

Department of Health and Human Services



**Office of
Inspector General**

**WORK PLAN
FISCAL YEAR 2001**

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Inspector General**



Department of Health and Human Services

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

Working with management, we will ensure effective and efficient HHS programs and operations.

*We Are Guardians
of the Public Trust*

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

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.

Department of Health and Human Services

Office of Inspector General



WORK PLAN FOR FISCAL YEAR 2001

INTRODUCTION

The Office of Inspector General (OIG) Work Plan is set forth in four chapters encompassing the various projects to be addressed during Fiscal Year (FY) 2001 by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The first three chapters present the full range of projects planned in each of the Department of Health and Human Services' (HHS) major entities: the Health Care Financing Administration, the Public Health Service agencies, and the Administrations for Children, Families, and Aging. The fourth chapter embraces those projects related to issues that cut across Department programs, including State and local government 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 that we perceive as critical to the mission of the OIG and the Department. Unless otherwise noted, reports on all projects are expected to be issued in FY 2001. 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. The Health Insurance Portability and Accountability Act of 1996, strengthened by the Balanced Budget Act of 1997, brought much needed authorities and resources to achieving this objective.

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 2001.

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 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 integrity 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 voluntary compliance programs and monitors ongoing corporate integrity agreements. The 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 developing new, and modifying existing, safe harbor regulations under the antikickback statute. Finally, OCIG counsels OIG components on personnel and operations issues, subpoenas, audit and investigative issues, and other legal authorities.

Internet Address

The FY 2001 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.os.dhhs.gov/oig>

Department of Health and Human Services

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HOSPITALS

One-Day Hospital Stays

We will continue a series of reviews to evaluate the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only 1 day in a hospital. Recent data indicate that approximately 10 percent of all Medicare patients admitted are released the following day. Our review will concentrate on the adequacy of existing controls to detect and deny unauthorized care.

OAS; W-00-00-30010; A-03-00-00007

Hospital Discharges and Subsequent Readmissions

This series of reviews will continue to examine Medicare claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same acute care prospective payment system hospital. We will review procedures in place for these related admissions at selected hospitals, fiscal intermediaries, and peer review organizations. With the assistance of the Health Care Financing Administration (HCFA), we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine the effectiveness of existing system edits used to identify and review related admissions.

OAS; W-00-00-30010; A-14-00-00043

Payments for Related Hospital and Skilled Nursing Stays

We will determine the extent of Medicare payments for short- and long-stay hospital and skilled nursing facility care that was provided sequentially to the same beneficiary. Inpatient services may be denied, based on peer review organization reviews, for patients admitted unnecessarily for one stay or multiple stays. As part of our review, we will assess HCFA's instructions on identifying and evaluating consecutive beneficiary stays at different providers, including skilled nursing facilities and prospective payment system-exempt units.

OEI; 09-00-00210

Satellite Hospitals

We will determine the extent to which satellite units and “hospitals-within-hospitals” provide long-term hospital care and examine the effectiveness of HCFA’s payment safeguard protections. Because of program integrity concerns, long-term-care satellite units are required

to have average stays of over 25 days to retain prospective payment system-exempt status. Further, if more than 5 percent of discharges from a hospital-within-a-hospital to its host hospital result in subsequent readmission to the hospital-within-a-hospital, the first stay may be denied. We will determine whether those conditions are being met.

OEI; 00-00-00000

Prospective Payment System Transfers

We will continue to support the Department of Justice's assistance to the Department in seeking recovery of overpayments and penalties from Medicare prospective payment system hospitals that incorrectly reported transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between prospective payment system hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is 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. We are working with HCFA to initiate a nationwide recovery of overpayments from hospitals that are not covered by the Justice Department's project.

OAS; W-00-97-30010; A-06-00-00006

Prospective Payment System Transfers Between Chain Members

We will review Medicare Part A controls to prevent improper payment of claims for transfers between chain members. During a recent review, we found that the receiving hospitals in many of the incorrectly reported prospective payment system transfers were members of the same chain. We are expanding our work to identify all medical institutions owned by chain organizations and to analyze the movement of Medicare patients within each chain organization. Additionally, selected chains may be separately reviewed at the request of the Justice Department or our Office of Investigations. We will prepare an advisory report to the HCFA Administrator detailing questionable patient transfer patterns.

OAS; W-00-98-30010; A-06-99-00050

Prospective Payment System Transfers: Administrative Recovery

We will work with HCFA and the Medicare fiscal intermediaries to administratively recover overpayments resulting from incorrectly reported prospective payment system transfers. Our work will focus on the incorrectly reported transfers declined for investigation. We are currently working with HCFA to draft instructions to the fiscal intermediaries. The

intermediaries' performance will determine whether it is necessary to issue individual regional reports recommending resolution action on the part of the HCFA regions.

OAS; W-00-98-30010; A-06-00-00041

Prospective Payment System Transfers During Hospital Mergers

We will determine the extent that prospective payment system hospitals improperly billed for Medicare inpatient transfers when merging or consolidating multiple hospitals. Our preliminary review identified a number of cases in which two or more hospitals merged or were consolidated under a single provider number and improperly reported Medicare patients transferred to the new provider number. In the case of a change of ownership (including consolidation of providers), Medicare regulations permit only the discharging hospital to bill and receive payment. Our preliminary work identified a number of hospitals for referral for investigation or recovery.

OAS; W-00-98-30010; A-06-99-00051, -00-00044

Postacute Services for Diagnosis-Related Groups Considered Transfers

We will assess early changes in utilization patterns for the 10 diagnosis-related groups for which postacute services are considered transfers rather than discharges for payment purposes. The Balanced Budget Act required the Secretary to select the 10 diagnosis-related groups. This review will examine whether providers exhibit different utilization patterns for these diagnosis-related groups, such as sending beneficiaries home for several days before admission to inpatient rehabilitation, using a second postacute provider to render care, issuing notices of noncoverage to beneficiaries, or coding inpatient stays to fall into other diagnosis-related groups.

OEI; 00-00-00000

Uncollected Beneficiary Deductibles and Coinsurance

We will continue a series of reviews addressing the reasonableness of Medicare payments to inpatient hospital providers that fail to collect deductible and coinsurance amounts from beneficiaries. Under current law, these uncollected patient liabilities may be reimbursed, in part, by the Medicare program. We will assess the impact of such payments and evaluate the effectiveness of existing controls to ensure their validity.

OAS; W-00-00-30010; A-04-00-06005

Diagnosis-Related Group Payment Limits

We will continue to assess the ability of Medicare contractors to limit payments to hospitals for patients who are discharged from a prospective payment system hospital and admitted to one of several post-acute-care settings. This limitation, imposed by the Balanced Budget Act of 1997, applies to certain diagnosis-related groups.

OAS; W-00-00-30010; A-04-00-01210

Outlier Payments for Expanded Services

We will continue to examine the financial impact of outlier Medicare payments made in unusual cases for inpatient care. The “extra” payments (i.e., in addition to diagnosis-related group payments) are made on behalf of Medicare beneficiaries who receive services far in excess of services rendered to the average Medicare patient.

OAS; W-00-00-30010; A-01-00-00503

Diagnosis-Related Group Payment Window - Hospitals

This review will determine whether hospitals have complied with the settlement agreements they entered into with the Office of Inspector General (OIG) to preclude duplicate billing for nonphysician outpatient services under the prospective payment system. The review will also determine the extent that duplicate claims have been submitted by Part B providers for services (e.g., ambulance, laboratory, or x-ray services) provided to hospital inpatients. Under the prospective payment system, hospitals are reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group. Separate payments for nonphysician services rendered within the diagnosis-related group payment window are not allowed.

After several OIG reviews, the Department of Justice conducted a nationwide project to recover overpayments plus penalties and interest through the Civil False Claims Act. As a result of this project, affected prospective payment system hospitals entered into settlement agreements to comply with Medicare billing rules for nonphysician services rendered in connection with inpatient stays and to eliminate the submission of duplicate claims.

OAS; W-00-00-30010; A-01-00-00506

Diagnosis-Related Group Payment Window - Part B Providers

This review will determine the extent of duplicate claims submitted by Part B providers for services, such as ambulance, laboratory, or x-ray services, provided to hospital inpatients. This is a companion review to our work at hospital providers. Under the prospective payment system, hospitals are reimbursed a predetermined amount, depending on the illness and its classification under a diagnosis-related group, for inpatient services furnished to Medicare beneficiaries. Separate payments for nonphysician services rendered within the diagnosis-related group payment window are not allowed whether the claims are submitted by hospital providers or by Part B providers, such as laboratories and ambulance companies.

OAS; W-00-01-30010; A-01-01-00000

Hospital Reporting of Restraint-Related Deaths

We will assess hospital compliance with Medicare requirements, issued July 1, 1999, to report all patient deaths that may have been caused by use of restraints or seclusion. We will examine HCFA's early experiences with hospital reporting and review Medicare claims and enrollment data to determine whether patient deaths are being reported.

OEI; 00-00-00000

Outpatient Prospective Payment System

We will review implementation of the new prospective payment system for care provided to Medicare beneficiaries by hospital outpatient departments. Previously, Medicare paid outpatient departments their reasonable costs. We will evaluate the effectiveness of internal controls intended to ensure that services are adequately documented, properly coded, and medically necessary. Controls over "pass-through" costs will also be reviewed.

OAS; W-00-00-30010; A-03-00-00019

Outpatient Pharmacy Services at Acute Care Hospitals

Our review will determine whether pharmacy services rendered on an outpatient basis were billed and reimbursed in accordance with Medicare requirements. With certain exceptions, Medicare Part B does not cover self-administered drugs. Survey work indicates that hospitals may have charged Medicare for self-administered drugs on an outpatient basis. This review will focus on periods before implementation of the outpatient prospective payment system.

OAS; W-00-01-30026; A-01-01-00000

Outpatient Medical Supplies at Acute Care Hospitals

This review will determine whether medical supply services rendered on an outpatient basis were billed and reimbursed in accordance with Medicare requirements. Our survey work indicates that hospitals may have charged Medicare for undocumented, unnecessary, and noncovered services. This review will focus on periods before implementation of the outpatient prospective payment system.

OAS; W-00-01-30026; A-01-01-00000

Followup on Peer Review Organizations' Complaint Process

We will evaluate the effectiveness of the Medicare peer review organizations' beneficiary complaint process. This followup to our 1995 report (OEI-01-93-00250) will examine the progress that HCFA has made in implementing our recommendations. It will also assess the current complaint process for accessibility, objectivity, responsiveness, timeliness, investigative capacity, enforcement follow-through, improvement orientation, and accountability.

OEI; 01-00-00060

HOME HEALTH

Home Health Compliance Programs

We will determine how many home health agencies have compliance programs in place. The OIG issued its "Compliance Program Guidance for Home Health Agencies" in August 1998 to address areas of concern both to the Government and the industry. We will also look at which elements of the OIG compliance program were implemented and examine the benefits and difficulties associated with their implementation.

OEI; 00-00-00000

Physician Involvement in Approving Home Health Care

This followup review will determine the extent of physician involvement in approving and monitoring home care for Medicare beneficiaries. Earlier OIG work found that physicians often did not have a relationship with their home health patients and relied extensively on home health agencies to determine the care needed. As part of our review, we will look at how frequently physicians examine home care patients and identify obstacles to physician

involvement in monitoring their patients. This will be particularly important as the new prospective payment system is implemented in FY 2001.

OEI; 00-00-00000

Impact of Prospective Payment System on Access to and Quality of Care

This study will assess how the prospective payment system for home health agencies is affecting Medicare beneficiaries' access to home health care and the adequacy of that care. Changing Medicare reimbursement from a cost-based system to a prospective system will alter the incentives in how home health agencies admit and treat Medicare beneficiaries. We will update prior work in which we evaluated access to home health services and measured indicators of quality of care under the interim payment system.

OEI; 02-00-00320

Home Health Prospective Payment System Controls

We will monitor implementation of the new prospective payment system used to pay home health agencies for providing care to Medicare beneficiaries. The prior payment system was based on cost reimbursement principles. We will evaluate the adequacy of controls intended to ensure that services are provided only to homebound individuals and are adequately documented, properly coded, and medically necessary. We will also evaluate controls over advance payments to providers.

OAS; W-00-00-30009; A-06-00-00065

Payments Based on Location of Service

We will continue to evaluate implementation of a relatively recent change in paying for home health care. Effective October 1997, home health services are to be paid based on the location where the service is provided (in the patient's home), rather than where the service is billed (typically the urban location of the parent home health agency).

OAS; W-00-99-30009; A-06-99-00063

Assessments Used for Case-Mix Adjustment

We will determine how implementation of the Outcomes and Assessment Information Set affects quality of care and home health reimbursement. Home health agencies are required to

conduct initial and periodic assessments of each patient's functional capacity. This assessment information helps to establish the case-mix adjustment used in determining the level of Medicare payment to a home health agency for a particular patient. We plan to examine the assessment process, the extent to which assessments are used to develop plans of care, and the case-mix accuracy.

OEI; 00-00-00000

Debt Management Process

A series of reviews will identify major obstacles inhibiting Medicare's ability to collect debts owed by home health agencies. Available data show that some debts are not liquidated and that HCFA collects only pennies on the dollar for debts owed by home health agencies that leave the Medicare program.

OAS; W-00-00-30009; A-14-00-00470

NURSING HOME CARE

Role of the Nursing Home Medical Director

We will examine how the role of the nursing home medical director has been interpreted and implemented and how the medical director affects quality of care. The Omnibus Budget Reconciliation Act of 1987 broadly requires nursing homes to designate a medical director to be responsible for implementation of resident care policies and coordination of medical care in the facilities. This review is one of a series on the quality of care in nursing homes.

OEI; 06-99-00300

Quality Assessment and Assurance Committees

We will examine the role and effectiveness of quality assessment and assurance committees in ensuring quality of care in nursing homes. The Omnibus Budget Reconciliation Act of 1987 requires each nursing facility to maintain a committee comprised of the director of nursing, a physician, and at least three other staff members. The committee is to meet at least quarterly to identify quality assessment and assurance activities and to develop and implement appropriate plans of action to correct identified quality deficiencies. The HCFA requires surveyors to determine whether a facility has such a committee and whether it has a method to "identify, respond to, and evaluate" issues in quality of care. However, surveyors are not required to

evaluate the committee's adequacy or effectiveness. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Nurse Aide Training

We will examine whether the Omnibus Budget Reconciliation Act of 1987 nurse aide training requirements are followed. The act requires that nurse aides complete a training and competency evaluation program within 4 months of employment, unless the individual has been deemed competent. This review is one of a series on the quality of care in nursing homes.

OEI; 00-00-00000

Family Experience With Nursing Home Care

We will assess the quality of care that Medicare and Medicaid beneficiaries receive in nursing homes, as perceived by their family members. The HCFA is responsible for ensuring that nursing homes that participate in the Medicare and Medicaid programs meet certain requirements for quality environment and services. Family members who visit their loved ones in a nursing home are in a position to provide an "insider's perspective" on the quality of care they see being delivered on a regular basis. We will conduct a mail survey of family members. This review is one of a series on the quality of care in nursing homes.

OEI; 04-98-00550

Consolidated Billing Requirements

We will determine the extent of overpayments during Calendar Year 1999 for Part B services subject to the consolidated billing provisions of the prospective payment system for skilled nursing facilities. As set forth in the Balanced Budget Act of 1997, consolidated billing requires that skilled nursing facilities bill Medicare for virtually all services rendered to their residents during Part A stays. Prior OIG work found that for over one-third of the claims reviewed, Medicare contractors made separate Part B payments to outside suppliers for services that were subject to consolidated billing. As a result, Medicare paid twice for the same service — once to the nursing facility under the Part A prospective system and again to an outside supplier under Part B.

OAS; W-00-00-30014; A-01-00-00538

Ineligible Stays in Skilled Nursing Facilities

This review will quantify improper payments, nationwide, for skilled nursing facility stays that did not meet Medicare's coverage conditions. In order to be paid by Medicare, a beneficiary's nursing home stay must be preceded by at least a 3-day inpatient hospital stay. Our survey work in one State disclosed that skilled nursing facilities received over \$900,000 in Medicare reimbursement for stays that did not meet the coverage conditions. Based on the State error rate, we estimate that Medicare could be paying over \$20 million a year for ineligible nursing stays nationwide. In addition to recommending corrective action, we will identify nursing homes where a pattern of this condition could indicate potential program fraud or abuse.

