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 CareI

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 HomesI

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 AgenciesI

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 HospitalsI

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 BenefitsI

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 BillingsI

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

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.