Department of Health and Human Services

Office of Inspector General

Work Plan

Fiscal Year 1998

June Gibbs Brown
Inspector General

Office of Inspector General

MISSION:

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

VISION

WE ARE GUARDIANS OF THE PUBLIC TRUST

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

VALUES

WE VALUE:

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

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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, and Office of Counsel to the Inspector General that are to be addressed during Fiscal Year (FY) 1998. 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 of the various project areas and a projected completion date for many of the work items that we perceive as critical to the mission of the OIG and the Department. However, as the work planning process tends to be ongoing and dynamic, the focus and timing of many of these projects can evolve in response to new information, new issues, and shifting priorities of the Congress, the President and the Secretary, and may be altered over time. Given these variables, the OIG objective still remains the targeting of available resources on those projects that best identify vulnerabilities in the Department's programs and activities that have been designed to serve and protect the safety, health and welfare of the American people and promote the economy, efficiency and effectiveness of the Department's programs.

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 1998.

Program Inspections

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

Investigative Focus Areas

The OIG's Office of Investigations (OI) conducts investigations of fraud and misconduct to safeguard the Department's programs and protect the beneficiaries of those programs from individuals and activities that would deprive them of rights and benefits.

The OIG concentrates its resources on the conduct of criminal investigations relating to the programs and operations of HHS. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses

in areas of program vulnerability that can be eliminated through corrective management actions, regulation or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

Legal Counsel Focus Areas

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

Internet Address

The FY 1998 OIG Work Plan and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

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

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Medicare Indirect Medical Education Payments

This review will determine the initial basis for and computation of indirect medical education payments to teaching hospitals. This data will be compared to more current data on actual costs hospitals indirectly incur as a result of physician training. We will use this information to evaluate the continuing need for and amounts of such payments. Medicare made indirect medical education payments of $5.6 billion in 1996 to compensate teaching hospitals for the higher costs they incur as a result of their overall expenses related to training physicians. The 1997 Balanced Budget Act reduces payments for indirect medical education from 7.7 percent to 5.5 percent in the year 2001 and thereafter.

OAS; W-00-98-30010; A-07-98-00000
Expected Issue Date: FY 1998

Medicare and Medicaid Payments for Graduate Medical Education

This review will determine whether there is duplication of graduate medical education reimbursements to hospitals by the Medicare and Medicaid programs. The Federal Government pays teaching hospitals for the costs they incur training medical residents through both programs. A recent GAO report identified concerns that duplication could be occurring. Our work will focus on selected States with the highest amount of total Medicare and Medicaid medical training costs.

OAS; W-00-98-30010; A-07-98-00000; A-02-98-00000
Expected Issue Date: FY 1998

Observational Stays Billed to Medicare

This study will determine the financial impact on the Medicare program and its beneficiaries of miscoded hospital outpatient observational stays. Observation services are furnished by a hospital on an outpatient basis and may include the use of a bed and periodic monitoring. Medicare reimburses for these services on a cost basis. The Prospective Payment Assessment Commission identified this as a problem area in

1994, because many of these observational stays should have been coded as inpatient admissions to the hospital. HCFA has subsequently changed its policy to deny coverage for observation stays longer than 2 days.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Diagnosis-Related Group Coding

This 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 (DRG) code for each discharge under the prospective payment system. This review will develop an approach to identify 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; 01-97-00010
Expected Issue Date: FY 1998

Revenue Codes Billed By Hospitals

This study will determine the extent to which hospitals are inappropriately billing Medicare for non-covered items through the use of general revenue codes. Revenue codes are billing codes which identify accommodation and/or ancillary charges covered by Medicare. Revenue codes are used when providers use a cost report, as opposed to billing on a prospective basis. However, in instances when a beneficiary's Part A inpatient coverage runs out, revenue codes are used to bill Part B for covered services. Likewise, if a beneficiary is having a procedure performed in a hospital on an outpatient basis, revenue codes are also used to bill Part B.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Hospital Services Billed Under Arrangement

This study will determine the extent to which hospitals purchase services under arrangement and identify the services that hospitals purchase most frequently. It will also assess the fiscal effects of these arrangements. Previous work conducted by the OIG has concluded that Medicare pays substantially more when nursing homes purchasing services "under arrangement" from ancillary service providers such as therapy/rehabilitation agencies and portable x-ray suppliers. "Under arrangement," means that a facility purchases ancillary services from a service provider who bills the facility rather than a Medicare contractor. The facility then includes those services as costs on the claims they submit to the fiscal intermediary, marking them up as much as 250 percent for overhead and administrative expenses. This study will determine if similar problems occur at hospitals.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Short-Stay Discharges At Non-Prospective Payment System Providers

This review will: (1) identify the extent of "short stay" discharges from a prospective payment system (PPS) hospital and to a hospital unit that is not part of the prospective payment system; (2) assess whether such stays were warranted; and (3) determine whether Medicare reimbursement should be adjusted if the beneficiaries were subsequently readmitted to the same PPS hospital that made the original referral. Examples of non-PPS providers include rehabilitative and psychiatric hospitals, or such units, within hospitals.

Acute care PPS providers have a financial incentive to discharge patients to non-PPS providers in order to reduce lengths of stay and at the same time receive payment at the full diagnosis-related group amount. Increased discharges could enable non-PPS providers to qualify for higher Medicare reimbursement through increases to their allowable operating cost target amount.

OAS; W-00-98-30010; A-01-98-00000
Expected Issue Date: FY 1998

Outpatient Psychiatric Services

This review will determine whether psychiatric services rendered on an outpatient basis are billed for and reimbursed in accordance with Medicare regulations. Medicare regulations require that payments be limited to covered services that are supported by medical records. We have indications from one fiscal intermediary that services rendered in outpatient hospital settings were not documented, not ordered by a physician, nor were covered services. We will determine if this is also a problem at other fiscal intermediaries.

OAS; W-00-98-30010
Expected Issue Date: FY 1998

Partial Hospitalization Services

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

OAS; W-00-98-30010; A-04-98-00000
Expected Issue Date: FY 1998

Experimental Drug Trials

We will conduct two reviews to determine whether hospitals and other providers are inappropriately billing Medicare for items or services provided to beneficiaries as part of research grants and experimental drug trials. Many research projects are funded by the Public Health Service and private foundations, whereas experimental drug trials are usually paid by pharmaceutical companies. We will determine if claims for these projects are also being paid by Medicare.

OAS; W-00-98-30010; A-06-98-00000
Expected Issue Date: FY 1998

Organ Transplant Costs

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

OAS; W-00-98-30001; A-04-98-00000
Expected Issue Date: FY 1998

Private Hospital Accreditation

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

OEI; 00-00-00000
Expected Issue Date: FY 1998

Prospective Payment System Transfers

We will continue to support the Department of Justice's assistance to the Department in seeking recovery of Medicare overpayments to Prospective Payment System (PPS) hospitals that incorrectly reported PPS transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between PPS hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay while the hospital receiving the transferred patient is to be paid a diagnosis related group

payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount.

OAS; W-00-98-30010; A-06-97-00006
Expected Issue Date: FY 1998

Prospective Payment System Transfers During Hospital Mergers

We will review transfers from acquired Prospective Payment System (PPS) hospitals to the acquiring PPS hospital to identify situations where Medicare paid the acquired hospital under the PPS transfer payment policy (per diem based payments) and the acquiring hospital the full diagnosis related group payment without the patient leaving the hospital bed. The PPS was designed to pay a hospital for all care a Medicare beneficiary needed for discharge. Where a PPS hospital is acquired, the patient does not leave the hospital bed, and the new owner receives a new provider number only one payment should be made by Medicare. We have noted a number of situations in which Medicare contractors paid both the acquired and the acquiring hospitals.

OAS; W-00-98-30010; A-06-98-00000
Expected Issue Date: FY 1998

Hospital Reporting of Patients Who "Left Against Medical Advice"

We will identify Prospective Payment System (PPS) hospitals that routinely report Medicare patients leaving the hospital against medical advice as a possible indicator of facilities trying to circumvent the PPS transfer payment policy. This policy exempts situations in which the patient left the first PPS hospital against medical advice (self-discharged). A significant increase in the reporting of "left against medical advice" transfers occurred since the OIG's first PPS transfer recovery project (January 1986 through November 1991).

OAS; W-00-98-30010; A-06-97-00059
Expected Issue Date: FY 1998

Duplicate Billing of Outpatient Hospital Services

We will compare the billing practices of hospital-based outpatient clinics and physicians who bill for similar services in the clinics. Services rendered in a hospital-based outpatient clinic are billed under Medicare Part B but through a fiscal intermediary. The physicians providing services in these clinics may be billing for the same services under Part B, but submitting their claims to the carrier. If both are billing for and receiving reimbursement for the same services, then duplicate payments result. These types of duplicate payments would be hard to routinely detect because bills are sent to different contractors.

OAS: W-00-98-30010; A-03-98-00000
Expected Issue Date: FY 1999

Hospital Closure: 1996

This will be the tenth in a series of reports on hospital closure, examining the extent, characteristics, reasons 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.

OEI; 04-97-00110
Expected Issue Date: FY 1998

Hospital Ownership of Physician Practices

This study will examine the prevalence and characteristics of hospital-owned physician practices. In recent years, integration in the health care marketplace has included hospital purchases of physician practices. This study will be the first in a series of reports aimed at determining what vulnerabilities to Medicare result from this growing trend. The report will describe: the number and types of physician practices owned by

hospitals, physician compensation arrangements, and hospitals' business objectives in pursuing physician practices.

OEI; 04-97-00090
Expected Issue Date: FY 1998

HOME HEALTH

Hospital Ownership of Home Health Agencies

This study is a follow-up to an OIG review entitled, "Hospital Discharge Planning" and will determine more precisely how and to what extent hospital ownership of home health agencies impacts on the referral to these agencies. This study will focus on discharges involving specific DRGs with co-morbidities and will analyze a number of factors including referral rates; length and cost of initial hospitalization; and length, cost, intensity and different types of home health agency services provided.

OEI; 02-94-00321
Expected Issue Date: FY 1998

General and Administrative Costs

Because of the large increase in home health expenditures during the last several years, we will conduct a series of reviews to determine the allowability of general and administrative (G&A) 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 salaries and fringe benefits and similar G&A costs to determine whether they are reasonable and related to patient care. We will also incorporate the results of our financial statement audit work into future general and administrative cost reviews.

OAS; W-00-98-30009; Various CINs
Expected Issue Date: FY 1998

Physician Case Management Billings

This review will determine if, when a home health claim has been denied by the regional home health intermediary, the Part B carrier also denies any related payments submitted by the physician for oversight of the plan of care. Payment to physicians for plan care oversight is to be recovered when a claim did not meet Medicare criteria for home health services. The intermediaries and carriers should be interacting with regard to such claims. Based on our early survey work, physician billings for plan care oversight could be substantially reduced based on the potential denial rate that should have taken place.

OAS; W-00-98-30009; A-06-98-00000
Expected Issue Date: FY 1998

Home Health Agency Cost Reports

Our limited-scope reviews will determine if, in their Medicare cost reports, home health agencies in selected States properly documented the reasonableness of costs such as salary, and miscellaneous and accrued costs for which reimbursement was claimed. In coordination with the appropriate regional home health intermediary and HCFA, we will select home health agencies based on total reimbursement, the average number of visits per patient and location. Our audit methodology will focus on a limited number of cost categories that can be reviewed in a relatively short period.

OAS; W-00-98-30009
Expected Issue Date: FY 1998

Home Health Agency Eligibility Reviews

At HCFA's request, we will continue to determine whether home health care visits claimed by various home health care providers meet Medicare reimbursement guidelines. We will determine if the home health visits are needed, properly authorized, and furnished to eligible beneficiaries. These reviews are being conducted

in partnership with HCFA and appropriate State agencies as a continuation of the review methodology developed under Operation Restore Trust.

OAS; W-04-97-30016; A-04-97-01165; A-0-4-97-01166; A-04-97-01169; A-04-97-01170; A-04-97-01171
Expected Issue Date: FY 1998

Home Health Aides

We will examine claims for home health aide services ostensibly provided to Medicare beneficiaries in residential care facilities in California. The State requires such facilities to provide assisted living services, such as meal preparation, room cleaning, and bathing in order to be licensed. The residents pay the facilities for these services. Nonetheless, past work has disclosed instances where home health aides (via home health agencies) claimed Medicare reimbursement as though they--not the resident care facilities--provided the services to beneficiaries. Our study will offer recommendations on how Medicare can prevent payments for these inappropriate claims.

OAS; W-00-98-30009; A-09-98-00000
Expected Issue Date: FY 1998

Overhead Costs of Home Health Agencies

This financial analysis will determine how much of Medicare payments to home health agencies are actually benefiting Medicare beneficiaries. Medicare reimburses home health agencies on the basis of their reasonable and allowable costs. We are finding, however, that few incentives exist for agencies to control costs and operate in a fiscally prudent manner. Indeed, an analysis of a major agency in California disclosed that only 46 cents of every Medicare dollar paid the agency was used to provide direct medical and aide services to beneficiaries. The majority of the Medicare payments--54 cents of every dollar--went for the agency's overhead and its subcontractors' overheads and profits. There are proposals to change how Medicare pays home health agencies--from a cost reimbursement system to a prospective payment system. Whether the current system is retained or changed, the findings

produced by this study will be of value in establishing fair and reasonable Medicare payments for home health services.