OAS; W-00-01-30014; A-05-01-00000

Followup on Mental Health Services in Nursing Facilities

This review will ascertain whether the Medicare program is still vulnerable from the expanded provision of mental health services to nursing facility residents. In a 1996 study, we found that Medicare had paid for medically unnecessary or questionable mental health services in nursing facilities in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent these inappropriate payments, such as developing guidelines for carriers, developing screens to implement the guidelines, conducting focused medical reviews, and providing physician education activities. This study will determine whether mental health services in nursing facilities continue to be inappropriately billed.

OEI; 02-99-00140

Therapy Services for Medicare Part B Nursing Home Patients

At HCFA's request, we will review the utilization and quality of care of physical, occupational, and speech therapy provided to nursing home patients in Calendar Year 1999 and billed to Medicare Part B by nursing homes, rehabilitation agencies, and hospital outpatient departments. The Balanced Budget Refinement Act of 1999 required HCFA to (1) recommend a mechanism to ensure the appropriate utilization of Medicare outpatient therapy and (2) establish a payment policy based on diagnostic categories, functional status, and prior use of therapy. This study will provide information to assist the agency in meeting these requirements.

OEI; 09-99-00560

Ancillary Medical SuppliesI

These ongoing reviews will determine whether certain skilled nursing facilities have claimed unallowable costs for ancillary medical supplies. Medicare reimbursement rules describe those items and services that are allowable as ancillary costs as opposed to routine costs. If costs are misclassified, we will quantify the financial impact of errors.

OAS; W-00-00-30014; A-09-00-00059

Followup on Survey and Certification ProcessI

This study will follow up on two reports, dated March 1999, on the State survey and certification process and trends in deficiency data from the Online Survey, Certification, and Reporting System. Since we issued those reports, HCFA has taken a number of steps to strengthen survey and enforcement efforts. We will evaluate these nursing home initiatives.

OEI; 00-00-00000

Complaint ProcessI

We will examine the timeliness and effectiveness of State nursing home complaint processes since HCFA's Complaint Improvement Project began. The Omnibus Budget Reconciliation Act of 1987 required each State to establish a complaint investigation process. As part of that process, HCFA requires that States investigate, within 2 working days, the most serious complaints alleging immediate jeopardy of the health or safety of residents. The timing, scope, duration, and conduct of other complaint investigations were left largely to the State survey agency. In March 1999, HCFA directed State survey and certification directors to investigate, within 10 working days, any complaint that alleges actual harm to nursing home residents. At the same time, HCFA initiated the Complaint Improvement Project to strengthen key elements of the complaint investigation and resolution process.

OEI; 00-00-00000

Use of PenaltiesI

We will examine availability and use of State and Federal penalties imposed on deficient nursing home providers. The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 set the standards that nursing facilities must meet to participate in Medicare and established the State survey and certification process to determine compliance with Federal standards. In December 1999, as part of its initiative on nursing homes, HCFA

issued new guidance to States on enforcing nursing home quality standards. We will examine trends in the use of penalties before and after the nursing home initiative.

OEI; 00-00-00000

HOSPICE CARE

Plans of CareI

This study will examine the variance among hospice plans of care and the extent to which services are provided to hospice patients in accordance with the plans of care. Although hospice patients are required to have plans of care, there are no requirements or minimum standards that the plans must meet. In previous OIG work on the nursing home population, we found that plans of care varied and that services were generally provided in accordance with the plans of care. We will examine the plans of care for both nursing home and non-nursing-home populations.

OEI; 00-00-00000

Hospice Payments to Nursing HomesI

We will examine the financial implications of Medicare hospice payments made on behalf of patients residing in nursing facilities. Our previous work found that current payment levels for patients in nursing facilities may be excessive. When a patient is entitled to both Medicare and Medicaid, the nursing home no longer bills the State Medicaid program for the patient's long-term care. Instead, the nursing home bills and receives payment from the hospice and the hospice is reimbursed by Medicaid. Medicaid payments for room and board are in addition to Medicare's daily fixed rate paid to the hospice. For private pay patients, Medicare pays the hospice and the resident continues to pay the nursing facility directly. This study will follow up on our early work with a special emphasis on private pay patients.

OEI; 00-00-00000

Use of Continuous Home Care by Hospice AgenciesI

This study will examine how fiscal intermediaries ensure that hospices provided the services for which they submitted claims. The Medicare hospice benefit provides for palliative care for patients who have a terminal diagnosis. The benefit covers four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. For routine, inpatient respite, and general inpatient care, only one rate applies per day. For continuous

home care, the payment is based on the number of hours of continuous care provided to the patient; a minimum of 8 hours must be provided for reimbursement at this level. We will focus on continuous home care because of its complexity, expense, and vulnerability.

OEI; 00-00-00000

PHYSICIANS

Physicians at Teaching HospitalsI

This initiative is designed to verify compliance with Medicare rules governing payment for physician services provided in the teaching hospital setting and to ensure that claims accurately reflect the level of service provided to patients. Previous OIG work in this area suggested that many providers were not in compliance with applicable Medicare reimbursement policies.

OAS; W-00-99-30021; Various CINs

Reassignment of Physician BenefitsI

We will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

OEI; 04-99-00660

Podiatrists' Medicare BillingsI

This national review will determine the extent to which podiatrists improperly bill Medicare. Our work at a podiatrist in one State disclosed a very high error rate (99 percent), and anecdotal evidence suggests that other podiatrists' claims may be a significant problem.

OAS; W-00-00-30021; A-09-99-00058

Podiatry ServicesI

This study will review podiatry claims to determine if the services met HCFA coverage policy. From 1992 through 1995, Medicare expenditures for nail debridement increased 46 percent, while Medicare expenditures for all other Part B services increased only 18 percent. We will examine a national sample of podiatry claims to gain a better understanding of the possible factor(s) affecting the extreme variation in allowed charges per thousand beneficiaries.

OEI; 04-99-00460

Advance Beneficiary NoticesI

We will examine the use of advance notices to Medicare beneficiaries and their financial impact on beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment. Indications are that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to noncovered laboratory services.

OEI; 00-00-00000

Critical Care CodesI

We will examine the use of two critical care codes that may be billed to Medicare only if the patient is critically ill and requires constant attention by the physician. Payment for critical care is based on the time spent with the patient. We will examine claim data to determine whether some physicians may be billing inappropriately for critical care as well as identify any other potential vulnerabilities.

OEI; 05-00-00420

Bone Density ScreeningI

We will evaluate the impact of the recent standardization and expansion of Medicare coverage of bone density screening. Bone mineral density studies can diagnose osteoporosis and assess an individual's risk for fracture. Before the Balanced Budget Act of 1997, coverage for bone mass measurements varied by carrier. Effective July 1, 1998, the act standardized coverage of

these studies. As the number of claims for bone density screening increases, there are questions about the appropriateness and quality of some services.

OEI; 00-00-00000

Role of Nonphysician PractitionersI

We will describe the scope of services that nonphysician practitioners provide to Medicare beneficiaries and identify any potential vulnerabilities that may have emerged since the Balanced Budget Act of 1997. Nurse practitioners, clinical nurse specialists, and physician assistants practice either in collaboration with or under the supervision of a physician and provide services according to their State's scope-of-practice requirements. Recent changes in the way Medicare pays for nonphysician practitioner services and concerns about the complexity of services they provide have increased interest in these providers.

OEI; 02-00-00290

Services and Supplies Incident to Physicians' ServicesI

We will evaluate the conditions under which physicians bill "incident-to" services and supplies. Physicians may bill for the services provided by allied health professionals, such as nurses, technicians, and therapists, as incident to their professional services. Incident-to services, which are paid at 100 percent of the Medicare physician fee schedule, must be provided by an employee of the physician and under the physician's direct supervision. Because little information is available on the types of services being billed, questions persist about the quality and appropriateness of these billings.

OEI; 00-00-00000

MEDICAL EQUIPMENT AND SUPPLIES

Medicare Payments for Equipment and SuppliesI

We will examine Medicare payment rates for a sample of medical equipment and supplies and compare the Medicare rates with the rates of other Federal and State health programs as well as with wholesale and retail prices. We will also compare supplier costs for these items with the Medicare-allowed charges.

OEI; 00-00-00000

National Supplier ClearinghouseI

We will review implementation of the National Supplier Clearinghouse, which was established to certify that durable medical equipment suppliers meet certain standards before receiving a Medicare billing number. The HCFA has consolidated processing of all durable medical equipment claims at four carriers, one of which maintains the clearinghouse. We will assess the extent to which the clearinghouse has met its goals and test the collected data for accuracy, completeness, accessibility, and usefulness.

OEI; 04-99-00670

Payments for Nebulizer DrugsI

This joint OIG/HCFA review will determine whether durable medical equipment (DME) suppliers submitted proper claims for nebulizer drugs and supplies to the Medicare region C carrier and were reimbursed in accordance with Medicare requirements. In 1998, Medicare payments for nebulizer drugs totaled \$486 million — an increase of \$57 million, or 13.3 percent, over the 1997 total of \$429 million. The region C carrier accounted for \$274 million, or 56 percent, of the 1998 national total.

OAS; W-00-00-30022; A-06-00-00053

LABORATORY SERVICES

Clinical Laboratory Improvement Amendments CertificationsI

We will determine whether laboratories are conducting tests and billing Medicare within the scope of their certifications under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Laboratories with certifications of waiver or physician-performed microscopy procedures may perform only a limited menu of test procedures. Moderate-and high-complexity laboratories are also restricted to testing certain preapproved specialty groups and must meet CLIA standards. We will use CLIA certification and Medicare billing records to assess compliance with these requirements.

OEI; 05-00-00050

Medicare Billings for Cholesterol TestingI

We will determine whether cholesterol tests billed to Medicare are medically necessary and accurately coded. Although total cholesterol testing can be used to monitor many patients,

Medicare claims reflect a preponderance of claims for lipid panels, which include HDL cholesterol and triglycerides also. Systems capable of doing all three tests, plus glucose, are advertised on the Internet as CLIA-waived. We will examine Medicare claims for the frequency of testing and the medical necessity of lipid panels.

OEI; 00-00-00000

Clinical Laboratory Proficiency TestingI

We will assess the policies and procedures used for proficiency testing under CLIA and examine the quality of the testing results. The CLIA requires all moderate- and high-complexity laboratories to enroll with an approved proficiency testing agency for certain tests. These agencies are responsible for grading the accuracy of a laboratory's results; repeated failures can cause the laboratory to lose approval to perform those and similar tests. Because of the critical importance of proficiency testing, we will examine the testing and grading process.

OEI; 00-00-00000

END STAGE RENAL DISEASE

Medicare Composite Rate ReimbursementI

We will review and suggest changes to the end stage renal disease composite rate, which is an "all inclusive" rate used for reimbursing facilities for dialysis patients. The current rate (about \$126 for free-standing facilities and \$130 for hospital-based facilities) is based on medical science practices and data as of 1973. We will determine whether including other drugs and services in the composite rate would be appropriate and assess the potential financial implications to the Medicare program.

OEI; 00-00-00000

Utilization Service Patterns of BeneficiariesI

We will describe the utilization of health care services by end stage renal disease beneficiaries and assess the medical necessity and accuracy of coding of selected categories of services provided outside the composite rate. Recent settlements with major corporations and

laboratories that serve end stage renal disease patients have raised questions about Medicare payments for a wide range of services.

OEI; 00-00-00000

Medicare Payments for EPOGEN®I

We will evaluate controls used to adjudicate potentially excessive Medicare claims submitted by dialysis facilities for the drug EPOGEN®. The Omnibus Budget Reconciliation Act of 1990 established the EPOGEN® reimbursement rate at \$11 per 1,000 units administered. The HCFA has since reduced the rate to \$10 per 1,000 units administered. During an ongoing review of outpatient services, we identified claims for an excessive number of units, e.g., 7.5 million units were claimed when, in fact, only 75,000 units were administered, resulting in an overpayment of approximately \$74,000.

OAS; W-00-01-30025; A-01-01-00000

Hepatitis TestsI

This study will identify Medicare payments to hospital laboratories for hepatitis tests provided to dialysis patients that were not reasonable and necessary for the diagnosis or treatment of illness at the frequency provided. The HCFA and the Centers for Disease Control and Prevention issue testing guidelines associated with the Hepatitis B Virus and other strains of hepatitis. These guidelines require that dialysis facilities consider a patient's immune status and susceptibility to the various strains of hepatitis in determining testing frequency.

OAS; W-00-01-30025; A-01-01-00000

Method BillingI

We will assess method II billing for end stage renal disease services for program vulnerabilities, the adequacy of HCFA oversight, the impact on nursing home residents, and beneficiary satisfaction. End stage renal disease beneficiaries have the option to elect method II, in which a durable medical equipment supplier provides dialysis supplies, rather than method I, in which an end stage renal disease facility provides supplies and services. The use of method II appears to be growing in some States. A series of reports will look at both financial and quality perspectives of method II.

OEI; 00-00-00000

Duplicate Payments for Office Visits to NephrologistsI

This review will identify situations in which Medicare made separate payments to nephrologists for dialysis patients' office visits that were already included in the monthly capitation payments for physician services during the same period.

OAS; W-00-00-30025; A-01-00-00519

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount onI Medicare Prescription DrugsI

We will determine the extent that average wholesale prices used to calculate Medicare reimbursement for prescription drugs have increased since January 1, 1998. Before that date, Medicare Part B payments for covered prescription drugs were based on the lower of the estimated acquisition cost or the national average wholesale price. The average wholesale price is reported by the industry and is generally inflated over actual acquisition costs. In an effort to reduce Medicare payments for prescription drugs, the Balanced Budget Act of 1997 required HCFA to apply a 5-percent discount to the published average wholesale price, beginning January 1, 1998. We will determine if average wholesale prices for Medicare-covered drugs have increased since that time disproportionately to other drugs and the effect of any such increases on Medicare savings.

OEI; 00-00-00000

Medicare Outpatient Prescription DrugsI

We will review Medicare-covered outpatient prescription drugs to quantify potential revenues that would result from a drug rebate similar to that used in the Medicaid drug rebate program. More specifically, we will calculate a rebate based on the difference between current reimbursement--average wholesale price minus 5 percent--and the "best price" which has already been identified for the Medicaid program. We will also project the rebate estimates to the proposed expanded Medicare drug program, if applicable.

OAS; W-00-01-30022; A-06-01-00000

Expected Issue Date: FY 2002

OTHER MEDICARE SERVICES

Beneficiaries' Experiences With Medigap InsuranceI

This study will assess beneficiary access to and experiences with Medigap insurance. Many beneficiaries purchase supplemental insurance policies, referred to as "Medigap" policies, to cover items and charges not covered by the Medicare program. The Federal Government regulates and sets policies on this insurance. As part of our study, we will assess the factors that influence a beneficiary's decision to purchase a Medigap policy.

OEI; 07-00-00580

Outpatient Diabetes Self-Management Training ServicesI

This national study will assess the reasonableness of Medicare payment rates for outpatient diabetes self-management training services. The Balanced Budget Act of 1997 expanded coverage for such services furnished by non-hospital-based programs and required that payments for the services be established after consultation with appropriate organizations, such as the American Diabetes Association. Our prior work indicated that payment rates appeared to be substantially higher than the actual cost of providing the services. We will compare payment rates with the costs of providing the services at a selected number of providers throughout the country.

OAS; W-00-00-30026; A-14-00-02802

Rural Health ClinicsI

We will follow up on our previous study of rural health clinics to determine whether our recommendations have been implemented and what changes have occurred as a result of the Balanced Budget Act of 1997. Our study, as well as a review by the General Accounting Office, sparked legislative change that capped provider-based rural health clinic reimbursement and created a triennial certification process to prevent the proliferation of clinics in nonrural areas. Our report offered a number of measures that HCFA could take to improve the functioning and oversight of this program.

OEI; 00-00-00000

Payments to Community Mental Health Centers That Withdrew From Medicare

We will review overpayments to community mental health centers (CMHC) that voluntarily withdrew from the Medicare program. A prior OIG/HCFR review in five States, which accounted for about 77 percent of CMHC partial hospitalization program (PHP) payments nationally during Calendar Year 1996, found that 93 percent of the services reviewed were ineligible for Medicare reimbursement. Accordingly, HCFR implemented corrective actions to ensure that only qualified providers participated in the Medicare PHP. Our current review will identify those CMHCs that voluntarily withdrew from participation in the Medicare program and will determine the Medicare payments they received from October 1995 to April 1999, the providers that received overpayments, and the amount of the overpayments.

