Department of Health and Human Services

Office of Inspector General

Work Plan

Fiscal Year 1997

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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; and
- 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

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Work Plan for Fiscal Year 1997

INTRODUCTION

The Office of Inspector General (OIG) Work Plan is set forth in five chapters that encompass the various projects of the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, Office of Enforcement and Compliance, and Office of Counsel to the Inspector General, Civil Recoveries Branch that are to be addressed during Fiscal Year (FY) 1997. The first four chapters present the full range of projects planned in each of the Department of Health and Human Services' (Department) major operating divisions: the Health Care Financing Administration, Public Health Service Agencies, the Administration for Children and Families, and the Administration on Aging. The fifth chapter embraces those projects related to issues which cut across Department programs, including State and local 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 and summary of the various project areas, and a projected completion date for many of the work items that we perceive as important and critical to the mission of the OIG and the Department. However, as the work planning process tends to be one that is ongoing and dynamic in nature, 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.

Operation Restore Trust

Operation Restore Trust continues into FY 1997 the attack on health care fraud, waste, and abuse through focused intergovernmental teams.

In ***Operation Restore Trust***, HHS designed an interdisciplinary project team of Federal and State government and private sector representatives to target abuse and misuse in California, Florida, New York, Texas, and Illinois. Together, these States account for 40 percent of the Nation's Medicare and Medicaid beneficiaries.

The team is focusing on nursing home care (including hospices), home health care, and durable medical equipment, three of the fastest growing areas in health care. Three agencies within HHS--the Office of Inspector General, the Health Care Financing Administration, and the Administration on Aging--are involved, as is the Department of Justice.

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 1997.

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 tend to be short-term program and management evaluations that focus on specific issues of concern to the Department, the Congress and the public. The program inspections identified in this Work Plan have been developed in the context of significant program

activities, expenditures of funds and services to program beneficiaries, and will serve as the major focus of OEI's workload during FY 1997. The results of these program inspections should generate rapid, accurate and up-to-date information on how well those program areas 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.

Enforcement and Compliance Issues

The Office of Enforcement and Compliance (OEC) is responsible for the imposition of mandatory program exclusions, as well as certain permissive program exclusions and civil money penalty and assessment actions not handled by the Civil Recoveries Branch of the Office of Counsel to the Inspector General (OCIG). It develops models for corporate integrity and compliance programs, monitors ongoing compliance agreements and promotes industry awareness of corporate compliance agreements developed by the OIG.

Litigation Coordination Focus Areas

The Office of Counsel to the Inspector General (OCIG), Civil Recoveries Branch, coordinates the OIG's role in the investigation and resolution of health care fraud cases. In all matters where the Department of Justice has an interest, OCIG is responsible for the

imposition of permissive exclusions as well as civil monetary penalties and assessments. In cases where the decision is made not to impose an exclusion from program participation, OCIG works with the health care provider to construct a program that will ensure future compliance with applicable laws and regulations. The OCIG also oversees the OIG's voluntary disclosure program, which provides companies a mechanism to self-report findings of Medicare fraud and participate in the investigation and resolution of the matter.

Internet Address

The FY 1997 OIG Work Plan and other OIG materials, including final reports issued, may be assessed on the Internet at the following address:

http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html

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HOSPITALS

Capital Cost Prospective Payment System

Our analysis of payments made to hospitals under the new prospective payment system for capital cost will identify winners (capital payments in excess of actual costs) and losers (capital payments less than actual costs) to determine whether the new system is reasonable, and to determine the effect on capital spending. If warranted, we will evaluate various policy options in order to assure that capital payments are reasonable. Effective October 1, 1991, Medicare pays inpatient capital-related costs on a prospective per discharge basis rather than on a reasonable cost basis.

OAS; W-00-96-30010; A-07-96-01182
Expected Issue Date: FY 1997

Outlier Payments

This review will determine whether: (1) hospitals are correctly reporting data related to days and costs that could affect outlier determinations; (2) Medicare fiscal intermediaries are correctly calculating outlier payments; and (3) intermediaries are correctly reporting data to HCFA. In addition to the basic hospital payment rates, Medicare pays for discharges involving day and cost outlier. "Outlier" cases are those having an unusually long length of stay or exceptionally high cost. A pilot review in one State indicates significant problems.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Medicare Losses Upon Sale of Hospitals

This study will assess the costs to the Medicare program of the recapture of depreciation regulations during the sale of hospitals participating in the program. Medicare includes not only direct patient care costs in its reimbursement equation but also costs associated with the updating and acquiring of buildings and equipment. Medicare shares a portion of the loss due to depreciation in these assets on a yearly basis. These depreciable assets may be disposed of through sale, scrapping, trade-ins, donations, exchange, etc. If the disposal of a depreciable asset (in this case the sale of a hospital) results in a gain or a loss, an adjustment is necessary in the provider's allowable cost. This system of accounting for gains and losses during the sale of depreciable assets is known as the recapture program. If the hospital sells for a profit, anything over its original value less depreciation, Medicare shares in the profit. If the hospital sells for a loss, Medicare shares in the loss. Concerns have been raised that sales are being artificially structured to report losses or to minimize profits in order to maximize Medicare payments at the time of sale or to minimize Medicare's recapturing of a portion of the profit.

OEI; 03-96-00170
Expected Issue Date: FY 1997

Multiple Providers Within the 72-Hour Payment Window

Our review will determine whether outpatient services provided to patients within 72 hours of admission to a hospital are being improperly billed to the Medicare program.

Under the Medicare prospective payment system, diagnostic services provided to a beneficiary by the admitting hospital (or by an entity wholly owned or operated by the hospital or by another entity under arrangements with the hospital) within 72 hours prior to the day of admission are included in the inpatient payment. Separate payments are not allowable because HCFA’s longstanding policy is to consider these nonphysician services as inpatient services. A nationwide computer match of inpatient and outpatient services identified over 1.1 million

claims valued at $200 million (2-year period 1992 and 1993) for nonphysician outpatient services rendered during the 72-hour payment window and by a provider other than the inpatient provider.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Quality Improvement Projects of the Medicare Peer Review Organizations

This study will assess the Medicare peer review organizations' (PROs) progress in conducting quality improvement projects under the Health Care Quality Improvement Program. In April 1993, the PROs began implementing their fourth round contracts with HCFA. These contracts marked major changes in the PROs' objectives and operations. The PROs now aim to improve the overall practice of medicine by working with the medical community in analyzing patterns of care and outcomes and by sharing their insights with that community. They focus on the performance of systems of care. We will assess the nature and source of quality improvement projects undertaken by the PROs and the nature and extent of the projects' results.

OEI; 00-00-00019
Expected Issue Date: FY 1997

Medicare Indirect Medical Education Payments

This review will evaluate the reasonableness of Medicare payments made to hospitals receiving indirect medical education payments and disproportionate share payments. Many experts believe that these two payments are in many ways duplicative and result in unreasonable payments to hospitals receiving both of them. We will review more current data used in payment computations.

Selected hospitals will be visited and key personnel will be asked how these payments are justified.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Medicare Disproportionate Share Payments

This review will evaluate the reasonableness of Medicare disproportionate share payments for various classes of hospitals. Preliminary data suggests that only urban hospitals with more than 100 beds need these payments. Further, as part of this study, we will visit hospitals and verify the data used to compute their actual payment.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Targeting Diagnosis-Related Group Miscoding

This joint review will determine the extent to which hospitals are incorrectly coding hospital discharges for Medicare payment. The basis for payments to hospitals is the diagnosis-related group code for each discharge under the prospective payment system. The HCFA does not currently have a process in place to validate the codes and assure that proper payment is made. This review will develop an approach to target facilities possibly engaged in inappropriate coding for more thorough review and proper remedial action. Approaches may include the use of changes in case-mix or commercial software currently used to detect billing irregularities.

OEI; 00-00-00018; OAS; W-00-97-30010
Expected Issue Date: FY 1997

Outlier Adjustment Follow-Up

This review will focus on improper periodic interim payments for outlier claims and adjustment transactions at Medicare fiscal intermediaries, that use the Florida Shared System. Our survey at one such intermediary revealed a system malfunction which caused improper payments. Although we believe that the malfunction has been corrected, the resulting Medicare overpayments may not have been identified and recovered. Specifically we will: (1) identify the policies and procedures in place to ensure that overpayments are not made by the system; (2) determine whether the overpayments were identified and recovered from the affected providers; and (3) determine if the systems malfunction affected non-periodic interim payment providers as well.

OAS; W-03-95-30128; A-03-95-00010
Expected Issue Date: FY 1997

Costs at Non-Prospective Payment System Providers

These reviews will determine whether administrative costs such as pensions and other post-retirement benefits and capital related costs claimed by non-PPS providers for Medicare reimbursement are properly supported and allowable based on applicable Federal regulations. There are over 1100 non-PPS hospitals nationally and another 2000 units in hospitals specifically excluded from PPS. We will review the costs incurred by these hospitals and units, and will also determine whether refinements in the current reimbursement system are needed.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Medicare Inpatient Psychiatric Care

We will follow up on our prior review of the Medicare lifetime limit of 190 days for psychiatric hospital care. At the time of passage of Medicare, inpatient psychiatric care was rendered, for the most part, in State psychiatric hospitals.

Our review found that the current lifetime limit is no longer effective because of changed patterns of inpatient psychiatric care. We found that over 82 percent of the program payments for inpatient psychiatric care is being paid to general hospitals, where the lifetime limit does not apply. We had recommended a 60-day annual and a 190-day lifetime limit for all psychiatric care regardless of the place of service. We believe that our recommended changes on the limits are still necessary, and will result in significant savings to the Medicare program.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Research Project Payments

We will identify the amount of overpayments for care provided to patients participating in clinical research projects who are also enrolled in the Medicare program. These clinical research projects are funded by the Public Health Service and include funds for care provided to patients. These same patients may also be Medicare beneficiaries. We will determine if claims for care paid for by the research projects are also being erroneously sent to Medicare for payment.

OAS; W-00-97-30010
Expected Issue Date: FY 1997

Hospital Closure: 1996

This study will be the 10th in a series of reports on hospital closure, examining the extent, characteristics, reason for, and impact of closures in 1996. In the mid to late 1980s, closure of general, acute care hospitals had 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. Few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there

is continuing interest in this phenomenon and our annual reports have become a standard reference on it. We will therefore continue this series.

OEI; 00-00-00025
Expected Issue Date: FY 1997

Medicare Contracting for Hospital Inpatient Services

This review will examine the potential savings to the Medicare program by eliminating urban hospitals' excess capacity caused by low inpatient occupancy. We will evaluate a possible policy change in which HCFA would award contracts to hospitals with the lowest bids and sufficient capacity to treat all Medicare beneficiaries served in a metropolitan area. Medicare beneficiaries could receive treatment at noncontract hospitals but would be responsible for charges above the average payment per discharge at contract hospitals. We believe that this policy option will help stabilize the financial status of the Part A trust fund.

OAS; W-00-95-30053; A-07-95-01136
Expected Issue Date: FY 1997

Organ Transplant Costs

This review will evaluate the financial and nonfinancial consequences of modifying the method used to pay for organs. Under the current system for reimbursing certified transplant centers and organ procurement organizations (OPO), organs procured by the procurement organization are shipped to the transplant center and the procurement organization are shipped to the transplant center and the procurement organization's interim rate (established by the intermediary based on the OPO's historical costs) is paid by the transplant center. An OPO's costs are accumulated on a cost report and reduced by revenues received, and any difference is paid by, or returned to, the Medicare program when the OPO's cost report is settled by the intermediary. The charge paid to the OPOs 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-00-97-30010
Expected Issue Date: FY 1997

Hospital Discharge Planning

This ***Operation Restore Trust*** study will determine how and to what extent hospital ownership of nursing facilities or home health agencies impacts the discharge planning decisions and Medicare beneficiaries' care. Medicare requires that hospitals employ discharge planners to identify patients' post-hospital needs early to ensure discharge to a safe environment with appropriate services. Concerns have been raised about the potential conflict of interest that arises when the hospitals own the nursing facilities or home health agencies which the discharged hospital patients are referred to.

OEI; 02-94-00320
Expected Issue Date: FY 1997

HOME HEALTH

Common Characteristics of Problem Home Health Agencies

This ***Operation Restore Trust*** review will determine if there are certain characteristics that are shared by home health agencies that are considered potentially problematic for the Medicare program. During the course of previous audits, investigations and evaluations conducted by the OIG, we have learned that HCFA regional officer and regional home health fiscal intermediaries have identified home health agencies that are considered problem providers. We will assess these entities to determine whether there are common ownership

characteristics, staffing patterns, and contract arrangements, as well as other factors.

OEI; 09-96-00110
Expected Issue Date: FY 1997

Eligibility Reviews

Based on survey work and risk analysis, we will perform reviews to determine whether home health care visits claimed by a selected provider (or providers) met Medicare reimbursement guidelines. We will determine if the home health visits are needed, properly authorized, and furnished to eligible beneficiaries. These reviews are in continuation to past ***Operation Restore Trust*** reviews performed last year.