OAS; W-00-98-30009; A-09-98-00000
Expected Issue Date: FY 1998

NURSING HOME CARE

Therapy in Nursing Facilities

A series of OIG reviews will evaluate the reasonableness of and costs associated with therapy services provided in skilled nursing facilities. The Medicare skilled nursing facility benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services. These rehabilitative services may include physical and occupational therapy which may be paid by either Medicare Part A or Part B: Part A if the services are provided by nursing home staff or by outside staff paid by the nursing facility; Part B if the outside provider bills Medicare Part B directly. Past OIG work has found that services purchased under arrangement with outside providers were significantly higher than salaried therapy costs.

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

OAS; W-00-98-30014; A-04-98-00000
OEI; 09-97-00120
Expected Issue Date: FY 1998

Revenue Codes Billed By Nursing Facilities

The OIG, using the methodology and protocol developed in its joint work with HCFA and Florida's Agency for Health Care Administration, will target abusive and unallowable or fraudulent use of certain revenue codes (for types of services billed) by skilled nursing facilities in Florida and other States.

OAS; W-00-96-30015; A-04-96-01145
Expected Issue Date: FY 1998

Physicians with Excessive Nursing Home Visits

We will identify and audit physicians with excessive visits to Medicare patients in skilled nursing facilities (SNF). The OIG nursing home project identified trends in Medicare and Medicaid payments and populations and identified aberrant providers of nursing home services by type of service. Using this data as well as other computer screening techniques, we identified physicians with aberrant billing patterns for visits to 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-09-97-00062; A-06-97-00050
Expected Issue Date: FY 1998

Financial Conflicts of Interest

We will examine nursing homes that have been purchased, either partially or wholly, by durable medical equipment supplier chains and/or physician groups. This review will look at claims submitted for Medicare beneficiaries in these homes and identify any aberrant billing patterns for services and supplies provided by owners with a substantial financial interest.

OAS; W-00-98-30014; A-03-98-00000
Expected Issue Date: FY 1998

Nursing Home Care After Less Than 3-Days of Hospitalization

This review will determine if payments 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. We plan to use HCFA's automated data to identify nursing homes in Illinois where the existence of this condition is indicative of potential abuse.

OAS; W-00-98-30014; A-05-98-00000
Expected Issue Date: FY 1998

Mental Health Services in Nursing Facilities: A Follow Up

We will determine the continued existence of vulnerabilities to Medicare resulting from the expanded provision of mental health services to nursing facility residents. In a 1996 OIG study, we found medically unnecessary or questionable Medicare mental health services in nursing facilities in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent inappropriate payments for these services, such as developing guidelines for carriers, developing screens to implement these guidelines, and conducting focused medical review and providing physician educational activities. This study will determine whether mental health services in nursing facilities continue to be inappropriately billed. Our work will be coordinated with that on outpatient mental health care.

OEI; 00-00-00000
Expected Issue Date: FY 1999

HOSPICE

Hospice and Hospital/Skilled Nursing Facility Overpayments

This 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-02-96-01047
Expected Issue Date: FY 1998

Part B Payments

We 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 1998

Hospice Reimbursement Rates

This review will examine the basis for periodic adjustments to hospice rates. Hospices are reimbursed by Medicare using a capitated daily reimbursement rate, with geographical variations. The rates were set by HCFA in the 1980s and they are adjusted upward periodically. We will determine the basis for the rates and their reasonableness.

OAS; W-00-98-30014; A-05-98-00000
Expected Issue Date: FY 1998

PHYSICIANS

Physicians at Teaching Hospitals (PATH)

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

OAS; W-00-96-30021; A-03-96-00006
Expected Issue Date: FY 1998 and FY 1999

Physician Perspectives on Medicare HMOs

This study will determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs). The OIG has issued numerous reports on Medicare HMOs over the past several years. Some of these reports have raised concerns with the impact of HMOs on the access and quality of

health care provided to Medicare beneficiaries. These previous studies have surveyed only Medicare HMO enrollees and administrators. This study will obtain the perspectives of another important player in the Medicare HMO industry, the physician.

OEI; 02-97-00070
Expected Issue Date: FY 1998

Physician Certification of Durable Medical Equipment

This study will assess how effectively physicians are meeting Medicare expectations that they act as controls against unnecessary use of non-physician services and supplies. This study will build on our work assessing the physician's role in home health (OEI-02-94-00170) and in completing certificates of medical necessity (OEI-03-96-00010). We will identify common obstacles and successes in ensuring that physicians perform this important service.

OEI; 00-00-00000; 00-00-00000
Expected Issue Date: FY 1998

Hospital Ownership of Physician Practices

We will assess Medicare billing practices and utilization when hospitals own physician practices. In recent years, integration in the health care marketplace has included hospital purchases of physician practices. Vulnerabilities may include inappropriate referrals (in either direction) between hospitals and physicians, excessive costs and billings, and overutilization of services when hospitals bill the Medicare program through physician practices they own.

OEI; 04-97-00090
Expected Issue Date: FY 1998

Accuracy of and Carrier Monitoring of Physician Visit Coding

We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for

evaluation and management services. Generally, the codes represent type and complexity of services provided, and patient status, such as new or established. Previous work by the OIG has found that physicians are not accurately or uniformly using visit codes. This analysis will build upon this previous work and add more definitive data regarding the accuracy of physician visit coding.

OEI; 00-00-00000; OAS; W-00-98-30021; A-04-98-00000;
Expected Issue Date: FY 1998

Use of Surgical Modifier

We will determine whether physicians are improperly using modifier 25 on their Medicare Part B claims to increase reimbursements. Modifier 25 is for physicians to claim "Significant, Separately Identifiable Evaluation and Management Service on the Day of Surgery"--the key words being "Separately Identifiable."

OAS; W-00-98-30021; A-04-98-00000
Expected Issue Date: FY 1998

Physician and Other Service Provider Use of Diagnosis Codes

This review will examine a sample of services paid by Medicare. By comparing Medicare claims to beneficiary medical records, a medical reviewer will determine the extent to which diagnosis codes on claims match the reason for ordering and providing various services. In a previous report entitled "Imaging Services for Nursing Facility Patients: Medical Necessity and Quality of Care" (OEI-09-95-00092), we found that physicians and other providers of imaging services do not follow HCFA's guidance on use of diagnosis codes.

OEI; 00-00-00000
Expected Issue Date: FY 1998

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-00-98-30021
Expected Issue Date: FY 1998

Multiple Discharges

We will determine whether duplicate payments have been made for day of discharge patient management services. Discharge day management can only be billed by the admitting physician. In one State, we have noted examples where two or more physicians are billing for discharge day management for the same beneficiary admission. We will develop a computer application to identify those beneficiaries whose discharge day management was billed by more than one physician during a single inpatient stay.

OAS; W-00-98-30021; A-03-98-00000
Expected Issue Date: FY 1997

Anesthesia Services

This review will identify anesthesiologists who bill for personally performed services and determine if these services were in compliance with Medicare regulations. We found several instances where anesthesiologists were improperly billing for supervising residents in three or more operating rooms at the same time.

OAS; W-00-98-30021; A-03-98-00000
Expected Issue Date: FY 1999

Critical Care Services

This review will focus on those providers who incorrectly bill Medicare for critical care based on the location of the patient and not the actual services provided by the physician. Critical care is that requiring the constant attention of the physician. It is usually, but not always, provided in a critical care area, such as a coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Physician

services for patients who are not critically ill but happen to be in a critical care unit are to be claimed using "subsequent care" hospital codes.

OAS; W-00-98-30021; A-03-98-00-00000
Expected Issue Date: FY 1999

Billing for Services Rendered By Physician Assistants

We will determine whether physicians are improperly billing for services rendered by physician assistants. Medicare allows physician assistants to render certain services as "incident to" services, which are billed by the employing physician as if the service was personally rendered by the physician. However, if the services do not fall under the "incident to" criteria, the employing physician must bill using a modifier which reduces the Medicare payment. Medicare is overpaying physicians who improperly bill physician assistant services as "incident to" rather than using the proper modifiers.

OAS; W-00-97-30021; A-06-97-00047
Expected Issue Date: FY 1998

Billing Service Companies

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

OAS; W-00-97-30021; A-06-97-00044
Expected Issue Date: FY 1998

Improper Billing of Psychiatric Services

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

OAS; W-00-97-30021; A-06-97-00045
Expected Issue Date: FY 1998

MEDICAL EQUIPMENT AND SUPPLIES

Allowances for Wound Care

This review will follow up our earlier work (Questionable Medicare Payments for Wound Care Supplies (OEI-03-94-00790) which identified $65 million in questionable allowances for wound care between June 1994 and February 1995. As a follow up, we will determine the impact of new Medicare guidelines on questionable allowances for wound care supplies in 1996. We will identify and analyze 1996 claims that exceed the established parameters. Suppliers who submit questionable claims will also be identified.

OEI; 03-94-00793
Expected Issue Date: FY 1998

Reimbursement for Diabetic Shoes

This review will determine the appropriateness of supplier billings for diabetic shoes. Medicare beneficiaries with diabetes have an increased risk of developing foot problems which could lead to amputation. Effective May 1, 1993, Medicare covers therapeutic shoes and related footwear designed to prevent the occurrence of serious foot problems. Medicare payments for such footwear have been increasing rapidly.

Preliminary allowances for 1996 climbed to more than $12 million, an increase of over 20 percent from 1995 figures. Because of this rapid increase, we will review program expenditures in this area to determine if abusive billings are occurring.

OEI; 03-97-00300
Expected Issue Date: FY 1998

Medical Necessity of Oxygen

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

OEI; 03-96-00090
Expected Issue Date: FY 1998

Orthotic Body Jackets

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

OEI; 04-97-00390
Expected Issue Date: FY 1998

Comparison of Payers for Hospital Beds

This study will compare Medicare payment methodologies and reimbursement levels for hospital beds with rates paid for the same items by other payers, e.g., other Federal programs, State Medicaid agencies, private insurance plans, managed care organizations. Information about rates and payment methodologies will be obtained from other payers and analyzed in relation to Medicare payments to determine

whether Medicare is paying excessively. The data will also be used to calculate potential savings of alternative reimbursement approaches. This study follows up work in progress analyzing Medicare payments for hospital beds under the capped rental methodology.

OEI; 07-96-00021
Expected Issue Date: FY 1998

Operations of Durable Medical Equipment Carriers

We will assess whether the establishment of the durable medical equipment regional carriers has met its 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, replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of these regional carriers with respect to medical guidelines, oversight of claims processing, and detection and referral of fraudulent activity.

OEI; 04-97-00330
Expected Issue Date: FY 1998

Durable Medical Equipment Credit Balances

This review will determine whether durable medical equipment providers 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-00-98-30007; A-04-98-00000
Expected Issue Date: FY 1998

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 strengthened quality standards under the Public Health Service Act and extended these requirements to all entities performing laboratory testing, including those in physicians' offices.

OEI; 05-92-01020
Expected Issue Date: FY 1998

Utilization of Laboratory Services

This study will review trends in utilization of Medicare laboratory services. We will review these changes in light of the Clinical Laboratory Improvement Amendments of 1988, new laboratory test procedures, changes in physician fee schedules and growth in managed care. We will also look at possible mechanisms that can be effectively used to control utilization, including bundling of services into physician office visit reimbursement. Such a proposal was advocated in a 1991 OIG report and was estimated to save $12 billion over 5 years.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Fraud and Abuse in Cytology Laboratories

This review will assess the extent that cytotech workload records may be falsified and the reliability of laboratory procedures in workload record keeping. The Clinical Laboratory Improvement Amendments of 1988 imposed strict limits on the number of cytology slides that could be read in a day. No more than 100 slides can be read by one person in a 24-hour period. This review is being undertaken at the request of

HCFA officials because they have found through their inspection activity that the limit is being circumvented.

OEI; 02-95-00290
Expected Issue Date: FY 1998

Claims for Outpatient Hospital Laboratory Services

This follow-up review will determine the adequacy of procedures and controls used by 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-00-98-30011; A-01-97-00000
Expected Issue Date: FY 1998

Independent Physiological Laboratories

This review will identify program vulnerabilities associated with independent physiological laboratories and explore ways to safeguard the Medicare program from fraudulent and abusive providers. Concerns about improper billing by independent physiological laboratories include upcoding, performance of medically unnecessary services, billing for services not rendered and billings by questionable providers. We will analyze claims and related data associated with a sample of providers to determine whether the providers are legitimate and whether the claims meet other criteria for reimbursement.

OEI; 05-97-00240
Expected Issue Date: FY 1998

END STAGE RENAL DISEASE

Epogen Reimbursement Relating to Hematocrit Levels

This review will determine whether HCFA's new policy on hematocrit levels will be effective in controlling the escalating cost to Medicare of the drug Epogen (EPO). EPO is a Medicare-covered drug used in the treatment of anemia associated with chronic renal failure. The HCFA recently issued a program memorandum (AB-97-2) which restricts payments for EPO when a patient's hemocrit reading exceeds a certain level.