OAS; W-00-99-30026; A-03-99-00005

MEDICARE MANAGED CARE

New Adjusted Community Rate Proposal Process

At HCFR's request, we will audit the adjusted community rate proposals of managed care organizations as required by the Balanced Budget Act. The new adjusted community rate proposal process is designed for managed care organizations to present to HCFR their estimate of funds needed to cover the costs of providing a Medicare package of covered services to an enrolled Medicare beneficiary. Our audits will focus on the propriety and accuracy of the proposals submitted.

OAS; W-00-00-30012; Various CINs

General and Administrative Costs

This review will examine the administrative cost component of adjusted community rate proposals and assess whether the costs were appropriate when compared with the Medicare program's general principle of paying only reasonable costs. Administrative costs include marketing costs, administrative salaries, interest expenses, and claim processing costs. The review will include several health maintenance organizations located throughout the United States.

OAS; W-00-98-30012; Various CINs

Cost-Based Managed Care Plans

At HCFA's request, we will evaluate the integrity of the cost reporting process used by cost-based managed care plans (Section 1876 Cost Plans and Health Care Prepayment Plans). The HCFA currently contracts with over 30 of these plans which provide services to more than 300,000 members. The plans file cost reports with HCFA outlining the costs they incur in providing health care. Although the reports are audited to ensure that costs are properly allocated, they do not undergo medical reviews to ensure that only Medicare-covered services are included.

OAS; W-00-00-30012; Various CINs

Enhanced Managed Care PaymentsI

We will conduct several reviews to determine whether HCFA has made proper enhanced capitation payments to risk-based health maintenance organizations (HMO). Risk-based HMOs receive enhanced capitation payments for beneficiaries who are institutionalized, in end stage renal disease status, or dually eligible for Medicare and Medicaid. Our reviews will focus on the accuracy of controls at both HCFA and the HMOs regarding special status categories warranting these enhanced payments.

OAS; W-00-99-30012; Various CINs

HMO ProfitsI

This review will compare the profitability of the Medicare line of business with operating results from HMOs' other lines of business. Under the terms of a Medicare risk-based contract, an HMO is required to absorb any losses incurred, and is permitted to retain any savings earned, on its Medicare line of business. We will use this information to determine whether HCFA needs to establish criteria on the profitability of Medicare risk-based HMOs.

OAS; W-00-01-30012; A-14-01-00000

Physician Incentive PlansI

We will review physician incentive plans included in contracts between physicians and managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on 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 affect the quality of care provided.

OEI; 05-00-00010

Managed Care Additional Benefits

This review will analyze the cost to Medicare managed care organizations for providing additional benefits to Medicare beneficiaries and determine the extent that beneficiaries receive such benefits. Additional benefits, which are provided to beneficiaries as part of their basic Medicare benefit package, vary among managed care organizations.

OAS; W-00-01-30012; A-14-01-00000

Prescription Drug Benefit

This review will provide information on the coverage and payment of prescription drugs in Medicare managed care plans. Fee-for-service Medicare generally does not pay for outpatient prescription drugs, although some drugs, such as injectables for chemotherapy and medications used with durable medical equipment, are covered. Medicare managed care plans may offer a capped prescription drug benefit, paying up to \$1,500 per year for drugs. We will examine the extent that beneficiaries use this benefit, how the limit is calculated for each beneficiary, which drugs are included, and how drug costs are determined by the managed care plan.

OEI; 03-00-00430

Final Verification of Marketing Materials

We will evaluate HCFA's final reviews of Medicare managed care marketing materials. A previous OIG study detailed how few 1998 marketing materials were in full compliance with HCFA's marketing guidelines, and a General Accounting Office report found that HCFA reviewers did not ensure that final copies of marketing materials incorporated required corrections. In response, HCFA instituted a new policy requiring that regional offices conduct final verifications of beneficiary notification materials before final HCFA approval. This study will examine the regional offices' policies and procedures for final verification of marketing materials.

OEI; 00-00-00000

Role of State Health Insurance Counselors

We will examine the role of Health Insurance Counseling and Assistance Program counselors in informing Medicare beneficiaries of their health insurance options. The Omnibus Budget Reconciliation Act of 1990 authorized State grants to develop programs which would provide health insurance information and counseling to Medicare beneficiaries. The volunteer counselors are required to participate in State training programs, which can vary by State. They provide their services in various settings, including the beneficiary's home, community centers, hospitals, retirement communities, and over the phone. We will look at how counselors are trained and whether they provide accurate information to Medicare beneficiaries.

OEI; 00-00-00000

Usefulness of Medicare+Choice Performance Measures

This review will examine the usefulness of Medicare+Choice performance measures from the perspective of Medicare beneficiaries. Medicare+Choice offers beneficiaries a broad array of insurance benefits from which to choose. One of the measures used for comparison is a Medicare version of the Health Plan Employers Data and Information Set, submitted by Medicare managed care organizations. Measuring quality is difficult because consumers, purchasers, and policymakers have different interests and priorities. We will examine how beneficiaries interpret and use the various performance measures and determine the adequacy of these measures for beneficiary decision-making.

OEI; 00-00-00000

Monitoring Medicare+Choice Managed Care Plans

We will assess how HCFA monitors the performance of Medicare managed care plans under the Medicare+Choice Program. In 1998, we reported on HCFA's managed care monitoring process and staffing. Since that time, HCFA has implemented the Medicare+Choice program, which contains numerous changes, including new types of managed care plans and additional responsibilities for the agency. This study will assess how HCFA has updated its monitoring procedures as a result of these changes.

OEI; 00-00-00000

Educating Beneficiaries About Medicare+Choice

We will evaluate the adequacy of HCFA's efforts to educate beneficiaries about their options under Medicare+Choice. The Balanced Budget Act of 1997 expanded Medicare's health plan options by creating the Medicare+Choice program. These new options provide beneficiaries with more flexibility on health care decisions but also necessitate an extensive education campaign to ensure informed choices. As part of this review, we will assess how well beneficiaries understand the program, the variety of choices available, the implications associated with the various choices, and where to get information about the program.

OEI; 00-00-00000

Beneficiary Understanding of Medicare+Choice Benefits

We will assess how well Medicare beneficiaries enrolled in Medicare+Choice plans understand their extra benefits and financial responsibilities. In the last 2 years, numerous managed care organizations dropped out of Medicare or withdrew from certain market areas. Starting in 2000, many managed care organizations that remained in the program have reduced the extra benefits provided and have increased the beneficiary co-payments and premiums. This study will examine how well beneficiaries understand these changes and determine the impact of the changes.

OEI; 00-00-00000

Medicare+Choice Compliance Programs

We will determine how many Medicare+Choice organizations have compliance programs in place. To address areas of concern to both the Government and the industry, OIG issued "Compliance Program Guidance for Medicare+Choice Organizations" in November 1999. We will also look at which elements of the OIG compliance program were implemented and examine the benefits and difficulties associated with their implementation.

OEI; 00-00-00000

Enrollment Incentives/Disincentives

This review will assess the extent to which Medicare managed care organizations encourage the enrollment of healthy beneficiaries and discourage the enrollment of sick beneficiaries. Managed care organizations are currently paid a set amount to provide all Medicare-covered services to beneficiaries enrolled in their programs and, under the current payment method, have a financial incentive to enroll healthier beneficiaries. Although the organizations are

required to enroll all eligible Medicare beneficiaries regardless of their age, health status, or the cost of the health services needed, there is some evidence that this does not always occur. Prior OIG work found that 18 percent of beneficiaries said that they were asked about health problems at the time of their application.

OEI; 00-00-00000

Fee-for-Service Costs Incurred by HMO Disenrollees

This review will examine the extent of and reasons for high fee-for-service costs incurred by beneficiaries who recently disenrolled from managed care organizations. In May 1999, we reported that beneficiaries who disenrolled from six managed care firms from 1991 to 1996 received inpatient services worth \$224 million within 3 months after disenrollment. In comparison, Medicare would have paid \$20 million in capitation payments to these six firms had the beneficiaries not disenrolled. This study will update that work and look at the reasons for a beneficiary's disenrollment before a high-cost fee-for-service procedure.

OEI; 00-00-00000

Disenrollee Feedback

We will obtain systematic disenrollee feedback on Medicare managed care organizations' performance and assess HCFA's implementation and use of disenrollee survey data. Our prior work demonstrated that structured surveys of disenrollees from managed care organizations could yield insightful information about service access and quality, plan performance, and reasons for disenrollment. We will update that information and examine the extent that HCFA uses disenrollment information.

OEI; 00-00-00000

Managed Care Organization Closings

This review will determine the impact on beneficiaries of recent closings of Medicare managed care organizations. In 1998, about 100 plans announced that they did not intend to renew their Medicare contracts or were reducing their service areas. In 1999, another 100 plans either withdrew from the Medicare program or reduced their service areas. We will look at the impact of the most recent withdrawals on beneficiaries' ability to access care and to obtain Medigap policies and their willingness to join or stay in Medicare managed care organizations.

OEI; 00-00-00000

MEDICAID MANAGED CARE

Marketing and Enrollment of Medicaid Managed Care Entities

We will determine whether managed care entities use appropriate marketing and enrollment practices for Medicaid beneficiaries. Under the Balanced Budget Act of 1997, managed care entities may not distribute marketing materials without prior State approval; may not distribute false or misleading information; must distribute marketing materials within the entire service area specified in their contract; and may not conduct door-to-door, telephone, or other cold-call marketing practices. We will evaluate how well States carry out these requirements.

OEI; 00-00-00000

Quality Improvement System for Managed Care

We will examine the extent that States use the Quality Improvement System for Managed Care standards and guidelines to measure the performance of Medicaid managed care organizations. These standards were developed by HCFA and other public and private agencies to serve as a model for State use. States that choose to adopt the standards and require managed care organizations to meet them will be in compliance with forthcoming regulations implementing the Balanced Budget Act of 1997 provisions pertaining to quality assessment and improvement. This review will look at the systems that States currently use to ensure quality assessment of managed care plans and how States monitor attainment of performance targets.

OEI; 00-00-00000

Medicaid Fee-for-Service and Managed Care Duplicate Payments

This review will determine whether Medicaid State agencies made fee-for-service payments to beneficiaries enrolled in Medicaid managed care programs. In selected States, we will examine the extent that any duplicate payments were made and their financial impact (both Federal and State) and determine whether controls are in place to prevent duplicate payments.

OEI; 00-00-00000

Emergency Services for Enrollees of Medicaid Managed Care

This review will assess how Medicaid managed care organizations are implementing the Balanced Budget Act's emergency service requirements. Under the statute, Medicaid managed care beneficiaries have the right to immediately obtain emergency care and services. A

managed care organization must pay for the cost of these services, and the services must be covered without regard to prior authorization or the emergency care provider's contractual relationship with the organization. Coverage of emergency services is to be determined under the "prudent layperson" standard; that is, services qualify as emergencies if a prudent layperson would interpret them that way. We will evaluate how managed care organizations are interpreting the prudent layperson standard and how frequently this interpretation is questioned.

OEI; 00-00-00000

MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Enrollment of Children in State Medical Insurance Programs

We will assess States' progress toward reducing the number of medically uninsured children and evaluate how States ensure that Medicaid and State Children's Health Insurance Program applicants are enrolled in the programs for which they are eligible. The Balanced Budget Revision Act of 1999 required that OIG evaluate these issues by sampling a number of States.

OEI; 05-00-00240

Role of Federal Health Centers

We will study the changing role of federally funded health centers in delivering health care to children covered by the State Children's Health Insurance Program and concurrent Medicaid expansions. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children's insurance program or expand the existing Medicaid program. We will study health centers' outreach to and enrollment of children in appropriate health insurance programs, their participation in managed care organizations, and their direct contracting with new and expanding programs.

OEI; 06-98-00321

Mental Health Screening and Services for Children

We will determine the extent of mental health services provided to children covered by Medicaid's Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. According to the December 1999 Surgeon General's report on mental health, about 70 percent of children in need of mental health services did not receive them. States must report to HCFA the amount of EPSDT screening conducted, but they are not required to report mental health

referrals. This study will focus on such issues as how much screening for mental health needs is conducted, whether certain practitioners or facilities are more likely to screen for mental health needs than others, how practitioners conduct the “assessment of mental health development” required by EPSDT, whether assessments are standardized, and to what type of mental health services children are referred.

OEI; 00-00-00000

Disenrollment From State Children’s Health Insurance Program

We will describe the current levels of State Children’s Health Insurance Program disenrollment and beneficiaries’ reasons for disenrolling. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children’s insurance program or expand the existing Medicaid program. Anecdotal evidence indicates that disenrollment levels are higher than HCFA anticipated. The HCFA recognizes the increased disenrollment rates but does not know why families are leaving the program. Furthermore, measuring the extent of disenrollment is problematic because States have different ways of capturing and reporting these data.

OEI; 00-00-00000

OTHER MEDICAID SERVICES

Reasonableness Edits

We will determine the adequacy of controls used by selected State agencies to adjudicate potentially excessive claims submitted by Medicaid providers. Prior OIG reviews found several instances of excessive payments made by State agencies. These payments occurred because claim processing system edits were not always extensive enough to evaluate the reasonableness of line item units and charges.

OAS; W-00-01-30013; A-01-01-00000

Mutually Exclusive Procedure Codes

We will determine the extent of potential overpayments or savings that could accrue to the Federal and State governments under the Medicaid program if edits were implemented to identify and deny payments for procedure codes that HCFA has identified as mutually exclusive. These procedures represent medical services that cannot reasonably be rendered in the same session to the same patient by the same provider. The codes are mutually exclusive of

one another based on either the Current Procedural Terminology definitions or the medical impossibility/improbability that the procedures could be performed at the same session. As part of the National Correct Coding Initiative, guidelines were established for billing a variety of services. Included within the guidelines, which are not mandated for use in the Medicaid program, are edits for mutually exclusive procedure codes.

OAS; W-00-00-30027; Various CINs

Payments for Services to Dually Eligible Beneficiaries

This study will determine whether adequate coordination exists between Medicare and Medicaid in the identification and collection of improper payments. In some cases, Medicaid recipients are eligible for Medicare in addition to Medicaid. In these instances, Medicare is the primary payer for covered services. In accordance with a State's particular plan, Medicaid assumes responsibility for the recipients' premiums, deductibles, and coinsurances. A November 1995 OIG report found that States did not review the appropriateness or necessity of their crossover payments. This study will assess the extent of any continuing lack of State notification of potentially improper payments.

OEI; 00-00-00000

Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees

At HCFA's request, we will determine the appropriateness of Medicaid fee-for-service payments for services provided to dually eligible beneficiaries enrolled in Medicare risk-based managed care organizations. These organizations are required to provide all Medicare-covered services in exchange for the capitation payments they receive. Most HMOs elect to offer additional benefits that are not available under Medicare fee-for-service, such as dental services, eyeglasses, prescription drugs, deductibles, and coinsurance amounts. Because Medicaid is always the payer of last resort, the State is required to take reasonable measures to determine the legal liability of third parties to pay for services furnished under the Medicaid program. Therefore, Medicaid expenditures on behalf of dually eligible beneficiaries are unallowable if the services are covered by the Medicare HMO.

OAS; W-00-00-30013; Various CINs

State Survey and Certification Costs

At HCFA's request, we are reviewing selected States' survey and certification costs to verify that costs have been allocated correctly among Medicare, Medicaid, and State licensing

agencies and that federally approved indirect cost rates have been applied. We will also study, to the extent possible, variations in survey and certification unit costs among the States to determine the extent that these variations reflect differences in salary and other costs versus efficiency (e.g., staff-hours allotted to a given type of survey) and other factors.

OAS; W-00-00-30013; A-05-00-00020

State Medicaid Agency Administrative Costs

We will review the use of administrative funds by State Medicaid agencies. In recent years, some States have focused on moving Medicaid beneficiaries out of the traditional fee-for-service environment and into managed care organizations. We have received information indicating that with this change, program administrative costs have increased significantly. Our review will determine the extent of this increase and the reason for it.