OAS; W-00-97-30016; A-04-96-02121
Expected Issue Date: FY 1997

General and Administrative Costs

Because of the large increase in home health expenditures during the last several years, we will conduct a series of ***Operation Restore Trust*** reviews to determine the allowability of general and administrative costs incurred in "chain" organizations and being billed to the Medicare program. Data indicates that some providers' costs (cost per visit) are significantly higher than their peers. We will concentrate our review on general and administrative costs (including salaries and fringe benefits) to determine whether these costs are reasonable and related to patient care. We will also incorporate the results of our financial statement reviews into future general and administrative cost reviews.

OAS; W-00-97-30016; Various CINs
Expected Issue Date: FY 1997

Medical Providers with Multiple Provider Numbers

This ***Operation Restore Trust*** review of home health agencies and other medical providers with multiple provider numbers will determine if current rules for medical provider participation in the Medicare program need to be changed. We believe that rules should be established to preclude providers excluded from the Medicare program under one provider number from continuing their participation in the program under other provider number(s). Our review will show that individuals and organizations which have been excluded from participation and owe the Medicare programs millions of dollars in overpayments are able to claim bankruptcy and obtain a new provider number and continue in business without liability for the overpayment amounts.

OAS; W-00-96-30016; A-04-96-01123
Expected Issue Date: FY 1997

Locating Billing Functions in High Cost Cities

This ***Operation Restore Trust*** review will determine whether home health agencies are maximizing their reimbursements by establishing billing functions in high cost limit locations rather than the geographical site in which the service was provided.

OAS; W-00-96-30016; A-06-96-00046
Expected Issue Date: FY 1997

NURSING HOME CARE

3-Day Hospital Stay

This ***Operation Restore Trust*** review will determine if payment for skilled nursing facility stays meet Medicare's coverage conditions. In order to be paid

by Medicare, a patient's nursing home stay must be preceded by a 3-day or more hospital stay. Our survey work in Illinois indicated some nursing home stays were reimbursed by Medicare although they were not preceded by the required hospital stay. Using HCFA's automated data we will try to identify nursing homes in Illinois where the existence of this condition is indicative of potential abuse.

OAS; W-00-95-20072; A-05-96-00018
Expected Issue Date: FY 1997

Subacute Care at Skilled Nursing Facilities

Our ***Operation Restore Trust*** review will determine whether Medicare incurs more costs for patients treated by facilities with hospital-based skilled nursing facilities (SNFs) than at hospitals without such units. There is a perception that hospitals are maximizing Medicare reimbursements by prematurely discharging some patients from acute care and transferring them to SNFs. Hospitals are thought to be collecting fixed prospective payment system payments for a treatment period as short as possible and then transferring patients to their own SNFs to collect additional cost-based reimbursements. Transferring patients to SNFs for what some refer to as "subacute care" is currently the subject of congressional interest. In addition to this review, we will continue reviews in this area as we evaluate results from our financial statement reviews.

OAS; W-00-95-20072; A-09-95-00089
Expected Issue Date: FY 1997

Therapy Services in Nursing Facilities

The Medicare skilled nursing facility (SNF) benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services. These services may include physical therapy, occupational therapy, and speech therapy. Although the routine services received during routine covered SNF stays are financed by Medicare Part A, therapy services may be provided directly and their costs included in Part A payments. This study will assess the

appropriateness of physical, occupational, and speech therapy services delivered to Medicare beneficiaries in nursing facilities. It will also ascertain whether Medicare beneficiaries in SNFs, when therapy is reimbursed by Part A, are also being reimbursed for these services by Medicare Part B.

OEI; 00-00-00021
Expected Issue Date: FY 1997

Subsidiary Rehabilitation Therapy Companies

This ***Operation Restore Trust*** review will examine the potential impact on Medicare therapy utilization and reimbursement for nursing homes and skilled nursing facilities that contract for therapy services with subsidiary rehabilitation therapy companies.

Patients at these facilities may receive physical, occupational or speech therapy services under Medicare Part A and B. Therapy services may be provided under arrangement with outside suppliers, which are reimbursed through the facility's Medicare cost report. Past OIG work found that services purchased under arrangement were significantly higher than salaried therapy costs. Given the recent increase in contracting out therapy services, Medicare reimbursement should be limited to the reasonable cost of the outside suppliers rather than the cost reported by the facility or billed by the rehabilitation agency. This may require a regulatory change.

OAS; W-00-96-30015; A-04-96-02117
Expected Issue Date: FY 1997

Revenue Codes: Florida Facilities

For this ***Operation Restore Trust*** project we will join with HCFA and the Florida Agency for Health Care Administration to review skilled nursing facilities (SNFs) using HCFA's "Survey Procedures for Long Term Care Facilities," with modifications, to focus on certain revenue codes that are suspected of being

abused with unallowable or fraudulent claims. The HCFA is project leader on this review of 20 targeted SNFs.

OAS; W-00-96-30015; A-04-96-01118; A-04-96-01124 through A-04-96-01142
Expected Issue Date: FY 1997

Revenue Codes: Facilities in Remaining Operation Restore Trust States

This ***Operation Restore Trust*** project complements HCFA's project of 20 targeted skilled nursing facilities in Florida. The OIG, using the methodology and protocol developed in the joint project in Florida, will target abusive and unallowable or fraudulent use of certain revenue codes by skilled nursing facilities in the other ***Operation Restore Trust*** States of New York, Illinois, Texas, Florida, and California. The 5 States together account for 40 percent of Medicare and Medicaid expenditures.

OAS; W-00-96-30015; A-04-96-01145
Expected Issue Date: FY 1997

Ancillary Medical Supplies

This ***Operation Restore Trust*** review will determine if unallowable charges and costs have been claimed for ancillary medical supplies by skilled nursing facilities (SNFs) and to identify any systemic weaknesses in Medicare's policies and procedures that need to be corrected to minimize payments for such costs. Medicare reimbursement rules describe those items and services which are allowable as ancillary charges and costs as opposed to routine costs, which are already considered in the facility reimbursement rate. Reviews conducted in California and Texas have identified items and services that are unallowable as

ancillary charges and costs. At a minimum, we expect this audit will enable HCFA to increase the effectiveness of focused medical reviews of SNFs.

OAS; W-00-96-30015; A-05-96-00051; A-05-96-00052; A-06-96-00045
Expected Issue Date: FY 1997

Physicians with Excessive Visits

This ***Operation Restore Trust*** review will identify and audit physicians with excessive visits to Medicare patients in skilled nursing facilities (SNF). Using computer screening techniques, we identified physicians in California with aberrant billing patterns for visits to SNF patients, such as an excessive number of visits in a given day and excessive visits to the same beneficiaries. Individual reviews will be conducted for those physicians with the most egregious billing patterns. We also plan to determine how the carriers could better identify and prevent such billings.

OAS; W-00-96-30015; A-09-96-00055
Expected Issue Date: FY 1997

Medicare Ambulance Transportation for Nursing Home Residents

This ***Operation Restore Trust*** study will assess potential policy issues and appropriateness of payments for ambulance services provided to Medicare beneficiaries residing in skilled nursing and other nursing facilities. In 1992, Medicare Part B paid an estimated $238 million for ambulance services to beneficiaries in these facilities. Approximately 18 percent of all Medicare beneficiaries in these settings received ambulance services. Substantial variation exists in the amounts spent under Medicare Part B for such services by State and by nursing home.

OEI; 09-95-00410
Expected Issue Date: FY 1997

Medicare Payments for Items Included in the Per Diem Rate of Medicaid Nursing Facilities

This ***Operation Restore Trust*** study will assess the extent to which the Medicare program may be making payments for covered items, supplies, or services that are included in Medicaid per diem nursing facility rates. There are many nursing home residents whose care is covered by both Medicare and Medicaid. For these patients, numerous services (e.g., durable medical equipment) may be covered by the Medicaid nursing facility rate and Medicare Part B. The guiding principle for payment is that Medicaid is the payer of last resort. We will assess how the system works in these circumstances.

OEI; 07-96-00040
Expected Issue Date: FY 1997

Drug Utilization in Nursing Homes

This ***Operation Restore Trust*** study will profile current Medicaid expenditures for prescription drugs in nursing homes, as well as the type and nature of pharmaceutical services provided in this setting. Prescription drugs are frequently used inappropriately in the nursing home setting. Adverse drug reactions, compliance problems, and overmedication are frequent drug therapy problems. New regulations were developed under Omnibus Budget Reconciliation Act of 1987 to address these concerns, and nursing homes are now required to have in place a monitoring committee and to perform drug regimens reviews for each resident. We will examine the level of services provided in a sample of nursing homes with Medicaid beneficiaries.

OEI; 06-96-00080
Expected Issue Date: FY 1997

Nail Debridement

This ***Operation Restore Trust*** study will determine why significant variances exist for nail debridement claims among carriers, and assess how carrier policies have affected payment for such claims. Expenditures for nail debridement increased 26 percent from 1991 to 1992 (1993 data not available), to reach $167 million. Increases of 370 percent and 800 percent occurred in two carriers for one code; four carriers account for half the total expenditures for another code; and two carriers account for half of the total for a third code. We believe much of this service occurs in nursing homes.

OEI; 04-94-00440
Expected Issue Date: FY 1997

HOSPICE

Eligibility for Hospice Care

These provider-specific ***Operation Restore Trust*** reviews will determine if payments made to hospices for beneficiaries determined to be terminally ill were appropriate and in accordance with program requirements. We will also evaluate various policy options in order to assess that necessary care is rendered only to eligible beneficiaries. In order to be eligible for hospice care under Medicare, an individual must be entitled to Part A, and be certified as terminally ill with a life expectancy of 6 months or less. Previous reviews determined that some hospices were improperly certifying beneficiaries as eligible for hospice care and were receiving millions of dollars in improper payments.

OAS; W-00-95-20072; A-05-95-00052; A-05-96-00024; A-06-96-00024; A-06-96-00027; A-06-95-00095; A-09-96-00064
Expected Issue Date: FY 1997

National Hospice Deficiencies

We will summarize conditions disclosed by ***Operation Restore Trust*** reviews of 12 hospice locations in Illinois, Florida, Texas and California. Problems of ineligible recipients, reimbursement caps, sales or marketing methods, and other systemic weaknesses will be presented in a report to HCFA together with recommendations or options that would tighten program controls. As we receive information from our financial statement reviews of hospice payments, we will begin additional reviews.

OAS; W-00-96-30015; A-05-96-00023
Expected Issue Date: FY 1997

Hospice and Hospital/Skilled Nursing Facility Overpayments

This ***Operation Restore Trust*** follow-up review will update and expand a recent nationwide review which disclosed a significant number of improper payments to hospitals and skilled nursing facilities for hospice patients. The review will include an evaluation of whether controls implemented by HCFA in response to the prior review are effective in preventing overpayments.

OAS; W-00-96-30015; A-02-96-01017
Expected Issue Date: FY 1997

Part B Payments For Hospice Patients

This ***Operation Restore Trust*** review will determine the appropriateness of payments made to physicians, durable medical equipment suppliers and other providers of Part B services 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-00-96-30015
Expected Issue Date: FY 1997

Hospice Services Provided to Patients in Nursing Facilities

This ***Operation Restore Trust*** study will examine how payments are being made for patients in nursing facilities who are also receiving hospice benefits. Our goal will be to identify systemic vulnerabilities that might result from overlapping Medicare and Medicaid payment policies and to suggest possible solutions. We will also describe how nursing home patients are enrolled in a hospice and explore how responsibilities between the hospice and nursing home are being delineated for the management and delivery of care to these terminally ill patients.

OEI; 05-95-00250
Expected Issue Date: FY 1997

Hospice: Referral Sources and Patient Care

This study will examine the appropriateness of services provided to hospice patients, the payments for those services, patient selection, and patient protections as well as referral sources. Medicare provides for two 90-day periods of hospice care, and one 30-day period, with a final unlimited period for terminally ill patients certified to have a life expectancy of 6 months or less. Covered services include nursing and physician services, counseling, durable medical equipment, home health aide services, and physical therapy. Once a patient is certified, elects a hospice, and is under a plan of care, the hospice is paid a prospective per diem rate for that patient, regardless of whether any services are rendered on a given day. The hospice's total yearly payments are subject to an aggregate cap per patient. Patients can revoke their choice of

hospice once per period. Evidence from OIG reviews and other sources indicate questionable payments being made in hospice services.

OEI; 04-93-00270
Expected Issue Date: FY 1997

PHYSICIANS

Variation in Utilization of Physician Services

This review will assess the variation in the use of physician services and attempt to explore both the discretionary and nondiscretionary influences on that variation. Physician services account for a significant portion of Medicare expenditures annually. Like most services, there is a significant variation in the utilization of physician services across the country. These variations may be the result of nondiscretionary influences (health status and demographics of population) or discretionary influences (physician payment styles). As part of our analysis, we will select a few procedures or groups of services for comparison. This study will provide insights about utilization and billing practices that will enable the OIG to target categories of potentially abusive billings for further review.

OEI; 00-00-00022
Expected Issue Date: FY 1997

Clinical Practice Billings

An OIG review of a physician group practice at an East Coast university teaching hospital disclosed that the practice was improperly billing Medicare for the services of supervising physicians or were billing for services at a level not supported by medical records. An OIG/Department of Justice (DOJ) project team negotiated a $30 million settlement with the physician group practice for

the years 1989 through 1994. The OIG and DOJ are expanding this review nationwide to determine if similar problems exist at other teaching hospitals.