OAS; W-00-98-30025; A-01-98-00000
Expected Issue Date: FY 1998

Dialysis Supply Kits

This study will determine whether Medicare payments for dialysis supply kits are appropriate. Medicare has created a separate benefit category known as "dialysis supplies and equipment" for beneficiaries who qualify for Medicare because they suffer from end stage renal disease. Such supplies and equipment are covered for patients who receive dialysis at home under the supervision of a Medicare-approved dialysis facility. In 1996, Medicare allowances for the two major procedure codes representing dialysis supply kits are projected to exceed $150 million for the year.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Bad Debts - Nationwide Chain

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 the Provider Reimbursement Manual. Under Medicare's composite rate reimbursement system, ESRD 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. Further, 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-00-98-30025; A-01-98-00000
Expected Issue Date: FY 1998

Dialysis Procedure/Evaluation and Management Code Double Billing

We will determine if renal/nephrology physicians are billing for a dialysis evaluation on the same day that they bill for evaluation and management services. The Medicare Carriers Manual states that a dialysis procedure cannot be paid on the same day as evaluation and management services, unless the services are unrelated to the dialysis, as dialysis and any related physician services are included in the monthly capitation payment. We will study this area to determine the significance of this issue.

OAS; W-00-98-30025; A-03-98-00000
Expected Issue Date: FY 1999

DRUG REIMBURSEMENT

Medicare Licensing Requirements for Drug Suppliers

This review will determine if entities that bill for providing drugs and similar medications to Medicare beneficiaries meet the required licensing requirements. Effective December 1, 1996, HCFA issued a new policy requiring entities which bill for providing drugs to Medicare patients to have pharmacy licenses. Previously, suppliers could bill the Medicare program for providing drugs even though they did not have pharmacy licenses in accordance with applicable State laws. Many suppliers had agreements with pharmacies to dispense the drugs, but the suppliers did the actual billing. The new policy was developed, in part, because of questionable practices encountered in South Florida.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Medicare Nebulizer Drugs

We will determine the extent to which durable medical equipment suppliers have either paid or received referral fees to or from other equipment suppliers for filling Medicare nebulizer drug prescriptions. We have identified some of these suppliers and referred them to our investigative staff. We will determine whether other suppliers have entered into similar arrangements.

OAS; W-00-98-30024; A-06-96-00048; A-06-96-00067; A-06-96-00068; A-06-97-00036; A-06-97-00042
Expected Issue Date: FY 1998

OTHER MEDICARE SERVICES

Medicare Beneficiary Satisfaction: 1997

This review will assess Medicare beneficiary satisfaction with the administration of the program, including timely processing of claims, response to inquiries, understanding of coverage and payment policies, and use of publications. This is the sixth such survey which can be used as a measurement of the program's performance in serving its clients. Previous surveys have shown generally high levels of satisfaction with the Medicare program.

OEI; 04-97-00030
Expected Issue Date: FY 1998

Comparison of Ambulance Reimbursement Policies

We will contact different payers (e.g., fee for service, contracts, health maintenance organizations, preferred provider organizations) to identify how much these groups are reimbursing ambulance suppliers for services. We will compare this data with Medicare reimbursement for the same services in similar geographic areas and use all

data to project savings for the geographic areas. Our recent studies of Medicare ambulance services have raised concerns that Medicare allowances may be excessive.

OEI; 09-95-00411
Expected Issue Date: FY 1998

Medical Necessity, Quality of Care, and Reimbursement of Ambulance Services

We will assess potential policy issues and the appropriateness of payments for ambulance services provided to Medicare beneficiaries through a sample of claims paid in 1996. In 1995, Medicare Part B paid approximately $2.0 billion for ambulance services. We will target high-volume providers who have billed at least 50 percent of their services associated with emergency room care (without subsequent inpatient admission), transportation to or from physicians' offices, or unexplained destinations.

OEI; 09-95-00412
Expected Issue Date: FY 1998

Scheduled Ambulance Transports of Beneficiaries With End Stage Renal Disease

This study will determine whether Medicare Part B's payment system takes advantage of the predictable nature of some ambulance transport for beneficiaries, e.g., those with end-stage renal disease. Persons with end stage renal disease must have dialysis treatments at least three times per week in order to survive. Under Medicare Part B, ambulance transport to dialysis facilities is covered if other forms of transport would endanger the beneficiary's health. The 1995 allowed charges for ambulance transports for beneficiaries with end stage renal disease were $183.5 million. This study will follow-up previous OIG work which found that payments for dialysis-related ambulance claims were based on an outmoded payment system.

OEI; 00-00-00000
Expected Issue Date: FY 1998

OIG-Excluded Providers

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

OEI; 00-00-00000
Expected Issue Date: FY 1998

Administrative Law Judges' Decisions

We will review the Medicare claims process, including the mechanism by which beneficiary claim denials are aggregated for appeal before Administrative Law Judges. An Administrative Law Judge is empowered to reverse a carrier denial of a claim or group of similar claims, resulting sometimes in substantial post-denial payments to providers and suppliers. Such reversals occur in 70 percent of the appeals submitted to these judges. Under existing laws, the Medicare program has limited recourse to appeal the decision of an Administrative Law Judge.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Inappropriate Anesthesiology Claims

This review will assist the Office of Investigations to determine whether the Medicare program has been inappropriately charged for anesthesiology services. The intermediary is concerned that a provider's billing practices for services furnished by

Certified Registered Nurse Anesthesia (CRNA) and the related costs included in its cost reports has resulted in double billing to the Medicare program.

OAS; W-04-97-30018; A-04-97-01167
Expected Issue Date: FY 1998

MEDICARE MANAGED CARE

Cost Data for HMOs

This review will focus on the verification and analysis of data used in the development of the adjusted community rates proposed by risk-based health maintenance organizations (HMO). This 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-04-97-30012; A-04-97-01164
Expected Issue Date: FY 1998

General and Administrative Costs

This review will determine if the administrative costs allocated for Medicare beneficiaries enrolled in risk-based health maintenance organizations (HMO) are proper. General and administrative costs include costs associated with enrollment, marketing, membership costs, directors salaries and fees, executive and staff administrative salaries, organizational costs and other plan administrative costs. Inflated general and administrative costs could increase plan profits 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. A cap on these costs would require legislative action.

OAS; W-00-98-30012
Expected Issue Date: FY 1998

Payments Based on Institutional Status

This review will determine if HCFA is making proper capitation payments to risk-based health maintenance organizations (HMO) for beneficiaries classified as institutionalized. Risk-based HMOs are paid based on a prospectively determined capitation rate. However, a higher capitation rate is paid for beneficiaries classified as institutionalized. Preliminary findings indicate that HCFA's 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-00-98-30012; A-10-98-00000
Expected Issue Date: FY 1998

Beneficiaries in Institutions in Ohio

We will review two large risk-based HMOs in Ohio to determine if Medicare beneficiaries reported as institutionalized actually were in institutions during periods when the HMOs received enhanced rate payments from Medicare. Medicare pays a higher capitation rate to risk-based HMOs for beneficiaries who are institutionalized. In a nationwide study of such HMOs, we have identified numerous Medicare beneficiaries who were incorrectly classified as institutionalized resulting in Medicare overpayments.

OAS; W-00-98-30012; A-05-98-00000
Expected Issue Date: FY 1998

Hospital Billings for Beneficiaries in HMOs

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-00-98-30012; A-07-98-00000
Expected Issue Date: FY 1998

Enrollee Access To Emergency Services

This study will determine if existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. Two OIG enforcement authorities are relevant: the so-called "anti-dumping" law and the Medicare/Medicaid health maintenance organization sanction authorities. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or reject a person who comes to the emergency room. The health maintenance organization sanctions protect Medicare and Medicaid beneficiaries from health maintenance organizations' unreasonable refusal to provide needed care. Violation of either protection may result in sanctions, including penalties and program exclusion. This study will examine whether the reach of these Federal enforcement authorities adequately protects patients who need and seek emergency care but are prevented from receiving such care by operations of managed care rules and hospital policies.

OEI; 00-00-00000
Expected Issue Date: FY 1998

End Stage Renal Disease Beneficiaries

This study will describe and assess the experiences of end stage renal disease beneficiaries in risk-based health maintenance organizations and whether their experience differs significantly from that of fee-for-service patients. Based on a 1993 OIG study of beneficiaries enrolled in or recently disenrolled from risk-based health maintenance organizations, disabled/end stage renal disease Medicare beneficiaries indicated that they experienced more enrollment and service access problems than their aged counterparts. Specifically, 39 percent said their health maintenance organization doctors failed to provide Medicare services when needed. These findings raise serious concerns about the responsiveness of health maintenance organizations when confronted with patients with this condition.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Disabled Medicare Beneficiaries

This study will describe and assess the experiences of disabled Medicare beneficiaries with risk-based health maintenance organizations. In 1993, about 3000 Medicare beneficiaries who were enrolled in, or recently disenrolled from, risk-based health maintenance organizations, responded to our survey on their health maintenance organization experiences. We had focused primarily on their enrollment and access to services. The responses of disabled Medicare beneficiaries, who comprised a sub-group of those surveyed, indicate that they may experience more enrollment and service access problems than their aged counterparts. Specifically, we reported that such disenrollees most often reported service access problems in several crucial areas of their health maintenance organization care.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Quality-of-Care Safeguards

This study will assess the fraud and abuse and quality-of-care safeguards that health maintenance organizations with Medicare contracts use in managing their provider networks. As of March 1, 1997, 5.1 million Medicare beneficiaries were enrolled in 368 managed care plans. About 70 percent of these plans are independent practice network arrangements in which an health maintenance organization contracts with physician groups, individual physicians, physician-hospital organizations, or other emerging entities for the provision of health care services. Many providers contract with multiple health maintenance organizations. To further complicate matters, mergers and buy outs of health maintenance organizations are occurring with increasing frequency, leading to further changes in network arrangements. As Medicare changes from a simple reimbursement program to one based on prudent purchasing of care in a health care marketplace, it must understand the contractual relationships between managed care organizations and their providers.

OEI; 00-00-00000
Expected Issue Date: FY 1998

National Marketing Guidelines for Medicare Managed Care Plans

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

OEI; 00-00-00000
Expected Issue Date: FY 1998

Physician Incentive Plans in Managed Care Contracts

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

OEI; 00-00-00000
Expected Issue Date: FY 1998

HMO Disenrollment

This review will examine HMO disenrollments to determine if HMOs are using prohibited practices to encourage unhealthy individuals to disenroll from their plans. Having unhealthy beneficiaries disenroll from their plans increases HMOs'

profitability. This review will identify both systemic problems and individual HMOs for an indepth audit of their enrollment/disenrollment practices.

OAS; W-00-97-30012; A-07-97-01200
Expected Issue Date: FY 1998

Medicare Beneficiary Experiences in HMOs

This study will update prior OIG work which obtained information directly from current Medicare enrollees and recent disenrollees from risk-based health maintenance organizations. We will ask beneficiaries about their experiences in obtaining appointments, access to specialist care, and other such experiences.

OEI; 06-95-00430
Expected Issue Date: FY 1998

Medicare HMO Beneficiaries Who Enroll in Hospice Care

We will determine whether Medicare HMOs hospice beneficiary eligibility determinations are proper and HMO payments are suspended timely. Health maintenance organizations participating in risk based Medicare contracts receive capitated rates for each enrollee. Only terminally ill patients are eligible to be enrolled in hospice care. Payments to the HMO on behalf of a Medicare enrollee who has elected hospice care are to be suspended, except for the portion of the payment applicable to additional benefits provided by the HMO contractor. By shifting non-terminally ill patients to hospice care or failing to suspend hospice enrollees timely, the HMO could overbill the Medicare program.

OAS; W-00-98-30012
Expected Issue Date: FY 1998

Medicare Payments to HMOs for Medicaid-Eligible Beneficiaries

This review will determine if any HMOs have submitted data to HCFA to increase their captation payments by claiming that Medicare beneficiaries were also eligible for Medicaid when they knew the information was not correct. The amount that Medicare pays HMOs for Medicare beneficiaries who are also eligible for Medicaid is higher than the amount it pays for beneficiaries in general. In November 1996, we

reported to HCFA that as much as $15 million may have been paid to HMOs in enhanced capitations payments for beneficiaries that were not eligible for Medicaid as reported by HMOs. Various investigative units are interested in this ongoing review.

OAS; W-04-97-30012; A-04-97-01154
Expected Issue Date: FY 1998

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

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

OAS; W-00-98-30012; A-06-98-00000
Expected Issued Date: FY 1998

HMO Costs, Revenue, and Profit

We will examine the overall profitability of a large HMO that has contracts with both Medicare and Medicaid. The study will include an analysis of costs and revenue by line of business and the overall profit or loss realized by the contractor for a defined period. The review will focus on an organization's profitability rather than issues covered in other reviews of risk contractors (i.e., reimbursement rate determinations concentrating on HCFA's rate setting procedures).

OAS; W-00-98-30012
Expected Issue Date: FY 1998

MEDICAID MANAGED CARE

Waivers for Persons with HIV/AIDS

This review will determine the impact of Medicaid managed care waivers granted to States for special services 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 in managed care settings. This study would determine the initial impact that these waivers have had on access to care, cost savings, and linkage with other programs, especially the Ryan White program.