OAS; W-00-01-30013; A-05-01-00000

Impact of Intergovernmental Transfers

We will analyze the use of intergovernmental transfers by State and local governments as a means of increasing Federal Medicaid matching funds. To maximize Federal reimbursement, States are increasingly adopting aggressive payment methodologies for public providers. These methodologies use the upper payment limits and intergovernmental transfers to generate additional funds. In five States, we will (1) determine the accuracy of the funding pool that was calculated by the State Medicaid agency for distribution to public providers as enhanced payments, (2) track the dollars transferred between local and State governments, and (3) determine how selected county-owned nursing facilities that received enhanced payments used the excess funds.

OAS; W-00-00-30013; Various CINs

Hospital-Specific Disproportionate Share Payment Limits

At HCFA's request, we are reviewing some States' disproportionate share hospital (DSH) payments to selected hospitals to verify that the States calculated the payments in accordance with their approved State plans and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act of 1993. Under the act, DSH payments to an individual hospital may not exceed that hospital's total unreimbursed costs. This provision took effect in State fiscal years beginning in 1994 and 1995 for public and private hospitals, respectively. The HCFA subsequently required that all inpatient hospital

State plan amendments contain an assurance that DSH payments to individual providers will not exceed the hospital-specific DSH payments limits.

OAS; W-00-00-30013; A-06-00-00026

Outpatient Psychiatric Services at Acute Care Hospitals

This review will determine whether psychiatric services rendered by acute care facilities on an outpatient basis are billed and reimbursed in accordance with Medicaid regulations. Our prior work found significant Medicare overpayments for such services. We will determine whether the problems we found with Medicare claims are also prevalent with claims submitted to State Medicaid agencies.

OAS; W-00-00-30013; A-02-00-01023

Nursing Facility Administrative Costs

This national review will determine whether nursing facilities that participate in the Medicaid program have claimed unallowable or highly questionable administrative expenses. Prior OIG work identified a nursing facility chain that falsely inflated the administrative expenses claimed for reimbursement on cost reports. Improper expenses included salaries and benefits for “ghost” employees, personal automobile expenses, and other expenditures that were unrelated to nursing facility operations.

OAS; W-00-01-30013; A-06-01-00000

State Oversight of Home- and Community-Based Waivers for the Mentally Retarded

We will examine State oversight policies and procedures for services provided in accordance with Medicaid home- and community-based waivers for the mentally retarded. These waivers, which must be approved by HCFA, allow States to provide community-based care to persons who otherwise would be institutionalized. In 1998, almost 240,000 individuals received these services at a cost of nearly \$7.5 billion. Each State is responsible for implementing its own oversight practices and for providing health and welfare assurances to HCFA for services provided through home- and community-based waivers. Recent news articles have raised concerns about the level of oversight provided in this program.

OEI; 00-00-00000

Claims for Residents of Institutions for Mental Diseases

Our review will determine whether States have improperly claimed Federal financial participation under the Medicaid program for 21-to 64-year-old residents of institutions for mental diseases. Our prior work found that some State Medicaid agencies were not in compliance with Federal regulations that prohibit Federal funding for services provided to such patients.

OAS; W-00-00-30013; A-02-00-01027

Community Mental Health Services

We will determine whether providers of community mental health services met State Medicaid agency reimbursement requirements. Our prior work involving Medicare payments to community mental health centers identified a large number of unallowable or highly questionable services. Many of these services were not reasonable and necessary for the patients' condition or were not properly authorized by or furnished under the general supervision of a physician. We will determine if these problems exist in States that offer community mental health services through the Medicaid program.

OAS; W-00-01-30013; A-04-01-00000

Durable Medical Equipment Reimbursement Rates

This review will determine the extent that Medicaid payments for durable medical equipment exceeded allowable Medicare rates. Since the beginning of FY 1998, one State's Federal share of payments to DME providers has exceeded the allowable rates by \$8 million. Both the State statute and the State Medicaid plan prohibit Medicaid DME payments from exceeding allowable Medicare rates. These excess payments occurred because the State improperly based DME reimbursement rates on the 1993 Medicare fee schedule, rather than on the Balanced Budget Act of 1997, which significantly reduced some Medicare reimbursement rates. We will expand our audit work to other States that cite the Medicare fee schedule in their State plans or that have legislation requiring the use of the Medicare fee schedule.

OAS; W-00-00-30013; A-05-00-00022

Durable Medical Equipment Payments on Behalf of Nursing Home Recipients

Our review will determine the adequacy of procedures and controls over Medicaid payments for durable medical equipment provided to residents of nursing facilities. Depending on how

each State's rate setting agency determines payments to nursing facilities, DME may be included in the facilities' per diem rate, in addition to the per diem rate, or billed directly to Medicaid by the DME provider. We will assess the appropriateness of payments to DME providers made on behalf of beneficiaries residing in nursing homes.

OAS; W-00-00-30007; A-01-00-00001

Followup on Clinical Laboratory Services

This review will follow up on our prior audits of clinical laboratory services in 22 States. We will determine the adequacy of State Medicaid agency procedures and controls over the payment of claims for clinical laboratory tests. Specifically, we will determine whether Medicaid payments for chemistry, hematology, and urinalysis tests were duplicated or exceeded amounts recognized by Medicare for the same tests. For clinical laboratory tests performed by a physician, an independent laboratory, or a hospital, Federal matching funds are not available to the extent that a State pays more than the amount Medicare recognizes.

OAS; W-00-00-30027; A-01-00-00003

Medicaid Outpatient Prescription Drug Pricing

At HCFA's request, we are updating our pricing studies on Medicaid outpatient prescription drugs. Our prior reviews, which were based on 1994 data, showed that the actual acquisition cost of brand name prescription drugs was 18.3 percent below average wholesale price and that the actual acquisition cost of generic drugs averaged 42.5 percent below average wholesale price. Recent studies conducted by the State of Utah showed that acquisition costs from June 1997 to May 1998 averaged 18.4 percent below average wholesale price for brand name drugs and 60.1 percent below for generic drugs.

OAS; W-00-00-30023; A-06-00-00023

Medicaid Drug Rebate Program

We will analyze the effect of new versions of existing drugs on the Medicaid drug rebate program. Part of the rebate calculation for brand name drugs is based on an inflation adjustment. The rebate is the amount by which the current average manufacturers price for a drug exceeds the base average manufacturers price, indexed to the consumer price index for urban consumers from the time a drug enters the market. Under current rules, a manufacturer could change a drug slightly (e.g., a change in color) to obtain a new national drug code, resulting in a new start for indexing purposes. We will calculate the increase in rebates that

would result from decreasing the base price for new versions of drugs by an amount equal to the percentage increase above the consumer price index for the earliest version of the drugs.

OAS; W-00-00-30023; A-06-00-00012

Unallowable Transportation Costs

We will determine whether payments for transportation claims met Medicaid reimbursement requirements. In one State, we found that nonemergency transportation claims were paid even though the trip dates did not coincide with medical provider claims for services on the same date. The State identified 57,000 transportation claims that did not match medical service provider claims. Our work will determine if this problem exists in other States.

OAS; W-00-00-30013; A-05-00-00017

Payments for Services to Deceased Beneficiaries

In selected States, we will determine whether providers billed and were reimbursed for Medicaid services that occurred after beneficiaries' dates of death. One State auditor's review determined that during a period of almost 6 years, the State paid \$82 million for services to 26,822 apparently deceased beneficiaries.

OAS; W-00-01-30013; Various CINs

MEDICARE CONTRACTOR OPERATIONS

Comparison of Payment Safeguard Activities

We will compare Medicare and Medicaid payment safeguard activities with those undertaken by other payers to determine promising approaches that could be adapted for HCFA programs. As national health care expenditures rise and public awareness of health care fraud increases, health care payers will continue to develop payment safeguards to control costs. These techniques may include prepayment screens, targeted medical review protocols, and establishment of special investigative units. This study will enhance the OIG's ability to reduce fraud and waste in addition to providing recommendations for Medicare and Medicaid fraud control.

OEI; 00-00-00000

Followup on Contractor Fraud Control Units

We will follow up on our previous studies of contractor fraud control units and identify factors that contribute to and work against successful program integrity operations. Our November 1996 report, "Carrier Fraud Units" (OEI-05-94-00470), noted deficiencies in carriers' ability to properly identify potentially fraudulent activity and to consistently develop payment information and in their case documentation, internal proactive safeguards, and external proactive safeguards. In our November 1998 report, "Fiscal Intermediary Fraud Units" (OEI-03-97-00350), we found that fraud units differed substantially in the number of complaints and cases handled and that some units produced few, if any, significant results. Additionally, half of the units did not open any cases proactively, and more than one-third did not identify program vulnerabilities.

OEI; 00-00-00000

Carrier Provider Education and Training

We will examine Medicare carriers' provider education and training efforts and identify any promising practices. These efforts, required and funded by HCFA, include training providers and their staff on the complexities of claims submission (such as coverage, payment, and billing policy); answering providers' requests for guidance on coverage, reimbursement, and medical necessity policy; and identifying providers that habitually submit claims that create processing problems and targeting them for training.

OEI; 00-00-00000

Controls Over Financial Management

This demonstration project will evaluate two Medicare contractors' internal controls over financial management. Such controls are critical to ensuring the integrity of information generated by financial systems that process 935 million claims and provide \$180 billion in fee-for-service payments annually. Our primary goal is to identify and prioritize internal control weaknesses in the areas of cash management, reporting and collecting overpayments, claim processing, cost report settlements, Medicare secondary payer and credit balances, and postpayment and prepayment reviews.

OAS; W-00-00-40014; A-01-00-00535, -02-00-00000

Source Code Controls

We will evaluate one Medicare contractor's controls over standard Medicare claim processing systems' source code. This computer code, written in a human-readable form, is routinely provided to contractors using the Fiscal Intermediary Standard System and the Common Working File. The capability of individual users to modify source code represents a significant risk to the integrity of the standard system software. The widespread availability of source code has been reported as a material weakness in OIG's report on the audit of HCFA's financial statements. We will review application access and change control policies and procedures to determine whether controls are in place to prevent unauthorized change.

OAS; W-00-01-40002; A-09-01-00000

General and Application Controls

We will evaluate a Medicare contractor's general and application controls related to processing Medicare claims. The review will focus on those controls related to (1) entity-wide security program planning and management, (2) access controls, (3) application software controls, (4) system software, (5) segregation of duties, (6) service continuity, and (7) mainframe operating system security.

OAS; W-00-01-40002; A-06-01-00000

Controls Over Exorbitant Payments

We will review the effectiveness of controls designed to detect and investigate exorbitant payments for services provided to Medicare beneficiaries. Preliminary data show that such payments have been made in the past. If appropriate, we will recommend remedies for deficiencies in the existing control structure.

OAS; W-00-00-30026; A-01-00-00502

Payments for Incarcerated Persons

We will examine the extent to which Medicare has made unallowable payments for jailed individuals. Medicare is legally obligated to pay for such individuals only if certain conditions are met. We expect to perform fieldwork at selected providers and Medicare intermediaries/carriers.

OAS; W-00-00-30003; A-14-00-00480, -04-00-05568

Payments for Deported Individuals

We will assess the adequacy of existing controls over payments made on behalf of individuals who have been deported from the country. Survey data show that such payments do exist. We will quantify the extent of such payments and, if warranted, recommend actions to preclude future unallowable payments.

OAS; W-00-00-30003; A-14-00-00440, -04-00-00000

Medicare Part B Payments for Durable Medical Equipment

This followup review will determine the adequacy of durable medical equipment regional carrier procedures and controls intended to prevent inappropriate Medicare Part B payments for DME provided to inpatients of skilled nursing facilities. By law, DME suppliers are not entitled to payments under Medicare Part B when beneficiaries are skilled nursing facility inpatients. However, two previous OIG reports identified millions of dollars in these improper payments.

OAS; W-00-00-30007; A-01-00-00509

Contractor Hearings and Appeals

This study will assess contractors' procedures for processing hearings and appeals. Our September 1999 report on the Administrative Law Judge hearing process for Medicare Parts A and B fee-for-service appeals noted that HCFA incurred considerable administrative costs through its contractors for processing appeals. The cost totaled over \$4 million for Medicare Part A and about \$75 million for Medicare Part B in FY 1996. We will evaluate appeals at the contractor level, including reconsiderations, reviews, and carrier hearings.

OEI; 04-00-00230

Suspension of Payments to Providers

We will assess the extent to which Medicare contractors suspended payments to providers in an effort to recoup Medicare monies and whether they complied with applicable rules. The Medicare program specifies separate procedures for suspensions involving providers that owe overpayments and providers that owe overpayments where fraud is suspected. When claims are suspended, they remain in that category until a determination is made to release monies to the provider or to offset the amount against a Medicare or other governmental obligation. This

study will examine the procedures used and circumstances surrounding decisions to suspend payments and determine the effectiveness of payment suspension in recouping overpayments.

OEI; 00-00-00000

Bankrupt Providers

This study will assess the frequency of bankruptcies among Medicare providers, the financial implication to the program, and the controls in place to prohibit bankrupt providers from reentering the Medicare program. Providers that participate in cost-based Medicare programs, such as home health agencies and community mental health centers, may encounter financial difficulties by receiving overpayments from Medicare that they are unable to repay or through fiscal mismanagement. Such providers often walk away from these debts, owing the Medicare trust fund millions of dollars. As part of this study, we will determine whether individuals who filed for bankruptcies later reentered the Medicare program under a different provider number.

OEI; 00-00-00000

Private Sector Use of Recovery Firms

This study will assess the extent to which recovery specialists are used in the private sector and the types of activities they undertake. Medicare contractors take a variety of actions to recover misspent program funds, and the Senate Appropriations Committee has strongly encouraged HCFA and OIG to explore the use of private recovery firms in the Medicare program. We will identify any issues and impediments to the effective use of recovery specialists by Medicare.

OEI; 04-00-00220

Contractors' Administrative Costs

This series of reviews requested by HCFA will audit administrative costs claimed by various contractors for their Medicare activities. Special attention will be given to costs claimed by terminated contractors. These reviews will determine whether the costs claimed were reasonable, allocable, and allowable under the terms of the contracts. We will coordinate the selection of the contractors with HCFA staff.

OAS; W-00-99-30004, W-00-00-30004; Various CINs

Unfunded Pensions

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-00-99-30005, W-00-00-30005; Various CINs

Pension Segmentation/Costs Claimed

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 of 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 contractors use a reasonable method for claiming reimbursement for pension costs under their Medicare contracts.

OAS; W-00-99-30005, W-00-00-30005; Various CINs

Pension Termination

At HCFA's request, these reviews will be performed at former Medicare carriers and intermediaries whose Medicare contracts have been terminated, resulting in the closing of their Medicare segments. We will determine the amount of any excess pension assets related to the Medicare segment as of the segment closing date. Regulations and the Medicare contracts provide that pension gains that occur when a Medicare segment closes should be credited to the Medicare program.

OAS; W-00-99-30005, W-00-00-30005; Various CINs

GENERAL ADMINISTRATION

Improper Medicare Fee-for-Service Payments

We will determine whether FY 2000 Medicare fee-for-service benefit payments were (1) furnished by certified Medicare providers to eligible beneficiaries, (2) made in accordance with Medicare laws and regulations, and (3) medically necessary, accurately coded, and sufficiently documented. Our determination will be made from a review of claims and patient

medical records, with the assistance of medical staff. We will use statistical sampling techniques to project results nationwide and to compute a national error rate. Collectively known as “improper payments,” these benefit payments could range from inadvertent mistakes to outright fraud and abuse. In FY 1999, estimated improper payments totaled \$13.5 billion, or 7.97 percent of the \$169.5 billion total spent on Medicare fee-for-service claims.

OAS; W-00-00-40011; A-17-00-02000

Collecting Nontax Delinquent Debt

As part of an initiative by the President’s Council on Integrity and Efficiency, we will assess HCFA’s process for collecting nontax delinquent Medicare debt, which is debt over 180 days delinquent. The Debt Collection Improvement Act of 1996 requires that Federal agencies maximize collections of delinquent debt owed to the Government and reduce losses arising from inadequate debt management activities. The objectives of our review are to determine whether (1) HCFA accurately reports Medicare delinquent debt and (2) HCFA’s debt management and collection activities follow the criteria set forth in the act.