OAS; W-00-96-30021; A-03-96-00006
Expected Issue Date: FY 1997

Physician Credit Balances

This review will determine whether physicians are reviewing their records for Medicare credit balances and refunding to their carriers those indicating an overpayment. A credit balance occurs when a provider receives and records higher reimbursement than the amount actually charged to a specific Medicare beneficiary. Some credit balances result from duplicate payments and in these cases a Medicare overpayment exists. Past OIG work which identified credit balances at hospitals resulted in significant recoveries for the Medicare program.

OAS; W-00-97-30021
Expected Issue Date: FY 1997

Physicians' Roles in Controlling Non-Physician Services and Supplies

This study will assess how effectively physicians are meeting Medicare's expectations that they act as controls against unnecessary use of non-physician services and supplies. This study will build on our prior work assessing the physician's role in home health and in completing certificates of medical necessity and identify common obstacles and successes in ensuring that physicians perform this important service.

OEI; 03-94-00400
Expected Issue Date: FY 1997

MEDICAL EQUIPMENT AND SUPPLIES

Lymphedema Pumps

This study will assess whether Medicare allowances for lymphedema pumps are excessive, if attending physicians have prepared required treatment plans governing their patients' use of the pumps, and whether physicians and suppliers are providing required oversight and monitoring services for beneficiaries using these devices, and how physicians determine whether a patient gets the most or least expensive pump. Lymphedema pumps are used to treat swelling of tissues in an affected body part due to the accumulation of excessive fluid. Medicare recently revised its lymphedema coverage and payment guidelines. Medicare allowances rose from $6.3 million in 1990 to over $113 million in 1995.

OEI; 00-00-00024
Expected Issue Date: FY 1997

Orthotics

This ***Operation Restore Trust*** study will determine the extent of questionable billing for orthotic supplies. The Medicare program reimburses the costs associated with braces that immobilize and shore up diseased, injured, or weakened body parts. These devices must be "rigid or semi-rigid" and must support part of the body and/or restrict or eliminate motion. Medicare allowed more than $63 million in 1994 for these supplies. Previous work by the OIG in the area of orthotic body jackets indicated that a substantial percentage of inappropriate payments were made.

OEI; 02-95-00380
Expected Issue Date: FY 1997

Lease-Purchase of Oxygen Concentrators

This study will determine if Medicare should encourage lease-purchase arrangements for oxygen concentrators. Medicare pays rent for certain pieces of durable medical equipment (called capped rental) until total reimbursement reaches 120 percent of the purchase price or 105 percent of the purchase fee if the beneficiary chooses the purchase option; from that point on, only maintenance charges are covered. In contrast, Medicare pays for oxygen and oxygen equipment (about $320 per month) for as long as the beneficiary needs it. If the same rules that apply to capped rental equipment were applied to oxygen and oxygen equipment, Medicare would cease making payments for rent after a period of time.

OEI; 00-00-00020
Expected Issue Date: FY 1997

Medical Necessity of Portable Oxygen

This study will examine medical necessity issues associated with Medicare coverage of oxygen systems. Medicare beneficiaries meeting the requirements for oxygen therapy can be provided oxygen using three systems: concentrators, gaseous, or liquid. Medicare beneficiaries may also qualify for coverage of a portable oxygen system, either by itself or to complement a stationary system, such as an oxygen concentrator. We will review Medicare claims for these services and assess the medical necessity of them. We will also assess the prescribing practices of physicians who order the systems and how Medicare monitors utilization and medical necessity for the systems.

OEI; 00-00-00040
Expected Issue Date: FY 1997

Pressure Reducing Support Surfaces

This ***Operation Restore Trust*** study will examine the appropriateness of Medicare billing for pressure reducing support surfaces. Support surfaces are one group of durable medical equipment used for the treatment of pressure sores. They are coded under one of 18 different HCFA common procedure coding systems (HCPCS) and categorized into three groups. In 1994, allowed charges under Medicare Part B for support surfaces totaled $116 million. We will determine the extent to which beneficiaries are using support surfaces, the medical necessity of the equipment, and whether allowed charges represent the service described under the coding.

OEI; 02-95-00370
Expected Issue Date: FY 1997

Beneficiary Satisfaction with Durable Medical Equipment Services

This study will determine the experiences and satisfaction of beneficiaries who receive durable medical equipment (DME), prosthetics, orthotics, and supplies, with the services provided by the Medicare DME regional carriers. The carriers are responsible for answering beneficiary inquiries and complaints, conducting beneficiary outreach, and responding to beneficiary allegations of fraud and abuse. Specifically, we will assess beneficiaries' satisfaction with the performance of the carriers, their understanding of coverage and reimbursement policies, and their knowledge and use of carriers' written products, appeals procedures, and outreach literature. Possible methods include a mail survey of beneficiaries who have used such equipment during the first 6 months of 1996, and a review of a sample of beneficiary complaints to ascertain how the equipment carriers responded to these complaints. Initial discussions with DME

carriers have been very positive, and they have expressed a strong interest in having the OIG conduct this survey.

OEI; 02-96-00200
Expected Issue Date: FY 1997

Capped Rental Payment for Durable Medical Equipment

This ***Operation Restore Trust*** study will determine whether Medicare is paying an appropriate amount for the "capped rental" of hospital beds, and for maintenance and servicing of this equipment when analyzed over the useful life of the equipment. Capped rental items such as hospital beds are reimbursed monthly for up to 15 months. A 1989 OIG review found that Medicare reimbursement rates for hospital beds were excessive because they failed to take into account the useful life of the bed and how many times it can be rented. This study may be followed by additional studies which assess the appropriateness of Medicare payments for wheelchairs, support surfaces, as well as other items reimbursed under the capped rental methodology.

OEI; 07-96-00220
Expected Issue Date: FY 1997

Provider Numbers for Durable Medical Equipment Suppliers

This study will review a sample of new durable medical equipment supplier applicants (pending applications) and a sample of suppliers that were recently issued numbers in metropolitan areas of the five ***Operation Restore Trust*** States. We will assess whether suppliers have a bona fide business site and inventories, as well as other standards recently mandated by HCFA. Results would be used to provide HCFA and the equipment carriers with insights on applicants and new providers, stop the issuance of any numbers to applicants who do not meet the

standards and analyze the need for further safeguards in the provider number process.

OEI; 04-96-00240
Expected Issue Date: FY 1997

Effectiveness of Durable Medical Equipment Regional Carriers

We will assess whether the establishment of the durable medical equipment regional carriers have met their intended objectives. Starting on October 1, 1993, HCFA began consolidating claims processing activities for durable medical equipment, prosthetics, orthotics, and supplies into four regional carriers. The four durable medical equipment regional carriers, known as DMERCs, replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of the DMERCs in terms of their medical guidelines, oversight of claims processing, and detection (and referral) of fraudulent activity.

OEI; 00-00-00027
Expected Issue Date: FY 1997

Enteral Nutrition Therapy: Equipment and Feeding Supply Kits

This ***Operation Restore Trust*** study will quantify the extent of payment for equipment and feeding supply kits associated with enteral nutrition therapy provided to residents of nursing homes. We will identify trends in payments between 1991 and 1995. Additionally, we will discuss coverage issues such as the appropriateness of reimbursement for equipment and supplies which are

readily available at the nursing home. This evaluation is an extension of previous work conducted on enteral nutrients provided to nursing home residents.

OEI; 06-92-00866
Expected Issue Date: FY 1997

Enteral Nutrition Therapy: Utilization and Medical Necessity

This ***Operation Restore Trust*** review will assess whether inappropriate payments are being made to Medicare beneficiaries for enteral nutrition. Enteral nutrition provides nourishment directly to the digestive tract of a patient who cannot ingest an appropriate number of calories. In 1994, the Medicare total allowed amount for enteral nutrition products and supplies was over $680 million.

OEI; 03-94-00022
Expected Issue Date: FY 1997

LABORATORY SERVICES

Clinical Laboratory Improvement Amendments

This study will determine how HCFA is enforcing the numerous provisions of the Clinical Laboratory Improvement Amendments of 1988; determine the relative strengths and weaknesses of its enforcement strategy; and recommend improvements if needed. The 1988 amendments strengthen quality standards under the Public Health Service Act and extend these requirements to all laboratories, including those in physicians' offices.

OEI; 05-92-01020
Expected Issue Date: FY 1997

Multiple Claims for Independent and Physician Laboratory Services

This review will determine the adequacy of procedures and controls used by Medicare carriers to process Medicare payments for clinical laboratory services performed by independent and physician laboratories. Clinical laboratory services include chemistry, hematology and urinalysis tests. The review will focus on whether providers properly bill for tests provided to the same beneficiary on the same day that were reimbursed on multiple claims. The review will also cover instances of potential overpayment in single claims, an issue that was addressed in our prior review titled "Medicare Part B Payments by Carriers for Chemistry Tests and Hematology Profiles Performed by Independent and Physician Laboratories" (A-01-94-00513).

OAS; W-00-96-30011; A-01-96-00509
Expected Issue Date: FY 1997

Claims for Outpatient Hospital Laboratory Services

This follow-up review will determine the adequacy of procedures and controls used by Medicare fiscal intermediaries to process Medicare payments for clinical laboratory services performed by hospital laboratories on an outpatient basis. Clinical laboratory services include chemistry, hematology and urinalysis tests. The review will focus on whether providers properly bill for tests provided to the same beneficiary on the same day. The need for more effective controls was addressed in our prior review, "Nationwide Review of Laboratory Services Performed by Hospitals as an Outpatient Service" (A-01-93-00520).

OAS; W-00-97-30011
Expected Issue Date: FY 1997

END STAGE RENAL DISEASE

Effectiveness of End Stage Renal Disease Patient Brochures: Facility Perspectives

This study is part of an overall effort to assess the effectiveness of HCFA's "Know Your Number" brochure for end stage renal disease patients. The HCFA developed this brochure to convey information to patients about the importance of dialysis. We will profile the experiences and perspectives of dialysis facilities that disseminate this brochure.

OEI; 06-95-00321
Expected Issue Date: FY 1997

Epogen Reimbursement and Related Services

This review will determine at what price dialysis facilities purchase the drug Epogen in order to provide HCFA the necessary information to set an appropriate payment rate. This review will also determine whether related blood tests should be included in the composite rate for dialysis treatments or included in the reimbursement rate for Epogen.

Under the end stage renal disease program, dialysis facilities are reimbursed $10 per 1,000 units of Epogen administered. Preliminary results indicate that dialysis facilities' purchase price is less than the current reimbursement rate. In addition, dialysis facilities receive rebates based on volume purchased which further lowers the cost of this drug.

OAS; W-00-97-30025
Expected Issue Date: FY 1997

Separately Billable End Stage Renal Disease Services

This review will determine whether frequently billed end stage renal disease (ESRD) laboratory tests and drugs should be included in the ESRD composite rate. The HCFA utilizes a prospective payment method for dialysis services by reimbursing ESRD facilities a composite rate per maintenance dialysis treatment. However, certain services are specifically excluded from the composite rate and are, therefore, considered separately billable services, i.e., some laboratory tests. During an OIG review of separately billable ESRD laboratory tests, we found seven lab tests which were routinely performed and separately billed by the hospitals included in our review. This review would focus on laboratory tests and drugs used routinely in the treatment of renal disease and determine if HCFA should include these services in the composite rate.

OAS; W-00-97-30025
Expected Issue Date: FY 1997

Bad Debts - Nationwide Chain Organization

This review will determine whether home office costs and bad debts reported by a nationwide chain organization are in accordance with Medicare reasonable cost principles, and provisions of Chapter 27 of the Provider Reimbursement Manual (Outpatient Maintenance Dialysis). Under Medicare's composite rate reimbursement system, end stage renal disease facilities are reimbursed 100 percent of their allowable bad debts, up to their unreimbursed Medicare reasonable costs. However, prior reviews have identified unallowable costs in cost reports for facilities claiming bad debts, thus overstating the reimbursable amount for bad debts. Furthermore, these facilities did not identify unallowable costs on prior cost reports. We will assess the internal controls for Medicare cost reporting,

cost allocation, and general ledger maintenance. We will also perform substantive testing to determine whether reported costs are allowable.

OAS; W-00-96-30025; A-01-96-00519
Expected Issue Date: FY 1997

DRUG REIMBURSEMENT

Medicaid Drug Rebates

The Omnibus Budget Reconciliation Act of 1990 required manufacturers to provide rebates to States based on Medicaid prescription drug utilization volume. The FY 1994 rebates reported by States totaled $1.7 billion. The OIG has conducted a series of reviews dealing with prescription drug issues resulting from this legislation. At HCFA's request, we have conducted audits of acquisition costs of drugs at the retail level and made comparisons to average wholesale prices. The OIG will continue to review pricing and reimbursement issues, including determination of whether Medicaid is receiving its appropriate share of rebates due from drug manufacturers.

• Average Manufacturer Price

The HCFA has requested that we review average manufacturer price for selected drug manufacturers. The average manufacturer's price is a very important component of drug rebates. These prices are calculated by the manufacturers and reported to HCFA as the bases for rebate billings. Some manufacturers have recently submitted revised figures which would require retroactive rebate adjustments in favor of the manufacturers. One manufacturer's retroactive adjustment is estimated to total $20 million.

The HCFA has advised all manufacturers that no retroactive claims will be paid until reviewed by the OIG.