OEI; 05-97-00210
Expected Issue Date: FY 1998

Impact on Mental Health Services

We will provide a preliminary description of the impact of managed care on the delivery of mental health services to the Medicaid population. State Medicaid programs are increasingly adopting managed care approaches. This study will gather information on how the managed care approach has affected: the number and types of services available to adults with serious mental illnesses and children with serious emotional disturbances; the mental health delivery systems (prior approval, limits on services, etc); and standards and performance measures.

OEI; 04-97-00340
Expected Issue Date: FY 1998

Helping Medicaid Recipients Make Informed Choices

We will assess HCFA's efforts to inform Medicaid recipients about managed care plans. There is widespread agreement that, like all consumers, Medicaid recipients need better information about the choices available to them between fee-for-service medicine and managed care, and among managed care health plans. We will review the types of information that HCFA provides to recipients and the methods used to

disseminate this material. In addition, we will assess its usefulness to recipients as they choose their health care coverage.

OEI; 00-00-00000
Expected Issue Date: FY 1998

MEDICAID REIMBURSEMENT

Medicaid Outreach & Eligibility Determinations Under Welfare Reform

We will evaluate States' use of administrative funds to enroll eligible children in the Medicaid program. While expressing the intent to preserve Medicaid eligibility for low-income eligible families, the automatic eligibility linkage to Medicaid through Aid to Families with Dependent Children was eliminated under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. However, enhanced matching funds are available to States for administrative costs for Medicaid eligibility determinations, up to a fixed national cap of $500 million. We will determine how States are using their administrative funds to support their Medicaid outreach and eligibility determination processes following implementation of the Act.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Outpatient Detoxification Services

This study will examine the linkage between detoxification services and further treatment in both inpatient and outpatient settings. Detoxification services are usually delivered to Medicaid recipients in hospitals or other residential facilities. Because of the high cost, some States (and many national private sector health insurance providers) have begun to cover some of these detoxification services in outpatient settings. Though some question the appropriateness of this, others believe this approach may be beneficial in motivating some clients into further treatment, breaking the "revolving door" sometimes associated with detoxification for some clients. In addition, the study will examine the appropriateness and cost-saving

nature of this policy. We will study how this policy has been implemented in the four States where this is being done and assess the implications for other States.

OEI; 07-97-00270
Expected Issue Date: FY 1998

Targeted Case Management

We will assess States' implementation of Medicaid targeted case management. States may provide this as an optional service under Medicaid. States have provided these services to special populations, including pregnant women, the chronically mentally ill, individuals infected with HIV, and persons with developmental disabilities. It is unclear how States have incorporated this program with other authorities for providing case management services. There are also concerns about compliance with certain regulations under the targeted case management options.

OEI; 00-00-00000
Expected Issue Date: FY 1999

Routine and Postpartum Care for Undocumented Aliens

This review will determine if States are incorrectly paying for routine prenatal and postpartum care to undocumented aliens. This review follows up one 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; 07-96-00310
Expected Issue Date: FY 1998

Adjustments to Medicaid Claims for Prior Quarters

We will determine whether a State's quarterly adjustments to Medicaid expenditures are allowable and adequately supported by financial records. A review of the State's

March 31, 1997 quarterly medical assistance claim disclosed substantial increases to Medicaid claims. We will determine the propriety of these adjustments.

OAS; W-00-98-30013; A-05-98-00000
Expected Issue Date: FY 1998

School-Based Medicaid Outreach Services

We will review the propriety of the costs claimed and the methodology used to accumulate and allocate the costs to the Medicaid program for school-based outreach services. Recently, there has been an increasing interest in securing reimbursement for Medicaid outreach activities provided by public education entities, such as, intermediate school districts. School based services are claimed for reimbursement at 90 percent Federal sharing for family planning, 75 percent for skilled professional medical services, and 50 percent for the remaining services. Costs are charged to the Medicaid program utilizing random time studies designed by CPA firms which reportedly receive a percentage of the reimbursements. During FY 1996, the one State's Medicaid Program claimed $30 million for these school-based services.

OAS; W-00-98-30013; A-05-98-00000
Expected Issue Date: FY 1998

Patients of Institutions for Mental Diseases

We will determine whether hospitals are still operating as institutions for mental diseases and submitting unallowable claims for Medicaid reimbursement. Federal law does not allow Medicaid reimbursement for services to individuals between the ages of 22 and 65 in institutions that primarily treat mental diseases. A State agency identified three hospitals in FY 1989 that, in its opinion, were operating as such institutions and submitting unallowable claims for Medicaid reimbursement. The Congress, however, wanted more information regarding the exclusion. It placed a moratorium on treating these hospitals as institutions for mental diseases until the Secretary provided the Congress with a report on the issues involved. The moratorium expired on December 31, 1995.

OAS; W-00-98-30013; A-05-98-00000
Expected Issue Date: FY 1998

Medicaid Drug Rebates

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. The Omnibus Budget Reconciliation Act of 1990 required drug 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.

OAS; W-00-98-30023; A-06-97-00032
Expected Issue Date: FY 1998

Basing Drug Rebates on Average Wholesale Price

This review will examine the potential savings which could be realized by requiring drug manufacturers to pay Medicaid drug rebates based on average wholesale price. Currently, rebates are based on the average manufacturers price paid by wholesalers for drugs distributed to the retail pharmacy class of trade. Most states reimburse for drugs based on a percentage of the wholesale price. The results of this review will establish a much needed connection between the calculation of Medicaid drug rebates and the calculation of Medicaid's reimbursement for drugs at the pharmacy level.

OAS; W-06-97-30023; A-06-97-00052
Expected Issue Date: FY 1998

A State's Pursuit of Medicaid Drug Rebates

We will assess a State's effectiveness in pursuing drug rebates. The drug rebate program is mandated by the Omnibus Budget Reconciliation Act of 1990. Under the program, drug labelers are required to rebate part of the drug price to the Medicaid agencies for drugs purchased through Medicaid. A State audit showed that the State was not properly pursuing and accounting for rebates.

OAS; W-00-97-30023; A-06-97-00032
Expected Issue Date: FY 1998

Medicaid Coverage of Chiropractic Benefits

The chiropractic benefit available to Medicaid beneficiaries differs from State to State, ranging from some States that do not offer any coverage for chiropractic care to some that offer substantial benefits. An increasing number of States are offering chiropractic care as part of their package of Medicaid benefits. This study will determine the level of chiropractic benefits which are currently provided Medicaid beneficiaries by each of the various State Medicaid programs.

OEI; 00-00-00000
Expected Issue Date: FY 1998

MEDICARE CONTRACTOR OPERATIONS

Preaward Reviews of Medicare Contractors

At the request of HCFA's contracting officers, we will review costs proposed by various prospective Medicare contractors. Prior preaward reviews have enabled HCFA to negotiate contract amounts which were much less than proposed.

OAS; W-00-98-30006; Various CINs
Expected Issue Date: FY 1998

Peer Review Organization Closeout Audits

This series of reviews requested by HCFA will determine the allowability of costs claimed by peer review organizations under contracts for "fourth round" contract activities. Audits of claimed costs will be performed by independent public accounting firms. We will assist HCFA as co-project officer for these 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-00-98-30004; Various CINs
Expected Issue Date: FY 1998

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 closeout audits of the peer review organizations.

OAS; W-00-98-30004; Various CINs
Expected Issue Date: FY 1998

Quality Improvement Projects for Medicare PROs

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 contract 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. We will assess the nature and source of quality improvement projects undertaken by the PROs and the projects' results.

OEI; 00-00-00000
Expected Issue Date: FY 1998

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-00-98-30004; Various CINs
Expected Issue Date: FY 1998

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-00-98-30005; Various CINs
Expected Issue Date: FY 1998

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-00-98-30005; Various CINs
Expected Issue Date: FY 1998

Fiscal Intermediary Fraud Units

This national study will evaluate the fraud control activities of Medicare's fiscal intermediaries, the contractors that process Part A claims and perform payment safeguard functions. The contractors fraud units are responsible for developing and referring cases to the OIG for recovery of maximum dollars possible through judicial and administrative processes. We will examine fiscal intermediaries' fraud control procedures and outcomes, including the amount of overpayments identified, number of referrals to the OIG for fraud investigations, and usefulness of referrals to the OIG. We will also review HCFA's oversight of fiscal intermediary fraud units.

OEI; 03-97-00350
Expected Issue Date: FY 1998

Medical Review

This study will assess how contractors are using medical review to deal with potential problem areas. Medicare carriers are using this approach to conduct much of their post payment reviews. Since physicians account for the majority of payments under Medicare Part B, much of the carriers' activity is expected to focus on this group. This study, following up on prior studies on Medicaid fraud control units and carrier fraud units, will assess how focused medical reviews are being performed by the carriers, what corrective actions are being pursued, and what educational interventions and/or referrals for fraud investigation are resulting from these activities.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Mutually Exclusive Medical Procedures

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

OAS; W-00-98-30003
Expected Issue Date: FY 1998

Duplicate Billings for Outpatient Services

We will determine the extent of duplicate billings resulting from outpatient claims being submitted to both intermediaries and carriers. Hospitals, nursing homes and other institutions (Part A providers) certified by the Medicare program submit their claims for reimbursement to intermediaries. Physicians, independent clinical laboratories and other (Part B) suppliers of services submit their claims for

reimbursement to carriers. We will assess vulnerabilities in the current systems that may lead to bills for some services being submitted to and paid by both.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Duplicate Billings for Home Health Equipment

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

OEI; 00-00-00000
Expected Issue Date: FY 1998

Fair Hearing Review Thresholds

This study will update previous OIG work which identified management efficiencies and savings that could be attained if fair hearing review thresholds were amended to be indexed to inflation. Currently, a beneficiary enrolled under Part B is entitled to a fair hearing if the claimed amount (one or combination of claims) is $100 or more, or if payment is not made promptly and a hearing request is filed within 6 months of the initial notice. These provisions were enacted in 1973. No changes to the thresholds have been made since that time.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Medicare's Correct Coding Initiative

We will evaluate Medicare's correct coding initiative, which is designed to improve the accuracy of Part B claims processed by Medicare carriers. Physicians use the HCFA common procedure coding system to bill Medicare for services provided to beneficiaries. We will evaluate the effectiveness of the initiative in detecting improper billings, and whether carriers are uniformly adopting practices being promoted by the initiative.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Provider Billing Numbers Issued to Resident Physicians

We will assess the extent of improper Medicare billings resulting from a control problem we noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities at another institution separate from the institution where the resident is pursuing his/her medical studies. We noted that a hospital in one State requested and received over 40 billing numbers for their residents over a 6 year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. We will determine the extent of this condition at the carrier in this State and other carriers.

OAS; W-00-98-30003; A-05-98-00000
Expected Issue Date: FY 1998

Control of Chiropractic Benefits

Chiropractic claims are one of the more frequently billed services to Medicare. While chiropractic benefits are not currently provided by all State Medicaid programs, an increasing number of States are preparing to offer these benefits. Due to the nature of the services, distinguishing between acute care (which is generally covered) and preventive care (which is not covered by Medicare and seldom covered by Medicaid) is difficult, creating control problems for Medicare carriers, State Medicaid agencies and private insurers. This study will identify the extent and nature of the control

problems and identify the mechanisms used by Medicare carriers, Medicaid agencies and private insurers to control the use of chiropractic benefits and to prevent fraud and abuse. In addition, this study will highlight the most effective control mechanisms currently in use.

OEI; 00-00-00000
Expected Issue Date: FY 1998

GENERAL ADMINISTRATION

Medicare as Secondary Payer

This study will assess the effectiveness of current procedures in preventing inappropriate Medicare payments when beneficiaries have other insurance that is required to pay primary. A 1991 OIG report found that inappropriate Medicare secondary payer payments totaled more than $637 million in 1988 and identified several leading causes. In addition to repeating the 1991 study, we will review the consistency of secondary payer provisions and determine whether standardization would facilitate the implementation of the provisions.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Medicare Secondary Payer Oversight

We will follow-up on HCFA's resolution of an OIG recommendation relating to the employer compliance with the Medicare secondary payer (MSP) Data Match Project. Our earlier report recommended that HCFA take action against employers that failed to provide the necessary employer group health plan information needed for the Data Match Project. In addition, a major insurance association agreed to a global settlement with the Department of Justice and HCFA to settle disputes over secondary payer claims. As part of the settlement, the association started a 3-year data exchange agreement with HCFA. Our review will examine what action HCFA is taking to

secure data exchange agreements with the association beyond the 3-year settlement and with other insurance companies not covered by the agreement.

OAS; W-00-98-30003
Expected Issue Date: FY 1998

Physician Referrals to Self-Owned Laboratory Services

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

OEI; 09-97-00250
Expected Issue Date: FY 1998

Medicare Part B Billings By State Owned Facilities

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

OAS; W-00-98-30030
Expected Issue Date: FY 1998

Joint Work With Other Federal and State Agencies

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and Inspectors General, Medicaid agencies, and HCFA financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate

program, and durable medical equipment. Future joint initiatives will cover managed care issues, hospital transfers, prescription drugs, laboratory services, non-physician outpatient services, and nursing home services. In addition, we will continue to work with the National State Auditors Association on a joint audit of long-term care in six States. Potential audit areas include evaluating the licensing and inspection of nursing homes and the reimbursement system.