OAS; W-00-01-40011; A-17-01-00000

Medicare Secondary Payer

We will conduct a series of reviews on Medicare payments for beneficiaries who have other insurance coverage. By statute, Medicare payments for such beneficiaries are required to be secondary to certain types of private insurance coverage. However, various OIG and GAO reports found that inappropriate Medicare secondary payer payments amounted to millions of dollars. We will assess the effectiveness of current procedures in preventing these inappropriate payments. For example, we will evaluate HCFA’s current procedures for identifying and resolving credit balance situations, i.e., situations in which payments from Medicare and other insurers exceed the providers’ charges. We will also evaluate the effectiveness of data sharing between Medicare and private insurers.

OAS; W-00-99-30030; A-14-99-00420, -02-00-00000

Corporate Integrity Agreements

We will continue to review compliance audit work plans and annual audit reports submitted by health care providers as required by the corporate integrity agreements the providers signed to

settle false claims actions. The objective of our reviews is to ensure that the requirements of the settlement agreements have been met.

OAS; W-00-00-30019; Various CINs

Joint Work With Other Federal and State Agencies

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and inspectors general, Medicaid agencies, and HCFA financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate program, and durable medical equipment. Future joint initiatives will cover hospice claims, managed care issues, hospital transfers, prescription drugs, laboratory services, outpatient therapy services, and transportation services.

OAS; W-00-00-30001; Various CINs

INVESTIGATIONS

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

The OIG concentrates its resources on the conduct of criminal investigations relating to HHS programs and operations. These investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in vulnerable program areas that can be eliminated through corrective management actions, regulation, or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

While each year literally thousands of complaints from various sources are brought to the OIG's attention for development, investigation, and appropriate conclusion, OI has targeted certain high-risk areas for continued investigative concentration for as long as there appears to be a high probability that wrongdoing will be uncovered, prosecuted, and deterred in these areas. Although OIG managers will continue to make their investigative decisions on a case-by-case basis, this Work Plan identifies several investigative focus areas in which we will concentrate our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

Medicare Part A

Medicare Part A helps pay for four kinds of medically necessary care: inpatient hospital care, inpatient care in a facility, home health care, and hospice care. Approximately 58 percent of the Medicare dollar is spent on Part A services. We will investigate facilities or entities that billed the Medicare program for services not rendered or that manipulated payment codes in an effort to inflate their reimbursement amount. We will also investigate business arrangements that violate anti-kickback statutes.

Medicare Part B

Medicare Part B helps pay for doctors' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies not covered by Medicare Part A. The most common Part B violation involves false provider claims to obtain payments. The OIG receives complaints from a variety of sources and conducts widespread investigations into fraudulent schemes in various areas of medical service. We will investigate a broad range of suspected fraud and present cases for both criminal and civil prosecution.

Medicare Part C

The Balanced Budget Act of 1997 established a new authority permitting HCFA to contract with a variety of different managed care and fee-for-service entities, including:

- coordinated care plans, HMOs, preferred provider organizations, and provider-sponsored organizations;
- religious fraternal benefit plans;
- private fee-for-service plans; and
- a 4-year demonstration project involving medical savings accounts.

Presently, 15 percent of Medicare beneficiaries are enrolled in managed care plans. The HCFA anticipates enrollment in Part C to increase to 33 percent by 2003.

The OIG is working directly with HCFA and the Department of Justice to ensure that the new Part C contracts meet the requirements for criminal, civil, and administrative actions. Additionally, we will continue to develop methods that identify schemes to defraud Medicare Part C.

Medicaid

The Medicaid program provides grants to States for medical assistance payments. The majority of States have taken advantage of available Federal funding to establish Medicaid fraud control units to investigate criminal violations. The OIG provides oversight of the fraud control units and will conduct Medicaid fraud investigations only in States without such units or where there is a shared interest. In addition to sustaining scrutiny of the principal health care programs administered by HCFA, the OIG will focus attention on HCFA grants and contracts with carriers and intermediaries.

Pneumonia Diagnosis-Related Group Upcoding Project

This cooperative effort with the Department of Justice focuses on information that hospitals have upcoded the diagnosis-related group for certain pneumonia claims from viral to bacterial pneumonia. By doing this, the hospitals obtained almost \$2,500 extra per claim in reimbursement. The OIG is looking at both civil and criminal implications.

Prospective Payment System Transfer Project

In another cooperative effort with the Department of Justice, the OIG is focusing on hospital misrepresentation of patient discharge status and the resulting false claims. By doing this, hospitals receive the full reimbursement under the diagnosis-related group when, in fact, the transferring hospital should be paid a lesser amount.

LEGAL COUNSEL

In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of civil and administrative health care fraud cases, including the imposition of program exclusions and civil monetary penalties and assessments and the negotiation of corporate integrity agreements. The OCIG represents OIG in administrative litigation, such as civil monetary penalty and program exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes and is responsible for developing OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2001 includes:

Compliance Program Guidance

We will continue to issue compliance program guidance to assist the health care industry in establishing voluntary corporate compliance programs and in developing effective internal

controls that promote adherence to applicable Federal statutes, regulations, and the program requirements of Federal health care plans. We plan to issue program guidance documents in FY 2001 pertaining to ambulance companies. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans while furthering the health care industry's fundamental mission to provide quality patient care.

Expected Completion Date: Ongoing

Corporate Integrity Agreements

We will continue to monitor providers' compliance with the terms of over 400 corporate integrity agreements (and settlements with integrity provisions) into which they entered in conjunction with the settlement of fraud and abuse allegations. We will increase the number of site visits to entities that are subject to the integrity agreements to verify compliance efforts and confirm information submitted by the entities to OIG. Included in this monitoring process will be the establishment of a tracking system to determine the overpayment amounts returned to the Medicare trust fund as a result of providers' having established certain mechanisms, including auditing and reporting, required by the OIG under corporate integrity agreements.

Expected Completion Date: Ongoing

Advisory Opinions and Fraud Alerts

As part of the OIG's ongoing efforts to prevent fraud and abuse through industry guidance, we will respond to requests for formal advisory opinions on the application of the anti-kickback statute and other fraud and abuse statutes to particular circumstances. We will also issue special fraud alerts and advisory bulletins, as warranted, to inform the health care industry more generally of particular industry practices that we determine are highly suspect.

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

In FY 2001, we anticipate publishing regulations for several new safe harbor exemptions from the anti-kickback statute. Also, we will continue to evaluate comments that we solicited from the public concerning proposals for additional safe harbors.

Expected Completion Date: Ongoing

Patient Anti-Dumping Statute Enforcement

We expect to continue the review, negotiation, settlement, and litigation of cases involving violations of the patient anti-dumping statute in FY 2001. In addition, we plan to continue our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG.

Expected Completion Date: Ongoing

Civil Monetary Penalties

We expect to promulgate regulations implementing the civil monetary penalty authorities applicable to Medicare+Choice organizations, codified at section 1857 of the Social Security Act, as well as Medicaid managed care, codified at 1903(m) of the act. In addition, we will continue our enforcement activities in this area and specifically focus on cases involving improper conduct by managed care organizations.

Expected Completion Date: Ongoing

Department of Health and Human Services

Office of Inspector General Projects



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CENTERS FOR DISEASE CONTROL AND PREVENTION

Evaluation Systems for HIV/AIDS Prevention Programs

We will examine the evaluation systems used by the Centers for Disease Control and Prevention (CDC) to monitor compliance with grant requirements and measure the effectiveness of the HIV/AIDS youth education/prevention programs that it funds. Half of all new HIV infections in the United States occur in people under age 25, and CDC reports that approximately 40,000 persons are infected each year. Through cooperative efforts with national organizations and the States, CDC supports training for more than 180,000 teachers annually on administering HIV youth education programs in schools. In each of the past 5 years, these programs received approximately \$46 million. The average grant received by each State is about \$217,000.

OEI; 00-00-00000

Oversight of National Academy of Sciences Study

At the request of the Senate Committee on Small Business, we will evaluate whether (1) the National Institute of Occupational Safety and Health has exercised appropriate oversight of a National Academy of Sciences (NAS) study of musculoskeletal disorders in the workplace and (2) expenditures of appropriated funds have been consistent with the legislative language authorizing their use. The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 provided \$890,000 to the Office of the Secretary for an NAS contract to "conduct a study of available scientific literature examining the cause-and-effect relationship between repetitive tasks in the workplace and musculoskeletal disorders"

OAS; W-00-00-50003; A-15-00-30002

Controls Over Program Budgeting and Accounting

We will determine whether CDC has established internal and management controls adequate to ensure that (1) budgets established for individual programs reflect any guidance provided by the Congress and the Department; (2) costs charged to those programs are based on the actual efforts of employees and use of other resources; and (3) financial reports provided to the Congress and the Department regarding the nature and extent of costs for specific programs and activities are timely, complete, and accurate.

Building on information obtained during our recent review of costs charged to the Chronic Fatigue Syndrome program, we will focus on programs for which CDC has received specific budgetary guidance or for which CDC officials have provided the Congress and the Department with detailed data related to program costs.

OAS; W-00-01-50003; A-04-01-00000

Followup on Chronic Fatigue Syndrome Management Issues

We will assess the effectiveness of CDC's actions in response to our May 1999 review of the Chronic Fatigue Syndrome program. The CDC agreed to implement a number of recommended actions designed to enhance its controls over budgeting and accounting functions for programs operating within its various centers, institutes, and offices. We will determine whether CDC's actions are adequate to prevent any recurrence of the problems identified during our prior review and, if appropriate, present additional recommendations to further enhance control systems.

OAS; W-00-01-50003; A-04-01-00000

Controls Over Physical Security

We will follow up on actions taken by CDC to improve controls over physical security at headquarters facilities in Atlanta, Georgia. In response to an OIG audit report, CDC agreed in July 1996 to specific actions to improve controls at these facilities. In FY 1997 appropriations, the Congress provided CDC with \$23 million to begin security improvements. We will determine whether our previous recommendations have been implemented and whether additional safeguards are necessary.

OAS; W-00-01-50003; A-04-01-00000

FOOD AND DRUG ADMINISTRATION

Retail Food Safety

We will examine the effectiveness of the Food and Drug Administration's (FDA) food safety activities in the retail food business. Nearly half of American food dollars are spent on foods sold at over a million retail food outlets and one and a half million vending operations. In accordance with the Public Health Service Act, retail establishments are inspected by States under Federal-State cooperative programs; FDA's primary role is to assist and advise State and local governments in carrying out the programs. Since 1978, FDA has issued a voluntary

“Food Code” that provides technical assistance to retail establishments and State and local monitors. The code has been adopted by 32 States. To monitor retail establishments and their voluntary compliance with the Food Code and other retail food safety guidance, FDA relies on more than 3,000 State and local agencies. We will examine the effectiveness of these cooperative relationships.

OEI; 00-00-00000

Oversight of National Conferences

We will examine FDA’s role in the National Conferences that oversee the Federal-State cooperative programs for food safety. Under these programs, States inspect shellfish, milk products, and retail establishments, and FDA’s primary role is to assist and advise State and local governments. Policy and standards for the cooperative programs are overseen by three distinct National Conferences, each made up of industry, Federal, State, and local regulators. We will examine FDA’s authorities to oversee the conferences and its role in setting standards for the cooperative programs to ensure the safety and quality of shellfish, milk, and retail products. The CDC recently estimated that food-borne diseases cause about 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths each year in the United States and that the annual cost of foodborne illness amounted to \$7.7 billion to \$23 billion.

OEI; 00-00-00000

Biennial Inspection Requirement

We will assess whether FDA is meeting its statutory requirement to inspect drug and device manufacturers every 2 years. Previous OIG work indicated that FDA is not doing so, even though such inspections are critical to ensure that firms comply with good manufacturing practices. 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-00-01-50004; A-15-01-00000

Expected Issue Date: FY 2002

Effectiveness of MedWatch

We will evaluate the effectiveness of MedWatch, FDA's medical products safety reporting program. The FDA is responsible for ensuring the safety and efficacy of all regulated, marketed medical products, including drugs, biologics, medical and radiation-emitting devices, and special nutritional products. Created in 1996, MedWatch was designed to (1) educate health professionals about the importance of monitoring for and reporting adverse reactions and other problems to FDA and/or the manufacturer, (2) enhance the effectiveness of

postmarketing surveillance of medical products, and (3) ensure that safety and labeling changes are rapidly communicated to the medical community, thereby improving patient care.

OEI; 00-00-00000

Expected Issue Date: FY 2002

Adverse Event Reporting System

We will assess the capability of the Adverse Event Reporting System (AERS) to support postmarketing surveillance of drugs and adverse drug experiences, one of FDA's chief responsibilities. In 1997, FDA began replacing the 1960's-designed Spontaneous Reporting System with AERS, a new computerized database system.

OAS; W-00-00-50004; A-15-00-30001

Orphan Products

We will evaluate the impact of the Orphan Drug Act of 1983 on the development of "orphan" products. An orphan disease is one that affects fewer than 200,000 Americans per year; currently, approximately 5,000 orphan diseases affect 20 million individuals. The Orphan Drug Act was intended to stimulate the private sector's development and marketing of treatments for these diseases, thereby improving patient access to new therapies.

OEI; 09-00-00380

Sponsors' Oversight of Implementation of Clinical Trials

We will examine how sponsors of clinical trials monitor the implementation of the trials by clinical investigators. Sponsors are normally drug, device, or biologic manufacturers that plan to submit an application for FDA approval. They are responsible for ensuring that clinical trials are conducted in accordance with FDA regulations but may delegate any or all of these responsibilities to a contract research organization. The FDA holds these organizations accountable for any delegated responsibilities. Our review will look at such issues as how often sponsors or contract research organizations visit clinical investigators, whether the results of such visits are shared with FDA, and how often sponsors or contract research organizations discontinue clinical investigators' participation in clinical trials.

OEI; 00-00-00000

Accreditation and Quality Oversight of Mammography Facilities

We will review the accreditation and regulatory oversight process for mammography facilities since the enactment of the Mammography Quality Standards Act of 1992. The act, which gave enforcement authority to FDA, includes requirements that all mammography facilities undergo periodic review of their clinical images; have an annual survey by a medical physicist; and meet federally developed quality standards for personnel qualifications, recordkeeping, and reporting. The law was reauthorized in 1998, extending it to 2002.

OEI; 00-00-00000

Followup on Blood Safety Issues

This review will examine FDA's efforts to improve its oversight of the safety of the Nation's blood supply. Our work will focus on problems the OIG previously identified regarding the blood error and accident reporting process, the blood recall process, and the inspection process for plasma fractionators. Our objective will be to determine if FDA has implemented the specific recommendations made in earlier OIG reports.

OAS; W-00-01-50004; A-03-01-00000

Bioterrorism Research Program

We will assess FDA's actions to implement its bioterrorism research program. The FDA has included \$11.5 million in its FY 2001 budget request to develop vaccines, diagnostic products, and rapid detection methods to counter bioterrorism threats. This review will build on an earlier assessment, conducted at the request of the Subcommittee on Oversight and Investigations, House Committee on Commerce, of FDA's FY 2000 activity in bioterrorism research.

OAS; W-00-01-50004; A-15-01-00000

Financial Disclosure Requirements

This review will examine FDA's requirements on the disclosure of financial conflicts by research investigators. In early 1999, FDA issued a regulation requiring investigators to disclose financial conflicts of interest that meet or supercede certain limits. Our study will assess the prevalence of conflicts and determine the nature and extent of FDA efforts to mitigate their potential influence.

OEI; 00-00-00000

HEALTH RESOURCES AND SERVICES ADMINISTRATION

State Licensing Boards and Discipline of Physicians

We will assess the performance of State boards responsible for the licensing and discipline of physicians. The State boards serve as a vital front line of protection for Medicare and Medicaid beneficiaries, as well as all health care consumers. The boards are responsible for ensuring that practicing professionals meet the minimum qualifications spelled out in State practice acts. Because of the Health Resources and Services Administration's (HRSA) relationship with the health professions and its own quality assurance activities (such as the National Practitioner Data Bank), it has a longstanding interest in licensing board activities.

OEI; 00-00-00000

Hemophilia Treatment Centers' Purchase of Drugs at Discount Prices

At HRSA's request, we will examine hemophilia treatment centers' efforts to purchase anti-hemophilic factor drugs at 340B discounted prices. Under Section 340B of the Public Health Service Act, drug manufacturers that sell to eligible PHS entities may not charge more for covered drugs than the average manufacturers' price decreased by a rebate percentage. Hemophilia treatment centers, which are funded by HRSA, qualify for discount pricing of anti-hemophilic factor under the law. However, concerns have been raised regarding the centers' ability to obtain discount drug prices.