OAS; W-00-96-30023; A-06-96-00051
Expected Issue Date: FY 1997

Prescription Drug Dispensing Fees

At HCFA's request, we will compare the Medicaid fees for drug dispensing to those paid by other insurers to determine whether Medicaid is, in effect, subsidizing these insurers. State Medicaid Pharmacy Administrators have recently complained that their dispensing fees are higher than those paid by other insurers such as managed care providers, which would amount to a Medicaid subsidy. If the Medicaid fees are higher, we will make recommendations to HCFA to encourage adjustment of the fees to the level of the predominant insurer.

OAS; W-00-97-30023
Expected Issue Date: FY 1997

Pharmacy Reimbursement

At HCFA's request, we will determine the percentage variance in several States between average wholesale prices and actual pharmacy invoice prices. Most States reimburse pharmacies for Medicaid prescription drugs using a formula which involves a percentage reduction from the average wholesale price. The Omnibus Budget Reconciliation Act of 1990 imposed a 4-year moratorium on States' reimbursement policies. The moratorium expired on December 31, 1994. The expiration of that moratorium allows States to evaluate and change their pharmacy reimbursement policies. This review will assist HCFA and the States in determining whether changes to their reimbursement policies are needed.

OAS; W-00-96-30023; A-06-96-00030
Expected Issue Date: FY 1997

Upper Payment Limits for Generic Drugs

The HCFA sets upper payment limits for certain generic drugs that States reimburse under their Medicaid programs. The limit is set for each selected group of like products at 150 percent of Average Wholesale Price (AWP) for the lowest priced product. Using our data base of pharmacy acquisition prices from our AWP audits in 11 States, we will do comparative analyses to determine the adequacy of HCFA's methodology for setting the upper limits.

OAS;W-00-97-30023
Expected Issue Date: FY 1997

Pharmacy Benefit Managers

This study will identify and assess the vulnerabilities posed by the increasing use of pharmacy benefit management systems. Approximately 150 companies are operating across the country to manage pharmacy benefit programs for private sector employers and payers. These benefit managers use various managed care techniques such as pharmacy networks, rebates and discounts, formularies, utilization controls, and disease management technologies. We will identify vulnerabilities posed by these arrangements, particularly with regard to the Medicaid program and its beneficiaries.

OEI; 01-95-00110
Expected Issue Date: FY 1997

OTHER MEDICARE SERVICES

Anesthesiology Services

This review will determine whether anesthesiologists billed for services in accordance with applicable Medicare rules and regulations. Anesthesiology services have ten possible modifiers, some of which restrict what the rendering anesthesiologists can do. To ensure that Medicare guidelines are met and that the anesthesiologist was available to provide the service, the review will examine medical records, surgery logs, anesthesia logs, vacation schedules, leave/work schedules, etc. The review will sample anesthesia billings for Medicare beneficiaries at hospitals nationwide.

OAS; W-00-97-30021
Expected Issue Date: FY 1997

Ambulance Payment Policies

We will review Medicare's current payment methodologies for ambulance services to determine whether they are economical. In 1994 Medicare allowed charges for ambulance services amounted to $1.7 billion, a three-fold increase since 1987. Currently there is a considerable variance in what Medicare carriers pay for specific procedure codes. There also appears to exist considerable variance in payments to ambulance providers often within the same area using the same type of equipment. We will attempt to explain these variances and document any weakness in the current payment mechanisms.

OEI; 05-95-00300
Expected Issue Date: FY 1997

MEDICARE MANAGED CARE

A. Service Delivery

Beneficiary Experiences

We will update prior OIG work which obtained information directly from current Medicare enrollees and recent disenrollees from risk health maintenance organizations (HMO). We will ask beneficiaries about their experiences in enrolling in an HMO, obtaining appointments, accessing specialist care, paying for out-of-area emergency care, and other such matters.

OEI; 06-95-00430
Expected Issue Date: FY 1997

Medicare's Oversight of Managed Care Plans

This review will assess how HCFA is meeting the challenges it faces in conducting oversight of managed care plans that contract with Medicare. We will determine the scope and adequacy of information that HCFA receives from managed care organizations and examine how HCFA uses this information. We will also assess HCFA's internal organizational capacity to make effective use of the information that it receives. As Medicare moves from its traditional role as a bill payer to an agency that oversees managed care delivery systems, it faces new responsibilities to assure quality of care provided under managed care plans.

OEI; 00-00-00032
Expected Issue Date: FY 1997

Managed Care and Disabled/End Stage Renal Disease Beneficiaries

This study will the assess experiences of disabled and end stage renal disease (ESRD) beneficiaries with risk-based managed care plans. We will identify successful models in integrating the disabled and elderly populations into managed care systems. A survey by the OIG (using 1993 data) of Medicare beneficiaries enrolled in risk-based health maintenance organizations (HMO) indicated that disabled and ESRD beneficiaries enrolled in these plans may experience more problems than their aged counterparts. Specifically, we reported that disabled/ESRD disenrollees most often reported access problems in several crucial areas of their HMO care; two-thirds wanted to leave their HMOs. Concerns have been raised about their being denied services because their care may be more expensive than other enrollees.

OEI; 00-00-00044
Expected Issue Date: FY 1997

Managed Care Flexible Benefit Option

This review will assess the extent to which managed care plans offer additional benefits that are not provided under traditional Medicare fee-for-service. We will review the extent to which these additional benefits are standardized and the extent to which beneficiaries understand them. Medicare managed care plans that generate profits that exceed 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 assess the array of benefits offered, and how they vary geographically and over time.

OEI; 00-00-00045
Expected Issue Date: FY 1997

Marketing Practices of Medicare Health Maintenance Organizations

This review will determine if health maintenance organizations (HMO) are using appropriate marketing and enrollment practices. Several HMO marketing and enrollment problem areas have been identified by the HCFA, the OIG, law enforcement agencies, as well as at congressional hearings. These include fraudulent enrollment, kickbacks and bribes.

Another area of concern is health screening by HMOs to enroll healthier beneficiaries, a problem suggested by the Mathematica Study, a research grant funded by HCFA, and supported by a recent OIG study. Such health screening is prohibited by regulations.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Medicare Beneficiary Satisfaction: 1996

This study will assess Medicare beneficiaries' satisfaction with the program, including timely processing of claims, response to inquiries, understanding of coverage and payment policies, and use of publications. We will conduct this study annually as a measurement of the program's performance in serving its clients.

OEI; 00-00-00047
Expected Issue Date: FY 1997

B. Managed Care Reimbursement

Health Maintenance Organization Profitability

This review will determine the health maintenance organizations' (HMO) level of profitability, and compare that profitability to its non-Medicare business. Under the Medicare program, risked-based HMOs receive capitated payments which are based on 95 percent of what Medicare would expect to pay for beneficiary treatments under the traditional fee-for-service (FFS) program. Even though HMOs are touted as being more cost effective providers than their FFS counterparts, HMO payments continue to be based on the FFS model. Recent media coverage has focused attention on HMOs' substantial profits, large cash reserves, and generous executive bonuses. We have noted that many payers have negotiated reductions in HMO rates, while Medicare recently increased its payment rates. Under the Tax Equity and Fiscal Responsibility Act of 1982, HMOs were permitted to retain all profits up to the level earned on their non-Medicare business.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Managed Care Payment Growth

This review will examine the appropriateness of increasing payments to health maintenance organizations (HMO) based on overall Medicare expenditure growth per person. Currently, payments rates for HMOs are determined annually for each county in the United States based on Medicare costs in the county's fee-for-service. Concern has been raised, especially in light of the financial status of the Medicare trust funds, about the rapid rate of payment increases which are

based oftentimes on inflated service utilization in the fee-for-service sector relative to the volume of services delivered on average in an HMO.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Cost Data for Risk-Based Health Maintenance Organizations

This review will focus on verification and analysis of data used in the development of the adjusted community rate proposals submitted by health maintenance organizations (HMO). The adjusted community rate represents the HMO's premium if it provided the Medicare covered services package to its general membership. An HMO must provide its Medicare enrollees with additional benefits if its rate is less than the Medicare payment. This review will help HCFA to ensure that the information submitted by the HMOs is accurate and supportable.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Components of Base Rate Calculations

This review will determine if the disproportionate share, graduate medical education, and indirect medical education components of the base rate calculation to health maintenance organizations (HMO) are justified. Medicare payments for these costs made under the fee-for-service program are included in the base rate as a first step when calculating HMO rates. We will determine if HMOs are contracting with providers who incur these expenses to see if these components are justified when calculating the HMO reimbursement rates.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

General and Administrative Costs

This review will determine if the administrative costs allocated for Medicare beneficiaries shown on the adjusted community rate proposal prepared by health maintenance organizations (HMO) are proper. General and administrative costs must be apportioned on the basis of the ratio of Medicare enrollees to the total enrollment of the HMO and include costs associated with enrollment, marketing, membership costs, directors salaries and fees, executive and staff administrative salaries, organizational costs and other plan administrative costs. Reduction in inflated general and administrative costs could increase plan profits and the plans would be required to return the excess to HCFA, lower Medicare enrollees' premiums, offer extra benefits to Medicare enrollees, or take a reduction in Medicare payments.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Proper Payments Based on Beneficiary Status

Our continuing series of reviews will determine if HCFA is making proper enhanced capitation payments to risk-based health maintenance organizations (HMO) only on behalf of those whose status justifies the higher rate. Risk-based HMOs are paid based on a prospectively determined capitation rate. A higher capitation rate (commonly called enhanced rate) is paid for beneficiaries classified as institutionalized, with end stage renal disease, or Medicaid eligible. We will also determine whether payments were made for deceased and out-of-area beneficiaries. Preliminary findings indicate that HCFA's data bases are not being updated for changes in beneficiary status. We will focus on both HCFA and HMO controls of beneficiary status with recommendations for corrective action.

OAS; W-00-96-30012; A-10-96-00001
Expected Issue Date: FY 1997

Nationwide Review of Medicaid-Status Beneficiaries Submitted By Health Maintenance Organizations

This review will examine the Medicaid special status classifications submitted by Medicare risk-based health maintenance organizations (HMOs) to determine whether overpayments have occurred. Risk-based HMOs receive fixed monthly payments for each enrolled Medicare beneficiary. The payment rate is increased for certain high-cost categories of beneficiaries. Medicare beneficiaries who are also eligible for Medicaid are one of these high-cost categories and are referred to as Medicaid special status beneficiaries.

OAS; W-00-96-30013; A-04-96-01119
Expected Issue Date: FY 1997

Enhanced Rate Setting for Institutional Status

This review will determine if Medicare enhanced payments to risk-based health maintenance organizations (HMOs) for institutional status beneficiaries duplicate payments included in the base capitation rate. The base capitation rate to HMOs is a cost estimate of anticipated per capita Medicare fee-for-service expenditures which includes the costs for skilled nursing facility care. In addition to a base rate, risk HMOs receive an enhanced payment amount for each beneficiary who is institutionalized (including those beneficiaries who are in a skilled nursing facility) for at least 30 days. We will determine the basis for the enhanced institutional rate and the amount estimated in the base rate for skilled nursing facility care. In addition, we will determine if the level and cost of care provided to beneficiaries in various institutional settings justify the enhanced rate.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Enhanced Rate Setting for End Stage Renal Disease Beneficiaries

This review will examine the appropriateness of the rate calculation to risk-based health maintenance organizations (HMOs) on behalf of end stage renal disease beneficiaries who receive dialysis treatment. There are two type of dialysis--hemodialysis which is primarily done in an outpatient facility, and peritoneal dialysis which is given in the home. We will examine the costs associated with both of these dialysis types to determine if the payment rates to the HMOs should reflect the difference in treatment costs.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Medicare's Enhanced Payments for Dual Eligible Status

This review will examine the relevance of the enhanced payment to health maintenance organizations (HMOs) for beneficiaries that are classified as Medicaid eligible. The capitation payment to HMOs is a cost estimate based on Medicare fee-for-service expenditures. Medicare pays HMOs an additional amount for beneficiaries that are classified as Medicaid eligible. This review will examine and compare the cost and utilization of services of beneficiaries who are classified as Medicaid eligible to those beneficiaries who are not.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Medicare Secondary Payer Issues

This review will determine if health maintenance organizations (HMO) are identifying and collecting primary payments under Medicare secondary payer provisions and properly accounting for these amounts in their annual rate proposals. The Medicare program is usually the primary payer for covered services provided to Medicare members of a HMO. However, there are instances

for which Medicare is the secondary payer, such as services covered by a State or Federal workers' compensation law, no fault insurance, or any liability insurance, or where a beneficiary is covered under an employers group health plan. When the Medicare program is not the primary payer, the HMO must identify payers that are primary to Medicare, determine the amounts payable by these payers; and take steps to assure that Medicare pays only secondary benefits. The HMOs must remove these services in the premium setting process regardless of their coordination efforts.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Medicare Bad Debts Due

This review will determine if Medicare bad debts are being claimed by health care providers for services rendered to health maintenance organization (HMO) beneficiaries for which the HMO is liable. When a beneficiary enrolls in an HMO, the HMO assumes financial responsibility for all covered services. If a beneficiary elects to receive services from outside the HMO network (unless emergency care is required), he/she is responsible for payment to the provider. A provider may be unable to collect outstanding liabilities from an HMO because the HMO has paid less than the provider's charges, the HMO has denied the claim, or the HMO is delinquent in payments. We want to determine if providers are charging these outstanding liabilities to the Medicare program as bad debts, and if so, quantify the amount that has been charged to Medicare.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Hospital Billings for Enrollees

This review will examine bills submitted to Medicare by hospitals on behalf of beneficiaries who are enrolled in a risk-based health maintenance organization (HMO). Under a Medicare risk contract, an HMO must provide all Medicare-covered services that are medically necessary. We will determine if any bills

were inappropriately reimbursed under the fee-for-service program. We will also determine if any additional payment amounts, such as on a passthrough basis, were inappropriately charged to the Medicare program.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Hospice Services Furnished Enrollees

This review will examine payments made for hospice care to beneficiaries enrolled in health maintenance organizations (HMO). If an enrollee elects Medicare hospice coverage, the care may only be furnished through a Medicare certified hospice that is paid directly by Medicare. Medicare capitation payments made to the HMO are suspended on the effective date of election of Medicare hospice benefits. Medicare payments for hospice service is greater than the monthly HMO capitation payment. We have noted instances where capitation payments have been reinstated for beneficiaries after they ended their hospice care election. We will determine if these beneficiaries were improperly certified as eligible for hospice care and if HMOs have shifted high cost beneficiaries to hospice care.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

MEDICAID MANAGED CARE

Targeted Case Management

We will assess States' implementation of Medicaid targeted case management. States may provide case management under Medicaid. States have targeted these services to special populations including pregnant women, chronically mentally ill, developmentally disabled, and those with HIV. Given the increasing State interest in including disabled, chronically ill populations under capitated

managed care plans, it is timely to review the effectiveness of State efforts in managing the care of these populations.