OAS; W-00-98-30001; Various CINs
Expected Issue Date: FY 1998

Sharing of Medicaid and Medicare Audit Findings

This review will examine the information sharing process for audits of nursing homes that are conducted by State auditors for Medicaid purposes and by fiscal intermediaries' auditors for Medicare purposes. In a survey in one State, we found that the State's auditors and the intermediary auditors were not consistently sharing audit results. Consequently, overclaims by nursing homes went undetected. We will determine if similar problems are occurring in other States.

OAS; W-00-98-30030
Expected Issue Date: FY 1998

MEDICARE TRANSACTION SYSTEM

Our Information Resource Management reviews in FY 1998 will focus on the Medicare Transaction System. This system is intended to be a single, integrated claims/transaction processing system which HCFA anticipates will be implemented over the next 5-7 years. The overall initiative includes several separate projects. We anticipate the following work in FY 1998.

Medicare Transaction System Implementation - Phase II

Our continued monitoring of the Medicare Transaction System will cover system design and development as well as, HCFA's millennium planning for conversion, use of transition systems and implementation of new system components. Our review

will focus on the capabilities being built into MTS to help Medicare better detect and deter fraud and abuse.

OAS; W-00-98-30008
Expected Issue Date: FY 1998

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. We will also determine the degree to which Medicare's use of the new system meets the requirements for a uniform provider numbering system as called for in the recently signed Health Insurance Portability and Accountability Act. Our review will include a determination of the extent previously identified weaknesses in Medicare provider enumeration are addressed.

OAS; W-00-98-30008
Expected Issue Date: FY 1998

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-00-98-30008
Expected Issue Date: FY 1999

Electronic Data Interchange in Medicare

This series of reviews will continue prior OIG electronic data interchange work including review of: (1) the adequacy of Medicare participation agreements to assure provider and plan accountability, particularly where third parties (e.g., billing services and claims clearinghouses) are involved; (2) the effectiveness of HCFA's promotional efforts (provider/plan training and outreach); (3) opportunities for increased/more effective use of electronic data interchange (particularly for electronic funds transfers and remittances); and (4) the degree to which standardization of electronic interchange is being used to facilitate collection of essential Medicare program management data.

OAS; W-00-98-30008
Expected Issue Date: FY 1999

INVESTIGATIONS

The OIG's Office of Investigations 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.

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.

Incontinence Care Fraud - Project “04"

As part of OIG efforts to reduce questionable allowances for incontinence care product billings and prosecute suppliers involved in such billings, the Office of Investigations launched a national investigation known as the Incontinent Care Case Project. Under this initiative, OIG, along with other law enforcement agencies, has developed over 30 cases against incontinence suppliers. These cases involved over $100 million in fraudulent Medicare claims. These investigations have resulted in recoveries of over $50 million through seizures and restitutions. Thus far, 8 cases have resulted in 13 prosecutions. In most of the cases, suppliers were billing for female external urinary collection devices but providing beneficiaries residing in nursing homes with diapers, which are not covered under Medicare. This work continues.

Pneumonia DRG Upcoding Project

The Pneumonia DRG Upcoding Project was initiated to identify hospitals that falsify the diagnosis and diagnosis related group on claims from viral to bacterial pneumonia. The Office of Investigations is currently working with the Department of Justice to initiate a nationwide project in this area.

Project Bad Bundle

The Office of Investigations launched Project Bad Bundle to identify hospitals that unbundle blood chemistry tests when using automated equipment and then bill for each analysis separately, or bill for an automated test in addition to several of the analyses separately. “Unbundling” refers to the illegal practice of submitting individual bills for separate tests that should be bundled together into a single bill for a group of related tests. The amount allowed under Medicare for this “bundled” amount is considerable lower than the sum of the amount for tests billed separately. Under this initiative, the total civil settlement to date is $8.8 million and involved 24 hospitals.

National Exclusions Project - Project Weed “QT”

Section 1128 of the Social Security Act requires that individuals and entities that engaged in specified misconduct be excluded from participation in all Federal health care programs. The Office of Investigations field offices are responsible for referral

and processing of proposed administrative exclusions of individuals and entities. The Project Weed commenced on July 1, 1996 and continued through March 31, 1997. Project WEED QT is a continuation of the initial project and will continue to focus on increasing the number and quality of these program exclusions.

Exclusion Data Transfer

We will collaborate with the Health Care Financing Administration to achieve full implementation of our goal to make available to Medicare contractors and Medicaid State Agencies current information about individuals and companies that have been excluded from the Medicare and Medicaid programs. We will do this via the internet. They need this information to ensure that health care providers who have been excluded from the programs cannot re-enter at another source.

Coordination with HCFA's Medicaid Bureau

We will coordinate with HCFA's Medicaid Bureau to assist the State Medicaid programs in strengthening and enforcing exclusion actions.

LEGAL COUNSEL

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. The OCIG also provides all administrative litigation services required by OIG, such as patient dumping cases and all exclusion administrative cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes, and is responsible for the development of new, and the modification of existing safe harbor regulations under the anti-kickback statute. Work planned in FY 1998 includes:

Fraud Alerts

We will issue several special fraud alerts to inform the health care industry of particular industry practices which OIG determines are highly suspect.

Expected Completed Date: FY 1998

Anti-Kickback Safe Harbors

We will evaluate comments from the public in response to OIG's solicitation of comments on the existing and additional proposals for safe harbor exemptions from the anti-kickback statute and, where appropriate, develop proposed regulations for additional safe harbors. We will also issue an interim final regulation implementing the new shared-risk exception to the anti-kickback statute.

Expected Completion Date: FY 1998

Implementing the Health Insurance Portability and Accountability Act of 1996 and Balanced Budget Act of 1997

We will prepare regulations to implement new exclusion and civil monetary penalty authorities contained in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the Balanced Budget Act of 1997 (Public Law 105-33) that have been delegated to the Inspector General for implementation.

Expected Completion Date: Ongoing

Implementation of Corporate Integrity Plans

We will continue to work with the OIG's Office of Evaluations and Inspections in reviewing the practices of providers who have had corporate integrity plans imposed in the settlement process. The OIG plans to use the results of this work to improve both the requirements of future corporate integrity plans and the monitoring process.

OCIG; 97-00004; OEI; 07-97-00280
Expected Completion Date: FY 1998

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 1997

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 1996, agency obligations and disbursements of Superfund resources amounted to about $58.7 million and $59.0 million, respectively.

OAS; W-00-98-50002; A-04-98-00000
Expected Issue Date: FY 1998

CENTERS FOR DISEASE CONTROL AND PREVENTION

Preventing Youth Tobacco Use

We will evaluate the Department's efforts in reducing tobacco use among youth. This initiative is one of six identified by the Secretary for highest priority within the Department. The CDC was designated as lead agency and was asked to work with participating OPDIVs and STAFFDIVs to develop and execute an implementation plan.

OAS; W-00-98-50003; A-04-98-00000; OEI; 00-98-00000
Expected Issue Date: FY 1998

Source and Application of Office of Director Costs at CDC

We will review the methodology used to determine the amount of administrative costs claimed by the CDC for its Office of Director activities. We will also review the adequacy of CDC's management controls designed to ensure that the costs of those operations are equitably allocated to the CDC's programs based on the services actually provided.

OAS; W-00-97-50003; A-04-97-04217
Expected Issue Date: FY 1998

FOOD AND DRUG ADMINISTRATION

FDA's Oversight of Blood Safety

We will review FDA's efforts to strengthen its oversight of blood safety. Building upon our previous work in this critical area, we will examine FDA's efforts to improve its processes for error and accident reporting, recall classification, and inspections. The area of blood safety, a perennial congressional concern, was the subject of OIG testimony in June 1997.

OAS; W-00-98-50004; A-03-98-00000
Expected Issue Date: FY 1998

Biennial Inspection Requirement

We will assess FDA's ability to meet its statutory requirement to inspect drug and device manufacturers every 2 years. Such inspections are critical for FDA to ensure that firms are complying with good manufacturing practices. Previous OIG work in this area indicated that FDA is not meeting this requirement. If FDA is unable to meet this legal requirement, we will examine the agency's efforts to develop alternative methods to assess compliance with good manufacturing practices.

OAS; W-00-98-50004; A-15-98-00000
Expected Issue Date: FY 1999

Review of Citizen Petition Process

We will review FDA's process for handling citizen petitions to determine if there are ways to make the process efficient and effective. The citizen petition process, which is provided for in the Code of Federal Regulations, allows anyone to request the Commissioner of Food and Drug to issue, amend, or revoke a regulation or order, or take or refrain from taking any other form of administrative action. A recent OIG review in the area of conjugated estrogens pointed to problems in the citizen petition process. In addition, the House Subcommittee on Oversight and Investigations, Committee on Commerce, is interested in improving the process as part of overall FDA reform.

OAS; W-00-97-50004; A-15-97-50002
Expected Issue Date: FY 1998

Prescription Drug Labeling Initiatives

This study will assess the progress on several initiatives FDA has underway to improve labeling for prescription drugs. Critics have charged that outdated labeling discourages optimal prescribing, inhibits promotional efforts, and may adversely affect reimbursement by third-party payers. In response to this criticism, FDA has announced several initiatives working with industry to bring labeling more up-to-date. Some of FDA's current initiatives include labeling for use by children and the elderly and adding information to now reflect accepted medical practice and treatment advances.

OEI; 00-00-00000
Expected Issue Date: FY 1999

FDA Warning Letters

This review 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.

OEI; 09-97-00380
Expected Issue Date: FY 1998

Hospital-Based Institutional Review Boards: Ensuring Human-Subject Protections

This review will examine the challenges facing hospital-based institutional review boards as they seek to ensure that human-subject protections are observed in clinical research. We plan to identify major challenges that face the boards, describe promising approaches that the boards have developed to address these challenges, and assess the implications of these challenges for NIH and FDA efforts to ensure that the boards function effectively.

OEI; 01-97-00190
Expected Issue Date: FY 1998

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; A-15-97-80002
Expected Issue Date: FY 1998

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Managed Care Organizations Reporting to the National Practitioner Data Bank

We will evaluate reporting to the National Practitioner Data Bank (Data Bank) by managed care organizations and provide a close look at managed care organizations' quality assurance activities. When a managed care organization "de-credentials" a physician or dentist or, removes or restricts clinical privileges for a period of more than 30 days on the basis of a professional review action, the "adverse action" against the practitioner must be reported to the Data Bank. Based on the increase nationally in the number of managed care organizations and the low level of reporting to the Data Bank, HRSA has requested that the OIG review the reporting issue.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Primary Care Effectiveness Reviews and Community Health Centers

This study will review the extent to which HRSA's use of the clinical protocol section of the "Primary Care Effectiveness Reviews" process adequately addresses the quality of care provided by community health centers. This will be the first national evaluation of this process. Primary Care Effectiveness Reviews are the oversight process that HRSA uses to monitor community health centers. They are conducted on site every 5 years and examine finances, administration, governance and clinical or quality of care issues. The clinical portion includes a review of physician credentialing, sample medical records, peer review activities, and patient satisfaction surveys. Our study will focus on "quality of care safeguards," consistent with other OIG work involving quality of care mechanisms/programs, which in turn is consistent with the Secretarial goal of improving the quality of health care for the HHS service population.

OEI; 00-00-00000
Expected Issue Date: FY 1999

Ryan White Primary Care and Substance Abuse Treatment

This review will determine whether Ryan White Title I grantees (eligible metropolitan areas) ensure that Ryan White funds are used as the payer of last resort for primary medical care and substance abuse treatment services to individuals with HIV/AIDS. The Ryan White Comprehensive AIDS Resources Emergency Act is intended to improve services for HIV positive individuals and their families; funds awarded under the Act are intended to be used as the payer of last resort. Since 1991, over $1.9 billion has been awarded. Historically, over 30 percent of Title I funds are spent on primary medical care and substance abuse treatment. Injection drug users are at great risk of acquiring HIV.

OAS; W-00-98-50005
Expected Issue Date: FY 1998

Ryan White Comprehensive AIDS Resources Act

This study would review the progress made by HRSA and grantees in implementing past OIG recommendations. According to the Department's FY 1998 budget, HHS is requesting over $1 billion to fund the Ryan White Program for the next fiscal year, a 42 percent increase from FY 1994. In 1995, OIG issued a series of reports on Ryan White. The recommendations contained in these reports reflected our concern that better monitoring and compliance activities (by both HRSA and grantees) were needed and that the program should place more emphasis on outcome evaluations at both the local and systems levels. The size of the Ryan White program has increased significantly since these reports were issued making the need for improved management, monitoring and compliance more urgent. Additionally, sufficient time has elapsed for the development and implementation of better management practices.