OAS; W-00-01-50005; A-01-01-00000

Drug Purchasing by Ryan White Grantees and Eligible Metropolitan Areas

We will examine Ryan White Title I grantees' and Eligible Metropolitan Areas' knowledge and use of various strategies to purchase drugs at the lowest available cost. Eligible Metropolitan Areas are those metropolitan regions (currently numbering 51) with the highest incidence of HIV disease. We will evaluate the efficiency and cost effectiveness of current Eligible Metropolitan Areas' drug purchasing arrangements and the level of coordination with

State AIDS Drug Assistance Programs. This study follows up on our “Ryan White Cost Containment Strategies” study (OEI-05-99-00610).

OEI; 00-00-00000

Coordination of HIV/AIDS Services by HRSA, CDC, and SAMHSA

We will examine the coordination of HIV/AIDS prevention and treatment services by HRSA’s Ryan White programs, CDC, and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Ryan White CARE Act requires the Secretary to ensure that HRSA, CDC, and SAMHSA coordinate the planning and implementation of Federal HIV programs to facilitate the local development of a complete continuum of HIV-related services. The statute also requires the Secretary to submit, no later than October 1, 1996, and biennially thereafter, a report concerning these coordination efforts, including a statement of whether and to what extent Federal barriers exist to integrating HIV-related programs. The required report has yet to be submitted.

OEI; 00-00-00000

Expected Issue Date: FY 2002

Coordinating Medicaid and Ryan White Services for People With HIV and AIDS

We will examine coordination between the Health Care Financing Administration’s Medicaid program and HRSA’s Ryan White programs. Funding 50 percent of all adults and 90 percent of all children with AIDS, Medicaid is the largest funder of HIV/AIDS care in the United States. In FY 1999, the Federal share of Medicaid spending on HIV/AIDS care was \$2.1 billion, or over 21 percent of total Federal HIV/AIDS spending, and the States’ share was \$1.8 billion. Ryan White Comprehensive AIDS Resource Emergency Act programs received over \$1.4 billion in FY 1999, almost 15 percent of total Federal HIV/AIDS spending for the year. These State and local programs provide health care services to people not eligible for Medicaid and ancillary services for Medicaid recipients and others. Our study will examine coordination efforts at the Federal, State, and local levels and describe their impact on HIV/AIDS care.

OEI; 00-00-00000

INDIAN HEALTH SERVICE

Impact of Self-Governance on IHS Services

We will assess the effect of Indian self-governance on the Indian Health Service's (IHS) ability to provide needed health care services to the Indian people. As tribes increasingly elect 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 that do not opt to provide their own care. We will determine (1) if controls are adequate to ensure that needed health care services are provided with compacting funds and (2) how nearby IHS facilities would be affected should compacting tribes be unable to adequately or fully meet the health care needs of their members.

OAS; W-00-01-50006; A-06-01-00000

Expected Issue Date: FY 2002

Tribal Self-Governance Compact Award Process

We will examine the IHS process for awarding compacts to tribes under the Tribal Self-Governance Demonstration Project. With nearly 20 percent of the IHS budget provided to Indian tribes through the compact mechanism, the agency needs to ensure that it has implemented the demonstration project as the Congress intended and has effectively used available authorities. Our review will focus on whether IHS has met key tenets of the legislative mandate.

OAS; W-00-97-50006; A-15-97-50003

Contracting With Tribes

This study will review IHS oversight of self-determination contracts with tribes. The Indian Self-Determination and Education Act of 1975 allows tribes and tribal organizations to operate their own health programs. We will focus on IHS area office operations, such as negotiating, monitoring, and reporting activities. This study will complement a recently completed review on the related subject of IHS compacts.

OEI; 00-00-00000

Recruitment and Retention of Staff

As IHS requested, we will focus on IHS problems with recruiting and retaining health care staff and attempt to provide recommendations to relieve these problems. Currently, IHS has a

10 percent vacancy rate, and understaffing is particularly acute in the areas of dental, pharmacy, and optometry services. In recent years, about one-third of departing dentists worked for IHS for less than 2 years.

OEI; 00-00-00000

Scholarship and Loan Repayment Programs

We will determine whether the recipients of IHS scholarship and loan repayment programs have fulfilled their obligations and, if not, what actions IHS has taken or should take to recover the funds awarded. Since FY 1998, IHS has awarded over \$34 million in scholarships and loan repayments to recruit and retain professionals to work in its own and tribal facilities. The scholarship program encourages qualified Native American students to pursue careers in health fields, while the loan repayment program is offered to IHS health care employees in a variety of fields, including physicians, nurses, dentists, pharmacists, and mental health professionals. Both programs obligate recipients to serve at an IHS or tribal facility in return for IHS financial support.

OAS; W-00-01-50006; A-15-01-00000

Expected Issue Date: FY 2002

Facility Maintenance and Repair

At IHS' request, we will determine, using industry benchmarks, whether current funding levels are appropriate to adequately maintain the agency's real property inventory. The inventory, estimated by IHS to have a replacement value of \$1.5 billion, includes hospitals, clinics, and health centers — all critical to meeting its health care delivery mission. According to IHS officials, the agency's buildings are old and costly to repair and could affect the quality of care provided to program beneficiaries.

OAS; W-00-00-50006; A-15-00-50002

NATIONAL INSTITUTES OF HEALTH

Superfund Financial Activities for Fiscal Year 2000

As required by Superfund legislation, we will conduct this annual financial audit of the National Institute of Environmental Health Sciences' payments, obligations, reimbursements, and other uses of Superfund monies. The Institute's Superfund activities, carried out by its own staff and through cooperative agreements, include training people engaged in hazardous waste activities and studying the effects of exposure to specific chemicals. During FY 1999, agency

obligations and disbursements of Superfund resources amounted to \$62.9 million and \$55.4 million, respectively.

OAS; W-00-01-50025; A-04-01-00000

Cancer Information Service Outreach Program

This study will review the effectiveness of the National Cancer Institute's Cancer Information Service outreach program. The mission of the program is to disseminate cancer information to "the medically underserved, including minority groups and people with limited access to health information and services." This outreach effort has never been evaluated. Our study is a follow-up to the recently completed review of the Cancer Information Service's telephone information service.

OEI; 00-00-00000

Commercialization of Intramural Biomedical Technology

This congressional requested review will assess the adequacy of the NIH process for providing biomedical technology developed in its intramural laboratories to the private sector for marketing to the public. Under the Federal Technology Transfer Act of 1986, Federal laboratories, including NIH, are mandated to collaborate with the private sector to facilitate the transfer of Federal technology to the marketplace. Biomedical technology discovered and/or developed in NIH intramural laboratories includes components of drugs, vaccines, devices, and research material.

OAS; W-00-99-50025; A-15-99-50003

Recruiting Human Subjects for Clinical Trials

This study, a follow-up to our report on "Recruiting Human Subjects for Industry-Sponsored Clinical Research," will determine whether the recruiting environment in NIH-funded clinical research is similar to that found in industry-sponsored research. It has been suggested that the pressures to recruit for NIH trials are lower than those of industry and that NIH and its investigators are unlikely to use recruiting practices that raised concern in our previous report, such as offering financial incentives to investigators and scanning patient databases. We will examine NIH trials to determine to what extent the same recruiting pressures are present and what methods are used to recruit subjects.

OEI; 00-00-00000

General Clinical Research Centers

We will assess NIH's monitoring and oversight of the General Clinical Research Centers program. The program annually provides approximately \$200 million in grants to over 751 centers, generally located in university-affiliated hospitals, which conduct clinical research on human subjects. The program funds the establishment and support of the clinical infrastructure, including funding for research beds and support staff at the centers. A recent audit of a research center raised questions regarding the NIH funding process and overall monitoring of the centers.

OAS; W-00-01-50025; A-01-01-00000

Loan Repayment Programs

We will determine whether the recipients of various NIH loan repayment programs have fulfilled their obligations and, if not, the actions that have been or should be taken to recover the loan funds. Through these programs, NIH aims to recruit health professionals into the areas of general, reproductive (contraception and infertility), and AIDS research and to recruit individuals from disadvantaged backgrounds. In general, the loan repayment programs provide direct financial repayment of educational loans in exchange for a 2- to 3-year period of obligated clinical research service at NIH. Since FY 1998, these programs have awarded over \$8.5 million in loan repayments. Our work will expand upon our review of NIH's National Research Service Awards program, which found systemic problems in tracking loan obligations.

OAS; W-00-01-50025; A-15-01-00000

Expected Issue Date: FY 2002

Oversight of Employees' Outside Activities and Potential Conflicts of Interest

We will review NIH's oversight of employees' outside activities and potential conflicts of interest. Under the guidance of the Office of Government Ethics, agencies are responsible for following regulations governing the behavior of Federal employees. These regulations address specific issues, including prohibitions on outside activities, potential conflicts of interest, and financial disclosure. As employees of the premier biomedical research institution in the United States, it is crucial that NIH personnel uphold the highest standards of integrity and independence.

OAS; W-00-00-50025; A-15-00-80001

Handling, Storage, and Disposal of Equipment Exposed to Hazardous Materials

We will determine whether NIH maintains adequate controls over the handling, storage, and disposal of equipment exposed to hazardous materials. The NIH uses hazardous materials in its hospitals, clinics, and research. If not properly handled, equipment exposed to hazardous material can contaminate individuals and resources. We reported in 1991 that NIH safety procedures were generally weak and frequently were not followed when moving property that had been exposed to hazardous materials. |

OAS; W-00-99-50025; A-15-99-00032

Security of NIH Laboratories

At the request of the Subcommittee on Oversight and Investigations, House Committee on Commerce, we will determine whether physical security at NIH research laboratories is adequate to contain hazardous materials used in research. The Subcommittee specifically requested that we examine NIH's security controls for bioterrorism research and controls for ensuring that physical security funds are appropriately spent. |

OAS; W-00-00-50025; A-15-00-00030

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Substance Abuse Treatment Needs of Welfare Recipients

We will examine the strategies States use to address the substance abuse treatment needs of welfare recipients. States' assessments of the employability of these recipients may indicate the need for appropriate substance abuse treatment. While welfare reform legislation provided additional funding for treatment programs, this funding is unlikely to meet the increased demand expected as recipients are referred to treatment programs to ultimately become employable. In FY 1999, for example, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided about \$1.3 billion in block grant funds to States for substance abuse treatment and prevention. We will attempt to find promising approaches for service delivery that respond to treatment needs within resource constraints. |

OEI; 00-00-00000

Community Support Program

This review will assess SAMHSA's response to our June 1993 report on the Community Support Program. The program, which is funded at about \$20 million annually, provides grants to State mental health authorities for services, research demonstrations, and projects involving consumers and families in the development of services. Our 1993 study made a number of recommendations to SAMHSA's Center for Mental Health Services.

OEI; 00-00-00000

State Psychiatric Hospital Downsizing and Closings

This study will analyze the reduction of available patient beds in State psychiatric hospitals and the closing of such hospitals. In 1965, the Congress excluded most Medicaid payments to State mental hospitals because the Federal Government did not want to assume this historical State responsibility. This exclusion coincided with congressional intent to fund community mental health centers and other community providers through such HHS programs as the Mental Health Services Block Grant and Medicaid. From 1996 to 1999, 14 States closed 211 State psychiatric hospitals, and in 1999, 6 States reported plans to close 8 more hospitals. Our review will focus on the number of beds removed from the system, the factors behind the closings, and the impact of such closings on mental health care.

OEI; 00-00-00000

PHS AGENCIES-WIDE ACTIVITIES

Critical Infrastructure Protection

We will evaluate the efforts of the PHS agencies, including the Program Support Center, to meet requirements for safeguarding critical computer systems. Presidential Decision Directive (PDD) 63, "Critical Infrastructure Protection," issued in May 1998, calls for a national effort to ensure the security of the increasingly vulnerable and interconnected physical and cyber-based infrastructures. Our review is part of the HHS-wide PDD 63 initiative.

OAS; W-00-00-40001; A-15-00-20002

Debt Management and Collection Services

We will evaluate debt management and collection services provided by the Program Support Center to PHS agencies. The Debt Collection Improvement Act of 1996 requires agencies to

transfer debts over 180 days delinquent to the Department of the Treasury for collection unless the debts are in a debt collection center designated by Treasury. In FY 1999, the Program Support Center received limited designation as HHS' debt collection center for a 3-year period and collected debts totaling \$190 million.

OAS; W-00-01-50019; A-15-01-00000

Expected Issue Date: FY 2002

Implementation of Government Performance and Results Act

We will assess selected PHS agencies' efforts to implement the Government Performance and Results Act of 1993. This act is intended to enhance the accountability of Federal programs by directing agencies to focus on program results. We will review the appropriateness of performance measures and data integrity issues related to measuring results.

OAS; W-00-01-50019; A-15-01-00000

Expected Issue Date: FY 2002

Disclosure Statements Filed by Colleges and Universities

The OMB Circular A-21, revised May 8, 1996, requires that colleges and universities disclose their cost accounting practices by filing disclosure statements. The statements are 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 equitably allocated to Federal projects. Our continuing reviews will determine whether disclosure statements are complete and accurate, reflect current practices, and comply with cost accounting standards and pertinent cost principles.

OAS; W-00-01-50007; Various CINs

Recipient Capability Audits

At the PHS agencies' requests, we will perform recipient capability audits of new organizations having little or no experience managing Federal funds. These audits will determine the adequacy of the organizations' accounting and administrative systems and their financial capabilities to satisfactorily manage and account for Federal funds. Such reviews provide management with strengthened oversight of new grantees.

OAS; W-00-01-50013; Various CINs

Reimbursable Audits

We will conduct a series of audits in accordance with the HHS responsibility to negotiate the indirect cost rates for approximately 95 percent of the Nation's nearly 3,000 colleges and universities. Audit cognizance requires that we perform 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 cost accounting standards incorporated in OMB Circular A-21.

OAS; W-00-01-50012; Various CINs

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 reviewed such issues as library allocations, medical liability insurance, internal service funds, fringe benefit rates, and space allocations. These audits helped to substantially reduce indirect cost rates at the institutions reviewed.

OAS; W-00-01-50010; Various CINs

Followup on Nonfederal Audits

These reviews will determine whether auditees have implemented the recommendations in prior nonfederal audit reports to correct reported findings. The OIG's National External Audit Review Center has identified certain prior audits by nonfederal auditors as having circumstances that need further investigation.

OAS; W-00-01-50019; Various CINs

INVESTIGATIONS

Referrals by Office of Research Integrity

As a result of a closer relationship being forged between the OIG's Office of Investigations (OI) and the Office of Research Integrity (located in the Office of the Assistant Secretary for Health), OI expects to investigate more scientific misconduct cases referred by that Office. These matters may involve allegations of fiscal improprieties, such as embezzlement or misappropriation of funds, or other fraudulent activity, such as falsification or fabrication of research data or plagiarism of confidential materials or intellectual property. Under HHS policies, the Office of Research Integrity may not directly investigate such issues but refer them to OIG when appropriate.

Department of Health and Human Services

**Office of Inspector General
Projects**



**ADMINISTRATIONS FOR CHILDREN,
FAMILIES, AND AGING
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TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Collecting AFDC Overpayments

This nationwide review will examine State practices for reporting and collecting Aid to Families with Dependent Children (AFDC) assistance overpayments since welfare reform. Although the AFDC program has been repealed and replaced with Temporary Assistance for Needy Families (TANF), States must return the Federal share of AFDC overpayment recoveries to the Government. A nonfederal audit in one State disclosed that the Federal Government had not been reimbursed for its share of recoveries.

OAS; W-00-00-20016; A-02-00-02004, -12-01-00000

Collection and Distribution of Child Support Arrearages

This review will determine whether, subsequent to welfare reform, States have appropriately distributed the collection of child support arrearages accrued while families were on AFDC. As in the case of AFDC overpayments, States must return the Federal share of overdue AFDC-related child support collected based on distribution requirements for families that formerly received or currently receive assistance.

OAS; W-00-01-20016; A-12-01-00000

Technical Assistance to States

We will examine States' experiences with and perceptions of technical assistance provided by the Administration for Children and Families (ACF) to State TANF agencies and determine opportunities for improvement. Under welfare reform, one of ACF's major responsibilities is to provide technical assistance to State and local entities.

