter. Our reports will provide HCFA's contracting officer with recommendations on the amount, if any, of the PROs' claimed costs that should be disallowed.

*OAS; W-00-98-30004; Various CINs
Expected Issue Date: FYs 1999 and 2000*

Claim Processing Contractors Administrative Costs

This series of reviews requested by HCFA will address costs claimed by various contractors for processing Medicare claims. Special attention will be given to costs claimed by terminated contractors. In the past, these reviews have been beneficial since HCFA has used the results to deny claims for millions of dollars of unallowable costs. We will coordinate the selection of the contractors with HCFA staff (using results of their completed risk assessment review guide) and determine whether the costs claimed were reasonable and allowable under the terms of the contracts.

OAS; W-00-98-30004; 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; Various CINs

Pension Segmentation/Charges

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 charging pension contributions to Medicare contracts.

OAS; W-00-98-30005; 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-00-98-30005; A-07-98-02522, A-07-98-00000

GENERAL ADMINISTRATION

Year 2000 Computer Renovation Plans

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

OAS; W-00-98-40007; A-14-98-02561

Expected Issue Date: Periodic Reporting FYs 1999 and 2000

OIG-Excluded Persons

We will examine how OIG exclusion data is used outside the OIG and identify improvements needed in the Government's ability to protect federally funded programs and their beneficiaries from fraudulent or poorly performing health care providers. Every year the OIG excludes 1,200 to 1,500 fraudulent or unqualified practitioners from Medicare and Medicaid participation for various durations. Interested parties are able to identify these excluded providers by virtue of broad dissemination of OIG exclusion data and other means. However, anecdotal indications are that interested parties other than HCFA do not use this information, even though these providers are potentially harmful to Federal programs and their beneficiaries.

OEI; 00-00-00000

Medicare Secondary Payer

This study will determine the extent to which Medicare inappropriately pays when beneficiaries have other insurance which is required to pay primary. By statute, Medicare payments for such beneficiaries are required to be secondary to certain types of private insurance coverage. A 1991 OIG report found that inappropriate Medicare secondary payer payments totaled more than \$637 million in 1988. Since that time, a

number of new initiatives have been implemented to prevent inappropriate payments. This study will help assess the effectiveness of these initiatives.

OEI; 07-98-00180

Employer Insurance Replies

In the past, we reported that Medicare often made overpayments for beneficiaries who had some form of private (often employer-sponsored) health insurance. Our earlier report recommended that HCFA take action against employers that failed to provide private insurance information for these dually eligible beneficiaries. In this follow-up review, we will evaluate the effectiveness of HCFA's corrective actions.

OAS; W-00-98-30003; A-02-98-01036

Physician Referrals to Self-Owned Laboratory Services

We will analyze HCFA's enforcement of the self-referral prohibition involving physicians and clinical laboratory services. Medicare law prohibits (with certain exceptions) payment to physicians who have certain financial relationships with other entities, including entities that provide clinical laboratory services. Other penalties may also apply for violations of this law. We will determine whether HCFA has adequate information (i.e., ownership and compensation data) to enforce the law and to document the actions taken to date.

OEI; 09-97-00250

Medicare Part B Billings by State-Owned Facilities

This review will use computer screens, developed by the OIG, to identify physicians with aberrant billing patterns of visits to patients in State-owned facilities. Prior focused medical reviews by Medicare contractors identified a variety of problems with these types of claims related to skilled nursing facilities. We will build on this prior work and determine if other types of State-owned facilities have similar problems.

OAS; W-00-98-30030; A-09-98-00072

Organ Transplant Costs

This review will evaluate the financial and nonfinancial consequences of modifying the method used to pay for organs. The current system involves reimbursement of certified transplant centers and organ procurement organizations. The charge paid to the procurement organization by the transplant center is included in the transplant center's cost report, and overhead is applied to this amount and reimbursed by Medicare. This overhead allocation adds 25 percent to the cost of organs procured and reimbursed by the Medicare program.

OAS; W-00-98-30030; A-04-98-00000

Joint Work with Other Federal and State Agencies

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and Inspectors General, Medicaid agencies, and HCFA financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate program, and durable medical equipment. Future joint initiatives will cover managed care issues, hospital transfers, prescription drugs, laboratory services, nonphysician outpatient services, and nursing home services. In addition, we will continue to work with the National State Auditors Association on a joint audit of long-term care in six States. Potential audit areas include evaluating the licensing and inspection of nursing homes and the reimbursement system.

OAS; W-00-99-30001; Various CINs

INVESTIGATIONS

The OIG's 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. HCFA anticipates enrollment in Part C to increase to 33 percent by 2003.

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

Medicaid

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

Pneumonia DRG Upcoding Project

This cooperative effort with the Department of Justice focuses on information that hospitals have upcoded the DRG for pneumonia claims from viral to bacterial pneumonia.

By doing this, the hospitals obtained almost \$2,500 extra per claim in reimbursement. The OIG is looking at both civil and criminal implications.

LEGAL COUNSEL

In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of all major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. The Office provides administrative litigation services required by OIG, such as patient dumping cases and administrative exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes and is responsible for the development of OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 1999 includes:

Compliance Program Guidance

We will continue to issue compliance program guidance to assist the health care industry in establishing voluntary corporate compliance programs and in developing effective internal controls that promote adherence to applicable Federal statutes, regulations, and the program requirements of Federal health care plans. We plan to issue program guidance documents during the first half of FY 1999 pertaining to independent third party billing companies, coordinated care plans in the Medicare + Choice program, and durable medical equipment companies. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans, while at the same time furthering the health care industry's fundamental mission to provide quality care to patients.

Expected Completion Date: Ongoing

Corporate Integrity Agreements

We will continue to monitor providers' compliance with the terms of over 250 corporate integrity agreements into which they have entered in conjunction with the settlement of fraud and abuse allegations. Included in this monitoring process will be the establishment of a tracking system to determine the amount of money returned to the

Medicare Trust Fund as a result of a provider's having established certain mechanisms, including auditing and reporting, required by the OIG under these 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 the growing number of requests for formal advisory opinions on the application of the anti-kickback statutes and other fraud and abuse statutes to particular circumstances. We will also issue special fraud alerts to inform the health care industry more generally of particular industry practices that OIG determines are highly suspect.

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

We will evaluate comments from the public in response to OIG's solicitation of comments on the existing and additional proposals for safe harbor exemptions from the anti-kickback statute and, where appropriate, develop proposed regulations for additional safe harbors.

Patient Anti-Dumping Statute Enforcement

We expect to increase the number of patient anti-dumping cases analyzed, negotiated, and litigated, with the resolution of approximately 50 such cases in FY 1999. In addition, we plan on continuing 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. In addition, we anticipate publishing guidance regarding identified problem areas under the statute, such as with respect to a hospital's obligations to provide emergency care to managed care enrollees.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG. In addition, we will review public comments and anticipate finalizing regulations which will implement the requirements of the Balanced Budget Act of 1997 with respect to program exclusions.

Expected Completion Date: Ongoing

Civil Monetary Penalties

We will be finalizing regulations which will implement new and revised civil monetary penalty (CMP) authorities delegated to the OIG, which were included in the Health Insurance Portability and Accountability Act of 1996. We will also be promulgating regulations for implementing the CMP authorities applicable to Medicare + Choice organizations, codified at section 1857 of the Social Security Act. In addition, we will be continuing our CMP enforcement activities and specifically focusing on cases involving improper conduct by managed care organizations.

Expected Completion Date: Ongoing