OEI; 00-00-00000
Expected Issue Date: FY 1999

Use of CARE Act Funding In New York

We will assess New York State's administration and use of Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds relative to the State's reimbursement pools for uninsured costs. The State administers three programs for HIV uninsured care: AIDS Drug Assistance (ADAP), ADAP Plus (Primary Care

Services), and HIV Homecare Services. The Ryan White CARE Act represents the largest authorization of Federal funds specifically designed to provide health and social services for people infected with HIV/AIDS. As part of this review, we will determine whether the State has systems and procedures in place to ensure the eligibility of the applicant for enrollment in the uninsured program (i.e., medical and income criteria) and the appropriateness and accuracy of payments made to providers. In addition, we will review the reasonableness, allocability, and allowability of the administrative costs claimed by the State for operating the programs.

OAS;W-00-98-50005; A-02-98-00000
Expected Issue Date: FY 1998

Utilization of PHS 340B Drug Pricing Program

This review will determine whether eligible PHS-funded entities are effectively utilizing the PHS 340B Drug Pricing Program. With the passage of the Veterans Health Care Act of 1992, some 13,000 PHS entities including State AIDS drug assistance programs became eligible to purchase discounted outpatient drugs through a special pricing program authorized by Section 340B of the Public Health Service Act and administered by HRSA's Office of Drug Pricing. Currently only 6,400 of the 13,000 eligible entities participate in the PHS 340B program.

OAS; W-00-98-50005; A-01-98-00000
Expected Issue Date: FY 1998

Training Programs in the Maternal and Child Health Bureau

We will evaluate the "Special Projects of Regional and National Significance" under the Maternal and Child Health Program. Title V of the Social Security Act provides that approximately 15 percent of the amount appropriated for the Maternal and Child Health Block Grant be set-aside for Special Projects of Regional and National Significance (in FY 1995, funding was $100 million). The funding for training has generally accounted for a major portion of the set-aside. According to HRSA budget data, $37 million was used to fund 161 training grants or projects in FY 1995. The training program has never been evaluated. This study will address several issues including how grants are awarded, what is being done to establish outcome data, to

what extent training is targeted to meet demand, what impact have the grants had on improving Maternal and Child Health services, and auditing of grants.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Cash Management Practices at Institutions Participating in the Health Professions and Nursing Student Loan Programs

The Health Professions Student Loan (HPSL) and Nursing Student Loan (NSL) Programs were established by Congress in response to anticipated shortages of doctors, nurses, and other health professionals. The law establishing HPSL in 1963 and NSL in 1964 authorized funds for use by educational institutions in making long-term, low-interest loans to eligible students. Our review will determine how well institutions are managing funds made available to them for these loan programs.

OAS; W-00-98-50005
Expected Issue Date: FY 1998

Reporting of Excluded Individuals and Entities

We will coordinate with HCFA and HRSA 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 Federal health care programs. The OIG's Office of Investigations is responsible for reporting and updating all exclusion and reinstatement actions of 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.

Expected Completion Date: Ongoing

INDIAN HEALTH SERVICE

Medicare Pricing for the Contract Health Services Program

We will analyze the potential cost savings and economic impact of a legislative proposal requiring hospitals to provide services at Medicare-like prices to IHS' Contract Health Services (CHS) program. The CHS program pays hospitals to care for eligible beneficiaries living outside of IHS' direct care boundaries or requiring specialty care. These hospital services are currently purchased using negotiated contracts, which generally do not reflect competitive rates. The IHS' proposed legislation will be comparable to similar amendments provided to both the Department of Veterans' Affairs and the Department of Defense in the late 1980's. Results of our analysis will be provided for Departmental consideration.

OAS; A-15-97-50001
Expected Issue Date: FY 1998

Mental Health Services Provided by IHS

The IHS has requested a review of the impact on Indian children and families of its consolidation of mental health and social services programs. In particular, the IHS would like an assessment of how the consolidation has affected services for addressing child abuse. As part of this study, the IHS asked that we include the management information system in our review.

OEI; 00-00-00000
Expected Issue Date: FY 1999

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-00-97-50006; A-06-97-00000
Expected Issue Date: FY 1998

Effectiveness of IHS Tribal Self-Governance Compact Award Process

We will assess the effectiveness of the process used by IHS to award self-governance compacts to tribes. With more funds being provided to Indian tribes through the compact mechanism--34 compacts totaling $350 million in FY 1997 and slated to increase--the agency needs to have and to follow sound policies and procedures for making compacting decisions. Our review will focus on: the process IHS uses to determine if a tribe is prepared to manage a compacting program (e.g. does the tribe have a business plan, financial and administrative controls, etc.); the propriety of the terms and conditions of the compacts; and the process of developing the compact funding levels.

OAS; W-00-97-50006; A-15-97-50003
Expected Issue Date: FY 1998

NATIONAL INSTITUTES OF HEALTH

The National Cancer Institute's Cancer Information Service

We will identify options that will reduce busy signal rates, abandonment rates, and wait times on the Cancer Information Service toll-free telephone service. A review of Cancer Information Service call data for 1995 through 1997 indicates a sharp increase in busy signal rates, abandonment rates, and wait times from 1995 to 1996. Despite improvements in the first quarter of 1997, callers in some parts of the country still experience busy signal rates of up to 50 percent.

OEI; 09-97-00360
Expected Issue Date: FY 1998

Superfund Financial Activities for Fiscal Year 1997

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 1996, agency obligations and disbursements of Superfund resources amounted to about $52.4 million and $44.5 million, respectively.

OAS; W-00-98-50025; A-04-98-00000
Expected Issue Date: FY 1997

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

SAMHSA's Treatment Improvement Protocols

We will determine the level of dissemination of specific SAMHSA Treatment Improvement Protocols and practitioners awareness and use of them. Treatment Improvement Protocols are relatively new consensus-based "best practice" guidelines developed by SAMHSA. The guidelines are designed to be used in the treatment of individuals with alcohol and other drug problems. Since 1993, SAMHSA has issued 22 Treatment Improvement Protocols and 3 more are currently in various stages of publication and development. Each has an initial publication of 50,000 copies. The SAMHSA disseminates these Protocols within HHS and to State alcohol and substance abuse directors. The National Clearinghouse for Alcohol and Drug Information is responsible for all other requested dissemination and is paid by SAMHSA $1 million per year for this work.

OEI; 07-96-00130
Expected Issue Date: FY 1998

State Systems Development Program

At SAMHSA's request, we will determine the impact of the agency's technical assistance to States under the State Systems Development Program. The State Systems Development Program which is administered by the SAMHSA's Center for Substance Abuse Treatment, consists of management reviews of State treatment programs. These reviews, called "technical reviews," are done by a private consulting company under contract to the Center and result in reports to the States. Technical assistance plans are developed as a result of these reports and technical assistance is subsequently provided to States. States are reviewed every 3 years.

OEI; 00-00-00000
Expected Issue Date: FY 1999

PROGRAM SUPPORT CENTER

Health Education Assistance Loan (HEAL) Defaulters

The OIG's Office of Investigations will assist the Program Support Center in its effort to publish its annual list of health care providers who defaulted on their HEAL loans.

Expected Completion Date: Ongoing

PHS AGENCIES-WIDE ACTIVITIES

Year 2000 Computer Renovation Plans

We will determine the adequacy of each of the PHS operating divisions' plans to meet Year 2000 project renovation and validation goals by the designated time frames. The Federal Government's Year 2000 project strategy regarding computer systems places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant well before December 31, 1999, to avoid widespread system failures. As of August 31, 1997, the Department reported to OMB that it had 166 mission-critical systems (124 related to PHS agencies). It also reported that over the next 2½ years,

renovation work remains to be done on 72 percent of these systems and that validation testing was necessary on 90 percent.

OAS; W-00-98-50019
Expected Issue Date: FY 1998

Disclosure Statements Filed by Colleges and Universities

OMB Circular A-21, revised May 8, 1996, now requires that colleges and universities disclose their cost accounting practices by filing a disclosure statement. The disclosure statement is designed to promote uniformity and consistency in the cost accounting practices followed by colleges and universities and to ensure that only allowable costs are claimed and that costs are allocated to Federal projects in an equitable manner. Our reviews of disclosure statements will determine whether they are complete, accurate, and reflect current practices and whether they are compliant with Cost Accounting Standards and pertinent cost principles.

OAS; W-00-98-50007; Various CINs
Expected Issue Date: FY 1998

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.

Other 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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WELFARE REFORM

State Capacity in Developing Data Systems

We will examine how States plan to measure the outcomes experienced by recipients under the Temporary Assistance for Needy Families (TANF) block grant, in concert with the other provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The TANF program transformed welfare into a system that requires work in exchange for time-limited assistance. The program is intended to end the dependence on Government benefits by promoting job preparation, work, and marriage. Our report will assess State infrastructure, capacity, and data collection efforts to satisfy data reporting requirements under the block grant. This review will discern what data States need to collect to measure outcomes as well as the potential ease and/or difficulty of collecting this data.

OEI-00-00-00000; OAS; W-00-98-20016; A-09-98-00000
Expected Issue Date: FY 1998

Maintenance of Effort

This review will examine how States have implemented the maintenance of effort provision under the Temporary Assistance for Needy Families program. States are required to expend at least 80 percent of their historical spending level (75 percent if they meet participation requirements) under AFDC and related programs. There may be some uncertainty about the circumstances under which expenditure of State funds count toward the maintenance of effort requirement.

OAS; W-00-98-20016; A-04-98-00000
Expected Issue Date: FY 1999

Cost Shifting by States

This review will examine whether States, with the help of consultants, are shifting costs to non-Temporary Assistance for Needy Families (TANF) programs. Prior to welfare reform, the open-ended AFDC program was the primary program that States charged administrative costs. Consultants continue to be instrumental in efforts to maximize Federal financial participation. Welfare reform eliminated AFDC and

Emergency Assistance, and capped TANF administrative costs. States may be motivated to shift some of these costs to other open-ended programs such as Child Support Enforcement. Additionally, some States may try to shift costs by tying TANF eligibility to eligibility for programs such as Medicaid and Food Stamps. This could have a significant impact on not only increasing the cost of other Federal programs but also minimizing administrative cost reductions expected under welfare reform.

OAS; W-00-98-20016; A-03-98-00000; A-09-98-00000
Expected Issue Date: FY 1999

State Fraud and Abuse Prevention Activities

This study will identify State fraud and abuse prevention and detection activities under the Temporary Assistance for Needy Families (TANF) Program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires State Plans for TANF to contain a fraud and abuse "certification." This is a certification by the chief executive officer of the State stating that the State has established and is enforcing standards and procedures to ensure against program fraud and abuse, including nepotism, conflicts of interest, kickbacks, and the use of political patronage. We will provide a comprehensive description of State fraud and abuse prevention and monitoring systems that will encompass both client and vendor fraud and abuse.

OEI; 00-00-00000
Expected Issue Date: FY 1999

CHILD CARE

State Utilization of Child Care Development Fund Matching Funds

We will identify barriers States encountered in spending their new Child Care Development Fund matching funds available to each State under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The Act created a single, integrated child care system under the amended Child Care and Development Block Grant Act of 1996 which created three separate funding streams. These funding streams are (1) discretionary funds, (2) mandatory funds, and (3) matching funds. The ACF requested this review due to concern that some States may not expend their matching funds. Therefore, we will determine why any funds may not

have been expended and what barriers States encountered in utilizing the matching funds.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Utilization of Tribal Child Care Funds - An Early Alert

We will produce an overview report which will describe the challenges Tribal Child Care agencies are facing to ensure effective use of increased child care funds as a result of the new welfare reform laws. This review will also describe their efforts in addressing those challenges, and their needs in meeting the challenges. With the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, additional child care funds are available to tribes through the Child Care Development Fund Tribal Mandatory Fund, in addition to the congressional appropriated discretionary funds. This doubles child care funds available to tribes to $60 million a year.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Technical Assistance Contracts for Quality Child Care

We will gather information regarding customer satisfaction of State agencies which administer the Child Care Development Fund with contracted technical assistance focused on improving quality of child care. The ACF contracts with a private entity to provide this technical assistance to State agencies. As States struggle to serve increasing numbers of children in child care as the result of welfare reform, the technical assistance provided through this contract will be critical to assist States in building and maintaining quality child care.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Low-Income Child Care Voucher

We will examine different low-income child care voucher programs to identify potential vulnerabilities and best practices. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, legislation consolidated four existing Federal child care subsidy programs into a single, integrated child care system that can provide assistance through grants, contracts, and certificates (commonly known as vouchers). Most States use multiple methods of providing child care assistance. While vouchers are an increasingly used mechanism to provide child care subsidies, little information is available about the provision of child care through vouchers. In addition, ACF's Child Care Bureau will find our report useful in determining what technical assistance States need regarding child care voucher programs.

OEI; 00-00-00000
Expected Issue Date: FY 1999

CHILD PROTECTIVE SERVICES

Interstate Compact on the Placement of Children

This study will describe if States are meeting their obligations under ACF's Interstate Compact on the Placement of Children. This compact was created 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 that certain States are not meeting their responsibilities under the compact such as ensuring a safe living environment and conducting periodic site visits for "out-of-State placement" children.

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

Service Effectiveness

We will determine whether (1) the services/treatment being prescribed to State Child Protective Services (CPS) clients are appropriately focused; (2) any service delays exist that could result in further occurrence of child abuse and/or neglect; and (3) follow-up is being done to determine service effectiveness. We will also determine if the State agencies are looking at recidivism rates to identify and correct the potential and/or leading causes of recidivism.