OEI; 00-00-00060
Expected Issue Date: FY 1997

Managed Care Providers and Early and Periodic, Screening, Diagnostic and Treatment Services

This study will examine how States ensure that managed care providers deliver legislatively mandated early and periodic, screening, diagnostic, and treatment (EPSDT) services. Such services include comprehensive health and development history, a comprehensive physical examination, appropriate immunizations, laboratory tests, and health education. Recent legislation set new goals for States in ensuring that Medicaid-eligible children receive services. Recent changes in HCFA's reporting requirements require that States provide information on such services for children enrolled in managed care arrangements.

OEI; 05-93-00290
Expected Issue Date: FY 1997

Managed Care Financial Reports

This review will determine the financial experiences and profit margins for the Medicaid portion of health maintenance organizations (HMOs). We found that two Pennsylvania HMOs had excessive profit margins for their Medicaid revenues. The State Medicaid Agency had not considered these excessive profit levels when establishing capitation rates. We also have indications of similar conditions in a large Midwest State. We will determine if this problem exists in other States.

OAS; W-00-95-30131; A-05-95-00060
Expected Issue Date: FY 1997

MEDICAID REIMBURSEMENT

Waivers for Persons with HIV/AIDS

This review will determine the impact of Medicaid waivers granted to States for special programs for persons with HIV/AIDS. Medicaid provides care for roughly 50 percent of adults with AIDS and 90 percent of children with HIV at a cost of about $4 billion annually. States with large numbers of HIV/AIDS patients have begun to experiment through waivers with the provision of care to this population. This study would determine the initial impact that these waivers have had in terms of access to care, cost savings, and linkage with other programs, especially the Ryan White program.

OEI; 00-00-00028
Expected Issue Date: FY 1997

Overpayments for Routine Prenatal and Post-Partum Care for Undocumented Aliens

This study will determine if States are incorrectly interpreting the law resulting in Medicaid overpayments for routine prenatal and post-partum care to undocumented aliens. The Medicaid statute defines eligible populations for medical assistance generally, and pregnancy related services specifically. This review would be a follow-up to that completed in 1994, to determine if States were correctly interpreting the law concerning emergency services for undocumented aliens. If such misinterpretation does exist, then we will identify any overpayments and seek recovery.

OEI; 00-00-00029
Expected Issue Date: FY 1997

Outpatient Detoxification Services for Alcohol and Drug Abuse Patients

Currently Medicaid pays approximately $300 million annually for inpatient detoxification services for alcohol and drug abuse patients. These services are usually delivered in hospitals or other residential facilities. Because of the high cost, some States have begun to cover some of these detox services in outpatient settings. Though some question the appropriateness of this, others find that detox services delivered by non-hospital providers may be beneficial in motivating clients into further treatment and breaking the "revolving door" nature of detox for some clients. This study would examine the appropriateness and cost-saving potential of this policy. We would study how this policy has been implemented in the four States where this is being done and assess the implications of the policy for other States.

OEI; 00-00-00040
Expected Issue Date: FY 1997

Hospital Stays Denied by Peer Review Organizations

This review will determine if Medicaid denials of inpatient acute care recommended by State Peer Review Organizations have been recovered and whether the State and Federal government have been credited with their share of the identified overpayments.

OAS; W-00-96-30013; Various CINs
Expected Issue Date: FY 1997

Patient Transfers

Our partnership work with State Auditors will identify incorrectly reported prospective payment system transfers in the Medicaid program and establish the feasibility of either recovering the overpayments or identifying cost savings.

Under Medicare rules, hospitals discharging Medicare beneficiaries are paid a prospectively determined amount based on the diagnosis-related group assigned to the hospitalization. However, when a patient is discharged from one hospital and is admitted in another on the same day, the first hospital's discharge is not considered a discharge for payment purposes. Rather, it is considered a transfer and is eligible for per diem payments. Where both hospitals receive full discharge payments an overpayment to the first hospital has occurred. Some State Medicaid Plans follow the Medicare rules or have very similar rules for hospital transfers. For these States, overpayments can occur in the Medicaid program for incorrectly reported transfers.

OAS; W-00-97-30013; Various CINs
Expected Issue Date: FY 1997

Medicaid Nonphysician Outpatient Services

We will identify incorrectly reported nonphysician outpatient service charges and establish the feasibility of recovering the overpayments. Under Medicare, hospitals are reimbursed on a predetermined amount for inpatient services depending on the illness and its classification under a diagnosis-related group amount. Separate payments for nonphysician outpatient services provided within 72 hours of the patient's admission to the hospital are not permitted. Similar problems can exist in the Medicaid program if the State Plans provide for hospital reimbursement based on payments which include allowances for pre-admission nonphysician services.

OAS; W-00-97-30013
Expected Issue Date: FY 1997

Clinical Laboratory Tests

This continuing nationwide review, will summarize the results of reviews of Medicaid payments for outpatient laboratory services in 13 additional States. Our prior report (A-01-95-00003) summarized the results of similar reviews in 14 States. We will determine the adequacy of procedures and controls used by

Medicaid State agencies to process payments for clinical laboratory services performed by independent and physician laboratories and hospital laboratories. Clinical laboratory services include chemistry, hematology and urinalysis tests. The review will focus on whether providers properly bill for tests provided to the same beneficiary on the same day.

OAS; W-00-96-30013; A-01-95-00003
Expected Issue Date: FY 1997

Nursing Home Therapy Copayments

This review will address excess Medicare co-insurance paid by Medicaid for the therapy costs of beneficiaries dually entitled to Medicare and Medicaid. Medicare payments are based on reasonable costs, whereas Medicare coinsurance is 20 percent of billings/charges. Consequently, the Medicare co-insurance paid by Medicaid, may exceed the cost of such therapy services allowed under a States Medicaid fee schedule.

OAS; W-00-97-30013
Expected Issue Date: FY 1997

Expanding Health Insurance Coverage to Children

A growing number of insurance policies contain clauses which exclude children from being covered such as the child's not residing in the policyholder's household. This review will determine the potential savings to the Medicaid program if commercial insurance companies were prohibited from excluding dependents from coverage who do not reside in the household of the policyholder. Several States have enacted such legislation and have gained considerable program savings as a result.

OAS; W-00-97-30013
Expected Issue Date: FY 1997

MEDICARE CONTRACTOR OPERATIONS

Preaward Reviews of Medicare Contractors

At the request of HCFA's contracting officers, we will perform a review of costs proposed by various prospective Medicare contractors. Included among the preaward reviews to be performed will be audits of cost proposals submitted for HCFA's Medicare Transaction System (MTS) contracts. The MTS will completely revamp Medicare claims processing and several proposals are expected for the multi-billion dollar expenditure. Prior preaward reviews have enabled HCFA to negotiate contract amounts which were much less than proposed.

OAS; W-00-97-30006; Various CINs
Expected Issue Date: FY 1997

Peer Review Organization Closeout Audits

This series of reviews requested by HCFA will determine the allowability of costs claimed by peer review organizations under cost reimbursement contracts for performing PRO fourth round contract activities. We will assist HCFA as co-project officer in these independent public accountant contracted audits and provide technical guidance and monitoring for these reviews. In addition, we will conduct special reviews of selected costs areas when requested to do so by HCFA.

OAS; W-00-97-30004; Various CINs
Expected Issue Date: FY 1997

Peer Review Organization Indirect Costs

These HCFA requested reviews will establish final indirect cost rates for peer review organizations (PRO) that bill using indirect cost rates. Final rates must be established in order to determine the allowable indirect costs properly charged to Medicare operations. These audits will be performed in conjunction with PRO closeout audits.

OAS; W-00-97-30004; Various CINs
Expected Issue Date: FY 1997

Claims 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 (per 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-00-97-30004; Various CINs
Expected Issue Date: FY 1997

Unfunded Pension Costs

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-00-97-30005; Various CINs
Expected Issue Date: FY 1997

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 for 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 the contractors are using a reasonable method for charging pension contributions to Medicare contracts.

OAS; W-00-97-30005; Various CINs
Expected Issue Date: FY 1997

GENERAL ADMINISTRATION

Medicare Secondary Payer Oversight

This nationwide review will examine problems in Medicare's efforts to recover Medicare Secondary Payer overpayments. Medicare has recovered substantial amounts of payments made that were the liability of other insurers, primarily group health insurers of working beneficiaries. Last year, HCFA entered into a global settlement with various Blue Cross/Blue Shield plans. We will determine if the terms of the settlement are being met by all parties. We will also review the exchange of information with other Government agencies insuring Medicare beneficiaries.

OAS; W-00-97-30003
Expected Issue Date: FY 1997

Excluded Providers

We will determine if the Medicare or Medicaid programs are reimbursing individuals or entities who have been excluded from participating in the programs. Medicare and Medicaid payments are prohibited for any items or services (other than those involving an emergency situation) furnished, ordered, or prescribed by a party that is excluded from participating in these programs. Also, payment is prohibited to any HMO that contracts with an excluded party.

OAS; W-14-95-30017; A-14-96-00202
Expected Issue Date: FY 1997

Joint Work With Other Federal and State Agencies

On an "as-needed" basis, we will coordinate with other Federal and State agencies (such as the Department of Justice) in various projects dealing with health care. For example, we will continue to be actively involved in qui tam cases. Our past work has played a key part in recovering millions of dollars.

OAS; W-00-97-30001
Expected Issue Date: FY 1997

Effect of Social Security Administration Split on Health Care Financing Administration Operations

This study will determine how the Social Security Administration (SSA) split off has affected HCFA operations. Effective March 31, 1995, the SSA, which until that time had been part of the Department of Health and Human Services, became a separate agency. Because of the close working relationships between SSA and HCFA, a series of memoranda of understanding were implemented to ensure that the split did not detrimentally affect SSA and HCFA operations. We will assess

whether any problems or obstacles have been encountered in implementing those agreements.

OEI; 00-00-00031
Expected Issue Date: FY 1997

INFORMATION RESOURCES MANAGEMENT

A. Medicare Transaction System Initiative

The Medicare Transaction System (MTS) is intended to be a single, integrated claims/transaction processing system which HCFA anticipates will be phased in beginning in 1997 with full implementation before the end of 1999. The overall MTS initiative includes several separate projects. We anticipate the following MTS work in FY 1997.

• Medicare Transaction System Implementation - Phase II

Our continued monitoring of the Medicare Transaction System will cover system design and development, proposed processing sites, HCFA's approach for acquiring telecommunications services, the sufficiency of system controls (including whether they will facilitate effective paperless processing), HCFA's transition and implementation planning as well as HCFA's overall management to date. Our review will identify areas of the system's implementation that are of especially high risk.

OAS; W-00-97-30008
Expected Issue Date: FY 1997

• National Provider Identifier/National Provider System

We will review the control requirements for the newly established National Provider Identifier/National Provider System, which will replace existing enumeration methodologies and processes in Medicare. Our review will include an examination of the system's integration with the Medicare Transaction System and other systems containing provider data to determine its potential effectiveness as a safeguard for the Medicare program and the degree to which the new system meets the requirements for a uniform provider numbering system as called for in the recently sighed Health Insurance Portability and Accountability Act. We will also determine the extent previously identified weaknesses in provider enumeration are addressed.

OAS; W-00-97-30008
Expected Issue Date: FY 1997

• Application Controls for Managed Care and New Medicare Activities

This series of reviews will address the effectiveness of the Medicare Transaction System controls to support group health plan operations and other managed care activities. These reviews will also examine the effectiveness of control requirements for the planned insurance file and other systems, such as those supporting beneficiary choice initiatives and other Medicare reforms as well as those providing the necessary tracking of beneficiary enrollment status. As Medicare beneficiaries become more knowledgeable about managed care, the potential exists for even greater enrollment in such plans. At the same time, HCFA is expecting major reforms in Medicare which will expand the types of plans available to

beneficiaries. HCFA's major new application system--the Insurance File--will support these planned reforms.