OEI; 00-00-00000

Expected Issue Date: FY 2002

Work Participation Data

We will examine the quality and uniformity of State data reported to ACF on TANF recipients' work participation rates. The ACF uses these data to monitor program performance and, specifically, to determine if States have met their federally defined work participation

target rates. The Personal Responsibility and Work Opportunity Reconciliation Act imposes financial penalties if States do not meet target rates.

OEI; 00-00-00000

Child Support Enforcement for Former TANF Recipients

We will evaluate State child support enforcement efforts on behalf of those who are no longer eligible to receive cash assistance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires that States impose specific limits on the time that families may receive cash assistance under the TANF program. Child support enforcement is critical to the self-sufficiency of families who have recently left TANF or who are nearing their time limit for receiving benefits. Study of this topic was a high priority for the child support enforcement workgroup, the Federal Office of Child Support Enforcement, and analysts in the office of the Assistant Secretary for Planning and Evaluation.

OEI; 07-00-00400

Temporary Assistance for Children Only

We will examine temporary assistance for children only and report on trends in States' use of this category. Children-only cases include households in which the parent is not eligible for benefits or a child is living with another adult (most commonly a grandparent or another relative). Currently, there is limited understanding of these types of cases, and the Department is concerned that States may create children-only cases as a way of avoiding penalties for failure to meet time limit or work participation requirements. This study will complement the recent study by the Assistant Secretary for Planning and Evaluation entitled "Understanding the AFDC/TANF Child-Only Caseload: Policies, Composition, and Characteristics in Three States."

OEI; 00-00-00000

State Diversion Program

This review will examine how State welfare agencies divert potential welfare applicants from applying for TANF and whether diverted applicants receive necessary services. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires States to reduce their welfare case loads over several years. To keep families off the rolls, States have employed diversion strategies designed to provide short-term assistance and services to families in crisis who would otherwise enter the welfare rolls. We will determine whether

families who are dissuaded from applying for TANF are given information about other supplemental benefits for which they qualify.

OEI; 00-00-00000

Use of TANF Funds

This review will examine how States have used TANF funds and their strategies for using unobligated balances. Many States have considerable balances resulting from significant caseload decreases. We will determine if there are other major factors influencing unobligated balances. This review will assist ACF in responding to a recent Office of Management and Budget (OMB) request for information on the States' use of TANF funds.

OEI; 00-00-00000

CHILD CARE AND PROTECTION

Child Protective Service Effectiveness

We will determine whether State Child Protective Service referrals were properly prioritized and resolved and whether any service delays could result in further occurrences of child abuse and/or neglect. We will also examine recidivism rates and the extent of State outreach efforts to alert the community to the problem of child abuse. Recent studies requested by the Congress found that approximately 1 million American children are victims of abuse and neglect annually and that many of these children and their families fail to receive adequate protection and treatment.

OAS; W-00-99-20018; A-04-99-00130, -12-00-00004

State Administrator Perspectives on Technical Assistance: An Update

At ACF's request, we will determine the perceptions of State child care administrators on the impact and success of technical assistance provided through the Child Care Technical Assistance Network. Our prior study indicated that while State child care administrators were generally satisfied with most aspects of the assistance provided, the assistance focused on services furnished through a sole contract provided with Child Care and Development funds. In February 1998, ACF created the Child Care Technical Assistance Network, expanding

efforts through seven independent contracts. Our study will be used to improve technical assistance provided to States through the network.

OEI; 00-00-00000

CHILD SUPPORT

Implementing State Child Support Disbursement Units

Using self-reported data from the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands, this congressionally requested study will describe the status of States' implementation of child support disbursement units. We will also make an in-depth evaluation of six States' implementation efforts. Under Title IV of the Social Security Act, each State is required to establish a State disbursement unit, a single system for receiving, distributing, and disbursing child support payments.

OEI; 06-00-00040, -00041

Child Support Payment Distribution

This review will examine a State distribution process for child support payments. Indications are that computer glitches and several layers of contracting and subcontracting agencies have contributed to significant delays in providing child support payments to custodial parents. Having several agencies involved in administering the payment system also increases the potential for charging significant and unnecessary administrative costs to the Federal Government.

OAS; W-00-01-20005; A-04-01-00000

Interstate Case Collections

We will determine whether the collection of child support across State lines has been enhanced as a result of the Uniform Interstate Protocol. This new protocol is intended to improve States' ability to establish, enforce, or modify a support order or to determine parentage across State lines. About 30 percent of child support cases are interstate cases. Differing State programs and the lack of an effective procedure to collect interstate child support have raised barriers to increased collections for these cases. The historical problems in collecting child support across State lines make a review of this new protocol timely.

OEI; 00-00-00000

Expected Issue Date: FY 2002

State Use of Wage Withholding

We will examine how States use wage withholding as a tool for collecting child support and whether they use it to its full potential. We will also review practices and policies that appear to allow for optimum use of this tool. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 required that States establish the bureaucracy to monitor all child support payments and to implement universal wage withholding. Wage withholding has been described as one of the most effective tools for collecting child support payments.

OEI; 00-00-00000

Insurance Intercept Program

We will determine the adequacy of State procedures for identifying and intercepting insurance payments from parents with child support debts. In region I, two States recently implemented highly successful insurance intercept programs; one State established a first-in-the-Nation Internet site to enable insurers to quickly cross-check insurance payments before payment. We will determine which States have enacted and implemented insurance intercept legislation and identify best practices. We will also examine the program's effectiveness in interstate cases and, if appropriate, the potential for improving collections using a national database or website.

OAS; W-00-01-20005; A-01-01-00000

Collecting Child Support From Federal Employees

We will evaluate efforts by HHS and the Department of Justice to enforce collection of child support from their respective agency employees. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 required all Federal agencies to provide information to the National Directory of New Hires to help States locate noncustodial parents employed by the Federal Government. Federal agencies must also cooperate with child support enforcement efforts and comply with wage withholding orders submitted by States. This review is part of a President's Council on Integrity and Efficiency Roundtable project.

OEI; 05-00-00300

State Use of State and National Directories of New Hires

We will determine whether States use the information provided through their State Directory of New Hires and the National Directory of New Hires to its fullest potential. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 mandated that each State

create an automated Directory of New Hires and report the data collected by the State system to the National Directory of New Hires. These automated systems were intended to assist States in establishing and enforcing child support orders. If the data from the directories are accurate and if States use the data effectively and timely, collection rates should improve. The Office of Child Support Enforcement anticipates that between 1997 and 2007, new hire reporting will bring in over \$6.4 billion in child support and that the numbers for paternity establishment and support orders will increase because of the availability of this information.

OEI; 00-00-00000

Penalties for Failure to Report New Hires

We will determine whether employers' compliance with requirements to report new hires increases as States impose stronger penalties for noncompliance. To improve child support collections, Federal law required all States to have a new-hire directory in place by October 1, 1997. States have chosen to impose various penalties for employers that fail to report new hires to the State directory. While Federal law requires a penalty of \$25 per unreported employee, with a maximum of \$500, one State holds employers in contempt and responsible for lost child support when they fail to report their new employees.

OAS; W-00-01-20005; A-01-01-00000

Expected Issue Date: FY 2002

Customer Access to Child Support Enforcement Agencies

We will examine State efforts to provide customers with access to child support enforcement information and services. These customers primarily include custodial parents, noncustodial parents, employers, and other State and local agencies. With the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, States were tasked to implement many new initiatives to enhance the enforcement and collection of child support payments. The new initiatives made customer access an even more necessary ingredient for ensuring efficient child support services. We have encountered anecdotal evidence that customer access is problematic. Systematic research will allow us to determine if problems exist, the breadth and depth of such problems, and their causes.

OEI; 06-00-00460

Support Programs for Noncustodial Parents

This review will assess State and local programs that provide group support, training, and incentives for unemployed and underemployed noncustodial parents and the programs' impact

on preventing or reducing child support arrearages. Effective programs could benefit custodial parents and States by increasing child support collections and decreasing enforcement costs.

OAS; W-00-01-20005; A-03-01-00000

Expected Issue Date: FY 2002

State Child Support Fees

We will review State practices and procedures relating to the waiver, implementation, use, and reporting of child support enforcement fees. States may impose these fees on custodial or noncustodial parents who are not TANF recipients to cover processing costs, such as locator services and court fees. Custodial and noncustodial parents have expressed complaints about the fees imposed by States.

OAS; W-00-01-20005; A-07-01-00000

Privatization of State IV-D Agency Services

This review will evaluate the adequacy of State agency controls and procedures for selecting and monitoring contractors that provide collection and payment processing services. We will determine whether States use performance-based contracts, conduct background checks, and examine contractor records to ensure effectiveness and minimize potential fraud and abuse. We will also review a sample of contractors. States are increasingly privatizing services once performed by State/county workers.

OAS; W-00-01-20005; A-03-01-00000

State Controls to Ensure Integrity of IV-D Personnel

We will evaluate State processes and screens used to ensure that State IV-D personnel are not delinquent in their payment of child support and do not perform duties that would constitute a conflict of interest. In the past, there have been allegations that State officials protected themselves from child support enforcement efforts or helped others avoid paying child support.

OAS; W-00-01-20005; A-12-01-00000

State Child Support Case Closure Activities

We will describe State case closure activities, highlighting successful strategies and exploring any challenges or vulnerabilities. Since 1989, Federal regulations have required that State child support agencies have a system for closing old and duplicate cases and cases lacking enough information to proceed. In March 1999, the Office of Child Support Enforcement

issued revised Federal regulations intended to balance the concern for ensuring “that all children receive the [child support] help they need” with the administrative concerns that State case loads include “only those cases in which there is adequate information or likelihood of successfully providing services.” Given the present incentive payment system, some advocates fear that States have such a strong financial incentive to close cases that some workable cases may be closed improperly, denying needed services to families.

OEI; 06-00-00470

INVESTIGATIONS

Child Support Enforcement Task Force Model

The OIG’s Office of Investigations and the Office of Child Support Enforcement developed a task force model that is being implemented in Columbus, Ohio; Baltimore, Maryland; Dallas, Texas; New York, New York; and Sacramento, California. It calls for the Office of Investigations, Federal Bureau of Investigations, U.S. Marshals, U.S. Attorney Offices, local law enforcement, local prosecutors, State child support agencies, and other interested parties in 20 States to join forces in creating a coordinated effort to identify, investigate, and prosecute criminal nonsupport cases. The task forces investigate intrastate as well as interstate cases, making the involvement of local law enforcement and prosecutors critical.

FOSTER CARE

Foster Care Eligibility Determinations

We will identify any barriers to effective implementation of the Title IV-E foster care eligibility determination process. States are legally obligated to serve all children in need of out-of-home placement and care. Under the 1996 TANF program, States are allowed to set their own standards for determining eligibility for public assistance. Potential barriers to effectively implementing Title IV-E foster care eligibility determination standards may include caseworkers’ lack of knowledge regarding the standards and inefficient or ill-defined procedures for making the determinations.

OEI; 00-00-00000

Child Abuse and Neglect in Foster Care

The objectives of this review will be to evaluate States' efforts in (1) ensuring consistent application of criteria when identifying and investigating abuse and neglect of children in foster care, (2) conducting central State registry background checks on all persons having contact with children in foster care, (3) maintaining and sharing information from the child abuse and neglect central registry, and (4) encouraging child-placing agencies to exchange information on abusive foster and adoptive parents who move from one agency to another.

OAS; W-00-01-20008; A-06-01-00000

Expected Issue Date: FY 2002

Foster Care Children's Access to Medicaid

We will examine foster care children's access to Medicaid services. Most of the more than 600,000 foster care children have Medicaid coverage that would guarantee them availability to Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) Program services. A GAO report, "Foster Care: Health Needs of Many Young Children Are Unknown and Unmet," estimated that 12 percent of foster care children received no routine health care, 34 percent received no immunizations, and only 1 percent received any EPSDT services in the three sites reviewed. This EPSDT rate is considerably lower than the rate that we found in an evaluation of Medicaid managed care. This study will provide a comprehensive view of health care services available to foster children covered by Medicaid.

OEI; 02-00-00360

Recruitment of Family Foster Care Providers

We will identify any barriers that States encounter in their recruitment of family foster care providers. The Social Security Act requires that States "provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed." However, Federal regulations do not define "diligent recruitment" efforts, leaving interpretation of this requirement to the States. The number of children in foster care almost doubled between the mid-1980's and 1998. This study will offer States information on model efforts found successful in reducing barriers to recruitment of family foster care providers.

OEI; 00-00-00000

Use of Federal Parent Locator System

We will examine best practices in child welfare agencies' use of the Federal Parent Locator System and determine whether any barriers impede the effective use of this system. Under the Adoption and Safe Families Act of 1997, child welfare agencies may request information from the system to locate the parents of a child or to expedite the termination of parental rights in order to plan permanent placement of a foster child. This study will offer information on the extent that the system is used and to what effect.

OEI; 00-00-00000

Licensing and Oversight of Group Homes

We will determine whether one State has properly implemented its revised licensing and oversight requirements for in-State and out-of-State foster care group homes. These requirements include stringent provisions on comprehensive group home evaluation visits, qualifications of group home administrators, standardized training and continuing education of facility managers and child care workers, visits to group homes by social workers and probation officers, controls over the placement of foster children in out-of-State facilities, and numerous other licensing and oversight requirements.

OAS; W-00-01-20008; A-09-01-00000

Expected Issue Date: FY 2002

Therapeutic Foster Care Per Diem Rates

We will evaluate the criteria used to determine whether therapeutic foster care is needed and whether the need for continued care at that level is adequately supported. Children who are considered to be emotionally disturbed and who cannot be properly cared for in regular foster care homes are placed in therapeutic foster care homes. Because these children require intensive monitoring and counseling, their per diem rates are considerably higher than rates for regular foster care. Our survey work in one State indicates that many children remained in therapeutic foster care homes after they no longer needed intense monitoring and counseling.

OAS; W-00-01-20008; A-05-01-00000

Expected Issue Date: FY 2002

State Foster Care Contracts With Local Agencies

We will review State foster care contracts with local child placement agencies. A consultant advised one State that 75 percent of the students receiving advice from a school counselor were foster care candidates. The State proposed amendments to its service and cost allocation plans, charged these school-based case management costs to the Title IV-E foster care

program, and increased its quarterly claim for administrative costs by \$6.5 million. The ACF regional office has deferred payment of the claim. We will determine the extent to which States claim such costs, whether the target populations are foster care candidates as defined by ACF, who determines whether clients are candidates for foster care, the rationale for the 75 percent factor, and whether the amounts charged by States represent costs for allowable services.

OAS; W-00-01-20008; A-07-01-00000

Expected Issue Date: FY 2002

Administrative Costs Billed by Child Placement Agencies

We will determine whether child placement agencies improperly billed for administrative costs when filing maintenance payment claims for Federal reimbursement. By statute, foster care maintenance payments cover a child's basic needs, such as food, clothing, shelter, and personal incidentals, but not administrative costs. Also, according to ACF policy, costs borne by child placement agencies are not eligible for Federal funding. During a review in one State, we found that these agencies had been reimbursed for maintenance payments that included administrative costs. We will review the State's procedures for reimbursing child placement agencies for maintenance payments and determine the extent of administrative costs paid.

OAS; W-00-01-20008; A-01-01-00000

HEAD START

Enrollment Claimed by Head Start Grantees

This review will determine whether Head Start grantees (1) generally met their budgeted enrollment within a reasonable time frame after the school year began and (2) reported to ACF, in a timely fashion, any excess funds due to underenrollment that could be allocated to other programs with greater need. We have indications from our past work that some grantees misrepresented actual enrollment of children to obtain maximum Federal funding for their programs.

OAS; W-00-01-20009; A-12-01-00000

Expected Issue Date: FY 2002

Blended Funding

We will determine whether combining several separate funding sources into one general-purpose fund (blended funding) resulted in Head Start grantees' charging a disproportionate share of costs to the Federal Government. The OMB Circular A-122 requires that costs be allocated in accordance with relative benefits received. Our recent review identified a serious

deficiency in one grantee's cost allocation system in which costs were inequitably charged to the Federal Government rather than allocated to other benefitting nonfederal programs. We will attempt to determine which practices and components of a cost allocation plan lead to an acceptable system for blended funding.