The child protective service investigation is to identify the risk factors (stressors) that led to or significantly contributed to the incident of child abuse and neglect. Remedial services and/or treatments are usually provided to the clients with the objective of eliminating or reducing the risk of harm to children in the household to an acceptable level.

OAS; W-00-98-20018; A-01-98-00000
Expected Issue Date: FY 1999

Hospital Reporting of Drug Toxicity Cases

We will determine whether hospitals are reporting cases of positive toxicity due to drugs in newborns to the appropriate authorities. Federal regulations require health care professionals and administrators to report, as soon as possible, suspected abuse when they have reason to suspect that a child has been abused. Physical abuse includes internal injuries or bodily harm as well as conditions associated with infants born with drugs in their systems. We will also determine whether cases of positive toxicity are used to develop a plan for providing services to the family to eliminate causes of the toxicity and related problems.

OAS; W-00-98-20018; A-01-98-00000
Expected Issue Date: FY 1999

CHILD SUPPORT

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 State audit indicated 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 1998

Collection Through Garnishment of Income Other than Wages

This review will examine whether States are making effective use of garnishment as a collection technique for non-wage income. Over the years, amendments to title IV-D have given States authority to use various methods to enforce collection of child support payments. Wage withholding is the method most often used by States. However, wage withholding is not effective for the self-employed nor for accessing nonwage income such as royalties, commissions, interest and dividends. States may be missing an opportunity to collect child support arrearages by garnishing income sources other than wages.

OAS; W-00-98-20005; A-03-98-00000
Expected Issue Date: FY 1999

Employer Compliance with New Hire Directories

This review will determine how States insure that all employers and employees are included in new hire directories. Welfare reform law requires all States to have a New Hire Directory in place by October 1, 1997. Each State Directory will be used to create the National New Hire Directory maintained by the Office of Child Support Enforcement to assist in interstate location of absent parents. If some employers are exempt or fail to comply, the effectiveness of the new hire directory could be reduced and more costly and difficult location techniques would have to be used.

OAS; W-00-98-20005
Expected Issue Date: FY 1999

Enhanced Collection Through the Use of Liens

This review will examine whether States are effectively using liens as a method to collect child support. States are required to have in effect and use procedures which stipulate that a lien will be imposed against real and personal property of an absent parent who is delinquent in child support payments. If States use liens as aggressively as they do license suspension, the child support collections could be enhanced. Both intrastate and interstate cases will be examined.

OAS; W-00-98-20005
Expected Issue Date: FY 1999

Medical Support Enforcement

We will determine whether States are enforcing medical support orders. Welfare reform and OBRA 1993 mandate that noncustodial parents enroll their children on their employer's health insurance plan. Welfare reform also streamlined the process of obtaining medical coverage by providing child support enforcement agencies with the authority to direct a noncustodial parent's employer to enroll the child in the parent's health plan. A current review of access to medical coverage by these children disclosed that three New England States may not be enforcing medical support orders as required by Federal regulations. One of the States has a certified system in place designed to automate the enforcement of medical support orders and other child

support functions. An absence of enforcement means that medical bills for uninsured children are paid by taxpayers through Medicaid or absorbed by health care providers.

OAS; W-00-98-20005; A-01-98-00000
Expected Issue Date: FY 1999

Health Insurance Detection and Medicaid Coordination

We will determine the progress State child support enforcement agencies have made in detecting available dependent health insurance and coordinating this information with State Medicaid agencies. Our review will compare information collected during two previous OIG studies that found that employer-related dependent health insurance was available to a significant number of absent parents, and that the Medicaid program would have saved over $32 million annually if available insurance had been detected. As an update to those studies, this current review will determine the number of absent parents with health insurance available and affordable to cover their dependents' medical expenses, child support enforcement agencies' detection of available health insurance, and the amount of money the Medicaid program would save if available employer group health insurance were utilized.

OEI; 00-00-00000; OAS; W-00-98-20005; A-01-98-00000
Expected Issue Date: FY 1999

State System Operation and Maintenance Contracts

This review will examine the adequacy of States' procurements of operation and maintenance services for their child support management information systems. The ACF has encountered some difficulty in having States pursue full and open competition for these maintenance and operation contracts, preferring to award them to the contractor who handled the original system implementation.

OAS; W-00-98-20005; A-09-98-00000
Expected Issue Date: FY 1999

State Child Support Satisfaction Survey

We will assess the current level of State Child Support Agencies' satisfaction with services provided by the Federal Office of Child Support Enforcement. The child support enforcement program is a critical component in ensuring economic security for millions of single-parent families and children in need of support. During FY 1994, about $10 billion in child support payments were collected through State title IV-D Child Support agencies. Currently, ACF is developing methods for gathering client satisfaction data for users of child support services, from both welfare and non-welfare recipients. This study may provide one mechanism for ACF to assess Office of Child Support Enforcement's performance and also to assist ACF in gathering feedback from States.

OEI; 00-00-00000
Expected Issue Date: FY 1998

Child Support Annual Report: A Customer Survey

We will assess customer satisfaction with the Office of Child Support Enforcement's Annual Report to Congress. Law mandates the Office of Child Support Enforcement to collect and report detailed information of child support activities and future goals for the program. In addition, Governmentwide initiatives such as the Government Performance and Results Act call for increased Government accountability, including focusing more on customer needs. The Office of Child Support Enforcement is a pilot project of the Government Performance and Results Act and is working with States to develop ways to survey child support customers to improve the program.

OEI; 00-00-00000
Expected Issue Date: FY 1998

INVESTIGATIONS

Project Child Support Enforcement

The Child Support Recovery Act makes it a Federal crime to willfully fail to pay a past-due child support obligation for a child living in another State. The past-due support obligation must be either greater than $5,000 or must have remained unpaid

for more than 1 year. Since being given authority to investigate violations of this Act, OIG's Office of Investigations has opened over 100 cases nationwide. In 1996, four subjects of these investigations were convicted and sentenced as a result of OIG efforts. To date in 1997, ten more individuals have been brought to justice with many more currently awaiting formal judicial adjudication.

FOSTER CARE

Quality Assurance Over State Foster Care Residential Facilities

We will review State licensing and quality assurance activities relating to residential foster care paid under title IV-E. According to the Child Welfare League of America, State licensing and oversight of residential foster care facilities varies considerably among the States. Although the Child Welfare League maintains standards for residential foster care, the Social Security Act requires States to have standards "which are reasonably in accord with recommended standards of national organizations." There is congressional concern over the disparity among States with respect to the quality of care and safety of children in residential foster care.

OEI; 00-00-00000
Expected Issue Date: FY 1999

Quality of Care

This effort will address whether privatization has had an effect on the quality of care received by foster children. In a prior review we found that the State agency administering the foster care program did not ensure that the standards for health and safety and the quality of services provided to foster children placed through private child nonprofit placing agencies were met. This review will determine whether the States are properly monitoring the private nonprofit child placing agencies to ensure that the foster children are receiving quality care.

We will profile the results of our work in a summary report to ACF covering violations found in several States. The report will also include the results of our

review of the handling of administrative costs by child placing agencies and the retention of maintenance payments.

OAS; W-00-98-20008; Various CINs
Expected Issue Date: FY 1999

Private Nonprofit Child Placing Agencies

This review will cover one aspect of privatizing the welfare system by looking at the States' use of private nonprofit child placing agencies for the placement of children in private foster homes, i.e., whether the private nonprofit child placing agencies contracting with States are improperly retaining a portion of the foster care maintenance payments as a service fee. A review in one State found that child placing agencies improperly retained an average of 38 percent of the funds intended to provide food, clothing and shelter for children under their care.

An overall report will be provided to ACF summarizing the results of reviews of payments made to private child placing agencies in several States. The report will also include the results of our work relating to quality of care and administrative costs.

OAS; W-00-98-20008; Various CINs
Expected Issue Date: FY 1999

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

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 1998

Independent Living Program

We plan to review the objectives, performance, and program results of one State's Independent Living Program. In order to determine if children are successfully transitioning from foster care to independent adult living, we will, if feasible, review State records to ascertain the outcomes of: (1) foster care youth who (a) have participated in the Independent Living Program, and (b) have not participated in the Independent Living Program; and (2) youth in the general population.

We will also review one regional ACF office's management and reporting efforts on information sharing among State Independent Living Programs.

OAS; W-00-98-20008; A-04-98-00000
Expected Issue Date: FY 1998

Retroactive Claims

This nationwide effort will determine whether retroactive claims submitted by the States for Federal sharing are supported and comply with Federal eligibility requirements for the foster care program. An analysis of claims data indicated that several States have made adjustments to their title IV-E claims. We will evaluate the adjustments to determine whether they are appropriate. Previous work in this area included a joint effort with ACF which resulted in identifying $6.4 million in a State's prior quarter adjustments which could not be supported.

Individual reports will be issued to the States as well as an overall report to ACF summarizing the results of title IV-E retroactive claims reviews conducted in the States.

OAS; W-00-98-20008; Various CINs
Expected Issue Date: FY 1999

Concurrent Payments

This review will determine whether State title IV-E Foster Care agencies (1) are exchanging information on eligibility requirements and benefits with local Social Security district offices and (2) have formal procedures to refer clients and their representatives to the local district office for consultation and/or application when appropriate. We will also determine whether appropriate adjustments were made. The ACF changed its policy to allow concurrent eligibility for Supplemental Security Income (SSI) benefits and title IV-E foster care. In cases where the child is eligible for both programs and payments are concurrently received from both, the child's SSI payment is to be reduced dollar for dollar by the amount of the foster care payment.

OAS; W-00-98-20008
Expected Issue Date: FY 1998

Training Costs

This series of reviews will determine whether States claimed administrative costs related to foster care training at the appropriate rate of 50 percent instead of the 75 percent rate allowed for certain training costs specified by Federal regulations. Training provided to current and prospective employees can be claimed for Federal reimbursement under title IV-E of the Social Security Act. States are entitled to Federal sharing at 75 percent to cover the eligible costs of training State and local personnel who administer the foster care program. Federal sharing at the rate of 50 percent is available for other administrative costs, including those related to training necessary for the operation of the foster care program.

OAS; W-00-98-20008
Expected Issue Date: FY 1998

Program Income

This review will determine the extent of inequitable distribution of program income in the foster care program as well as other Federal programs. Prior reviews of the foster care program in one State showed that program income, such as proceeds from

insurance companies, was first credited to the State's share of the expenditure. Any remaining income was offset to the Federal expenditures relating to the payments.

OAS; W-00-98-20008; A-03-98-00000
Expected Issue Date: FY 1998

Adoption 2002

We will take an early look at the Department's progress in meeting the proposed action steps detailed in *Adoption 2002*. This initiative was developed by the Department in response to the President's directive to move children more rapidly from foster care to permanent homes and at least double, by the year 2002, the number of children in foster care who are adopted or permanently placed out of the public foster care system. Our review will cover such action steps as that requiring the Department and States to establish preliminary baseline data for FY 1997 on the number of adoptions and guardianships and annual incremental targets for FYs 1998 - 2002. Based on draft legislation, the date for the completion of this step is September 30, 1997.

OAS; W-00-98-20008
Expected Issue Date: FY 1999

Adoption and Foster Care Analysis and Reporting System

We will review the reliability and completeness of the Adoption and Foster Care Analysis and Reporting System in one or more States. This system, which was established in response to the need for better data collection, will provide information on children in foster care and children adopted through the public child welfare system. States are required to collect case-specific data on all children in foster care for whom the State child welfare agency has responsibility for placement, care or supervision, regardless of their eligibility. In addition, States are required to collect data on all adopted children who were placed by the State child welfare agency, and on all adopted children for whom the State provides adoption assistance. States were required to begin submitting data in June 1995. Penalties for non-submission or submission of poor quality data will be effective with submissions due in May 1998.

OAS; W-00-98-20008; A-03-98-00000
Expected Issue Date: FY 1999

HEAD START

Infant and Toddler Initiative (Early Head Start)

We will review implementation of the new Early Head Start initiative. This new program established by the 1994 Head Start Reauthorization Act, provides early, continuous, and comprehensive services to low-income or at-risk children from birth to age 3, to pregnant women, and to the families of such children.

Our review will include an early look at the implementation of ACF's recently developed performance standards for this new initiative.

OAS; W-00-98-20009
Expected Issue Date: FY 1999

Facilities' Compliance with Health and Safety Standards

We will review Early Head Start and Temporary Assistance for Needy Families (TANF) grantees' compliance with health and safety standards. Welfare reform legislation requires the provision of child care services under TANF. Both Early Head Start and TANF require that children be cared in decent, safe and healthy environments. Previous OIG reviews showed that, in addition to improvements needed at the State level, greater Federal oversight was needed to improve the health and safety conditions of the Nation's child care programs.

OAS; W-00-98-20009; A-09-98-00000
Expected Issue Date: FY 1999

Head Start Social Services

We will address the effectiveness and impact of the Head Start family needs assessment, which provides the framework for the delivery of social services to Head Start families. The December 1993 "Final Report of the Advisory Committee on Head Start Quality and Expansion" noted that a major area of improvement was assuring the delivery of social services. The study would also evaluate program expenditures for social services to determine if they are cost effective. In addition, we

will try to determine why such a significant variation exists in the amount spent per child on social services by different grantees.