OAS; W-00-97-30008
Expected Issue Date: FY 1998

B. Other Information Resources Management Reviews

• Application Controls in the Medicare Fee-for-Service Environment Under the Medicare Transaction System

This series of reviews will determine whether the new Medicare Transaction System's (MTS) application controls in the fee-for-service setting adequately addresses known/previously reported problems in existing Medicare claims processing systems. This issue is of concern as HCFA now plans to use selected existing systems during the 2-year implementation phase of MTS and to rely upon them as a baseline for current fee-for-service processing requirements.

OAS; W-00-97-30008
Expected Issue Date: FY 1998

• Electronic Data Interchange Under the Medicare Transaction System

Among other objectives, this continuation of prior OIG work will cover the adequacy of Medicare participation and electronic data interchange agreements to assure provider and plan accountability in the Medicare Transaction System, particularly where third

parties (e.g., billing services and claims clearinghouses) are involved.

OAS; W-00-97-30008
Expected Issue Date: FY 1998

Peer Review Organization Systems

This series of reviews will: (1) determine the effectiveness, efficiency and economy of current management information systems in facilitating achievement of peer review organization (PRO) program objectives; and (2) identify issues having national impact.

The PROs, their subcontractors, and other HCFA contractors--including Clinical Data Abstraction Centers--use data processing extensively to support the very sensitive Medicare postpayment utilization review functions under the PRO program. At the same time, HCFA is implementing a new nationwide, standardized management information system--the Standard Data Processing System (SDPS)--to facilitate the collection of uniform program management, administrative, and budgetary information on PRO operations.

OAS; W-00-97-30008
Expected Issue Date: FY 1998

Health Care Financing Administration's Operations at the Single Site Facility

This series of reviews continues our prior work on physical security at the HCFA Data Center located at its new single site facility. Initially, we will examine results of any applicable risk analyses or related studies performed by or for HCFA. We will then evaluate any potential HCFA vulnerability caused by a changeover of facilities management contractor, implementation of a LAN-based end-user computing environment at the single site, and operational setup at its new facility. Further work will include an assessment of HCFA's disaster

recovery and contingency plan as well as any significant security risks resulting from increased access to the data center by outside contractors (e.g., Medicare processing centers and fiscal intermediaries and carriers).

OAS; W-00-97-30008
Expected Issue Date: FY 1998

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 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.

While each year literally thousands of complaints from various sources will be brought to the OIG's attention for development, investigation and appropriate conclusion, the Office of Investigations 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 be concentrating our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

Operation Restore Trust

The OI will be monitoring all ***Operation Restore Trust*** developments to identify appropriate targets for investigation, and will work closely with other team partners to achieve all goals of the ***Operation Restore Trust*** project. Cases initiated will be added to the inventory of investigations already being conducted in the nursing home, home health care and durable medical equipment industries.

The ***Operation Restore Trust*** project is a 2-year pilot, which includes the establishment of a voluntary disclosure pilot program component that allows entities to self-disclose billing errors or fraud that they discover. The voluntary disclosure program's purpose is to encourage industry participation to ferret out fraudulent and abusive business practices within their respective industries. Cooperating entities gain an opportunity to negotiate a mutually agreeable settlement of criminal, civil and administrative liabilities appropriate for the actions disclosed.

Incontinent Care Project

The Office of Investigations developed a prototype national project involving incontinent care supply providers based on the observation of national trends and patterns related to these providers. The OIG has sponsored national conferences to outline a coordinated approach to the problem, and secured the support and commitment of various partners in the project.

Primarily, the project targets marketing and billing schemes of providers supplying incontinent care "kits" and certain other items to nursing home residents. Early indications are that excessive payments have been made for supplies relating to routine care and care deemed to be not medically necessary, and that excessive payments have been made for the maximum monthly quantity allowed by Medicare.

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 Medicare 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: doctor's services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies which are not covered by Medicare Part A. The most common Medicare Part B violation involves false claims to obtain payments to which the provider is not entitled. 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.

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 sustained scrutiny of the principal health care programs administered by HCFA, the OIG will focus attention on HCFA grants and contracts with carriers and intermediaries.

ENFORCEMENT AND COMPLIANCE

The Office of Enforcement and Compliance is responsible for the imposition of mandatory program exclusions, as well as certain permissive program exclusions and civil money penalty and assessment actions not handled by the Office of Litigation Coordination (discussed below). It develops models for corporate integrity and compliance programs, monitors ongoing compliance agreements and promotes industry awareness of corporate compliance agreements developed by the OIG.

Work planned during FY 1997 includes:

Credentialling

We will coordinate our efforts with other Federal agencies in the area of credentialling. When a provider applies to become a member of an health maintenance organization (HMO), for example, the HMO is required to verify whether that individual has been excluded from the Medicare and Medicaid programs. This coordination effort will decrease the number of inquiries the OIG receives from private insurers.

OEC; 97-00002
Expected Completion Date: FY 1997

Compliance Plans

We will develop model compliance plans which will offer guidance to OIG and Department of Justice negotiators in developing civil settlements for health care providers. These plans will focus on labs, hospitals, clinics, etc.

OEC; 97-00003
Expected Completion Date; Ongoing

LITIGATION COORDINATION

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the investigation and resolution of health care fraud cases. In all matters where the Department of Justice has an interest, OCIG is responsible for the imposition of permissive exclusions as well as civil monetary penalties and assessments. In cases where the decision is made not to impose an exclusion from program participation, OCIG works with the health care provider to construct a program that will ensure future compliance with applicable laws and regulations. The OCIG also oversees the OIG's voluntary disclosure program, which provides companies a mechanism to self-report findings of Medicare fraud and participate in the investigation and resolution of the matter.

Work planned during FY 1997 includes:

Permissive Exclusion Criteria

We will develop nonbinding guidelines to be used in assessing whether to impose a permissive exclusion pursuant to section 1128(b)(7) of the Act on a health care provider. The Inspector General's exclusion authority under this section extends to individuals and entities that have committed Medicare or State health care program fraud as specified in the Civil Monetary Penalty Law or the criminal provisions of section 1128B of the Act, including the anti-kickback statute. In determining whether to impose an exclusion under this section, OCIG considers a number of criteria which suggest that the party's continued participation in Medicare and Medicaid will not pose a risk to the programs or their beneficiaries. The guidelines will identify these factors and how they are used to assess a provider's trustworthiness.

OCIG; 97-00001
Expected Completion Date: FY 1997

Provider Self-Disclosure Initiative

We will review the results of the voluntary disclosure pilot program initiated under ***Operation Restore Trust***. We believe that a program which promotes self-disclosure of evidence of Medicare fraud serves both the interests of the Government and the health care community. We will continue to work with Government representatives and provider groups to develop a viable disclosure mechanism. Problems with the pilot program will be identified together with recommendations or options that would enhance the success of this initiative.

OCIG; 97-00002
Expected Completion Date: Ongoing

Department of Health and Human Services

Office of Inspector General

Public Health Service Agencies

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AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

Superfund Financial Activities for Fiscal Year 1996

As required by Superfund legislation, we will conduct this annual financial audit of the Agency for Toxic Substances and Disease Registry's Superfund receipts, obligations, reimbursements, and other uses of the Superfund. The Agency carries out its Superfund activities with its own staff and through cooperative agreements with States and private contractors to perform health related studies required by Superfund legislation. During Fiscal Year 1995, agency obligations and disbursements of Superfund resources amounted to about $68.8 million and $62.1 million, respectively.

OAS; W-00-97-50002
Expected Issue Date: FY 1997

FOOD AND DRUG ADMINISTRATION

Regulation of Institutional Review Boards

We will examine current regulations of institutional review boards and their role in ensuring protection of human subjects in clinical research. Federal regulations outline an important role for these boards in ensuring informed consent for all clinical trial subjects. Additionally, some review boards are taking a more active role in oversight to ensure enhanced patient protection.

OEI; 05-94-00490
Expected Issue Date: FY 1997

Management Controls Over Investigational New Drugs

We will assess the adequacy of FDA controls over investigational new drugs. An FDA-approved application for such drugs allows drug sponsors to perform clinical tests on human subjects in order to develop data to support the approval of their drugs. The

sponsors are to comply with certain requirements, including those to prevent the commercialization of investigational drugs. Our work in this area is prompted by a case at the University of Minnesota in which, using grant funds from the NIH, an investigational drug was sold for profit in violation of FDA regulations. This activity resulted in health hazards to some patients and millions of dollars earned in profits that were not reported to the Federal Government.

OAS; W-00-96-50004; A-15-96-50001
Expected Issue Date: FY 1997

Device Safety Alerts

We will determine the effectiveness of safety alerts and other public health advisories sent out by FDA's Center for Devices and Radiological Health. Post marketing surveillance is one method by which FDA assures safety of approved devices. Safety alerts are used to inform the medical community of post-marketing problems. The FDA has little data indicating how effective these communications have been, or if any improvements are needed.

OEI; 05-94-00140
Expected Issue Date: FY 1997

Warning Letters

This study will evaluate the process and effects of issuing warning letters for violations identified during inspections. The FDA issues warning letters to notify regulated entities about violations of a given regulation or policy under the agency's authority. The warning letter represents the first line and most readily available of FDA's regulatory actions that may be taken against a regulated company not in compliance. Regulated industry has alleged that variations exist across the different district offices of FDA.

OEI; 00-00-00035
Expected Issue Date: FY 1997

Use of Credit Cards for Small Purchases

We will review FDA's management controls related to credit cards used for small purchases under $2,500. In Fiscal Year 1995, FDA issued over 900 VISA credit cards to authorized employees who used the cards 13,000 times to purchase about $4.4 million worth of goods. We will assess FDA's controls regarding: issuance of the credit cards; pre-approval of purchases; records maintained by cardholders; and the documentation of the disposition of the items purchased. Our review will take into consideration the small purchase reforms suggested by a recent General Accounting Office report.

OAS; W-00-97-50004
Expected Issue Date: FY 1997

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Ryan White Comprehensive AIDS Resources Emergency Act of 1990

We will assess HRSA's monitoring of funds awarded under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act relative to supplanting level-of-effort, and payor of last resort requirements. The Ryan White CARE Act represents the largest authorization of Federal funds specifically designated to provide health and social services for people infected with HIV/AIDS. Earlier OIG reports raised concerns about recordkeeping and fiscal management of this program. We will determine whether HRSA, States, and eligible metropolitan areas have systems to assure that: (1) the required level of effort for HIV-related activities has been maintained; and (2) funds received under Ryan White Act are not used to pay for goods or services that have been or would be paid by private insurance, a State compensation program, or any Federal or State health benefits program. We intend to expand on this work as part of an overall assessment of HRSA's monitoring of Ryan White awards.

OAS; W-00-95-50015; A-01-96-01501; A-02-95-02517
Expected Issue Date: FY 1997

Recipients' Experiences with Bone Marrow Transplants

We will identify barriers, other than antigen matching, to bone marrow transplantation and make appropriate recommendations. The Congress in 1990 passed a law calling for a national registry; it is now funded at $40 million for 3 years by the Health Resources and Services Administration (HRSA). Oversight was awarded to HRSA in recognition that the donor program was a service delivery program rather than a basic research effort. We recently completed a study of the National Marrow Donor Program from the standpoint of donor recruitment and retention, the geographical overlap of donor centers, and a cost comparison of fee-for-service reimbursement and cost-based reimbursement to donor centers for their recruitment efforts. We will conduct a follow-up study focusing on recipient experiences.

OEI; 00-00-00039
Expected Issue Date: FY 1997

National Practitioner Data Bank

At the request of HRSA, we will examine the extent to which health care entities are in compliance with the Health Care Quality Improvement Act of 1986 regarding the requirement to report to the National Practitioner Data Bank any adverse actions taken against a health care practitioner. The information in the Data Bank serves to alert State licensing authorities and health care entities that there may be a problem with a particular practitioner's professional competence or conduct.

OAS; W-00-97-50005
Expected Issue Date: FY 1997

Federal Occupational Health

As requested by HRSA, we will evaluate management issues facing its program on Federal Occupational Health, an entrepreneurial service program using reimbursements from its client Federal agencies instead of a direct appropriation. This program competes with other public and private-sector occupational health providers for Federal agency occupational health business.

OAS; W-00-97-50005
Expected Issue Date: FY 1997

Performance Measurements

As part of the overall effort by the Department to collect information on performance measurements, the Assistant Secretary for Planning and Evaluation has asked the OIG to examine State and local government programs designed to use performance or outcome measures for managing public health service programs.

OEI; 05-96-00270
Expected Issue Date: FY 1997

INDIAN HEALTH SERVICE

Impact of Self-Governance on Indian Health Service Services

We will assess the effect of Indian self-governance on IHS' ability to provide needed health care services to the Indian people. As an increasing number of tribes are electing to manage their own health care through self-governance compacts, IHS must ensure that there are no limits or reductions in the direct care it provides to tribes who do not elect to provide their own care. We will determine: (1) if there are adequate controls to ensure that needed health care services are provided with compacting funds; and (2) the impact on nearby IHS facilities should compacting tribes be unable to adequately or fully meet the health care needs of their members.