OAS; W-00-01-20009; A-09-01-00000

Matching Contributions

We will review the matching contributions (cash or in-kind) reported by Head Start grantees. Grantees are generally required to provide 20 percent of total program costs. The matching share must be from nonfederal sources, must be program related, and may be in the form of cash or in-kind contributions. Our recent work indicated that the value of matching contributions could be inflated or unreasonable or could represent unallowable costs. We will also determine, if possible, the effects of TANF work requirements--and the possible resulting loss of volunteers--on grantees' ability to meet their projected in-kind contributions.

OAS; W-00-01-20009; A-07-01-00000

Construction and Renovation of Head Start Facilities

We will determine whether ACF's review and approval of the purchase and renovation of Head Start facilities were adequately planned, supported, and in compliance with requirements. We will also determine whether all necessary documents to protect the Government's interest were obtained, including purchase agreements, deeds of trust, and proofs of insurance. This work will expand on our earlier review, requested by ACF, in which we found that grants were awarded to buy property without the necessary information, such as appraisals and building inspection reports. In addition, restrictions imposed by supplemental funding sources (funds other than Head Start funds) were not considered to ensure that awards did not conflict with Head Start requirements.

OAS; W-00-00-20009; A-09-00-00061

OTHER ISSUES

Critical Infrastructure Protection

We will evaluate ACF's efforts to safeguard its critical infrastructure. Presidential Decision Directive (PDD) 63, "Critical Infrastructure Protection," issued in May 1998, calls for a

national effort to ensure the security of the increasingly vulnerable and interconnected physical and cyber-based infrastructures. Our review is part of the HHS-wide PDD 63 initiative.

OAS; W-00-00-40001; A-12-00-00005

Safeguarding Persons With Disabilities

This review will determine State procedures to identify, investigate, and resolve reports of abuse of persons with disabilities. We will determine the information that appropriate State and Federal agencies and protection and advocacy groups are collecting and whether the Department can use this information to evaluate the effectiveness of federally funded programs for the disabled.

OAS; W-00-99-20002; A-01-00-02502

Social Services and Targeted Refugee Assistance Programs

We will evaluate State administration and operation of the social services and targeted assistance programs for refugees. Prior reviews have shown deficiencies relating to States' contracting for employment services, oversight of contractors, and use of funds.

OAS; W-00-01-20017; A-04-01-00000

Verification of Immigrant Status and Citizenship

We will review implementation of immigration and citizenship verification procedures required by 1996 welfare reform legislation. The statute restricts access to Federal public benefits, including child welfare, TANF, Medicaid, and Developmental Disabilities, to certain qualified aliens. Qualified aliens include legal permanent residents, asylees, and refugees and exclude undocumented aliens and aliens admitted on a temporary basis for work, study, or pleasure. This review will determine (1) provider and recipient awareness of eligibility criteria, (2) the nature and extent of verification procedures, and (3) the impact of verification procedures on providers and applicants. Information from this review will be of interest to the HHS work group on immigration.

OEI; 00-00-00000

Office of Refugee Resettlement Grant Administration

We will review the effectiveness of Office of Refugee Resettlement practices and procedures for selecting, monitoring, and closing out discretionary grants. Recent audits of other ACF

programs showed significant problems with grantee performance. We will determine if grant and program officials take steps to weed out problem grantees and if assistance is provided to high-risk grantees.

OAS; W-00-01-20002; A-12-01-00000

Data Used to Support Performance Measures

We will examine ACF's use of State-supplied data for performance measurement in one or more major programs, including TANF. In passing the Government Performance and Results Act, the Congress emphasized that the usefulness of agency performance reports was largely dependent on congressional confidence in the reported data. We will determine whether ACF takes adequate steps to screen State data for reliability and whether selected States have adequate controls in place to ensure that their data are reliable and valid.

OAS; W-00-01-20002; A-07-01-00000

Expected Issue Date: FY 2002

State Agency Child Welfare Information System

We will conduct a joint programmatic and fiscal review of the State Agency Child Welfare Information System. This HHS-financed computer system (75 percent matching for implementation) is designed to allow child welfare workers on-line access to other State human service and health programs, such as TANF, child support, and Medicaid. The system is intended to help with case management, thus allowing child welfare workers more time for supporting the needs of children and their families. By FY 2003, Federal and State costs for the system will total about \$1.6 billion. We will address the reliability of the data, the effectiveness and impact of the system, and the appropriateness of costs charged.

OAS; W-00-00-20002; A-02-99-02008
OEI; 00-00-00000

Contract Administration

This followup review will determine the adequacy of steps taken by ACF to improve its contract administration. Prior reviews identified problems in the solicitation, award, monitoring, and closeout of contracts. Particular attention will be given to consultant services contracts.

OAS; W-00-01-20002; A-12-01-00000

Expected Issue Date: FY 2002

Audit Resolution Process

This review will follow up on ACF's efforts to reduce its backlog of unresolved audit findings. We will identify the reasons for and impact of untimely resolution. A prior review disclosed that program officials had given little attention to audit resolution.

OAS; W-00-01-20003; A-12-01-00000

Expected Issue Date: FY 2002

ADMINISTRATION ON AGING

Critical Infrastructure Protection

We will evaluate the Administration on Aging's (AoA) efforts to safeguard its critical infrastructure. Presidential Decision Directive (PDD) 63, "Critical Infrastructure Protection," issued in May 1998, calls for a national effort to ensure the security of the increasingly vulnerable and interconnected physical and cyber-based infrastructures. Our review is part of the HHS-wide PDD 63 initiative.

OAS; W-00-00-40001; A-12-00-00007

Funding the Aging Network

We will describe the response of State units on aging and area agencies on aging to a static funding level under the Older Americans Act and the effect on services to older Americans. The AoA funding to the aging agency network has remained essentially unchanged at about \$850 million for most of the 1990's. In response to level funding and an increased demand for services, State units on aging have sought funding from other Federal sources. We will determine how the additional funding sources have changed the service package offered to the traditional AoA population.

OEI; 00-00-00000

Supportive Services

In selected States, we will determine whether (1) AoA's supportive service programs duplicate other HHS programs, specifically Medicaid and Medicare, and (2) barriers continue to impede opportunities for expanding services. The AoA's supportive services, designed to enable older Americans to remain in their homes and communities, include transportation, in-home, community, and care giver support services. In FY 2000, about \$310 million is available

nationwide to fund these services; for FY 2001, HHS requested \$450 million, of which \$125 million is for services to support family care givers of older persons.

OAS; W-00-01-20001; A-12-01-00000

Followup on Long-Term-Care Ombudsman Program

This followup review will examine the capacity of the long-term-care ombudsman program and report on trends in complaint data from the National Ombudsman Reporting System. In March 1999, we reported that the capacity of the ombudsman program to monitor and ensure quality of care in nursing homes was limited. We also found that ombudsman complaints were steadily increasing, including complaints about serious quality-of-care problems. We will examine changes in the process since our earlier reports.

OEI; 00-00-00000

Data Used to Support Performance Measures

This review will examine AoA's use of State-supplied data for performance measurement. We will determine whether AoA takes adequate steps to screen State data for reliability and whether selected States have adequate controls in place to ensure that data are reliable and valid. In passing the Government Performance and Results Act, the Congress emphasized that the usefulness of agency performance reports was largely dependent on congressional confidence in the reported data. In response to concerns expressed by the House Appropriations Committee, AoA is developing and field-testing new performance outcome measures for the aging network

OAS; W-00-01-20001; A-12-01-00000

Department of Health and Human Services

Office of Inspector General Projects



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FINANCIAL STATEMENT AUDITS

The Government Management Reform Act of 1994 seeks to ensure that Federal managers have at their disposal the financial information and flexibility necessary to make sound policy decisions and manage scarce resources. This act broadened the Chief Financial Officers (CFO) Act of 1990 by requiring annual audited financial statements for *all* accounts and associated activities of the Department of Health and Human Services (HHS) and other Federal agencies. The audited FY 2000 consolidated HHS financial statements are due to the Office of Management and Budget (OMB) by March 1, 2001.

Audits of FY 2000 Financial Statements

The following audits of FY 2000 financial statements will be completed and reports issued during FY 2001:

Health Care Financing Administration

OAS; W-00-00-40008; A-17-00-02001

Administration for Children and Families

OAS; W-00-00-40010; A-17-00-00001

Health Resources and Services Administration

OAS; W-00-00-40013; A-17-00-00003

Indian Health Service

OAS; W-00-00-40013; A-17-00-00004

National Institutes of Health (NIH)

OAS; W-00-00-40013; A-17-00-00007

Centers for Disease Control and Prevention

OAS; W-00-00-40013; A-17-00-00008

Food and Drug Administration

OAS; W-00-00-40013; A-17-00-00006

Substance Abuse and Mental Health Services Administration

OAS; W-00-00-40013; A-17-00-00002

Program Support Center

OAS; W-00-00-40003; A-17-00-00005

Administration on Aging

OAS; W-00-00-40010; A-17-00-00019

Consolidated HHS Financial Statements

OAS; W-00-00-40009; A-17-00-00014

FY 2000 Statement on Accounting Standards (SAS) 70 Examinations

The following SAS 70 examinations of HHS service organizations will support FY 2000 financial statement audits:

Center for Information Technology (NIH Computer Center)

OAS; W-00-00-40012; A-17-00-00010

Program Support Center - Major Administrative Support Services:

Payment Management System

OAS; W-00-00-40012; A-17-00-00011

Accounting Operations - Division of Financial Operations

OAS; W-00-00-40012; A-17-00-00009

Payroll Operations

OAS; W-00-00-40012; A-17-00-00012

FY 2000 Financial-Related Reviews

Federal Agencies' Centralized Trial Balance System (FACTS) Verification

OAS; W-00-00-40012; A-17-00-00013

Office of Personnel Management Agreed-Upon Procedures

OAS; W-00-00-40012; A-17-00-00015

Payment Management System Agreed-Upon Procedures

OAS; W-00-00-40012; A-17-00-00016

Audits of FY 2001 Financial Statements

Work is expected to begin in FY 2001 on the following audits of FY 2001 financial statements:

Health Care Financing Administration

OAS; W-00-01-40008

Expected Issue Date: FY 2002

Administration for Children and Families

OAS; W-00-01-40010

Expected Issue Date: FY 2002

Health Resources and Services Administration

OAS; W-00-01-40013

Expected Issue Date: FY 2002

Indian Health Service

OAS; W-00-01-40013

Expected Issue Date: FY 2002

National Institutes of Health

OAS; W-00-01-40013

Expected Issue Date: FY 2002

Centers for Disease Control and Prevention

OAS; W-00-01-40013

Expected Issue Date: FY 2002

Food and Drug Administration

OAS; W-00-01-40013

Expected Issue Date: FY 2002

Substance Abuse and Mental Health Services Administration

OAS; W-00-01-40013

Expected Issue Date: FY 2002

Program Support Center

OAS; W-00-01-40003

Expected Issue Date: FY 2002

Administration on Aging

OAS; W-00-01-40010

Expected Issue Date: FY 2002

Consolidated HHS Financial Statements

OAS; W-00-01-40009

Expected Issue Date: FY 2002

FY 2001 SAS 70 Examinations

The following SAS 70 examinations of HHS service organizations will support FY 2001 financial statement audits:

Center for Information Technology (NIH Computer Center)

OAS; W-00-01-40012

Expected Issue Date: FY 2002

Program Support Center - Major Administrative Support Services:

Payment Management System

OAS; W-00-01-40012

Expected Issue Date: FY 2002

Accounting Operations - Division of Financial Operations

OAS; W-00-01-40012

Expected Issue Date: FY 2002

Payroll Operations

OAS; W-00-01-40012

Expected Issue Date: FY 2002

PROGRAM INTEGRITY AND EFFICIENCY

Compliance With Presidential Decision Directive 63

As part of an initiative by the President's Council on Integrity and Efficiency to review the establishment and implementation of critical infrastructure protection plans at Federal agencies, we will oversee the Department's efforts in complying with Presidential Decision Directive (PDD) 63. Issued in May 1998, PDD 63 requires all Federal agencies to assess the risk and vulnerability of their mission-essential infrastructure to combat cyberterrorism. The

HHS is in the midst of complying with this directive by identifying all mission-essential infrastructures and determining their level of criticality.

Our initial efforts will focus on the operating divisions until Departmentwide plans are formalized to include business partners of key mission-essential infrastructures. We will assess the process for identifying mission-essential infrastructures and test the underlying system controls and the effectiveness of the processes intended to ensure data availability, integrity, and confidentiality and to reduce the risk of errors, fraud, and security infractions. Our work at the individual operating divisions is noted, where applicable, in the preceding chapters.

OAS; W-00-00-40001; A-17-00-30030

Annual Accounting of Drug Control Funds

We will determine whether HHS agencies are in compliance with the Office of National Drug Control Policy (ONDCP) requirements for annual accounting of drug control funds. Each year, agencies that participate in the National Drug Control Program are required to submit to ONDCP a detailed accounting of all prior-year drug control funds, along with an accompanying OIG “authentication.” We will make this authentication to express a conclusion on the reliability of the HHS assertions regarding its FY 2000 drug control funds, estimated at \$3.1 billion.

OAS; W-00-01-50019; A-15-01-00000

High-Risk Grantees

The OIG and the office of the Assistant Secretary for Management and Budget will conduct joint on-site reviews of certain ACF and PHS grantees on the Department’s high-risk list. Because of concerns that audits conducted under Office of Management and Budget (OMB) Circular A-133 may not be adequately disclosing problems at grantees, the reviews will address grantee financial management practices and controls. We will determine whether additional grantee audits or reviews of the effectiveness of HHS agencies’ grant administration are warranted.

OAS; W-00-01-20011 & -50019; A-12-01-00000, -15-01-00000

State Use of Self-Insurance Refunds

We will determine whether self-insurance refunds provided by a State to participating agencies were properly credited to the Federal Government. 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 OMB Circular A-87 cost principles for State and local governments preclude excess charges to Federal programs. Our previous review disclosed that the State had accumulated excess reserves in its self-insurance funds as of June 30, 1996. In an attempt to reduce the excess amounts, the State refunded approximately \$4 million to participating State agencies.

OAS; W-00-01-20011; A-04-01-00000

Expected Issue Date: FY 2002

State Cost Allocation Plan

We will examine the equitableness of a State's allocation of costs to Federal programs. The State Auditor General has cited significant inequities in the State's cost allocation plan, including \$2.6 million that was overcharged to the Federal Government because of improper allocation methods or other errors.

OAS; W-00-01-20011; A-04-01-00000

Escheated Warrants

We will determine whether States with a large percentage of escheated warrants (uncashed and unclaimed checks) are promptly crediting the Federal programs for the warrants. Federal regulations require that States refund the Federal portion of escheated warrants. Previous reviews found that States did not always timely or properly report the warrants.

OAS; W-00-00-20011; Various CINs

State Pensions

These reviews will determine whether the Federal Government received equitable benefit when surplus State pension funds were withdrawn, transferred to other State funds, or used to cover State expenses. Previous reviews disclosed significant problems with pension plan costs charged to Federal programs.

OAS; W-00-00-20011; A-02-00-02000

Preadward and Postaward Contract Audits

The Department awards contracts and contract modifications in excess of \$5 billion annually. Selection of the type of audits to be performed (preaward or postaward) is based on risk analyses and other factors developed by the Department's operating divisions, specifically the Contract Audit Users Group, and is 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 conducted for each of the Department's operating divisions.

To ensure maximum return on OIG resources devoted to contract audit work, we will (1) use streamlined, cost-saving audit techniques in conducting preaward audits, (2) rely to the maximum extent possible on nonfederal audits, and (3) focus the collaborative risk-based selection process on those audits that will result in savings to the Department.

OAS; W-00-01-50009 & -50011; Various CINs

Nonfederal Audits

Under OMB Circular A-133, State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards are required to have an annual organizationwide audit of all Federal money they receive. We will continue to review the quality of these audits by nonfederal auditors, such as public accounting firms and State auditors, in accordance with the circular. The objectives of our reviews are to ensure that the audits and reports meet applicable standards, identify any followup work needed, and identify issues that may require management attention.

We also provide up-front technical assistance to nonfederal auditors to ensure that they understand Federal audit requirements and to promote effective audit work. In addition, we 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.