OEI; 00-00-00000
Expected Issue Date: FY 1999

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. Our work will assist ACF in identifying those areas requiring more extensive technical assistance.

OAS; W-00-98-20009
Expected Issue Date: FY 1998

Asset Management Practices

Using our national sample of Head Start grantees, we will review grantees' asset management policies and practices to determine if their systems are capable of recording, segregating and adjusting the current value of assets and the Federal interest in them. In addition, the understatement of the assets value will be quantified. We will also determine whether grantees no longer participating in Head Start, have shared with the program the disposition of assets. Organizationwide audit reports usually do not include an inventory of the assets acquired with Head Start funds nor the Federal Government's interest in them. Accordingly, any assets that may be shown in the financial statements have not been validated showing proper value.

OAS; W-00-98-20009
Expected Issue Date: FY 1999

Pre-Award Review of Grantees' Budget Plans

We will assist ACF in identifying unneeded and unreasonable expenditures included in grantees' proposed operating budgets and to determine if this situation is prompted by a lack of fiscal capabilities within the grantee. The potential savings which result from our reviews could be used to increase program enrollments, or possibly to fund

additional grantees.

OAS; W-00-98-20009; A-02-98-00000
Expected Issue Date: FY 1999

Information Systems and Automated Data Processing

At the request of the Head Start Bureau, we will review the current availability and level of sophistication of electronic data processing (EDP) capabilities of Head Start grantees for quickly communicating and providing relevant and timely information to Federal program management.

After ACF has implemented the Grant Administration Teaching and Evaluation System (GATES), we will determine if the policies and procedures established to effect the movement of data from the prior Head Start data systems assure that accurate and complete information is being transferred.

OAS; W-00-98-20009; A-09-98-00000
Expected Issue Date: FY 1999

Head Start Termination Actions

We will examine the costs to the Federal Government (including charges to the grant) related to termination of a Head Start grant for deficiency, in order to identify ways of reducing the cost and time associated with this process. Because Head Start grantees can use Federal grant funds to pay the costs of defending themselves against adverse action, they have no incentive to avoid long and costly administrative legal proceedings. Delays permit deficient grantees to operate programs that are not in the best interests of the children and families involved and place Federal funds at risk.

OAS; W-00-98-20009
Expected Issue Date: FY 1998

OTHER ISSUES

State Developmental Disabilities Councils Funded by the Administration on Developmental Disabilities

We will examine the effectiveness of State Developmental Disabilities Councils funded by the Administration on Developmental Disabilities (ADD). The Developmental Disabilities Basic State Grants program assists States in developing and implementing a comprehensive Statewide plan for meeting the needs of persons with developmental disabilities. A basic program goal is the development of a comprehensive system that provides a coordinated array of services. The FY 1997 funding for the State councils was approximately $65 million. The Commissioner of the Development Disabilities Administration requested our review. The Administration previously performed onsite monitoring every 3 years, but because of funding cuts, stopped this practice in 1992.

OEI; 00-00-00000
Expected Issue Date: FY 1999

State Protection and Advocacy Systems for the Disabled

A consolidated report will be prepared summarizing the findings related to fiscal management and internal controls of selected State protection and advocacy systems for the disabled and the monitoring performed at the Federal level.

OAS; W-00-97-20017; A-03-97-00000
Expected Issue Date: FY 1998

Administration of Native Americans Grants

We will examine the award process and the administration of grants to support programs promoting the economic and social self-sufficiency of Native Americans.

The Administration for Native Americans provides approximately $29 million in grants to support projects that are expected to result in sustained improvements in the

social and economic conditions of Native Americans within their communities, and at the same time to increase the likelihood of achieving their economic and social goals.

OAS; W-00-98-20018
Expected Issue Date: FY 1998

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 1998

Emergency Assistance Retroactive Claims

This review will examine the amount and nature of any retroactive claims by States as well as FY 1996 claims for juvenile justice costs. A number of consultants have entered into contingency fee contracts with States to maximize Federal financial participation under the emergency assistance (EA) program. This effort may be shifting considerable costs to EA from other Federal and State programs. Preliminary work in one State indicates that many claims contain unallowable and unsupported costs.

OAS; W-00-98-20017; Various CINs
Expected Issue Date: FY 1999

Management and Performance of OCS Discretionary Grants

This review will examine the Office of Community Services (OCS) oversight of discretionary grants as well as grantees' use of funds and achievement of program objectives. Annually, OCS awards grants to provide assistance for projects which sponsor employment, training, and business development opportunities for low-income residents. These grantees are generally nonprofit organizations who either carry out the project themselves or through profit-making businesses as subgrantees. Prior work has identified instances in which grant monies have not been properly used and project objectives not met.

OAS; W-00-98-20018; A-09-98-00000; A-04-98-00000
Expected Issue Date: FY 1998

Refugee Resettlement Cash and Medical Assistance Payments

We will determine if a State agency 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 1998

Progress of Empowerment Zones/Enterprise Communities

This joint project with USDA and HUD will assess State and subgrantee compliance with the terms and conditions and effective use of the Empowerment Zone/Enterprise Communities (EZ/EC) program funds. We will also determine whether grantees fully consider and build on Federal programs underway in their locales which also address community and economic enrichment. The 1993 Omnibus Budget Reconciliation Act authorized HUD to designate 6 empowerment zones and up to 65 enterprise communities in urban areas. The USDA was authorized to designate 3 empowerment

zones and 30 enterprise communities in rural areas. The HUD and USDA are charged with programmatic responsibilities. The HHS is charged with fiscal responsibilities.

OAS; W-00-98-20003
Expected Issue Date: FY 1998

Statewide Automated Child Welfare Information System

This review of the implementation of Statewide Automated Child Welfare Information Systems will study States' use of Federal funds, the capabilities of the systems, the reliability of the data, and the appropriateness of costs charged. These comprehensive statewide systems are to support the administration of services offered under the titles IV-E and IV-B programs. Each system is independently designed according to a State's needs.

In FY 1995, States spent about $100 million in Federal funds on these systems. Federal funding was authorized by the 1993 Omnibus Budget Reconciliation Act at a 75 percent Federal match. To be eligible for the enhanced match, State systems must meet certain statutory requirements, and, to the extent feasible, provide electronic data exchange with data collection systems operated under AFDC, Medicaid, child support enforcement and the National Child Abuse and Neglect data system.

OAS; W-00-98-20017
Expected Issue Date: FY 1998

Department of Health and Human Services

Office of Inspector General

Administration on Aging

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ADMINISTRATION ON AGING

Outreach Activities

We will examine the effectiveness of outreach activities of the AoA on Medicare fraud. The AoA received funds to train aging network staff and long-term-care ombudsmen to recognize and report fraud and abuse. Additionally, AoA received funds for 12 demonstration projects to train retired professionals (such as teachers, accountants, and lawyers) in local communities to serve as both volunteer resources and educators to Medicare beneficiaries on detecting and reporting Medicare fraud. The AoA awarded these demonstration grants in June 1997. We will collaborate with AoA on outreach activities and evaluate the impact of the activities to date. We will also assist in developing performance measures for evaluating both the outreach activities and the 12 demonstration projects. The AoA requested this study.

OEI; 00-00-00000
Expected Issue Date: FY 1998

State Registries on Abusive Employees

This review will evaluate the adequacy of the registries maintained by States to record findings of abuse and convictions of staff employed in long term care facilities. A prior OIG audit disclosed problems with one State's registry for nurse aides. We will randomly select States for this review. Our work will aid in identifying ways to more accurately profile employees with histories of abuse to avoid placing residents at risk.

OAS; W-00-98-00000
Expected Issue Date: FY 1998

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.

OAS; W-00-97-20001
Expected Issue Date: FY 1998

Respite Care and Adult Day Care

We will determine how States distribute funds for respite care and adult day care programs under Title III of the Older Americans Act, as amended, with particular emphasis on programs for those who suffer from Alzheimer's Disease. The Older Americans Act of 1965 provides financial assistance to States for social service and nutrition programs for the 60+ population. Among the services provided under the Act are respite care and adult day care. The Administration on Aging requested a study to determine how well States are using these funds.

OEI; 00-00-00000
Expected Issue Date: FY 1999

Department of Health and Human Services

Office of Inspector General

Departmentwide

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Work is expected to begin in FY 1998 on the following audits:

Related audit activity to support financial statement audits:

PROGRAM INTEGRITY AND EFFICIENCY

INVESTIGATIONS

GOVERNMENT MANAGEMENT REFORM ACT OF 1994 and CHIEF FINANCIAL OFFICERS ACT OF 1990 and GOVERNMENT PERFORMANCE AND RESULTS 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 consolidated HHS financial statement to the OMB is due by March 1, 1998.

Also covered by financial statement audits are the performance measures and goals required by the Government Performance and Results 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 1998:

Health Care Financing Administration--FY 1997

OAS; W-00-96-30102; A-17-95-00051
Expected Issue Date: FY 1998

Administration for Children and Families--FY 1997

OAS; W-00-97-00000; A-17-97-00000
Expected Issue Date: FY 1998

Health Resources and Services Administration--FY 1997

OAS; W-00-97-00000; A-17-96-00000
Expected Issue Date: FY 1998

Indian Health Service--FY 1997

OAS; W-00-96-40013; A-17-97-00000
Expected Issue Date: FY 1998

National Institutes of Health--FY 1997

OAS; W-00-96-40013; A-17-97-00000
Expected Issue Date: FY 1998

Centers for Disease Control and Prevention--FY 1997

OAS; W-00-96-40013; A-17-97-00000
Expected Issue Date: FY 1998

Food and Drug Administration--FY 1997

OAS; W-00-96-40013; A-17-97-00000
Expected Issue Date: FY 1998

Substance Abuse and Mental Health Services Administration--FY 1997

OAS; W-00-96-40013; A-17-97-00000
Expected Issue Date: FY 1998

Combined Financial Statements--FY 1997

OAS; W-00-96-40011; A-17-97-00000
Expected Issue Date: FY 1998

Related audit activity to support financial statement audits:

NIH Computer Center

OAS; W-00-96-40012
Expected Issue Date: FY 1998

Program Support Center--Major Administrative Support Services:

Payment Management System

OAS; W-00-96-40012; A-17-97-00000
Expected Issue Date: FY 1998

Accounting Operations--Division of Financial Operations

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

Payroll Operations

OAS; W-00-96-40012
Expected Issue Date: FY 1998

Work is expected to begin in FY 1998 on the following audits:

Health Care Financing Administration--FY 1998

OAS; W-00-97-40008
Expected Issue Date: FY 1999

Administration for Children and Families--FY 1998

OAS; W-00-97-40010
Expected Issue Date: FY 1999

Health Resources and Services Administration--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Indian Health Service--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

National Institutes of Health--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Centers for Disease Control and Prevention--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Food and Drug Administration--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Substance Abuse and Mental Health Services Administration--FY 1998

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Consolidated Financial Statements--FY 1998

OAS; W-00-97-40009
Expected Issue Date: FY 1999

Related audit activity to support financial statement audits:

NIH Computer Center

OAS; W-00-97-40013
Expected Issue Date: FY 1999

Program Support Center--Major Administrative Support Services:

Payment Management System

OAS; W-00-97-40012
Expected Issue Date: FY 1999

Accounting Operations--Division of Financial Operations

OAS; W-00-97-40012
Expected Issue Date: FY 1999

Payroll Operations

OAS; W-00-97-40012
Expected Issue Date: FY 1999

PROGRAM INTEGRITY AND EFFICIENCY

Review of Self-Insurance Funds

This assignment will determine the reasonableness of fund balances in the State self-insurance funds. Self-insurance funds provide reserve type self-insurance for State activities and properties administered by State, county and municipal governments. The cost of insurance, or premiums, is billed to the appropriate government agencies. Excess reserves result from premiums collected and interest earned in excess of claims and operating expenses. The Office of Management and Budget (OMB) Circular A-87 cost principles for State and local governments preclude the charging of such reserves (excess costs) to Federal programs. States should identify and refund the Federal share of excess reserves, take steps to avoid future excesses and ensure that self-insurance funds are properly accounted for in future Statewide Cost Allocation Plans.

OAS; W-00-98-20017
Expected Issue Date: FY 1998

Statewide Cost Allocation Plan Section II Costs

At selected States we will examine the equitableness of States' allocations to Federal programs of costs such as pensions, self-insurance, and telecommunications. Also, we will determine whether refunds to the Federal Government or rate adjustments are

necessary. The HHS, by virtue of the magnitude of its funding, negotiates the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

OAS; W-00-98-20017
Expected Issue Date: FY 1998

Pensions

This review will determine whether investment earnings are lost as a result of State agency delays in forwarding Federal funds drawn down for pension contributions and whether certain reserve balances maintained in the State pension plans are contingency reserves. Previous reviews have disclosed significant problems with the pension plan costs charged to Federal programs.

OAS; W-00-98-20017
Expected Issue Date: FY 1998

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-00-98-20003
Expected Issue Date: FY 1998

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) 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.

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.