OAS; W-00-96-50006; A-06-96-00058
Expected Issue Date: FY 1997

Mental Health Services Provided by the Indian Health Service

We will evaluate the impact of the consolidation of mental health and social services on Indian children and families. The Indian Health Service, which recently reorganized its mental health and social services programs, requested that we assess how this change has affected services for addressing child abuse. As part of this review, the IHS specifically requested a review of their management information system for these services.

OEI; 00-00-00070
Expected Issue Date: FY 1997

Indian Health Service's Office of Program Integrity and Ethics

We will evaluate the organization structure and operation of the Office of Program Integrity and Ethics in the IHS. The Program Integrity and Ethics staff is responsible for investigating allegations against IHS staff and tribal employees involved in health care activities funded by the Service. The Director of IHS requested this study so that the organization may be able to optimize its activities as IHS downsizes and moves forward with its re-design efforts.

OEI; 00-00-00036
Expected Issue Date: FY 1997

"High-Risk" Agency Management Improvements

Our review will determine the effectiveness of corrective actions taken by IHS to address material internal control deficiencies. Such deficiencies led the OMB in the early 1990's to declare IHS a "high risk" agency. We plan to assess IHS' efforts to correct internal control weaknesses related to such critical areas as: contract health services, property management, and alcohol and substance abuse program management.

OAS; W-00-96-50006; A-15-96-50003
Expected Issue Date: FY 1997

NATIONAL INSTITUTES OF HEALTH

National Cancer Institute Smoking Studies

We will determine if American Stop Smoking Intervention Study Team (ASSIST) program funds are being properly spent and whether the program is meeting its goals. The House Appropriations Committee, in expressing concern about whether the National Cancer Institute is adequately overseeing this program, noted that questions have been raised about some of the expenditures in the program. The Committee strongly urged the

Inspector General to conduct an audit of the contractors in the program to determine if the funds are being properly spent and that the program is meeting its goals.

OAS; W-00-97-50025
Expected Issue Date: FY 1997

Equity of Equipment Depreciation and Use Allowances Claimed by Universities

We will evaluate the equity of a provision in OMB cost principles that permits universities and nonprofit organizations to recover depreciation expenses and equipment use allowances in excess of their actual cost outlays. The provisions of OMB Circular Nos. A-21 and A-122 currently allow universities and nonprofits to claim depreciation and use allowances on equipment items which are donated by third parties and items which are purchased under separate nonfederal agreements at no cost to the university or nonprofit organization. Further, in some instances, organizations are allowed to claim use allowances on equipment which is fully depreciated. The claimed depreciation and use charges are included in the calculation of the research indirect cost rates and recovered (or reimbursed) when the rates are applied to Federal research agreements.

OAS; W-02-95-50085
Expected Issue Date: FY 1997

Use of Credit Cards for Small Purchases

We will review NIH's management controls related to credit cards used for small purchases under $2,500. We will assess NIH's controls regarding: issuance of the credit cards; pre-approval of purchases; records maintained by cardholders; and the documentation of the disposition of the purchased items.

OAS; W-00-97-50025
Expected Issue Date: FY 1997

Superfund Financial Activities for Fiscal Year 1996

As required by Superfund legislation, we will conduct this annual financial audit of the National Institute of Environmental Health Sciences' payments, obligations, and reimbursements, and other uses of the Superfund. The Institute carries out its Superfund activities with its own staff and through cooperative agreements to train persons who are engaged in hazardous waste activities and to study effects of exposure to specific chemicals. During Fiscal Year 1995, agency obligations and disbursements of Superfund resources amounted to about $58.8 million and $56.2 million, respectively.

OAS; W-00-97-50025
Expected Issue Date: FY 1997

PHS AGENCIES-WIDE ACTIVITIES

Preaward and Post Award Contract Audits

Annually the Department awards contracts/modifications in excess of $5 billion. Selection of the type of audits to be performed (preaward or post award) is based on risk analyses and other factors developed by the Department's operating divisions, specifically the Contract Audit Users Group, and cleared and coordinated by the Office of Grants and Acquisition Management, Assistant Secretary for Management and Budget, and the OIG. A series of annual reviews will be performed for each of the Department's operating divisions.

To ensure maximum return on OIG resources devoted to contract audit work we are: (1) utilizing streamlined audit techniques in conducting preaward audits for a cost-saving; (2) relying to the maximum extent possible on nonfederal audits; and (3) focusing the collaborative risk-based selection process on those audits that result in savings to the Department.

Recipient Capability Audits

At PHS agencies' request we will perform recipient capability audits of new organizations having little or no experience managing Federal funds. These audits determine the adequacy of each organization's accounting and administrative systems and their financial

capabilities to satisfactorily manage and account for Federal funds. Such reviews provide management with strengthened oversight over new grantees.

Reimbursable Audits

We will conduct a series of audits in response to certain requirements in OMB Circular A-21 and audit requests from other Federal agencies. This Circular assigns audit cognizance for approximately 95 percent of the Nation's nearly 3,000 colleges and universities to the Inspector General of HHS. Audit cognizance requires that we perform required audits at these schools including those requested by other Federal agencies. Our audits may include activities related to the review of disclosure statements filed by universities in conjunction with the newly required Cost Accounting Standards recently incorporated in Circular A-21.

Indirect Cost Audits

We will provide assistance, as requested, to the Department's Division of Cost Allocation on specific indirect cost issues at selected institutions. In previous years we have reviewed such issues as library allocations, medical liability insurance, internal service funds, fringe benefit rates, and space allocation. These assist audits have aided in substantially reducing indirect cost rates at the institutions reviewed.

Follow-Up on Nonfederal Audits

These reviews will determine whether the recommendations contained in prior nonfederal audit reports have been implemented by the auditee to correct reported findings. Certain prior audits conducted by nonfederal auditors have been identified by OIG's National External Audit Review group as having circumstances that need further investigation.

Investigative Activities

The PHS agencies are responsible for health research, protection, and improvement programs including those of the FDA, NIH, CDC, and IHS. Investigations of fraud in PHS agencies' programs are diverse, complex, and often critical to protecting the health of the American people. Investigations will address bribery, grant and contract fraud, research fraud, and allegations of wrongdoing in each of these programs.

Department of Health and Human Services

Office of Inspector General

Administration for Children and Families

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OTHER ISSUES

CHILD SUPPORT

States' Use of License Revocation in Child Support Enforcement

This joint review between the Office of Child Support Enforcement audit staff and the OIG will assess the effectiveness of judicial and administrative processes used by State child support enforcement programs in revoking various types of State licenses belonging to delinquent non-custodial parents. In recent years, many States have enacted legislation directing State licensing authorities to restrict professional, trade, sporting, business, and/or vehicle driving and registration licenses of people with child support arrearages. Specifically, we will determine the best practices that might be employed with the implementation of a nationwide Federal standard on license revocation. Officials estimate that such a nationwide program could generate as much as $2.5 billion in child support payments over 10 years and reduce Federal welfare payments by $400 million.

OAS; W-00-96-20005, A-01-96-02502
Expected Issue Date: FY 1997

"Good Cause" Exceptions for Child Support

This review will describe State policy authorizing the use of the "good cause" provision by child support enforcement caseworkers. The "good cause" provision may be invoked when the custodial parent believes that the parent or the child is in danger from the absent parent or if the custodial parent believes that exposure to the absent parent's lifestyle would damage the child in some way. When a caseworker designates a IV-D case enforcement order as "good cause", the custodial parent is free to receive public assistance funds without pursuing child support. Prudent application of the "good cause" policy is necessary to insure protection of the child and custodial parent but, if abused, could prevent effective and appropriate enforcement of child support orders.

OEI; 00-00-00011
Expected Issue Date: FY 1997

Wage Withholding Job Change Situations

This joint review will assess State procedures for withholding wages for child support when the wage earner changes jobs. Wage withholding is one of the best techniques to ensure collection of child support and prevent custodial parents from requiring public assistance payments. Data from a Maryland State audit indicate that about 30 percent of wage earners with a garnishment order changed jobs and have continuing income but are no longer paying the mandated child support. Wage withholding through the new employer had not been accomplished in a timely manner. We will assess the timeliness and effectiveness of selected States' procedures to ensure follow-up, location and initiation of wage withholding at the new employer when the agency fails to receive employer remittances from non-custodial parents. We will conduct a phone survey with the remaining States to evaluate their procedures for efficiently transferring or amending garnishment orders when workers change jobs.

OEI; 00-00-00042
OAS; W-00-97-20005
Expected Issue Date: FY 1997

Delinquent Child Support by Departmental Grantees

We will determine if departmental grantees and service providers have child support orders in place and are delinquent in paying child support. Currently, less than half of outstanding child support is being collected. This study will compare lists of departmental grantees and State child support records to determine the extent of nonpayment of child support. We are focusing on Medicare providers, National Health Service Corps grantees, and National Institutes of Health grantees. The results of this study could provide further information to locate absent parents.

OEI; 07-95-00390
Expected Issue Date: FY 1997

State Child Support Systems

This study will explore experiences of State child support enforcement agencies in implementing required automated data systems. In 1980, the Congress promoted the development of automated systems to improve child support program performance.

Later, the Child Support Amendments of 1984 and the Family Support Act of 1988 extended 90 percent matching funds for these systems and set an October 1, 1995 target date for States to meet Federal requirements before funding is discontinued. Only one State has met the October 1, 1995 deadline for having a certified State system.

OEI; 04-96-00010
Expected Issue Date: FY 1997

Effectiveness of the Federal Parent Locator Service

We will review the processes and data used by the Federal Parent Locator Service, a computerized national network operated by the Office of Child Support Enforcement, to help locate noncustodial parents who owe child support. The Service has access to a wide variety of State and Federal data and represents the most current locator data available. The Service has been criticized as not being useful due to long turnaround times and old data.

OEI; 07-96-00050
Expected Issue Date: FY 1997

INVESTIGATIONS

Project Child Support Enforcement

We will make use of the deputation authority granted by the Department of Justice to our Office of Investigations to investigate violations of the Federal child support enforcement statute. In 1992, Congress enacted the Child Support Recovery Act, which provided a new Federal statute, allowing Federal level prosecution of non-paying parents who reside in a State other than that of their child. The OIG will use its authority to investigate non-paying parents who, by the lack of financial support to their child, have impacted any of the Department's programs, such as AFDC or Medicaid. Identification of the non-paying parent is a continuous joint effort within the OIG.

FOSTER CARE

Kinship Care - "Physical Removal," Home Licensing and Approval Requirements

At ACF's request, we will evaluate New York City's compliance with the title IV-E "physical removal," home licensing and approval requirements of foster children placed in the homes of relatives. The ACF's interpretation of the statute requires the child's physical removal from the contrary-to-the-welfare home within 6 months prior to the initiation of court proceedings. Recent Departmental Appeals Board decisions have upheld ACF's position.

Additionally, in selected States, we will review cases not supported by sufficient evidence indicating that a child's continued residence in the home was contrary to his/her welfare, and/or that reasonable efforts were made to preclude the child's removal. The HHS Departmental Appeals Board, in a recent decision, sustained 13 cases in Illinois that were questioned by the OIG for lack of evidence indicating that appropriate action was taken to retain children in their homes. We believe that the DAB decision clarifies acceptable documentation and supports pursuing this area in other States to recover ineligible Title IV-E costs.

OAS; W-00-96-20008; A-02-96-02006
Expected Issue Date: FY 1997

Support Payments for Children in Foster Care

This review will determine if States have improved their efforts to establish support orders based on a parent's ability to pay, and to collect and credit support payments for children in State and Federal foster care programs. Section 11 of the 1984 Child Support Amendment Act requires States to secure and enforce child support collections from the non-custodial parent on behalf of children receiving foster care maintenance payments under the Federal Title IV-E "where appropriate." Previous OIG reports found that few child support collections are made on behalf of foster care children in either the State or Federal programs, and, in cases where support payments were collected, the payments were incorrectly distributed. Our review will focus on timely Foster Care agency referrals to Child Support Enforcement agencies, coordination between the agencies and,

in handling of collections and appropriate credits to the IV-E program. Results can be provided in partnership with State auditors for use in State-administered programs.

OAS; W-00-97-20008
Expected Issue Date: FY 1997

Level of Care Needed for Children Entering Foster Care

This review will determine whether title IV-E foster care payments are being made in accordance with established criteria when making a change in the level-of-care. We will also determine if foster care payments are being made at the established level-of-care rate. Improper level-of-care classifications can result in the child not receiving the level-of-care needed and could result in higher than necessary payments by the Federal Government.

OAS; W-00-96-20008; A-06-96-00033
Expected Issue Date: FY 1997

OTHER ISSUES

Interstate Compact on the Placement of Children

This study will describe current States' experiences and obligations under ACF's Interstate Compact on the Placement of Children. This compact was drafted in response to the lack of protections and supportive services provided to children sent into out-of-State placement. When a child is placed in another State, the receiving State must provide required services for the protection of children. The ACF has been receiving complaints from States that other receiving States are not meeting their obligations under the compact.

OEI; 02-95-00041
Expected Issue Date: FY 1997

Community Service Block Grants

This review of Community Services Block Grants will: (1) evaluate New Jersey's and Puerto Rico's bases for distributing funds to grantees; and (2) determine whether States require their grantees to design programs directed at ameliorating the causes of poverty and measure program achievements. We will also determine whether States adequately monitor program accomplishments.

