

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.