Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents and the extent to which these drugs were prescribed and paid for in accordance with Federal regulations.
(OEI; 07-08-00150; expected issue date: FY 2010; work in progress)

Other Part A and Part B Providers Payments

Physician Billing for Medicare Hospice Beneficiaries

We will review the extent of Part B billing for physician services provided to Medicare hospice beneficiaries. The regulations at 42 CFR § 418.304 list the physician services that are already covered by Medicare under the hospice benefit. The regulation provides that for physicians employed by or in an arrangement with the hospice, payments for certain services are reimbursed to the hospice as part of the hospice payment while other services are paid to the hospice under the Part B Medicare Physician Fee Schedule. Physicians may receive reimbursement for hospice services under Medicare Part A or Part B. This study is a followup to recent OIG studies on hospice care. We will determine the frequency of and total expenditures for physician services under Part A and Part B for hospice beneficiaries. We will identify whether physicians double-billed hospice services to Part A and Part B.
(OEI; 02-06-00224; expected issue date: FY 2010; work in progress)

Trends in Medicare Hospice Utilization

We will review Medicare Part A hospice claims to identify trends in hospice utilization. When the hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 122, Medicare did not cover more than 210 days of hospice care per beneficiary. Congress changed the benefit in section 4443 of the BBA, implemented by CMS at 42 CFR § 418.21, to eliminate the limit on the number of days covered by Medicare. Since then, the number and types of diagnoses associated with hospice utilization have increased and longer stays have become more common. We will examine the characteristics of hospice beneficiaries, geographical variations in utilization, and differences between for-profit and not-for-profit providers.
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Medicare Incentive Payments for E-Prescribing

We will review Medicare incentive payments made in 2010 to eligible health care professionals for their 2009 electronic prescribing (e-prescribing) activities. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), § 132, amended the Social Security Act, § 1848(m), to provide for incentive payments to eligible health care professionals for e-prescribing beginning in 2010 and continuing through 2013. Physicians will be eligible for incentive payment if they are "successful electronic prescribers." In its final rule for the calendar year (CY) 2009 Physician Fee Schedule, 73 Fed. Reg. 69726 (Nov. 19, 2008), CMS stated that successful electronic prescribers will be those physicians who report on CMS's e-prescribing quality measure with respect to at least 50 percent of cases in which services are billed to Medicare Part B. We will assess whether, and, if so, the extent to which incentive payments for e-prescribing activities in 2009 were made in error. In addition, if erroneous payments were made, we will assess CMS's actions to remedy erroneous payments and its plans for overseeing

contractors' compliance with 42 CFR § 422.504 and examine the processes that they use to ensure that contractors fulfill their contractual obligations.
(OEI; 00-00-00000; expected issue date: FY 2010, new start)

Health Care Organizations' Compliance With Standards on Culturally and Linguistically Appropriate Services in Medicare

We will review whether health care organizations comply with Office for Civil Rights (OCR) and Office of Minority Health (OMH) issuances regarding the prohibition in section 601 of Title VI of the Civil Rights Act of 1964 against national origin discrimination and the protection that provision affords to persons with limited English proficiency. Pursuant to Executive Order 13166, which required Federal agencies to publish guidance regarding the applicability of Title VI to persons with limited English proficiency, OCR issued its "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons." Further, in March 2001, OMH published national standards for adoption or adaptation by stakeholder organizations. Section 187 of the MIPPA requires OIG to review the extent to which Medicare providers and plans are complying with the OCR guidance and OMH standards and to describe the costs associated with or savings related to the provision of language services to comply with these guidances.
(OEI; 00-00-00000; expected issue date: FY 2010, new start)

Medicare Part D Prescription Drug Program

The MMA established a Medicare outpatient prescription drug benefit, known as Medicare Part D, which took effect on January 1, 2006. This voluntary benefit is available to all Medicare beneficiaries. The 2009 "Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" stated that during CY 2008, Part D expenditures were approximately $49.3 billion and, under intermediate assumptions, were estimated to reach $140.8 billion in 2018.

The administration of Part D is dependent upon extensive coordination and information sharing among Federal and State government agencies, drug plan sponsors, contractors, health care providers, and third-party payers. CMS and drug plan sponsors share responsibility for protecting the Part D program from fraud, waste, and abuse. Payments to drug plan sponsors based on bids, risk adjustments, and reconciliations add to the complexities and challenges of the benefit.

Descriptions of our ongoing and planned reviews of Medicare Part D program administration follow.

Duplicate Drug Claims for Hospice Beneficiaries

We will review the appropriateness of drug claims for individuals who are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. Per the "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 11, § 30.2, CMS publishes the hospice payment rates, which include prescription drugs (used for pain relief and symptom control) related to the beneficiary's terminal illness. Hospice providers are paid per diem amounts, which

include payments for these drugs. Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), a drug prescribed for a Part D beneficiary shall not be considered for payment if the drug was prescribed and dispensed or administered under Part A or Part B. Therefore, Medicare Part D drug plans should not pay for drugs that are covered under the Part A hospice benefit. We will determine whether payments made under Part D are correct, supported, and not duplicated in hospice per diem amounts. We will also determine the extent of duplication between Part D payments and Part A hospice payments and identify the controls to prevent duplicate drug payments.
(OAS; W-00-09-35307; W-00-10-35307; various reviews; expected issue date: FY 2010; work in progress)

Duplicate Medicare Part A and Part B Claims Included With Part D Claims

We will review claims submitted for payment under Medicare Part D to determine whether they were duplicated in Medicare Part A or Part B. Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), a drug prescribed for a Part D beneficiary shall not be considered for payment if the drug was prescribed and dispensed or administered under Part A or Part B. Medicare Part A covers drugs for beneficiaries who are receiving treatments as inpatients of hospitals. Drugs covered under Medicare Part B include injectable drugs administered by a physician, certain self-administered drugs, drugs used in conjunction with DME, and some vaccines. Medicare Part A and Part B do not cover most outpatient prescription drugs that may be covered under Part D. We will also determine the extent to which payments for the sampled Part D claims were correct and supported.
(OAS; W-00-09-35409; W-00-10-35409; various reviews; expected issue date: FY 2010; work in progress)

Medicare Part D Reconciliation Calculations

We will review whether CMS's Part D reconciliation calculations were performed in accordance with applicable regulations. Pursuant to the Social Security Act, § 1860D-15(e), Medicare shares a portion of sponsors' losses or profits from the Part D program. Regulations at 42 CFR § 423.343 provide for retroactive adjustments and reconciliations to account for changes in health status risk or a difference in the amount payable to a sponsor for eligible individuals and the amount actually paid. These adjustments are calculated based on information provided by the sponsors. We will determine whether payments made to sponsors or recoveries made by CMS were correct and properly paid or received for the end-of-year reconciliations.
(OAS; W-00-10-35232; various reviews; expected issue date: FY 2010; work in progress)

Medicare Part D Data Submitted by Sponsors for Reconciliations

We will review the accuracy of Part D sponsors' data submissions for reconciliation purposes to CMS, pursuant to Federal regulations at 42 CFR §§ 423.343(c)(1) and (d)(1). Specifically, we will determine the accuracy of prescription drug event (PDE) data and direct and indirect remunerations (DIR) data (which are required information for reconciliation purposes) reported in accordance with these provisions. The PDE summary is a record that documents the final adjudication of a dispensing event. Regulations at 42 CFR § 423.308 state that DIR data include discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or