Community Service Block Grants are awarded to States to develop programs designed to address the causes of poverty. The States, in turn, award grants to local agencies that are required to provide services which have a measurable effect on the poverty in their communities. A review in one State found that the State did not: (1) use subgrantees' application information to allot the grant funds; (2) adequately monitor the grant program; (3) validate the accomplishments of subgrantees; or (4) require its subgrantees to develop programs that responded to the highest priority needs of the community.

OAS; W-00-96-20006; A-02-96-02003; A-02-96-02004
Expected Issue Date: FY 1997

Child Abuse and Neglect

We will determine if there are breakdowns in States' child protective service programs, that allow child abuse and neglect to continue and/or recur. The ACF's Child Abuse and Neglect program provides funding for these State activities.

Child abuse and neglect is a widespread, rapidly growing problem. Approximately 1 million of the 3 million cases of child abuse and neglect reported annually are substantiated, which means a child is abused and/or neglected every 30 seconds. Research has shown that some of the problems related to the increasing number of unsubstantiated cases of abuse and neglect may be directly related to the intake or screening process of child protective services. Some problems may have caused a "revolving door syndrome" for some maltreated children.

OAS; W-00-97-20018
Expected Issue Date: FY 1997

State Protection and Advocacy Systems for the Disabled

These reviews will assess the fiscal management and internal controls of selected State protection and advocacy systems for the disabled. Nationwide expenditures for these activities exceeded $47 million in FY 1996 for services provided to nearly 58,000 clients. A previous OIG review has uncovered serious financial mismanagement at one protection and advocacy agency. Given the nature of these activities coupled with diminished monitoring at the Federal level increases the likelihood that similar situations may exist.

OAS; W-00-97-20017
Expected Issue Date: FY 1997

Administration for Children and Families Grant Oversight: Follow-Up

The objective of this review will be to evaluate policies and procedures recently implemented by ACF to improve the efficiency and effectiveness of ACF's oversight of grantee performance. Previous reviews have found that the Division of Community Discretionary Programs (the grant oversight office in ACF) did not ensure departmental grants policies and procedures were followed especially in determining whether grant goals and objectives were achieved. The ACF responded by instituting Business Process Reengineering pilots of the grants process.

OAS; W-00-97-20002
Expected Issue Date: FY 1998

Reimbursement Rates and the Rate Structure for Foster Family Agencies

We will determine whether California has a reasonable rate structure for the administrative component of the foster care payment and whether unallowable expenditures are included in the amounts reimbursed. The monthly foster care payment to foster family agencies includes a basic rate, a special care increment, a social work component, and an administrative component.

OAS; W-00-96-20008; A-09-96-00071
Expected Issue Date: FY 1997

Problem Head Start Grantees

We will identify from a national sample of Head Start grantees trends and problems in areas such as procurement, purchases, construction and renovation of facilities, allocation of administrative costs, matching of federal funds and other fiscal difficulties. We will quantify potential savings to the program as well as identify unallowable costs for recovery by ACF. Program officials are concerned that they have limited resources available to monitor and assist grantees to meet program performance standards.

OAS; W-00-97-20009
Expected Issue Date; FY 1997

Office of Community Services Grantee

This review will determine if an Office of Community Services grantee used its grant funds to meet program objectives. The OCS awards Urban and Rural discretionary grants to develop an economic base to make jobs and training available for low income individuals. Review of the grant files indicates that funds may have been inappropriately used. Our review was requested by the Assistant Secretary for Management and Budget.

OAS; W-00-97-20006
Expected Issue Date: FY 1997

Refugee Resettlement Cash and Medical Assistance Payments in Florida

We will determine if the Florida Department of Health and Rehabilitation Services has controls in place to prevent the payment of refugee cash assistance and refugee medical assistance after a refugee's period of eligibility has expired. The Refugee Act of 1980 authorized States, subject to the availability of appropriations, to provide assistance to refugees during the first 36 months they are in the country.

OAS; W-00-96-20017; A-04-96-00104
Expected Issue Date: FY 1997

Department of Health and Human Services

Office of Inspector General

Administration on Aging

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ADMINISTRATION ON AGING

Elder Abuse Identification and Resolution

Our review of elder abuse will evaluate States' systems, which are part of AoA's ombudsman program, to identify, investigate, and resolve complaints of elder abuse, neglect, and exploitation . The review will include identification of barriers, best practices, and patterns of abuse. We will also work with the several State Utilization Review Units to screen Medicaid files to identify potential elder abuse for investigation by the State Medicaid Fraud Control Units. Experts estimate that as many as 1.5 to 2.0 million older Americans may be victims of elder abuse each year, and the number is expected to increase as the Nation's elderly population continues to grow.

OAS; W-00-96-20001; A-12-96-00016
Expected Issue Date: FY 1997

Background Checks - Nursing Home Employees

This review will determine and document the need for stronger Federal requirements for conducting background checks to deter the incidence of elder abuse in nursing homes. Requirements for background checks will be compared and an assessment made of rates of elder abuse cases identified in nursing homes that conduct employee background checks with those that do not. A recent study showed that a large number of nursing home employees have prior criminal records. Also, a network news story alleged 300 incidents of elder abuse among nursing home residents in one State. At some nursing homes which do conduct background checks, as many as 40 percent of the applicants are not hired because of their police records.

OAS; W-00-96-20001; A-05-96-00051
Expected Issue Date: FY 1997

Involuntary Transfers of the Elderly - Psychiatric Facilities

This study will determine if Medicare and Medicaid funds are inappropriately spent for inpatient psychiatric care when the elderly are involuntarily committed into psychiatric

facilities. Current regulations create a financial incentive by allowing the temporary transfer of residents from retirement or nursing homes to for-profit psychiatric facilities. Federal funds pay for the inpatient treatment while, at the same time pay the nursing/retirement home to reserve the resident's bed. These psychiatric services may not benefit the patient's condition or could be provided more cost-effectively at a nursing home. A recent network news story reported that thousands of elderly people are being forced out of their retirement and nursing homes and into for-profit mental hospitals.

OAS; W-00-97-20001
Expected Issue Date: FY 1997

Department of Health and Human Services

Office of Inspector General

Departmentwide

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Program Support Center--Major Administrative Support Services:

Work is expected to begin in FY 1997 on the following audits:

Related audit activity to support financial statement audits:

Program Support Center--Major Administrative Support Services:

PROGRAM INTEGRITY AND EFFICIENCY

GOVERNMENT MANAGEMENT REFORM ACT OF 1994 AND CHIEF FINANCIAL OFFICERS ACT OF 1990 and GOVERNMENT PERFORMANCE AND RESULT ACT OF 1993

The Government Management Reform Act of 1994 seeks to ensure that the Federal managers have at their disposal the financial information and flexibility necessary to make sound policy decisions and manage scarce resources. This Act broadens the Chief Financial Officers (CFO) Act of 1990 to require annual audited financial statements--commencing with FY 1996--for *all* accounts and associated activities of selected Federal agencies (includes HHS and its operating divisions). The first reporting of the consolidated HHS financial statement to the OMB is due by March 1, 1997.

Also covered by financial statement audits are the performance measures and goals required by the Government Performance and Result Act of 1993. This Act requires Federal agencies to prepare strategic plans that include performance measures and goals.

The following financial statement audits will be completed and reports issued during FY 1997:

Health Care Financing Administration--FY 1996

OAS; W-00-96-30102; A-17-95-00051
Expected Issue Date: FY 1997

Administration for Children and Families--FY 1996

OAS; W-00-96-40010; A-17-96-00002
Expected Issue Date: FY 1997

Health Resources and Services Administration--FY 1996

OAS; W-00-96-40013; A-17-96-00005
Expected Issue Date: FY 1997

Indian Health Service--FY 1996

OAS; W-00-96-40013; A-17-96-00004
Expected Issue Date: FY 1997

National Institutes of Health--FY 1996

OAS; W-00-96-40013; A-17-96-00008
Expected Issue Date: FY 1997

Centers for Disease Control and Prevention--FY 1996

OAS; W-00-96-40013; A-17-96-00007
Expected Issue Date: FY 1997

Food and Drug Administration--FY 1996

OAS; W-00-96-40013; A-17-96-00003
Expected Issue Date: FY 1997

Substance Abuse and Mental Health Services Administration--FY 1996

OAS; W-00-96-40013; A-17-96-00006
Expected Issue Date: FY 1997

Related audit activity to support financial statement audits:

NIH Computer Center

OAS; W-00-96-40012
Expected Issue Date: FY 1997

Program Support Center--Major Administrative Support Services:

Payment Management System

OAS; W-00-96-40012; A-17-96-00047
Expected Issue Date: FY 1997

Information Technology Service (Parklawn Computer Center)

OAS; W-00-96-40012
Expected Issue Date: FY 1997

Accounting Operations--Division of Accounting Operations and Division of Fiscal Services

OAS; W-00-96-40012
Expected Issue Date: FY 1997

Payroll Operations

OAS; W-00-96-40012
Expected Issue Date: FY 1997

Combined Financial Statements--FY 1996

OAS; W-00-96-40011; A-17-96-00009
Expected Issue Date: FY 1997

Work is expected to begin in FY 1997 on the following audits:

Health Care Financing Administration--FY 1997

OAS; W-00-97-40008
Expected Issue Date: FY 1998

Administration for Children and Families--FY 1997

OAS; W-00-97-40010
Expected Issue Date: FY 1998

Health Resources and Services Administration--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

Indian Health Service--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

National Institutes of Health--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

Centers for Disease Control and Prevention--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

Food and Drug Administration--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

Substance Abuse and Mental Health Services Administration--FY 1997

OAS; W-00-97-40013
Expected Issue Date: FY 1998

Related audit activity to support financial statement audits:

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OAS; W-00-97-40013
Expected Issue Date: FY 1998

Program Support Center--Major Administrative Support Services:

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OAS; W-00-97-40012
Expected Issue Date: FY 1998

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OAS; W-00-97-40012
Expected Issue Date: FY 1998

Accounting Operations--Division of Accounting Operations and Division of Fiscal Services

OAS; W-00-97-40012
Expected Issue Date: FY 1998

Payroll Operations

OAS; W-00-97-40012
Expected Issue Date: FY 1998

Consolidated Financial Statements--FY 1997

OAS; W-00-97-40009
Expected Issue Date: FY 1998

PROGRAM INTEGRITY AND EFFICIENCY

Internal Service Funds - New York

This study will determine if New York is maintaining excessive accumulated surplus balances in its telecommunications internal service fund. A recent review disclosed that the State's telecommunications fund had a surplus balance of about $10 million at the end of its Fiscal Year 1995. Internal service centers are in-house enterprises that provide services to other operating units within the State government. The service center's operating costs are recovered through fees charged to users. User fees should be designed to recover not more than the aggregate cost of operations.

OAS; W-00-97-20003
Expected Issue Date: FY 1997

Preaward and Post Award Contract Audits

Annually the Department awards contracts/modifications in excess of $5 billion dollars. Selection of the type of audits to be performed (preaward or post award) will be based on risk analyses and other factors developed by the Department's operating divisions, specifically the Contract Audit Users Group, and cleared and coordinated by the Office of Grants and Acquisition Management, Assistant Secretary for Management and Budget and the OIG. A series of annual reviews will be performed for each of the Department's operating divisions.

To ensure maximum return on OIG resources devoted to contract audit work we are: (1) utilizing streamlined audit techniques in conducting preaward audits for a resource savings of approximately $30,000 per audit; (2) relying to the maximum extent possible on nonfederal audits; and (3) focusing the collaborative risk-based selection process on those audits that result in savings to the Department.

Nonfederal Audits

We will review the quality of audits prepared by nonfederal auditors in accordance with OMB circulars A-128 and A-133. Under these circulars, State and local governments, colleges and universities and nonprofit organizations receiving Federal awards, are required to have an annual organization-wide audit which includes all Federal money they receive. We provide up-front technical assistance to nonfederal auditors to facilitate a clear understanding of the Federal audit requirements and promote effective audit work. In addition, we identify, analyze, and record electronically the audit findings reported by nonfederal auditors for use by Department managers.

Our reviews provide Department managers with assurance about the management of Federal programs and identify significant areas of internal control weaknesses, noncompliance with laws and regulations, and questioned costs that require formal resolution by Federal officials.

INVESTIGATIONS

Investigative Activities

The OIG will investigate employee fraud and misconduct related to the administration of the Department's programs. Previous areas have included conflict-of-interest, embezzlement, and accepting bribes or gratuities.

ENFORCEMENT AND COMPLIANCE

Reporting of Excluded Individuals and Entities

We will coordinate with HCFA and the Public Health Service to develop a system for uploading exclusion data into the National Practitioners Data Bank for use by hospitals, licensing boards, and professional medical societies to obtain information on health care practitioners who have been excluded from participation in the Medicare and State health care programs. The OIG is responsible for reporting and updating all exclusion and reinstatement actions on these programs. The implementation and ongoing maintenance

of this system will enable hospitals and others to determine whether an individual practitioner has been excluded from participation in the Federal health care programs, the basis for that exclusion, and the practitioner's current program reimbursement eligibility status.

OEC; 97-00001
Expected Completion Date: Ongoing